TRUST BOARD MEETING IN PUBLIC
AGENDA

07 September 2017 at 09.30am – 12.00noon

Postgraduate Medical Centre, St Albans City 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
01/51	**Opening and welcome**	To note	N/A	Chair	Verbal
02/51	**Patient experience presentation**	To receive	N/A	Chief Nurse	Presentation
OPENING					
03/51	**Apologies for absence** Ginny Edwards	To note	N/A	Chair	Verbal
04/51	**Conflicts of interests**	To note	N/A	Chair	Paper
05/51	**Minutes of the meeting held on 06 July 2017**	For approval	N/A	Chair	Paper
06/51	**Board action log from 06 July 2017 and previous meetings and decision log**	To note	N/A	Chair	Paper
07/51	**Chair's report**	To note	N/A	Chair	Paper
08/51	**Chief Executive's report**	To note	N/A	Chief Executive	Paper
PERFORMANCE					
09/51	**Integrated performance report – month 4**	For discussion	Trust Executive Committee	Chief Operating Officer	Paper
10/51	**NHS England's emergency preparedness, resilience and response annual assurance**	For approval	Safety and Compliance Committee	Chief Operating Officer	Paper
PROVIDE SAFE EFFECTIVE CARE (BAF RISK 1)					
11/51	**Quality improvement plan update – month 5**	For information and assurance	Trust Executive Committee	Chief Nurse	Paper
12/51	**End of life care annual report 2016/17**	For information and assurance	Clinical Outcomes and Effectiveness Committee	Chief Nurse	Paper

13/51	**Infection prevention and control annual report 2016/17**	For information and assurance/ Approval	Clinical Outcomes and Effectiveness Committee	Chief Nurse	Paper
14/51	**Biannual establishment review – adult inpatient wards**	For information and assurance	Safety and Compliance Committee	Chief Nurse	Paper
15/51	**Safeguarding annual report 2016/17**	For information and assurance	Safety and Compliance Committee	Chief Nurse	Paper
RETAIN AND ENGAGE WORKFORCE (BAF RISK 2)					
16/51	**Report on medical revalidation 2016/17**	For information and assurance	Patient and Staff Experience Committee	Medical Director	Paper
17/51	**Annual public sector equality duty report 2016/17**	For approval	Patient and Staff Experience Committee	Director of Human Resources	Paper
DELIVER A LONG TERM STRATEGY (BAF 9)					
18/51	**Strategy update – month 5**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
19/51	**Bi-monthly corporate risk register update**	For information	Safety and Compliance Committee	Deputy Chief Executive	Paper
COMMITTEE REPORTS					
20/51	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
21/51	**Assurance report from Audit Committee** **a) Annual report from Audit Committee**	For information and assurance	Audit Committee	Committee Chair/Chief Financial Officer	Paper
22/51	**Assurance report from Clinical Outcomes and Effectiveness Committee**	For information and assurance	Clinical Outcomes and Effective Committee	Committee Chair/ Chief Nurse	Paper
23/51	**Assurance report from Safety and Compliance Committee**	For information and assurance	Safety and Compliance Committee	Committee Chair/Chief Nurse	Paper
24/51	**Assurance report from Patient and Staff Experience Committee**	For information and assurance	Patient and Staff Experience Committee	Committee Chair/Director of Human Resources and Organisational Development	Paper
ANY OTHER BUSINESS					
25/51	**Any other business previously notified to the Chairman**	N/A	N/A	Chair	Verbal

QUESTION TIME					
26/51	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
27/51	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
28/51	**Draft agenda for next board meeting**	To approve	N/A	Chair	Paper
29/51	**Date of the next board meeting in public:** 05 October 2017, Terrace Executive Meeting Room, Watford Hospital	To note	N/A	Chair	Verbal

West Hertfordshire Hospitals NHS
NHS Trust

Acronyms and abbreviations

A

AAA Abdominal Aortic Aneurysm
AAU Acute Admissions Unit
A&E Accident and Emergency
ABPI Association of the British Pharmaceutical Industry
AC Audit Commission
ACS Adult Care Services
ADM Assistant Divisional Manger
AGS Annual Governance Statement
AHP Allied Health Professional

B

BAF Board Assurance Framework
BAMM British Association of Medical Managers
BAU Business as usual
BC Business Continuity
BCP Business Continuity Plan
BGAF Board Governance Assurance Framework
B&H Bullying and Harassment
BISE Business Integrated Standards Executive
BMA British Medical Association
BME Black and ethnic minorities
BSI Bloodstream infection

C

CAB/C&B Choose and Book
Caldicott Guardian The named officer responsible for delivering and implementing the Confidentiality and patient information systems
CAMHS Child and adolescent mental health services
CAS Central Alert System
CCG Clinical Commissioning Groups
CCIO Chief Clinical Information Officer
CCORT Clinical Care Outreach Team
CCU Critical Care Unit
CD Clinical Director
C.Diff Clostridium Difficile
CEO Chief Executive Officer
CfH/CFH Connecting for Health
CFO Chief Financial Officer
CHD Coronary heart disease
CIO Chief Information Officer
CIP Cost improvement programme
CIS Care Information Systems
CMO Chief Medical Officer
CNO Chief Nursing Officer
CNS Clinical Nurse Specialist
CNST Clinical Negligence Scheme for Trusts
COI Central Office of Information
COO Chief Operating Officer
COPD Chronic Obstructive Pulmonary Disease
COSHH Control of Substances Hazardous to Health
CPA Clinical Pathology Accreditation
CPD Continuing Professional Development

CPOP Clinical Policy and Operations
CFPG Capital Finance Planning Group
CPR Cardiopulmonary resuscitation
CQC Care Quality Commission
CQUIN Commissioning for Quality & Innovation
CRS Care Records Service
CSE Child sexual exploitation
CSSD Central Sterile Service Department
CSU Clinical Support Unit
CT Computerised Tomography

D

DCC Direct Clinical Care
DD Divisional Director
DGH District General Hospital
DGM Divisional General Manager
DM Divisional Manager
DIPC Director of Infection Prevention and Control
DH or DoH Department of Health
DNA Did Not Attend
DNR Do Not Resuscitate
DO Developing our Organisation
DoC Duty of Candor
DoLS Deprivation of Liberty Safeguards
DPH Director of Public Health
DQ Data Quality
DTA Decision to admit
DTOC Delayed Transfers of Care
DQ Data Quality

E

EA Executive Assistant
EADU Emergency Assessment and Discharge Unit
ECG Echocardiogram
ECIP Emergency Care Improvement Programme
ED Emergency Department
ED Executive Director
EDD Expected Date of Discharge
EDS Equality Delivery System
EIA Equality Impact Assessment
ENHT East & North Herts NHS Trust
ENT ear, nose and throat
EoE East of England
EoL End of Life
EPAU Early Pregnancy Assessment Unit
EPRR Emergency Preparedness, Resilience and Response
ERAS Enhanced Recovery Programme after Surgery
ESR Electronic Staff Record
EWTD European Working-Time Directive

F

FBC	Full Blood Count
FBC	Full Business Case
FCE	Finished Consultant Episode
FFT	Friends and Family Test
FD	Finance Director
FGM	Female genital mutilation
FOI	Freedom of Information
FRR	Financial Risk Rating
FSA	Food Standards Agency
FT	Foundation Trust
FY	Full Year

G

GDC	General Dental Council
GGI	Good Governance Institute
GMC	General Medical Council
GP	General Practitioner
GUM	Genito-urinary medicine
GOO	General other outcome

H

H&S	Health and Safety
HAI	Hospital Acquired Infection
HAPU	Hospital Acquired Pressure Ulcer
HCAI	Healthcare-Associated Infections
HCC	Hertfordshire County Council
HCT	Hertfordshire Community NHS Trust
HDA	Health Development Agency
HDD	Historical Due Diligence
HDU	High Dependency Unit
HEE	Health Education England
HHH	Hemel Hempstead Hospital
HES	Hospital Episode Statistics
HIA	Health Impact Assessment
HITP	Hertfordshire Integrated Transport Partnership
HON	Head of Nursing
HPA	Health Protection Agency
HPFT	Hertfordshire Partnership NHS Foundation Trust
HR	Human Resources
HRG	Health Related Group
HSC	Health Service Circular; (House of Commons) Health Select Committee
HSC	Health Scrutiny Committee, sub-committee of Overview and Scrutiny Committee, Hertfordshire County Council
HSE	Health and Safety Executive
HSMR	Hospital Standardised Mortality Ratio (Rates)
HSO	Health Service Ombudsman
HTM 00	Health Technical Memorandum
HUC	Herts Urgent Care
HVCCG	Herts Valley Clinical Commissioning Group

I

IBP	Integrated Business Plan
IC	Information Commissioner
ICAS	Independent Complaints Advocacy Service
ICNs	Infection Control Nurses
ICO	Information Commissioners Office
ICT	Information, Communications and Technology
IDT	Integrated Discharge Team
IVF	In Vitro Fertilisation
ICU	Intensive Care Unit
IDVA	Independent domestic violence advisors
IG	Information Governance
IMAS	Interim Management Service
IM&T	Information Management and Technology
IP	Inpatient
IPR	Integrated Performance Report
IRGC	Integrated Risk and Governance Committee
ISE	Integrated Standards Executive
IST	Intensive Support Team
IT	Information Technology
ITFF	Independent trust financial facility
ITU	Intensive Treatment Unit

J

JSNA	Joint Strategic Needs Assessment

K

KLOE	Key Line of Enquiry
KPI	Key Performance Indicator

L

LAs	Local authorities
LABV	Local Asset Backed Vehicle
LAT	Local Area Team (of NHS England)
LCFS	Local Counter Fraud Service
L&D	Learning and Development
LDB	Local delivery board
LGBT	Lesbian Gay Bisexual and Transgender
LHCAI	Local Health Care Associated Infections
LHRP	Local Health Resilience Partnerships
LMC	Local Medical Committee
LSMS	Local Security Management Specialist
LSP	Local Service Provider
LTFM	Long Term Financial Model

M

MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Agency
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning Score
MHAC	Mental Health Act Commission
MHRA	Medicines and Healthcare Products Regulatory Agency
MIU	Minor Injuries Unit
MMC	Modernising Medical Careers
MMR	Measles, mumps, rubella
MRET	Marginal rate emergency tariff
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus

N

NE	Never Event
NED	Non Executive Director
NHS	National Health Service
NHS CFH	NHS Connecting for Health
NHSE	NHS England
NHSLA	NHS Litigation Authority
NHSTDA	NHS Trust Development Agency
NHSP	NHS Professionals
NHSP	Newborn Hearing Screening Programme
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
#NoF	Fractured Neck of Femur
NPSA	National Patient Safety Agency
NSF	National Service Framework
NTDA	NHS Trust Development Agency

O

OBC	Outline Business Case
OD	Organisational Development
OJEU	Official Journal of the European Union
OLM	Oracle Learning Management
OMG	Operational Management Group
ONS	Office for National Statistics
OOH	Out of Hours Service
OP	Outpatient
OSC	(local authority) Overview and Scrutiny Committee
OT	Occupational Therapist/Therapy

P

PA	Programmed Activities
PAC	Public Accounts Committee
PACS	Picture Archiving and Communications System
PALS	Patient Advice and Liaison Service
PAM	Premises Assurance Model
PAS	Patient Administration System
PAS 5748	Publicly Available Specification 5748 - provides a framework for the planning, application and measurement of cleanliness in hospitals
PbR	Payment by Results
PCC	Primary Care Centre
PCT	Primary Care trust
PEG	Patient Experience Group
PFI	Private Finance Initiative
PHO	Public Health Observatory
PID	Project Initiation Document
PLACE	Patient Led Assessment of the Care Environment
PMO	Programme Management Office
PMR	Provider Management Regime
PPI	Proton Pump Inhibitors
PPI	Patient and Public Involvement
PR	Public Relations
PSED	Public Sector Equality Duty
PSQR	Patient Safety, Quality and Risk Committee
PTL	Patient Tracker List

Q

QA	Quality Assurance
Q&A	Questions and Answers
QG	Quality Governance
QGAF	Quality Governance Assurance Framework
QIA	Quality Impact Assessment
QIP	Quality Improvement Plan
QIPP	Quality, Improvement, Prevention and Promotion
QRP	Quality Risk Profile
QSG	Quality and Safety Group

R

R&D	Research and Development
RA	Registration Authority
RAG	Risk and Governance/Red Amber Green
RCA	Root Cause Analysis
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RES	Race Equality Scheme
RFH	Royal Free Hospitals NHS Foundation Trust
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RSRC	Risk Summit Response Committee
RTT	Referral to Treatment
RTTC	Releasing Time to Care

S

SACH	St Albans City Hospital
SCBU	Special Care Baby Unit
SES	Single Equality Scheme
SFI	Standing Financial Instructions
SHMI	Standardised Hospital Mortality Index
SHO	Senior House Officer
SI	Serious Incident
SIC	Statement of Internal Control
SIRG	Serious Incident Review Group
SIRI	Serious Incident Requiring Investigation
SIRO	Serious Incident Risk Officer
SLA	Service Level Agreement
SLR	Service Line Reporting
SLM	Service Line Management
SMG	Strategic Management Group
SMS	Security Management Service
SOC	Strategic Outline Case
SQ	Safety and Quality
SPA	Supporting Professional Activity
SRG	System Resilience Group
STEIS	Strategic Executive Information System
ST & M	Statutory and Mandatory
STP	Sustainability and Transformation Programme
SUI	Serious Untoward Incident (same as Serious Incident, more commonly used).

T

T&D	Training and Development
TDA	Trust Development Authority (also known as NTDA)
TEC	Trust Executive Committee
TLEC	Trust Leadership Executive Committee
T&O	Trauma and Orthopaedic
TOP	Termination of Pregnancy
TOR	Terms of Reference
TPC	Transformation Programme Committee

T

TSSU	Theatre Sterile Service Unit
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
TVT	Tissue Viability Team

U

UCC	Urgent Care Centre

V

VFM	Value For Money
VTE	Venous Thromboembolism

W

WACS	Women's and Children's Services
WBC	Watford Borough Council
WFC	Workforce Committee
WGH	Watford General Hospital
WHHT	West Hertfordshire Hospitals NHS Trust
WHO	World Health Organisation
WRVS	Women's Royal Voluntary Service
WTD	Working-time directive
WTE	Whole Time Equivalent (staffing)

Y

YTD	Year to date
YCYF	Your care, your future

Declaration of Board members and attendees conflicts of interest
07 September 2017

Agenda item: 04/51

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 06 July 2017
at 9.30am - 12.00noon

Terrace Executive Meeting Room, Watford Hospital

Agenda item: 05/51

Chair	Title	Attendance
Professor Steve Barnett	Chair	Yes
Members		
John Brougham	Non-Executive Director	Yes
Helen Brown	Deputy Chief Executive	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	Yes
Ginny Edwards	Non-Executive Director	Yes
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	Yes
Paul da Gama	Director of Human Resources	Yes
Lisa Emery	Chief Information Officer	Yes
Jean Hickman	Trust Secretary (notes)	Yes
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	No
Dr Arla Ogilvie	Divisional Director, Medicine	Yes
Sally Tucker	Chief Operating Officer	Yes

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/50	**Opening and welcome**		
01.01	The chairman opened the meeting and welcomed the board and members of the public.		
02/50	**Organ donation update**		
02.01	The chair welcomed Fiona Loud, chair of the trust's organ donation committee and Debbie Walford, specialist organ donation nurse to the meeting and invited them to update the board on the work of the organ donation committee. The board was advised on the activities, awareness events and training undertaken by the committee and was encouraged to be informed that since the organ donation committee was established in 2014, 52 patients had benefitted from organ donation.		
02.02	Ginny Edwards asked whether the organ donation committee would welcome an opt-out policy towards organ donation as had recently been announced in Scotland. Fiona Loud responded that the committee would welcome a consultation in England to gain public opinion on the subject.		
02.03	The chief nurse advised that the trust worked closely with local hospices around end of life care and acknowledged further work was required to link organ donation with end of life care.		
02.04	The chair thanked Fiona, Debbie and the organ donation committee for their excellent work.		
OPENING			
03/50	**Apologies for absence**		
03.01	Apologies were received from the divisional director for surgery, anaesthetics and cancer.		
04/50	**Conflicts of interests**		
04.01	There were no changes to the register of interests which had been circulated prior to the meeting.		
05/50	**Minutes of the meeting held on 01 June 2017**		
05.02	13.08 – The medical director advised that the trust had now implemented a strategy to repatriate cardiology MRI patients.		
06/50	**Board action log from 01 June 2017 and previous meetings and decision log**		
06.01	All actions were either completed or confirmed to be on track.		
07/50	**Chair's report**		
07.01	The chair presented his report to the Board and highlighted a number of key areas. An update on the Care Quality Commission's future approach to monitoring following the outcome of a consultation was noted.		
07.02	The board welcomed a successful application for £1m for funding to improve the emergency department (ED). It was noted that the redevelopment of the ED would play a key part in the trust's winter plan.		
07.03	The chair advised that during volunteers' week in June he had hosted a breakfast event for volunteers and also attended a thank you lunch where a number of volunteers had received awards for their long service to the trust.		
07.04	It was reported that Herts Valleys Clinical Commissioning Group had		

Agenda item	Discussion	Lead	Dead-line
	approved a strategic outline case (SOC) on the redevelopment of acute services. The case would now be required to be approved by the sustainability and transformation partnership. The chair advised that there had been constructive discussions with NHS Improvement and the challenge was now to obtain resources to fund the work to deliver the SOC.		
07.05	Resolution: The board noted the report.		
08/50	**Chief Executive's report**		
08.01	The board received a report from the chief executive. She advised that the trust was progressing with its plans to become a smoke free environment from October 2017. She informed the board that a communications plan was in development and the trust was learning from how other trusts had achieved this. In response to a question posed by the chair on how the policy would be enforced, the chief executive confirmed that additional security would be available for the first three months to reinforce the patients, staff and visitors of the policy. She assured the board that smoke-free champions and volunteers, together with clear signage would help to raise awareness and reinforce the policy. It was confirmed that the smoke free policy included vaping.		
08.02	The chief executive advised the board that due to lack of assurance from clinical colleagues, the trust was involved in detailed meetings with senior CGI executives, the trust's IT provider.		
08.03	Paul Cartwright requested an update on strategy at all Board meetings. The director of strategy agreed and confirmed that this would commence from the next meeting.	HB	09/17
08.04	Ginny Edwards asked for confirmation on the lessons learnt from the maternity case which had been reported by the media recently. The chief nurse advised that this was an historical case, which the board and sub-committees had been monitoring. The board was assured by the executive that measures had been taken to make improvements and these had been translated and embedded into learning throughout the trust.		
08.05	Resolution: The board noted the report.		
PERFORMANCE			
09/50	**Integrated performance report- month 2**		
09.01	The chief information officer presented an integrated performance report and highlighted areas of good performance and areas which required improvement.		
09.02	The board reviewed the performance of VTE and the medical director advised that an audit had highlighted that the trust's coding system was not in line with other trusts. The audit criteria had been amended which was expected to ensure compliance with the 95% target.		
09.03	The director of human resources advised the board that the workforce indicators now reflected the changes agreed by the board at its meeting in June 2017.		
09.04	Phil Townsend pointed out a varied performance pattern in complaints and asked for clarity around this deviation. The chief nurse confirmed that this was due to a variation in the number of complaints for each division. She gave assurance that areas with a high number of complaints were allocated additional resources. It was reported that		

Agenda item	Discussion	Lead	Dead-line
	work was ongoing with assistant divisional managers to improve their insight into the complaints process and the board was advised that an event had been held with a complainant that had further aided divisional understanding. The divisional director for unscheduled care confirmed that the division received additional resources due to the high number of complaints received and the divisional directors in attendance assured the board that key themes from learning were discussed at divisional governance meetings, including cross divisional complaints. The chief executive acknowledged that the IPR did not fully reflect the position or explanation for the difference in performance by divisions and advised that she would discuss the format of the complaints data in future reports with the chief nurse.	KF/TC	09/17
09.05	JB noted that the indicator summary in the IPR did not demonstrate how close the trust was to achieving its agency spend target. The director of human resources agreed and pointed out that the addition of the workforce board assurance framework scorecard to the report gave a more accurate reflection of the level of performance.		
09.06	Ginny Edwards welcomed the sustained improvement in mortality and asked how the board could be assured that this was reported accurately. The medical director advised that the data was externally calculated by Dr Foster, a leading provider of healthcare variation analysis and clinical benchmarking.		
09.07	Paul Cartwright noted an improvement to the number of delayed transfers of care (DTOC) and asked what actions had resulted in the improved performance. The chief operating officer advised that joint working with healthcare colleagues had realised some improvement, however she cautioned that DTOC was still a significant challenge. The chief executive explained that the improvement related to healthcare DTOC and not social DTOC, which had a worsening position and advised that the trust remained a significant outlier.		
09.08	In response to a question by Phil Townsend on the low response rate to the friends and family test, the chief nurse explained that the rate related to the number of people who responded to the test and not whether they would recommend the trust to their friends and family. She advised that the 'test your care' metrics was a good indicator of quality and safety. Jonathan Rennison enquired whether the trust had considered best practice by other trusts to improve the response rate. The chief nurse confirmed that texting was being considered in the emergency department; however the cost implications needed to balance against the benefits. The divisional director for medicine suggested that iPads could be used in clinical areas to collect FFT test data from patients.		
09.09	The chair acknowledged the improvements to the IPR over the past year and requested that major changes in performance and significant areas where the trust was an outlier to be highlighted on the report coversheet to ensure that the board's attention remained focused on key areas.	LE/ST	09/17
09.10	The non executive directors asked for clarity on emergency performance benchmarked against national data. The chief executive advised that performance was variable and therefore difficult to benchmark; however she confirmed that it was routinely around the middle of the national performance table.		
09.11	The chief financial officer presented a report on the latest financial position. He advised that the savings target was £21.9m in order to		

Agenda item	Discussion	Lead	Dead-line
	achieve a control total of £15m deficit. Of this, £13.7m had been assigned to divisions and of this; over 60% had been identified. Income was falling below plan year to date, particularly clinical income (£468k).		
09.12	The chief financial officer assured the board that capital expenditure continued to be carefully prioritised in advance of funding approval for £17m of the £23m capital budget; spend to date was reported to be £0.6m. The £17m outstanding authorisation of capital spend had been reduced to £16m following a successful bid for £1m to support the creation of an eight bedded clinical decision unit in the emergency department. The chief financial officer warned that only thirty percent of invoices were being paid within the 40 day timeframe. Paul Cartwright asked and received assurance that slower payment of bills was not impacting on smaller suppliers.		
09.13	The board was advised that a detailed discussion on the position with regard to capital expenditure and the cost improvement programme was on the private session of the agenda.		
09.14	Resolution: The board noted the report.		
SAFE EFFECTIVE CARE (BAF RISK 1)			
10/50	**Quality improvement plan update**		
10.01	The chief nurse presented a paper which provided information that the quality improvement plan (QIP) was being delivered effectively. She advised that the QIP had migrated onto a new project management system, including the key actions and milestones for each project. The chief nurse advised that the trust executive committee (TEC) was reviewing deep dives into projects and the agenda of a board development session in July had focused on the QIP. It was noted that in response to a 'must do' action to improve the referral to treatment (RTT) pathway, the report summarised RTT performance to ensure ongoing monitoring. The board was advised that there were 70 projects rated as green and were on track to deliver. Two milestones were rated as amber and had been reviewed and actions taken to address issues.		
10.02	Ginny Edwards asked for clarity around the methodology used to track quality improvement. The chief nurse acknowledged the importance of having one clear methodology to track quality which was well understood across the organisation and she assured the board that, although this was in place in some areas, it would be further developed as part of the development and delivery of the quality strategy.		
10.03	Resolution: The board noted the report.		
11/50	**Quality Account 2016/17**		
11.01	The quality account 2016/17 was presented to the board by the chief nurse. She advised that the account had been reviewed and approved by the audit committee on behalf of the board at an extraordinary meeting on 30 May 2017. It was reported that the quality account had been published on the Trust's website and on the NHS Choices website in line with national requirements.		
11.02	The non-executive directors welcomed the excellent report and enquired whether there had been any response from key stakeholders. The chief nurse advised that the account had received favourable comments from Healthwatch Hertfordshire and Herts Valleys Clinical Commissioning Group.		
11.03	Resolution: The board noted the report.		

Agenda item	Discussion	Lead	Dead-line
12/50	**Bi-annual infection and prevention control report**		
12.01	The board received a report from the chief nurse on progress made towards achieving the infection prevention and control objectives over the past six months. She highlighted that there had been a sustained reduction in the rate of *Clostridium difficile* infections when benchmarked against the East of England rates. One MRSA had been reported over a 12 month period.		
12.02	Jonathan Rennison noted the detailed report and, in order to allow the board to seek appropriate assurance, asked for future reports to highlight areas of significant change since the previous board report.		
12.03	Resolution: The board noted the report.		
13/50	**Quarterly update on guardian of safe working**		
13.01	A quarterly update on the safe working of doctors within the trust was received by the board. The Director of Human Resources noted that a large number of trainees would move onto the new contract in August and September 2017. Good engagement with educational supervisors and senior clinical teams was reported and welcomed by the board. It was noted that an in-house system for managing exception reporting had been developed to reduce the number of unresolved reports, the majority of which had been managed by an offer of time off in lieu. It was reported that to date no reports had resulted in a fine.		
13.02	The board thanked Dr Burridge for his excellent work and the well written report.		
13.03	Resolution: The board noted the report.		
14/50	**Stakeholder engagement strategy**		
14.01	The deputy chief executive provided a verbal update on the development of a stakeholder engagement strategy. She advised that following a review by the patient and staff experience committee, the strategy would be updated and presented to the board in September 2017.		
14.02	The chair reminded the board that a shadowing programme had been developed which allocated shadowing responsibilities to all board members.		
14.03	Paul Cartwright enquired on the plans to communicate messages on the redevelopment of acute services. The deputy chief executive advised that there would be a discussion in the private session of the board on key communication activity.		
14.04	Resolution: The board noted the verbal update.		
GOVERNANCE			
15/50	**Update on corporate risk register**		
15.01	The board received a summary of the corporate risk register, following a full review of the register by the risk review group. It was noted that there was a review underway by the deputy chief executive of all risks with a risk score of 15 or more. Divisional risks scoring 10 – 12 were also being reviewed to provide assurance on the risk profile and further enhance the quality of information around controls and actions in the risk register.		
15.02	Phil Townsend asked for the board to be made aware of any emerging risks and any immediate mitigating actions being taken. The deputy chief executive advised that the nature of risk meant that the report was dynamic; however she acknowledged that the data in the report could be stronger and agreed to consider how this could be reflected in future	HB	09/17

Agenda item	Discussion	Lead	Dead-line
	reports.		
15.03	John Brougham asked for clarity on the monitoring process of risk by the committees. The deputy chief executive confirmed that the vast majority of risks had been reviewed by the lead committee prior to board, however timing was an issue in some cases. It was agreed that as the board could not receive full assurance on the management of risks that had not been reviewed by a committee, the governance process would be discussed at the next safety and compliance committee meeting. Ginny Edwards assured the board that risks were regularly reviewed by the patient and staff experience committee and advised that the committee requested further evidence in cases where full assurance was not received.	HB	09/17
15.05	Phil Townsend said he had been encouraged on a recent visit to clinical areas at Watford that all senior staff he had met had been able to articulate the risks in their own areas and the correct risk management process. The chief nurse advised that this had also been highlighted by commissioners during a quality assurance visit, as well as staff having a good understanding of improvements that had been made to the services in their areas.		
15.06	Resolution: The board noted the report.		
16/50	**Review of terms of reference and work plans for board and committees**		
16.01	The deputy chief executive presented updated terms of reference and work plans for the board and its committees. She advised that the governance structure had been refreshed to reflect the trust moving into the delivery phase of its strategy to redevelop acute services. The deputy chief executive assured the board that the responsibilities of the committees had been comprehensively reviewed to ensure that all areas and risks were covered across the corporate governance structure. The board was informed that the updated terms of reference and work plans had been reviewed by the appropriate committees and recommended for approval by the board.		
16.02	It was noted that the terms of reference for the board should read that the board met 11 times during the year.	JH	09/17
16.03	Paul Cartwright noted that some minor changes had been requested by the audit committee to be incorporated into the final terms of reference.	JH	09/17
16.04	Resolution: The terms of reference and work plans for the board and committees were approved.		
17/50	**Assurance report from Finance and Investment Committee**		
17.01	John Brougham presented a report on the latest work of the finance and investment committee. He advised that the committee had reviewed and endorsed its revised terms of reference and recommended that the board ratify an interim revenue support loan application for £2.3m to cover revenue funding requirements for June 2017. John Brougham informed the board that there would be a report on an independent trust financing facility (ITFF) funding application in the private session of the meeting, together with a report on concerns relating to the delivery of the cost improvement programme.		
17.02	Resolution: The board noted the assurance report.		
18/50	**Assurance report from Audit Committee**		
18.01	John Brougham presented an assurance report on the work of the audit committee. He advised that the substantive chair had been absent from the last audit committee meeting. It was reported that the committee		

Agenda item	Discussion	Lead	Dead-line
	had reviewed and recommended the annual accounts, annual report, governance statement and quality account for approval by the board. He noted that the external auditor opinion had been discussed and it had been agreed that the wording of the opinion would be reviewed to offer a more balanced view. He advised the board that the finance team had been thanked by the external auditors for their cooperation which had allowed the audit to be carried out efficiently.		
18.02	Resolution: The board noted the report and formally approved the annual accounts, annual report, governance statement and quality account 2016/17.		
19/50	**Assurance report from Safety and Compliance Committee**		
19.01	Phil Townsend presented a report on the work of the safety and compliance committee. He noted that many of the items were covered on the board meeting agenda. The excellent extensive work that had been undertaken to support the trust to deliver compliance against the national emergency preparedness, resilience and response framework was highlighted and the chief operating officer agreed to circulate a report to non executive directors.	ST	09/17
19.02	Resolution: The board noted the report.		
20/50	**Assurance report from the Patient and Staff Experience Committee**		
20.01	The board received an assurance report from Ginny Edwards on the latest work of the patient and staff experience committee. She advised that the committee had requested greater scrutiny around fire safety training compliance, enhanced IT within the human resources department to improve hire rates, developments to the patient experience scorecard and more work to be undertaken to develop the stakeholder engagement strategy.		
20.02	Resolution: The board noted the report.		
ANY OTHER BUSINESS			
21/50	**Any other business**		
21.01	No other business was reported.		
CORPORATE TRUSTEE			
22/50	**Assurance report from the Charitable Funds Committee**		
22.01	Jonathan Rennison presented a report on the work of the charitable funds committee. The corporate trustee was recommended to release £150k from investments to meet financial commitments. Three projects had been considered by the committee for funding; carers support team (£10k), kissing it better (£21,632k) and support for staff health and wellbeing (£48k). The committee had approved the funding subject to assurance being provided that the majority of the costs could be covered by existing designated funds and that any requirement for unrestricted funds was within the available resourcing.		
22.02	In response to a question posed by the chair, Jonathan Rennison confirmed that progress had been made to the fund management arrangements; however there was further work to do.		
22.03	It was reported that the committee had reviewed a plan for the development and delivery of the audit of the annual accounts 2016/17. It was noted that when the audit had been completed, it would require final sign-off by the chair of the corporate trustee.		
22.04	Jonathan Rennison informed the board that the head of charity had tendered her resignation and he formally expressed his thanks to her for the progress she had made to the charity over the past year. After		

Agenda item	Discussion	Lead	Dead-line
	careful consideration by the committee, it was recommended that the governance and fundraising arrangements be separated and a time limited role or consultant be recruited to continue the governance work whilst discussions commenced with other NHS and healthcare charities to explore collaboration, joint working and support opportunities.		
22.05	Resolution: The corporate trustee noted the report. It approved the recommended way forward to the future management of the charity.		
23/50	**Questions from Healthwatch Hertfordshire**		
23.01	There were no representatives from Healthwatch Hertfordshire in attendance at the meeting.		
24/50	**Questions from our patients and members of the public**		
24.01	Alan Russell, vice chair of Hertfordshire Community NHS Trust (HCT) asked whether the handover of responsibility for Simpson ward was progressing well. The chief executive responded that the trust had a good, open relationship with HCT and hoped that the changes to Simpson ward would provide an improved experience for patients; this would be tested over the coming months by close scrutiny, including spot visits to the service.		
24.02	Questions were raised on the current position with regard to delayed transfers of care (DToC) and funding shortfalls in sustainability and transformation partnerships. The chief executive noted that operational relationships were good across the region; however there was a profound and systematic challenge with regard to DToC. Ginny Edwards reminded the board of previous provider collaborative meetings which she believed had been highly functional and had delivered good outcomes and suggested that these might be re-established. The chair said that this suggestion would be discussed outside of the meeting and raised at a future regional chair meeting.		
ADMINISTRATION			
25/50	**Draft agenda for next board meeting**		
25.01	The draft agenda was approved.		
26/50	**Date of the next board meeting**		
26.01	The next board meeting will be held 07 September 2017 in the postgraduate centre, St Albans city hospital.		

Agenda item 06a/51

Action log Part 1 – 07 September 2017
(from meeting held on 01 June 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	09/2017	Work is underway to consider this action and will be completed in October 2017. Action deferred to October 2017
2	11.02/48	Follow up report when the guidance on learning from deaths has been confirmed.	Medical Director	09/2017	An action plan is in progress and being completed. Version 1 of the Trust's policy to be agreed and ratified week commencing 28/08/17. This includes how to respond to relatives/carers of patients who have died and also a roll out programme from 27 September 2017 for consultants and senior nurses of structured judgement review (the method of case note review of a patient who has died). The Board will receive a quarterly report from December 2017 of a variety of metrics, including numbers of deaths.

3	09.06/49	Future reports to include a trajectory to demonstrate the direction of travel and allow the board to measure progress.	Chief Nurse	09/2017	The data will be included in future reports. Action closed.
4	09.12/49	Benchmarking of cancelled outpatient operations against other NHS trusts to be included in future integrated performance reports. Also text to demonstrate the work being undertaken to improve mandatory training targets to be included.	Chief Information Officer/ Chief Operating Officer/ Director of Workforce	09/2017	National outpatient benchmarking is not currently available, therefore it cannot be included in the integrated performance report. Mandatory training is now compliant (90+%). Action closed.
5	08.03/50	Update on strategy at all future board meetings.	Deputy Chief Executive	09/2017	On agenda and on work plan. Action closed.
6	09.04/50	Data regarding complaints in the integrated performance report to be reviewed to fully reflect the position with regard to the variation in performance across divisions.	Chief Nurse	09/2017	The data will be included in future reports. Action closed.
7	09.09/50	Major changes in performance and significant areas where the trust is an outlier to be highlighted in the coversheet of the integrated performance report.	Chief Information Officer/Chief Operating Officer	09/2017	The data will be included in future reports. Action closed.
8	15.04/50	As the board could not receive full assurance on the management of risks that had not been reviewed by a committee, the governance process to be discussed at the next safety and compliance committee meeting.	Deputy Chief Executive	09/2017	The timing of future corporate risk register reports to board will follow bi-monthly review by the safety and compliance committee. Action closed.
09	16.02/50	Terms of reference for the board to be amended to show that the board meets 11 times per year.	Trust Secretary	09/2017	Terms of reference amended. Action closed.
10	16.02/50	Minor changes to be incorporated into the final terms of reference for the audit committee.	Trust Secretary	09/2017	Terms of reference amended. Action closed.
11	19.01/50	Report on the extensive work that had been undertaken to support the trust to deliver compliance against the national emergency preparedness, resilience and response framework to be circulated to non executive directors.	Chief Operating Officer	09/2017	Report circulated. Action closed.

12	15.04/50	Consider how the data in the corporate risk register report could be made stronger.	Deputy Chief Executive	09/17	The data in future corporate risk register reports being reviewed to better reflect the current position. Action closed.

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	16.04/51	The terms of reference and work plans for the board and committees	Approved
06/07/2017	18.02/51	The board approved the annual accounts, annual report, governance statement and quality account 2016/17.	Approved
06/07/2017	22.05/51	The corporate trustee approved the recommended way forward to the future management of the charity	Approved

Trust Board Meeting
07 September 2017

Title of the paper	**Chair's report**
Agenda item	**07/51**
Lead Executive	**Professor Steve Barnett, Chair**
Author	**Jean Hickman, 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.

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: 07/51

Trust Board Meeting – 07 September 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

Update to the single oversight framework

2.1. NHS Improvement (NHSI) is updating the Single Oversight Framework (SOF) to reflect feedback, changes in national policy priorities and developments in our oversight approach. There are no proposed changes to the underlying framework itself, i.e. the five themes under which we assess performance, the approach to monitoring, identifying and responding to support needs and the segmentation of providers.

2.2. In the draft 2017/18 version NHSI has edited and revised the format and presentation of the framework and made a small number of changes to the information and metrics used to assess providers' performance under each theme, and to the indicators that suggest that additional support may be required.

2.3. NHSI are inviting feedback from stakeholders on whether the changes are clear and practicable. This engagement process will run until 18 September 2017, after which it intends to publish the updated SOF in early October 2017, and introduce the changes during Q3 (October to December 2017).

Legislative agenda changes

2.4. Parliament has published a number of Bills relating to arrangements for Brexit, including the Immigration Bill. Set against figures obtained by the Health Foundation which show a 'sharp decline' of 96 per cent in the number of nurses from the EU registering to practise in the UK since July 2016, the Immigration Bill will allow the UK to end EU rules on free movement, 'whilst still allowing the UK to attract the brightest and the best.'

2.5. Also a draft Patient Safety Bill was announced in July 2017 which will aim to improve how the NHS investigates and learns from mistakes through the establishment of a new independent body, whilst also encouraging staff to engage with the body through the creation of a 'safe space.'

2.6. Further measures for the NHS include a commitment to mental health reform as the government moves toward a new mental health act, and a commitment to bring forward proposals for consultation to improve social care.

Care Quality Commission update

2.7. The Care Quality Commission (CQC) closed a second consultation on 08 August 2017 on a further set of proposals which will help shape the next steps for the regulation of health and social care in England. This second consultation outlined further proposals applying to all regulated sectors including proposals on the registration, monitoring, inspection and rating of new models of care and large or complex providers, and proposals relating to requirements for fit and proper persons.

2.8. The CQC has also been asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 12 local authority areas. These reviews will include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources.

2.9. The CQC will look specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The review will not include mental health services or specialist commissioning however, through case tracking, will look at the experiences of people living with dementia as they move through the system. On completion of the review the CQC will report its findings to local authority health and wellbeing boards.

Sustainability and Transformation Partnerships

2.10. NHS England has released ratings for the 44 sustainability and transformation partnerships (STPs). Each STP was given an overall rating based on performance across nine domains: emergency care; elective care; patient safety; general practice; mental health; cancer; demand management; leadership and finance. STPs are categorised as ‘outstanding’, ‘advanced’, ‘making progress or ‘needs most improvement. The Hertfordshire and west Essex STP has been rated as ‘making progress’.

2.11. Of the 44 STPs, five have been rated as ‘outstanding’, 20 as ‘advanced’, 14 as ‘making progress’ and five as ‘needs most improvement’.

NHS Improvement leadership changes

2.12. NHS Improvement’s current Chair, Ed Smith, ended his term of office on 20 July 2017. The recruitment process for a new Chair is ongoing and, in the meantime, Richard Douglas has been appointed as interim Chair. The appointment will be until 31 December 2017 or until a new Chair is appointed.

2.13. The Chair of NHSI is legally appointed as both the Chair of Monitor and Chair of the NHS Trust Development Authority.

CQC leadership changes

2.14. Professor Ted Baker has been appointed as the new Chief Inspector of Hospitals. Professor Baker was previously the Deputy Chief Inspector of Hospitals and took over the role from Sir Mike Richards when he retired at the end of July 2017.

2.15. Sir Robert Francis QC and Paul Rew have been reappointed as non-executive directors for a second three-year term.

Freedom to speak up update

2.16. NHSI has sent 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.

2.17. With NHS England, NHSI is developing a whistleblower's support scheme for providers, with the key aim of supporting individuals who have raised concerns in the public interest about risk, malpractice or perceived wrongdoing in the NHS and experienced employment difficulties as a result. NHSI has recruited Wendy Webster to the post of Employment Support Manager and she will be responsible for the development and implementation of the scheme.

2.18. NHSI are seeking to recruit panel members to review the applications to the scheme and anticipate the panel will comprise the following individuals:

- former NHS whistleblowers
- NHS professionals who would understand the applicant's profession and have the relevant clinical/managerial expertise
- executives/ senior managers /clinicians with experience of regulations and the framework for managing performer concerns where relevant and/or an equivalent NHS manager with the relevant knowledge and expertise

3. LOCAL NEWS AND UPDATE

CQC inspection

3.1. The Trust welcomed the Care Quality Commission (CQC) into its hospitals for a planned re-inspection on 30 August to 01 September 2017. The inspection focused on five key questions: Is it safe? Is it caring? Is it responsive? Is it effective? Is it well led?

3.2. Thank you to staff across the whole organisation for their huge efforts in getting ready for the inspection.

3.3. As is common with visits of this type, the CQC team has given the Trust some immediate feedback and then, in line with its normal procedures, the CQC will issue a formal report in early 2017. The Trust will respond to the official findings at that time.

Redevelopment of hospitals

3.4. At its board meeting on 29 June 2017, the Herts Valleys Clinical Commissioning Group (HVCCG) approved the Trust's strategic outline case (SOC) to redevelop the hospital at Watford and to further develop St Albans as a site for planned care. The HVCCG supported the Trust's preferred option of a redevelopment of the Watford and St Alban's sites, in favour of buying and building on a new site.

3.5. A formal letter of support has also been provided by the STP Chief Executives Group. The STP CEOs also confirmed their support for the Princess Alexander Hospital redevelopment strategic outline case. Both schemes have been submitted for STP capital funding via the national STP capital allocation process.

3.6. Having received formal confirmation of commissioner and STP support the SOC has now been formally submitted to NHS Improvement for review.

Watford Riverwell

3.7. Watford Riverwell, formerly Watford Health Campus, held two community exhibitions in July 2017 to give local people an opportunity to review the latest plans for the southern zone of the Riverwell Scheme and talk about the progress being made.

3.8. A clean-up session was also held in July 2017 marking the start of a project to improve the River Colne that runs through the Watford Riverwell site. Trust directors were among those helping alongside the Mayor of Watford, representatives of the council, Kier and local school children.

3.9. The Board will be updated on the Watford Riverwell project in the private session of its meeting in September 2017.

Clinical Commissioning Group Consultation

3.10. Herts Valleys Clinical Commissioning Group (CCG) and NHS East and North Hertfordshire CCG, are responsible for planning and paying for local health care and making sure that residents receive good care. The two organisations launched a consultation in July 2017 to hear the views of local people on how to spend the limited money available to the NHS in Hertfordshire.

3.11. They are consulting on the following issues:

- IVF and specialist fertility services
- Requiring patients to improve their health before non-urgent surgery
- Prescribing of medicines available to buy over-the-counter
- Prescribing of gluten-free foods
- Female sterilisation procedures
- Vasectomy procedures (Herts CCG area only).

3.12. The consultation runs until 14 September 2017.

New simulation suite

3.13. A new facility which simulates an acute care environment, providing realistic clinical training facilities, was officially opened in July 2017. This facility enables multi-disciplinary staff to take part in simulated scenarios, such as the management of acutely unwell patients and work on communication and team working.

3.14. A life-like mannequin that can replicate the reactions of ill and rapidly deteriorating patients and can even cry and show pain is part of the suite.

3.15. Thank you to the League of Friends for their donation of £60,000 which part funded the new facility, together with a grant of £250,000 from the Sign Up to Safety national initiative

Improvements to the discharge lounge

3.16. A new enhanced discharge lounge was officially opened at Watford hospital in July 2017. The improved facility is larger and a more pleasant environment for patients to wait once they are well enough to be discharged and are preparing to leave hospital. The lounge has been improved to include wall-mounted TVs, radio and books and the creation of two trolley spaces means that patients who aren't able to sit can benefit from leaving a busy ward and wait in the lounge before leaving hospital.

3.17. Thank you to the League of Friends for their kind donation of £17,000 to fund this work.

Activity day for potential doctors

3.18. GCSE and A level students who are hoping to become doctors visited the Trust for a day recently to take part in lectures, activities and group work to give them a taste of the roles on offer which includes other hospital careers, such as allied healthcare professionals.

3.19. Doctors from different stages of their careers and specialties took part in the day and gave the students an idea of basic medical practice, including CPR, taking blood, examining the eye and urine analysis.

Annual General Meeting

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

3.21. Members of the public and staff are very welcome to attend from 6pm for refreshments and displays. The annual report and annual review will be published at the meeting. These reports will be available by visiting the Trust's website www.westhertshospitals.nhs.uk.

3.22. The official meeting will run from 6.30pm – 8pm where there will be an opportunity to hear about the work the Trust has done over the past year.

Hertfordshire and west Essex STP

3.23. The Chairs of the Hertfordshire and west Essex Sustainability and Transformation Partnership (STP) met on 11 July 2017. The agenda for the meeting included a progress report on the plans for priority workstreams, financial projects, capital plans, budget and risks. The chairs also discussed a draft STP Memorandum of Understanding.

3.24. The Hertfordshire and west Essex STP includes two county councils, three hospital trusts, four community and mental health trusts, three clinical commissioning groups, one ambulance trust, 166 GP practices, two health and wellbeing boards, thirteen district and borough councils, two branches of Healthwatch and hundreds of health and social care partners, including voluntary and community organisations.

Celebrating our staff

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

- Antonio de Martino, Staff nurse, A&E at Watford who were awarded a Celebrating Excellence Staff Award for their excellent mentorship skills
- Non EU overseas nurses for achieving 90% pass rate on a key exam which they must pass before they can start working as a registered nurse
- The stroke department for maintaining an AA rating for the third time in a year. As well as the AA rating, the service is in the top 16% across the UK in the Sentinel Stroke National Audit Programme
- The Hertfordshire and Bedfordshire Agency Consortium (health trusts across Herts and Beds who have worked collaboratively to save money) have won a BMJ Careers Award. This is the consortium's second award in a year
- Avni Shah who has achieved her Accredited Clinical Coding (ACC) qualification, earning herself a double distinction in both exam papers to become a qualified clinical coder
- Marion Harvey, who was Deputy Head of Dietetics before recently retiring, has been awarded an IBEX honour by the Trade Union Board for displaying an unwavering commitment to the work of the trade union for over three decades
- The Starfish ward for holding a successful family fun day in August 2017 which raised £1,700 towards a new echo machine
- A team on outpatient physiotherapy department for tackling the Three Peaks – Ben Nevis, Scafell Pike and Snowdon – to raise funds for Arthritis Research

- The pre-registration student nurses who received an award in the following categories:
  - Babita Malla (student in commitment)
  - Amy Hagan (student in care)
  - Flora Ojukwu (student in quality)
  - Emma Swan (mentor in commitment)
  - Clare Attard-Montalto (mentor in care)
  - Emma Pope (mentor in quality)
- The winners of the Gurney Awards which recognises local innovations in clinical or professional practice.
  - 1st prize to Drs Francesca Hinds, Naomi Oraha, Mohammad Islam, Latha Thangaraj. (*A simple intervention to reduce falls and polypharmacy in the elderly)*
  - 2nd prize *to* Dr Katrina Abernethy. (*Blood gas analyser audit*)
  - *3rd prize to* Dr Rajesh Shankar.(*Chlorhexidine spray: what is the extent of spread of droplets – research project*)

4. KEY MEETINGS

- Attended a clinical engagement event
- Chaired a consultant paediatric appointment panel
- Met with the Divisional Director for Surgery, Anaesthetics and Cancer
- Attended an STP Chairs Oversight Board meeting
- Met with Manny Lewis, Managing Director, Watford Borough Council
- Met with Councillor Alec Campbell, Leader of St Albans Council
- Chaired a Royal Free Hospital/West Herts Partnership Board meeting
- Attended an NHS Improvement Midlands & East Chairs networking event
- Chaired a Board Business Workshop
- Toured the Women's and Children's Unit at Watford Hospital with Wendy Wilson of the Patients' Panel
- Chaired a consultant frailty appointment panel
- Attended the NHS Hertfordshire Chairs meeting
- Met with the Divisional Director for Medicine
- Toured the Acute Admissions Unit at Watford Hospital with Wendy Wilson of the Patients' Panel

5. RECOMMENDATION

5.1. The Board is asked to note the report.

Professor Steve Barnett
Chair

September 2017

Trust Board Meeting

07 September 2017

Title of the paper	**Chief Executive's report**
Agenda item	**08/51**
Lead Executive	**Katie Fisher, Chief Executive Officer**
Author	**Jean Hickman, 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: 08/50

Trust Board Meeting – 06 July 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

'Getting it Right First Time' programme

2.1. A series of Getting it Right First Time' **(**GIRFT) speciality visits are taking place this year. Following a recent GIRFT trauma and orthopaedic review visit, the Trust has:

- Ring-fenced beds on Beckett ward, St Albans for orthopaedic surgery patients
- Created a 13-bed elective orthopaedic unit on Flaunden Ward at Watford. This work will be completed by mid-September.
- Suspended (or moved to other providers) operations on joints that require metal work insertion until the new unit on Flaunden is open.

Rotation of doctors in training

2.2. August is the month in which the Trust welcomes a new intake of FY1 foundation programme doctors. This year the process is complicated by the introduction of the new terms and conditions of service for further rotations/doctors. The new doctors received a week of induction and shadowing sessions, ahead of a changeover on 02 August 2017.

Move of Simpson ward

2.3. The management for Simpson ward at Hemel Hempstead hospital transferred to Hertfordshire Community NHS Trust (HCT) on 01 August 2017.

2.4. Simpson ward, which has 21 beds, is used to care for patients who no longer require the acute care provided at Watford hospital and are being assessed prior to deciding where their longer term care needs will best be provided. HCT will run Simpson ward alongside its inpatient rehabilitation beds on St Peters ward at Hemel Hempstead Hospital.

Issues with non emergency patient transport

2.5. 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 which is being taken very seriously by the Trust. The contract is held jointly by Hertfordshire Valleys Clinical Commissioning Group (CCG) and East and North Hertfordshire CCG. The Trust is working closely with the CCGs and the third party transport provider in order to address the current issues and to improve the transport service for patients.

Improving discharge

2.6. To help patients progress through their care pathway and be ready for discharge from hospital sooner, the Trust has adopted a new approach called 'Red2Green'. Staff are encouraged to consider whether a patient needs a scan, an x-ray or blood test and if so, to turn a 'red' day (where they do not make progress through their care pathway) into a valuable 'green' day (they have everything they need to bring them closer to the goal of getting home).

2.7. The longer a patient lies inactive in bed, the worse it is for their wellbeing so the Trust is also helping patients to get up, get dressed and get moving through the #endPJparalysis campaign. Patients are also being encouraged to take greater responsibility for their health by asking questions about their care and their discharge.

2.8. To improve the patient experience further, the discharge summary has been reviewed and updated. A discharge summary is written by the doctor caring for a patient in hospital to inform their GP about what happened during the hospital stay. This allows GPs to change a patient's prescription(s) according to the advice of the hospital doctors, chase any test results which weren't available whilst the patient was in hospital, and arrange further investigations or referrals as necessary.

2.9. The discharge summary has been amended as a result of collaborative work between junior doctors, consultants, IT staff, pharmacists, coding staff, senior clinical managers and a GP representative.

2.10. One of the changes is to the name of the document, which will now be called an admission summary. Other changes include new data entry screens for clinicians and a new printed format to the admission summary.

Information screens

2.11. An audit of information screens, including televisions and check-in kiosks, in public areas across the Trust's hospitals has been undertaken to ensure that all screens are working and displaying up to date and relevant information. Going forward, the communications team will centrally coordinate all forms of information screens to ensure that they link in with the Trust's website and other forms of communication materials.

Flu vaccination programme

2.12. The Trust has started to plan its 2017/18 flu vaccination campaign to keep patients and staff well over the winter months. The campaign will include all staff and aims to decrease sickness absence, reduce the risk of cross-infection and to have a positive impact on the delivery of high quality care.

2.13. This year's campaign will be led by a multi-disciplinary steering group chaired by the Director of Human Resources and Organisational Development. The steering group members will include a clinician, head of nursing, flu programme manager and teams from infection prevention and control, occupational health and communication.

2.14. The Chief Nurse and Medical Director will lead key communications across the Trust and there will be a cohort of dedicated flu champions, which will be trained and have allocated areas to administer vaccinations. A dedicated programme manager will oversee the campaign and coordinate vaccinator champions and measure performance against targets on a weekly basis.

2.15. The vaccination programme will be underpinned by a communication plan and will be monitored by the Trust Executive Committee and the Patient and Staff experience Committee

2.16. 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.

Relocation of outpatient physiotherapy

2.17. The Trust's outpatient physiotherapy activity was previously being delivered from a gymnasium at Watford hospital and, on a temporary basis, the Runcie Rehabilitation Unit at St Albans hospital.

2.18. In order to improve this service for patients and to assist with the redevelopment of the emergency department at Watford hospital, outpatient physiotherapy services have been consolidated into the West Hertfordshire Therapy Unit which is located in a former rehabilitation unit in Jacketts Field, Abbots Langley.

Developing a quality strategy

2.19. Work will begin in September 2017 on the engagement of a three-year quality strategy which will set out how the Trust will ensure it is delivering the outcomes needed to achieve its vision of providing the very best care to every patient, every day.

2.20. The quality strategy will set out a strategic framework for driving continuous quality improvement. This will be achieved by setting clear goals, identifying key quality priorities, providing methodologies for driving and evaluating improvement and ensuring success and learning is shared.

2.21. The strategy will be developed, designed, and implemented by staff; therefore a key element of the work will involve staff engagement.

2.22. The strategy will be finalised with implementation from March 2018.

New pathway for alcohol detoxification

2.23. A new ambulatory pathway for alcohol detoxification has been launched with CGL Spectrum. This means that patients who are being detoxified from alcohol, and who are otherwise medically fit, can now be discharged from hospital to continue their alcohol detoxification in the community under the supervision of a specialist nurse.

Noise at night

2.24. Following feedback from the friends and family test and the national annual inpatient survey which showed that increasingly more patients are unable to sleep at night due to noise on wards, the Trust has relaunched its Noise at Night campaign.

2.25. A lack of sleep impedes recovery and can increase length of stay so the campaign aims to make staff more aware of the small measures they can take to reduce overnight disturbances. These include keeping voices down when talking to patients or colleagues, reducing bed moves through better forward planning and ensuring patients are aware eye masks and ear plugs are available for them.

New maternity and neonatal equipment

2.26. Another new development is an iSeeU project which allows mothers on the postnatal ward to see their babies in the neonatal unit at Watford by the use of a tablet to transmit sound and images between the clinical areas. This offers mothers greater involvement in their baby's care and gives them a chance to feel closer to their baby.

Smoke free hospitals

2.27. As from 01 October 2017, the Trust will be smoke free in order to offer a more pleasant environment to patients, staff, volunteers and visitors. Practical steps will be taken to encourage no smoking on site, including removing smoking shelters, improving signage and raising staff awareness.

3. COMMUNICATIONS REPORT

3.1. Media

The Trust received coverage over a variety of topics during June and July including:

- The Watford Observer reported new plans for a retirement village – named Watford Riverwell. The brand new village, which will consist of 250 homes, will be built to "ease hospital bed pressure".
- Building Better Healthcare, Health Imaging, Health IT Central and Dot Med reported that we have recently signed a five-year contract with Carestream Health to replace our PACs system. This means that our radiologists and physicians can access the clinical tools they need to carry out the 300,000 radiology exams they practice every year.
- The Hillingdon and Uxbridge Times reports online and in its sister title the *Watford Observer* that patient Rita Pocknell – aged 74 – praised staff at Watford Hospital for her treatment during her stay with Pneumonia. She is full of praise for the international staff on both wards that helped her pull through.
- Our Chief Information Officer, Lisa Emery talked to Digital Health News about the importance of resilience. When asked why she became an NHS chief information officer she said: "at the time, it was a relatively new role generally, and the first time this trust had a chief information officer post. It offered the opportunity to lead change and make a difference."
- The Watford Observer ran a story online and in its print edition about the £1 million from the Department of Health given to us to help us prepare for the winter influx of patients through our emergency department.

- Our very own MasterChef winner, Saliha Mahmood-Ahmed, visited the Watford Hospital's Busy Bees nursery to help parents explore how to eat healthily without breaking the bank. Saliha also launched the nursey's involvement in a national healthy eating campaign for children under five which was reported by The Hillingdon and Uxbridge Times
- The Watford Observer , the St Albans and Harpenden Review and The Sun report that marketing boss Paul Jory 59 was left with just 40 per cent movement in his arm after a spider's poison spread a flesh-eating infection. Paul praised Watford Hospital for "saving his life".
- The Watford Observer reported on the opening of the new simulation suite at Watford Hospital. The suite replicates an acute care environment, providing realistic clinical training facilities. It enables multi-disciplinary staff to take part in simulated scenarios, such as management of the acutely unwell patient, and improve key skills such as communication and team working.

Media

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

July 2017	Positive coverage	Neutral coverage	Negative coverage	Rebuttals/not run
National coverage	2	1	0	0
Coverage (Watford)	10	0	1	0
Coverage (Dacorum)	1	0	0	0
Coverage (St Albans)	4	0	0	0
Letters coverage	1	0	0	0

Website

Number of unique visitors to our website	Month's Figures 17/18		Month's Figures 16/17		Total Quarter 1 (April – June)	Total 17/18	Total 16/17
	June	July	June	July			
Total Page Views	470,944	488,259	359,196	362,145	1,364,707	1,364,707	4,901,513
Top 5 pages visited	39,168	39,625	34,228	33,763	106,195	106,195	370,658

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

1. Watford wards and departments
2. Contact
3. Parking
4. Our hospitals
5. Pathology

Internal Communications

	July 2017/18	June 2017/18	Total Quarter 1 (April - June)	Running total 17/18
Number of news stories shared with staff on intranet	5	4	10	15
Number of staff e-newsletters produced	9	9	15	24
Number of CEO briefings	6	6	12	18
Number of Herts & Minds newsletters	1	1	1	2

Freedom of Information

	Month's Figures 2017/18		Total Quarter 1 (April – June)	Running total 2017/18	Total 2016/17
	July	June			
Number of FoIs received	95	39	153	148	662
Compliance within 20 day deadline	94.7%	95%	95%	95%	94.3%
No of FoIs received from media outlets	8	6	24	32	100

Social Media

Twitter	Followers	Posts	Likes	Retweets
June 2017	5774	49	217	139

In June the Trust gained 135 new followers and tweeted 49 times.

Our tweet, “We’d like to celebrate our highest ever annual recruitment to our clinical trials achieved by the R&D dept for 2016-2017 – over 1,250” received the most engagement with 26 likes and nine retweets.

Twitter

Twitter	Followers	Posts	Likes	Retweets
July 2017	5821	77	357	192

The Trust gained 35 followers in July. Our overall engagement in July improved a great deal as we have had more likes and retweets than in the previous month. Our likes increased by 140 and we had 54 more retweets than last month.

“Physiotherapists changed my life, says patient” was the most engaged post in July, with 31 likes and 12 retweets.

The Trust gained 136 new followers in June and posted 23 times on Facebook.

This month two of our posts received over 100 likes. This is the first time two posts have received over 100 likes in one month. Our post informing the public that our staff will be dressed in scrubs during the heatwave was the most engaged post.

Facebook	Followers	Posts	Likes	Reach	Shares	Comments
June 2017	1043	23	540	39, 452	95	44

This post received 227 likes (the most liked post on Facebook). The post reached 18,875 people, was shared 62 times and received 28 comments.

Our post promoting an interview with one of our nurses received the second most engagement. The post received 110 likes, reached 6,015 people, shared 12 times and received nine comments.

4. RECOMMENDATION

4.1. The Board is asked to note the report.

Katie Fisher
Chief Executive

September 2017

Trust Board Meeting
06 September 2017

Title of the paper	**Integrated Performance Report**
Agenda item	**09/51**
Lead Executive	**Sally Tucker, Chief Operating Officer**
Author	**Lisa Emery, Chief Information Officer**
Executive summary **(including resource implications)**	The Integrated Performance Report covers the August reporting period (July 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 recorded cases of *C.difficile* (4 in June) • There was one case of MRSA bacteraemia (0 YTD in June) • There were 10 mixed sex accommodation breaches (vs. 4 in June) • Harm free care dropped slightly to 89.7%* (93.0% in June) Responsive: • RTT (incomplete) performance dropped slightly to 90.0%* (90.7% in June) • ED 4 hour wait performance dropped to 82.9% (89.0% in June) • Ambulance turnaround times (both indicators) increased from June • Breast symptomatic performance decreased to 88.6% (92.3% in June) • Formal delayed transfers of care increased to 6.7% (5.1% in June) Well Led: • Appraisal rate improved a compliant position of 90.2% (90.0% in June) • Staff turnover (rolling 3 months) increased to 13.7% (12.0% in June) • Daycase FFT response rate improved to 39.2% (26.9% in June) • Maternity FFT response rate improved to 52.5% (44.8% in June) • Trust I&E deficit fallen to £1.61m (1.6%) behind plan (0% in June) 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.

Integrated Performance Report

August 2017

(July data)

Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Effective Caring

Reporting sub committees – COE and S&C

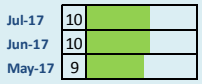
Areas of good performance

- 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)

New to category this month:

- Clostridium difficile was better than the monthly threshold (zero cases recorded) and better than the year to date threshold (6 vs 12) *(pages 3 & 17)*

Achieving



Jul-17	10
Jun-17	10
May-17	9

Better than national average

Jul-17	11
Jun-17	12
May-17	10

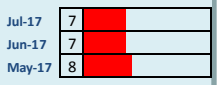
Areas requiring performance improvement

- VTE risk assessment was below threshold *(pages 4 & 19)*
- Admissions to stroke ward within 4 hours was below the performance standard *(pages 4 & 14)*
- There were 10 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 but in line with the internal improvement trajectory *(pages 3 & 15)*

New to category this month:

- There was one case of MRSA bacteraemia *(pages 3 & 17)*

Not achieving



Jul-17	7
Jun-17	7
May-17	8

Worse than national average

Jul-17	8
Jun-17	7
May-17	6

Responsive

Reporting sub committee – TEC

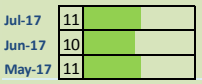
Areas of good performance

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

Achieving



Jul-17	11
Jun-17	10
May-17	11

Better than national average

Jul-17	9
Jun-17	9
May-17	8

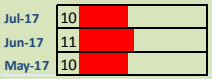
Areas requiring performance improvement

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

New to category this month:

None

Not achieving



Jul-17	10
Jun-17	11
May-17	10

Worse than national average

Jul-17	5
Jun-17	5
May-17	6

Well led

Reporting sub committee – PSE

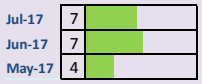
Areas of good performance

- 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)*

New to category this month:

- Appraisals was better than target *(pages 7 & 31)*

Achieving



Jul-17	7
Jun-17	7
May-17	4

Better than national average

Jul-17	5
Jun-17	5
May-17	3

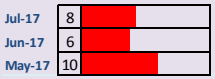
Areas requiring performance improvement

- A number of workforce indicators continue to report underperformance, including staff turnover rate (rolling 12 months) and vacancy rate *(pages 7 & 30-32)*
- 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)*
- Agency pay was worse than target *(pages 7 & 30)*

New to category this month:

- Staff turnover (rolling 3 months) was worse than target *(pages 7 & 30)*

Not achieving



Jul-17	8
Jun-17	6
May-17	10

Worse than national average

Jul-17	5
Jun-17	5
May-17	10

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	May-17	Jun-17	Jul-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	✓ 88.4	✓ 83.1	✓ 83.7			MD	Mar-17	Y	National	100	Mar-17		G	
		Crude Mortality Rate (Non elective ordinary)**	3.5%	✓ 2.6%	✓ 2.3%	✓ 2.2%	✓ 2.5%	3.5%	MD	Jul-17	Y	National	2.96% (East of Eng.)	Mar-17		G	
	●	30 Day Emergency Readmissions - Combined *	4.0%	✗ 7.1%	✗ 7.1%	✗ 7.7%	✗ 7.3%	4.0%	MD	Jul-17	Y	National	11.4%	2011-12		G	£ Marginal tariff reimbursement, possible penalties
		30 Day Emergency Readmissions - Elective *	n/a	2.9%	2.8%	3.8%	3.2%	n/a	MD	Jul-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
		30 Day Emergency Readmissions - Emerg *	n/a	10.8%	11.1%	10.8%	11.0%	n/a	MD	Jul-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties^
		Number of patients with a length of stay > 14 days *	tbc	364	320	330	1369	tbc	MD	Jul-17		Local	n/a			G	£ Reduction in reimbursement vs largely fixed costs. No penalty levied.
		Staff FFT % recommended care	tbd NHSI^	66.8%	N/A	61.5%	63.8%	tbd NHSI^	DoW	Mar-17	Y	National	n/a			G	
		Inpatient Scores FFT % positive	tbd NHSI^	94.8%	93.7%	90.6%	93.3%	tbd NHSI^	CN	Jul-17	Y	National	96.1%	Jun-17		G	
		A&E FFT % positive	tbd NHSI^	93.0%	90.2%	90.5%	90.7%	tbd NHSI^	CN	Jul-17	Y	National	87.6%	Jun-17		G	
		Daycase FFT % positive	tbd NHSI^	98.2%	98.6%	98.8%	98.6%	tbd NHSI^	CN	Jul-17	Y	National	n/a			G	
		Maternity FFT % positive	tbd NHSI^	96.8%	94.8%	92.8%	94.3%	tbd NHSI^	CN	Jul-17	N	National	96.8%	Jun-17		G	
	●	% Complaints responded to within one month or agreed timescales with complainant	85%	✗ 62.1%	✗ 50.8%	✗ 50.9%	✗ 54.9%	85%	CN	Jul-17	N	Local	n/a			R	
		Complaints - rate per 10,000 bed days	tbd NHSI^	31.3	41.3	31.3	33.3	tbd NHSI^	CN	Jul-17	N	National	n/a			R	
		Reactivated complaints		0	5	6	28	n/a	CN	Jul-17	N	Local	n/a			R	
	●	Mixed sex accommodation breaches	0	✗ 9	✗ 4	✗ 10	✗ 29	0	CN	Jul-17	N	National	40 Trusts breaching	Jun-17		G	£ Penalties from CCG. £250 per day per service user.
		Clostridium Difficile	3	✓ 1	✗ 4	✓ 0	✓ 6	12	CN	Jul-17	Y	National	2.7 average	Jun-17		G	£ Penalties from CCG, fines from other statutory authorities. £10,000 per case above threshold.
	◆	MRSA bacteraemias	0	✓ 0	✓ 0	✗ 1	✗ 1	0	CN	Jul-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	1	3	7	12	tbc	CN	Jul-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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West Hertfordshire Hospitals NHS Trust

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Indicator	Target	May-17	Jun-17	Jul-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	Jul-17	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities, prosecution^
		Serious incidents - number*	tbd NHSI^	4	1	3	11	tbd NHSI^	MD	Jul-17	Y	National	n/a			A	
		% of patients safety incidents which are harmful*	n/a	12.5%	10.8%	9.7%	11.1%	n/a	MD	Jul-17	Y	National	n/a			A	
		Medication errors causing serious harm *	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Jul-17	Y	National	n/a			A	
	●	CAS Alerts: Number issued each month	n/a	11	16	5	5	n/a	CN	Jul-17	Y	National	n/a			A	
		CAS alerts not acknowledged within 48 hours	0	✓ 0	✓ 0	✓ 0	✓ 0	0	CN	Jul-17		National	n/a			A	
		Number of falls*		94	85	100	393		CN	Jul-17	Y	Local				G	
		Number of falls with harm*		21	16	24	85		CN	Jul-17	Y	Local				G	
	●	Harm Free Care*/**	95.0%	✗ 91.3%	✗ 93.0%	✗ 89.7%	✗ 92.0%	95.0%	CN	Jul-17	Y	National	94.2%	Jul-17		G	
		% New Harms (Safety Thermo - New/All Harms)*/**	tbd NHSI^	16.4%	17.9%	22.2%	17.7%	tbd NHSI^	CN	Jul-17	Y	National	37.0%	Jul-17		G	
		Pressure Ulcers New Harms*/**	tbd NHSI^	3	3	4	11	tbd NHSI^	CN	Jul-17	Y	National	WHHT 0.65 vs 0.96	Jul-17		G	
		Falls New Harms*/**	tbd NHSI^	1	1	2	4	tbd NHSI^	CN	Jul-17	Y	National	WHHT 0.33 vs 0.51	Jul-17		G	
		Catheter & UTI New Harms*/**	tbd NHSI^	1	1	5	8	tbd NHSI^	CN	Jul-17	Y	National	WHHT 0.82 vs 0.3	Jul-17		G	
		VTE New Harms*/**	tbd NHSI^	4	2	3	11	tbd NHSI^	CN	Jul-17	Y	National	WHHT 0.49 vs 0.40	Jul-17		G	
	●	VTE risk assessment*	95.0%	✗ 91.3%	✗ 92.6%	✗ 92.1%	✗ 91.5%	95.0%	MD	Jul-17	Y	National	95.5%	Q4 2016		A	
		Caesarean Section rate - Combined*	26.5%	✗ 30.1%	✓ 24.7%	✓ 26.1%	✗ 27.6%	26.5%	MD	Jul-17	Y	Local	26.7%	Apr15-Aug15		A	
		Caesarean Section rate - Emergency*	n/a	18.5%	13.4%	16.5%	16.3%	n/a	MD	Jul-17	Y	Local	15.3%	Apr15-Aug15		A	
		Caesarean Section rate - Elective*	n/a	11.7%	11.3%	9.6%	11.3%	n/a	MD	Jul-17	Y	Local	11.4%	Apr15-Aug15		A	
		Maternal deaths	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Jul-17	N	National	n/a			G	
	●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 61.5%	✗ 71.4%	✗ 60.9%	✗ 65.5%	90.0%	COO	Jul-17	Y	National	54.8%	Mar-17		G	
		Stroke patients spending 90% of their time on stroke unit *	80.0%	✗ 74.4%	✓ 81.0%	✓ 82.6%	✗ 79.9%	80.0%	COO	Jul-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.

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West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	May-17	Jun-17	Jul-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%	✗ 75.0%	✗ 72.3%	✗ 78.0%	✗ 73.5%	90.0%	COO	Jul-17	Y	Local	76.1%	Jun-17		G	
	●	Referral to Treatment - Non Admitted*	95.0%	✗ 90.3%	✗ 89.8%	✗ 89.5%	✗ 89.7%	95.0%	COO	Jul-17	Y	Local	90.7%	Jun-17		G	
	●	Referral to Treatment - Incomplete*	92.0%	✗ 90.7%	✗ 90.7%	✗ 90.0%	✗ 90.4%	92.0%	COO	Jul-17	Y	National	90.3%	Jun-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	Jul-17		National	1544 (all Trusts)	Jun-17		G	
		Diagnostic wait times	99.0%	✓ 99.2%	✓ 99.6%	✓ 99.2%	✓ 99.3%	99.0%	COO	Jul-17	Y	National	98.1%	Jun-17		G	£ CCG penalty of £200 in respect of each excess breach above the threshold
	●	ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 84.0%	✗ 89.0%	✗ 82.9%	✗ 83.1%	95.0%	COO	Jul-17	Y	National	90.3%	Jul-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	Jul-17	Y	National	73 (all Trusts)	Jul-17		G	£ CCG penalty £1,000 per incidence
	●	Ambulance turnaround time between 30 and 60 mins	0	✗ 292	✗ 323	✗ 395	✗ 1,432	0	COO	Jul-17	Y	Local	n/a			R	£ CCG penalty £200 per service user waiting over 30 mins
	●	Ambulance turnaround time > 60 mins	0	✗ 141	✗ 85	✗ 174	✗ 727	0	COO	Jul-17	Y	Local	n/a			R	£ CCG penalty £1,000 per service user waiting over 60 mins
		Cancer - Two week wait *	93.0%	✓ 96.4%	✓ 94.4%	✓ 94.6%	✓ 94.7%	93.0%	COO	Jul-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%	✓ 94.7%	✗ 92.3%	✗ 88.6%	✗ 90.0%	93.0%	COO	Jul-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%	✓ 99.4%	✓ 97.7%	✓ 98.8%	96.0%	COO	Jul-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	Jul-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%	✗ 92.3%	✓ 100.0%	✓ 100.0%	✓ 97.9%	94.0%	COO	Jul-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%	✓ 95.0%	✗ 84.8%	✓ 86.4%	✓ 89.3%	85.0%	COO	Jul-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%	✓ 100.0%	✓ 100.0%	90.0%	COO	Jul-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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West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	May-17	Jun-17	Jul-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	Jul-17	Y	National	n/a			G	
	●	Number of patients not treated within 28 days of last minute cancellation	0	✗ 3	✗ 9	✗ 7	✗ 22	0	COO	Jul-17	Y	National	8 (avg. all Trusts)	Q1 17/18		G	
	●	Delayed Transfers of Care (DToC)*	3.5%	✗ 6.6%	✗ 5.1%	✗ 6.7%	✗ 6.4%	3.5%	COO	Jul-17	Y	National	6.0%	Feb-16		G	£ Marginal tariff reimbursement, possible penalties
		Delayed Tranfers of Care (DToC) beddays used in month		1,486	1,429	1,364	5,827		COO	Jul-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
	●	Outpatient cancellation rate	8.0%	✗ 11.1%	✗ 11.2%	✗ 11.5%	✗ 11.5%	8.0%	COO	Jul-17	Y	Local	n/a			G	
		Outpatient cancellation rate within 6 weeks^	5.0%	✓ 3.9%	✓ 3.8%	✓ 3.8%	✓ 4.0%	5.0%	COO	Jul-17	Y	Local	n/a			G	
	●	Patient initiated cancellations (all)		12.5%	13.1%	13.5%	12.9%		COO	Jul-17	Y	Local				G	
		Hospital + Patient initiated cancellations (all)		23.6%	24.3%	24.9%	24.4%		COO	Jul-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*

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Indicator Summary

Domain		Indicator	Target	May-17	Jun-17	Jul-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%	✗ 16.3%	✗ 16.1%	✗ 16.1%	✗ 16.2%	12.0%	DoW	Jul-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Staff turnover rate (rolling 3 months)	12.0%	✗ 13.2%	! 12.0%	✗ 13.7%	✗ 13.5%	12.0%	DoW	Jul-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Nurse Band 5 Turnover Rate				✗ 26.7%	✗ 26.7%		DoW	Jul-17	Y	Local	n/a			G	
		% staffleaving within first year (excluding medics and fixed term contracts)		19.2%	19.3%	18.6%	19.2%		DoW	Jul-17	Y	National	n/a			G	
		Sickness rate	3.5%	✓ 3.1%	✓ 2.9%	✓ 3.0%	✓ 3.1%	3.5%	DoW	Jul-17	Y	National	3.8% (EoE orgs)	Dec-15		A	£ Payments made to staff for nil productivity
	●	Vacancy rate	9.0%	✗ 12.7%	✗ 13.0%	✗ 12.3%	✗ 12.7%	9.0%	DoW	Jul-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%	✗ 76.5%	✗ 90.0%	✓ 90.02%	✓ 90.0%	90.0%	DoW	Jul-17	Y	National	85% (local survey)	Dec-15		G	
		Mandatory Training	90.0%	✗ 89.2%	✓ 92.1%	✓ 91.7%	✓ 90.2%	90.0%	DoW	Jul-17	Y	Local	86% (local survey)	Dec-15		G	
	●	% Bank Pay**	8.0%	✗ 9.9%	✗ 10.3%	✗ 9.1%	✗ 9.7%	8.0%	DoW	Jul-17	Y	Local	n/a			G	£ Costs at established rates rather than premium
	●	% Agency Pay**	8.0%	✗ 8.2%	✗ 8.0%	✗ 9.0%	✗ 8.7%	8.0%	DoW	Jul-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%	✓ 18.5%	✓ 18.9%	✓ 18.6%	✓ 18.8%	22.6%	DoW	Jul-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)*		✓ 7.3%	✓ 7.5%	✓ 8.5%	✓ 7.9%		DoW	Jul-17	Y	National	n/a			G	£ Premium payments of various types vs established rates
	●	Inpatient FFT response rate	50.0%	✗ 19.9%	✗ 22.2%	✗ 21.9%	✗ 21.4%	50.0%	CN	Jul-17	Y	National	26.0%	Jun-17		G	
	●	A&E FFT response rate	15%	✗ 3.8%	✗ 4.7%	✗ 5.7%	✗ 4.3%	15.0%	CN	Jul-17	Y	National	13.0%	Jun-17		G	
		Daycases FFT response rate	tbd NHSI^	37.5%	26.9%	39.2%	32.1%	tbd NHSI^	CN	Jul-17	Y	National	n/a			G	
	◆	Staff FFT response rate	50%	✗ 16.2%	N/A	✗ 15.7%	✗ 14.7%	50%	DoW	Mar-17	Y	National	n/a			G	
		Staff FFT % recommended work	tbd NHSI^	57.4%	N/A	58.5%	57.5%	tbd NHSI^	DoW	Mar-17	Y	National	n/a			G	
		Maternity FFT response rate	35%	✗ 29.0%	✓ 44.8%	✓ 52.5%	! 38.9%	35%	CN	Jul-17	N	National	24.0%	Jun-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

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West Hertfordshire Hospitals NHS NHS Trust

Detailed reports

Finance (Overview)

Financial Overview as at 31 July 2017

Month 4 Income & Expenditure

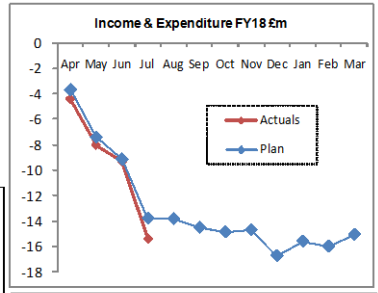
£m	Plan	Actual	Var
Surplus / (Deficit)	(4.6)	(6.0)	(1.4)

£m	Year to Date		
Surplus / (Deficit)	(13.8)	(15.4)	(1.6)

Statutory / Regulatory Duties

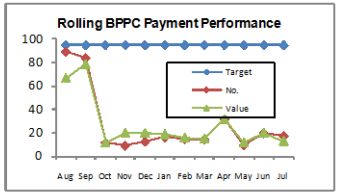
Breakeven	The Trust has a deficit plan of £15m for FY18.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 31/07/17 equated to 8.6 days' spend	R
BPPC	Month 4 performance - % by number and % by value (95% target)	R

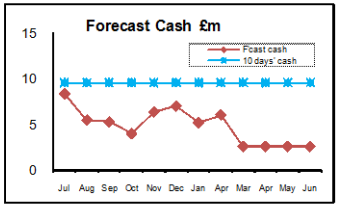
Financial Risk Rating	FY18	3

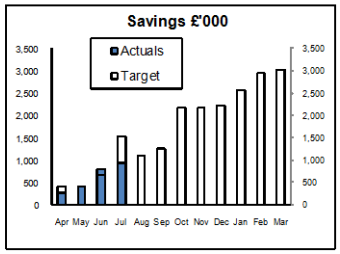


FY18 YTD Variance by Division

	£m	% Budget
Medicine	0.6	214
Unscheduled Care	(0.4)	(10)
Surgery	(1.2)	(37)
Women's	0.2	4
Clinical Support	0.4	17
Estates & Facilities	0.0	0
Corporate	0.3	2
Other	(1.5)	
Total	(1.6)	







Operational performance

Control total of £15.0m deficit received and accepted by the Trust. Deficit of £15.4m YTD July (£1.6m adverse to plan) including CQUIN & STF adjustments relating to missing the prior year control total (£0.9m & £0.7m respectively). The Trust would have been on plan if not for these two factors; Even so, the year will become progressively more challenging financially and the detailed finance report explains the intended recovery plans.

Savings and outlook for FY18

Savings achieved at £2.45m up to M4, slightly ahead of plan, i.e. projects costed vs actual delivery). 2017/18 Trust savings target is £21.9m to a control total of £15.0m. Of this, £13.7m has so far been assigned to divisions and £9.3m identified, i.e. £3.4m gap + unassigned total of £8.2m = £11.6m to find.

Forecast for the year is still to achieve the control total, with a number of risk areas identified and mitigation underway.

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 actions throughout the year, monitored primarily through Finance & Investment Committee.

Finance (I&E)

West Hertfordshire Hospitals NHS Trust

Statement of Comprehensive Income (I&E)

Month 4 (Jul) Budget	Month 4 (Jul) Actual	Month 4 (Jul) Var		FY18 Budget	YTD Budget	YTD Actual	YTD Var	Prior Year Actual
			Volumes					
3,202	3,387	185	Elective	42,806	14,076	14,456	380	13,968
3,659	4,406	747	Non elective	49,525	16,104	16,810	706	16,452
34,614	36,817	2,202	Outpatient	433,803	149,045	147,432	(1,613)	143,849
8,703	10,136	1,433	A&E	117,791	38,301	39,931	1,630	39,669
£000's	£000's	£000's	**NHS REVENUE**	£000's	£000's	£000's	£000's	£000's
4,084	4,096	11	Elective	55,461	17,894	17,433	(461)	17,843
7,461	8,102	640	Non elective	100,978	32,835	34,773	1,938	31,930
5,229	5,274	45	Outpatient	70,191	22,624	22,257	(368)	23,899
1,185	1,401	217	A&E	16,032	5,213	5,431	217	4,973
1,018	974	(45)	Critical care	13,781	4,481	4,493	12	4,795
3,176	2,931	(245)	Other NHS revenue	42,978	13,975	13,337	(638)	13,476
22,153	**22,777**	**625**	**TOTAL NHS REVENUES**	**299,421**	**97,022**	**97,723**	**701**	**96,916**
22	12	(9)	Private Patients	259	86	72	(14)	81
756	155	(601)	Other non-NHS clinical income	11,306	2,394	1,794	(600)	4,645
777	**168**	**(610)**	**TOTAL Non NHS Clinical**	**11,565**	**2,481**	**1,866**	**(615)**	**4,726**
716	719	3	Education & Training	8,590	2,863	2,938	75	2,796
1,117	1,173	56	Other Revenue	15,193	5,128	5,343	215	5,427
1,833	**1,892**	**59**	**TOTAL OTHER REVENUE**	**23,784**	**7,992**	**8,282**	**290**	**8,223**
24,763	**24,837**	**74**	**NET HOSPITAL REVENUE**	**334,769**	**107,495**	**107,871**	**376**	**109,865**

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 M4.

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 100% achievement at this stage less PY adjustment.
- Final FY17 income remains under discussion.

Operational performance

NHS income was £701k above plan YTD (£625k above in month), with a favourable variance in Non-Elective (£1,938k) offset by Elective (£461k), Outpatients (£368k) and Other (£638k).

Other income was £325k adverse YTD (£551k in month) primarily due to STF income assumptions offset by favourable car parking income.

Finance (I&E)

Statement of Comprehensive Income (I&E)

Month 4 (Jul) Budget	Month 4 (Jul) Actual	Month 4 (Jul) Var		FY18 Budget	YTD Budget	YTD Actual	YTD Var	Prior Year Actual
18,695	17,632	1,063	Permanent / Bank Staff	222,984	74,697	70,578	4,118	64,836
534	1,745	(1,210)	Agency	6,340	2,086	6,740	(4,654)	9,846
(571)		(571)	Unidentified pay savings	(9,391)	(679)		(679)	
18,658	**19,377**	**(719)**	**TOTAL PAY**	**219,933**	**76,103**	**77,318**	**(1,215)**	**74,682**
1,507	1,707	(199)	Drugs	21,313	6,764	7,295	(531)	7,319
2,476	2,353	123	Clinical services	32,729	10,598	10,135	463	10,596
6,171	6,614	(442)	Non-clinical services	70,608	24,396	25,177	(781)	24,062
(323)		(323)	Unidentified non-pay savings	(5,692)	(246)		(246)	
9,832	**10,673**	**(842)**	**TOTAL NON-PAY**	**118,959**	**41,512**	**42,607**	**(1,095)**	**41,978**
(3,727)	**(5,213)**	**(1,486)**	**EBITDA**	**(4,123)**	**(10,120)**	**(12,055)**	**(1,935)**	**(6,795)**
709	630	79	Depreciation & Amortisation	8,500	2,836	2,447	389	2,611
129	134	(5)	Interest	1,545	518	584	(66)	525
73	73	0	Dividends Payable	872	292	291	2	813
(4,638)	**(6,049)**	**(1,411)**	**Surplus / (Deficit)**	**(15,040)**	**(13,766)**	**(15,375)**	**(1,609)**	**(10,744)**

Outlook for FY18

The FY forecast remains within the control total, noting likely variations up and down the I&E statement as CIPs are identified and operational changes managed (>£13m unidentified at M4 + STF income issues are greatest risks).

Operational performance

Pay costs were £1.2m adverse YTD (Medical £0.9m adv, Other Clinical £0.4m adv & Unidentified CIP £0.7m, offset by Non-Clinical £1.1m fav). Focus on agency management continues agency cost trend established in FY17, £0.3m behind plan YTD.

Non-pay costs were £0.8m 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

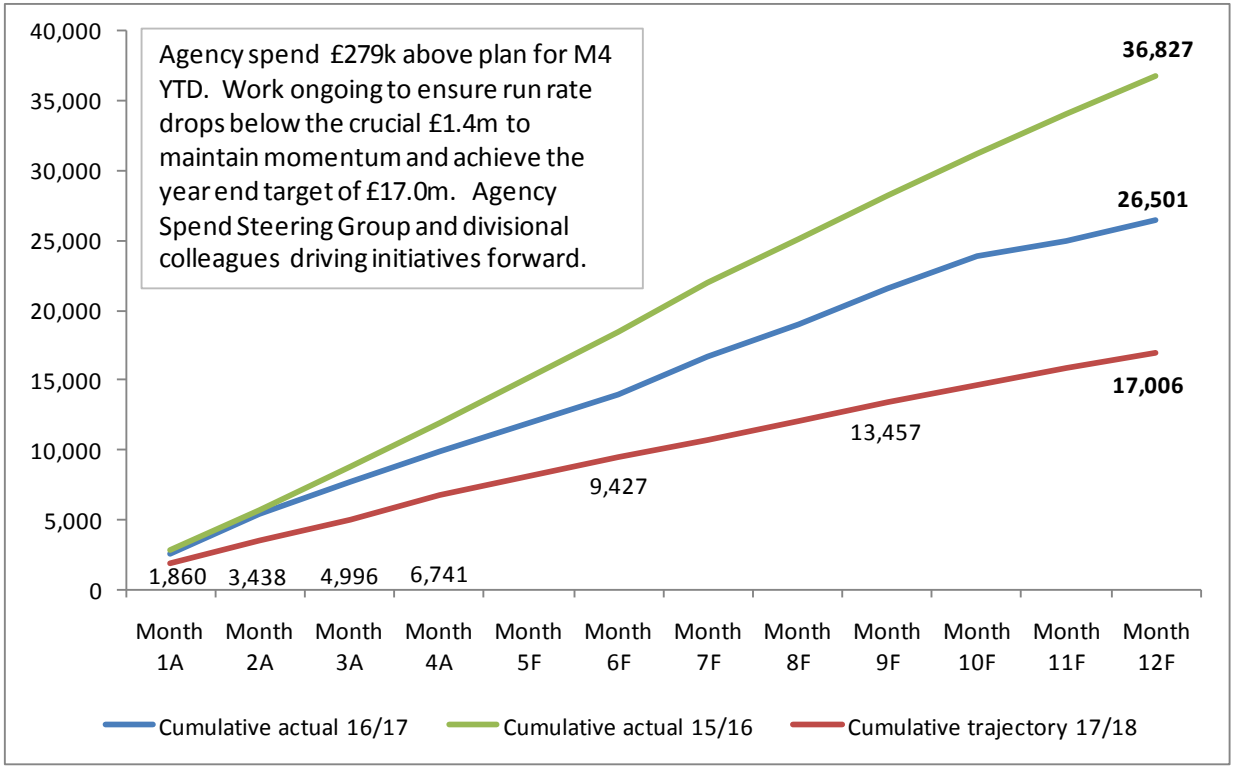
CIP schemes are a combination of expenditure, income, and transformational schemes.
All cross-cutting CIP themes are closely monitored through formal meetings and operational actions. Targets must be met, alongside other important schemes, in order to avoid greater financial difficulties for the Trust,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

Finance (Agency)

Agency spend trajectory

	Month 1A	Month 2A	Month 3A	Month 4A	Month 5F	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	8,084	9,427	10,770	12,113	13,457	14,640	15,823	17,006
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	1,343	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 on target First month results were slightly higher than planned, with months 2 & 3 coming back in line. Plans being implemented to maximise the chances of achieving Q2-4 and FY targets.

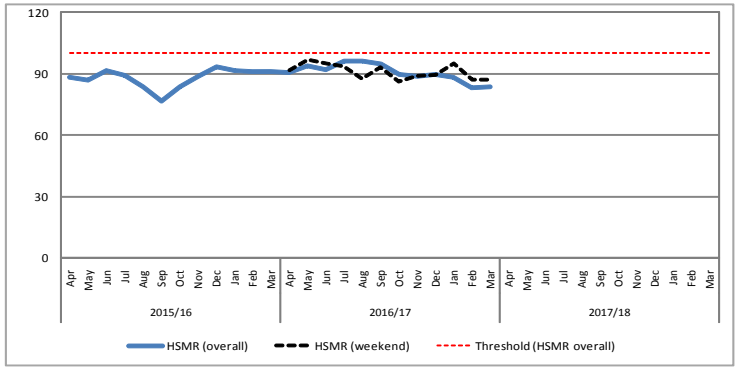
Safe, effective, caring

Reporting sub committee - S&C & COEC

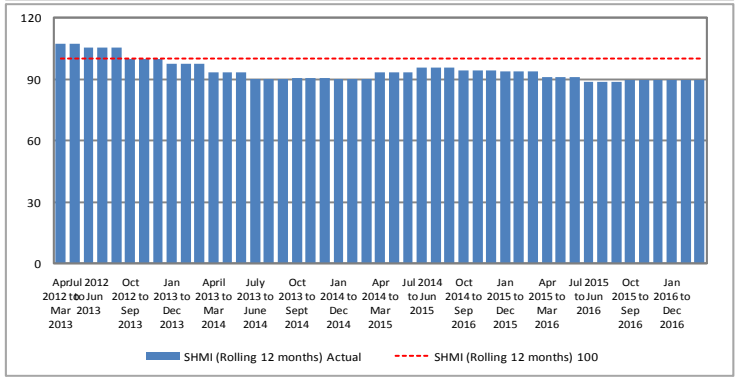
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

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

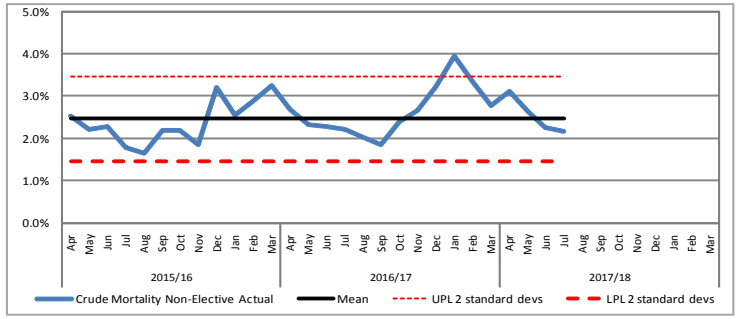
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



Hospital mortality indices continue to demonstrate sustained improvement. Recent intelligence from Dr Foster benchmarks he Trust against the Shelford group , which would place WHHT as one of six trusts in that peer group that sit within the 'lower than expected' range, and has the third lowest HSMR within the East of England region. Nationally, WHHT had the 23rd lowest HSMR out of 136 non specialist trusts, placing the Trust in the top 17% when compared across England.

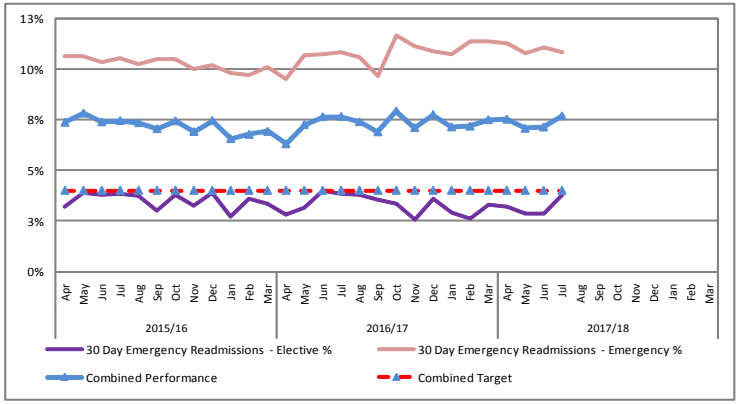
For the most recent 12 month period (April 2016 to March 2017), the Trust's HSMR of 90.7 was in the 'lower than expected' range.

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'.

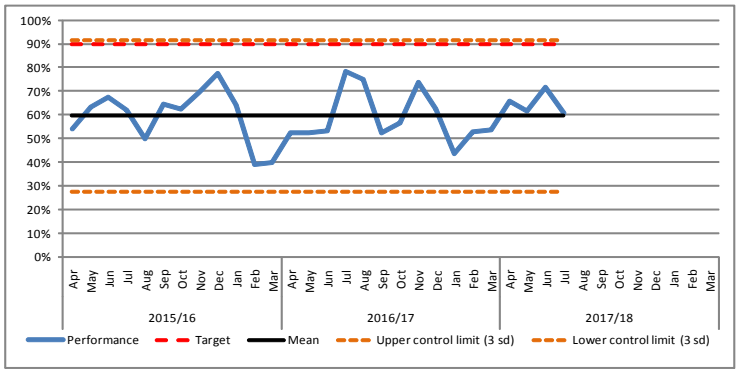
% Emergency re-admissions within 30 days following an elective or emergency spell*



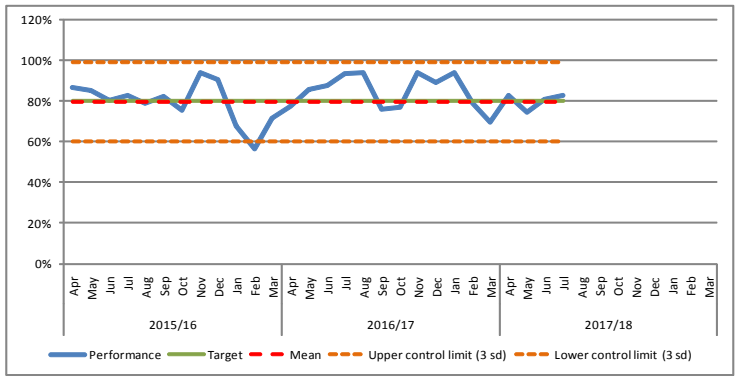
Emergency Readmissions
Combined emergency readmission rates, including both emergency and elective admissions have remained at a similar level to the previous month. The indicator includes all patients with more than one admission to the hospital within a period of 30 days, regardless of whether the 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.

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)

Stroke
Performance during July was 60.9% (target 90%) for admission within 4 hours to the stroke unit, with 90% of 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 a long 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.

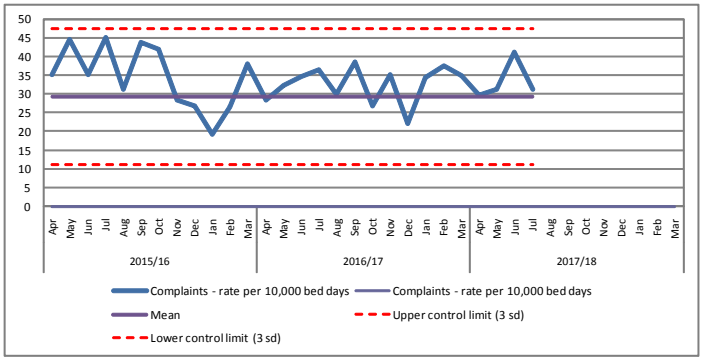
Maintaining ring fenced capacity for stroke patients remains a focus operationally.

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%

West Hertfordshire Hospitals NHS
NHS Trust

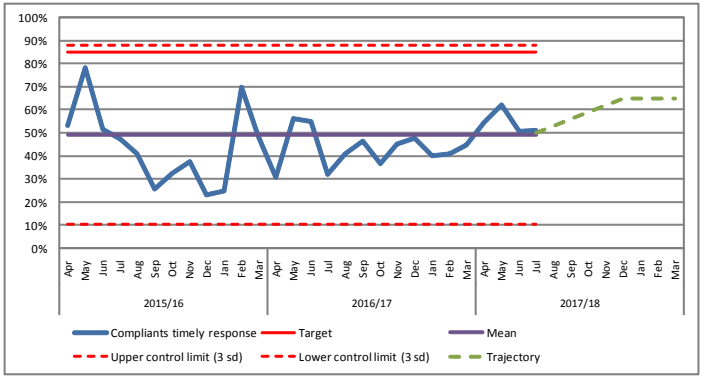
Complaints - rate per 10,000 bed days



Complaints rate per 10,000 bed days

61 new complaints were received in July, of which 25% (15) relate to Surgery, Anaesthetics and Cancer (SAC), 23% (14) relate to Unscheduled Care (USC), 20% (20) relate to environment (nearly all Transport related) 10% (6) relate to Women's and Children's (WACS), 5% (3) relate to Clinical Support , 3% (2) relate to corporate & only 2% (1) complaint received for Medicine. This month the most common themes were transport (13 - 21%), admissions, discharge and transfer arrangements (12 - 20%), clinical care (10 - 17%), cancellation of appointments (7 - 11%,) and communication (6 - 10%).

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

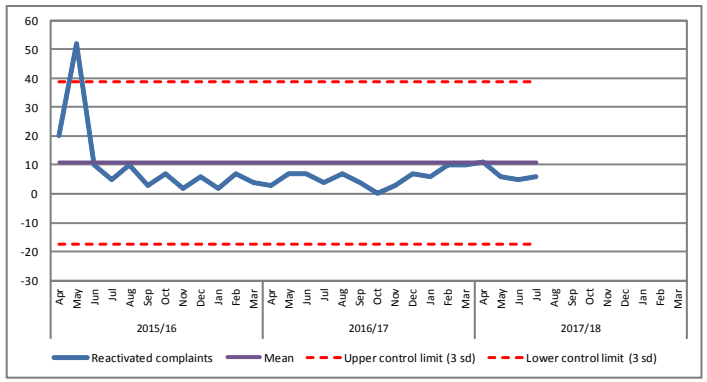


% Complaints responded to within one month or agreed timescales with complainant

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 July 51% of complaints were responded to on time. 52 responses were sent in total. Consistent application of validation of response times has improved data quality, resulting in a more accurate performance measure. Complaints responded to on time, by division, is as follows

	May-17	Jun - 17	Jul - 17
Trust wide	62.1%	52%	51%
Medicine	100%	67%	67%
USC	33.3%	31%	33%
SAC	66.7%	57%	57%
WACS	55.6%	42%	31%
Environment	25%	67%	33%
CSS	87.5%	100%	100%
Corporate	100%	50%	N/A

Number of reactivated complaints



	Target	Jul– 17
% of complaints acknowledged within 3 working days	100%	78%
% of complaints responded to within the agreed timescale	85%	51%

Six complaints were reactivated in July, of which five were because the complainant was dissatisfied with the response. However, review of each of these complaints confirms they were answered in full.

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

Intentionally blank

Safe, effective, caring

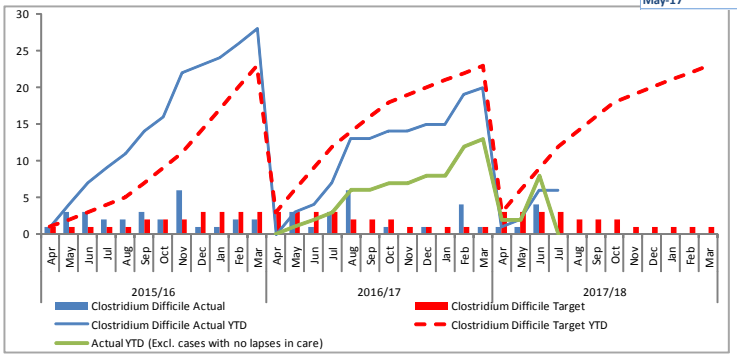
Reporting sub committee - S&C & COEC

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

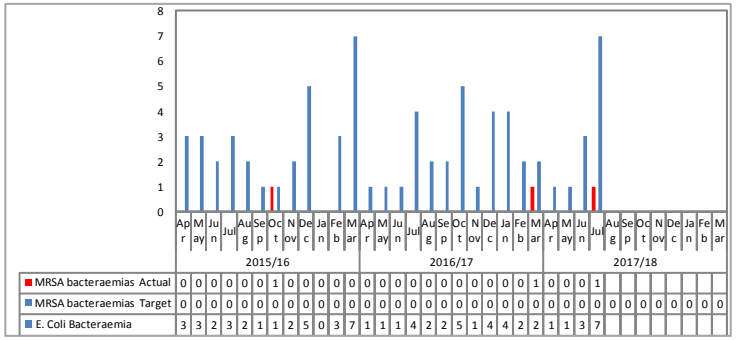
Performance relative to targets/ thresholds

	Achieving	Not achieving
Jul-17	2	4
Jun-17	4	2
May-17	3	3

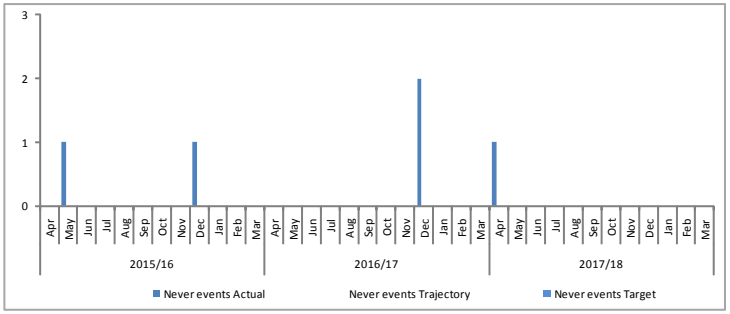
Clostridium Difficile



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 July. 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. 1 MRSAb was reported in July. Following Post Infection Review (PIR) which included all organisations involved in the patient's care pathway, it was agreed to assign this case to WHHT. Key learning: 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.

E. Coli bacteraemia (*E colib*)

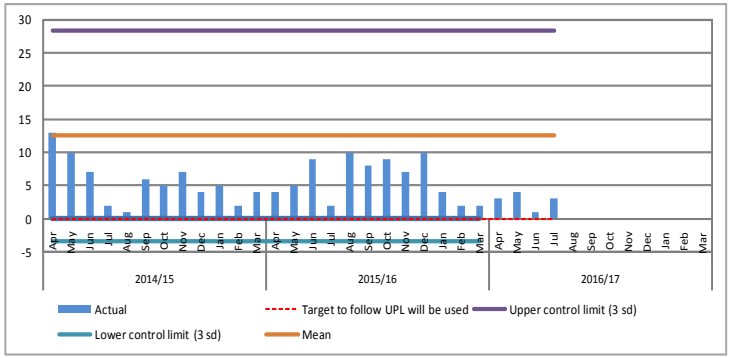
7 cases of post 48hrs E. colib were reported in July. The target set for the CCG this year is a 10% reduction which equates to 36 cases. There is no target for WHHT. The national DIPC has asked organisations to work together across the whole health and social care sector to jointly develop an improvement 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

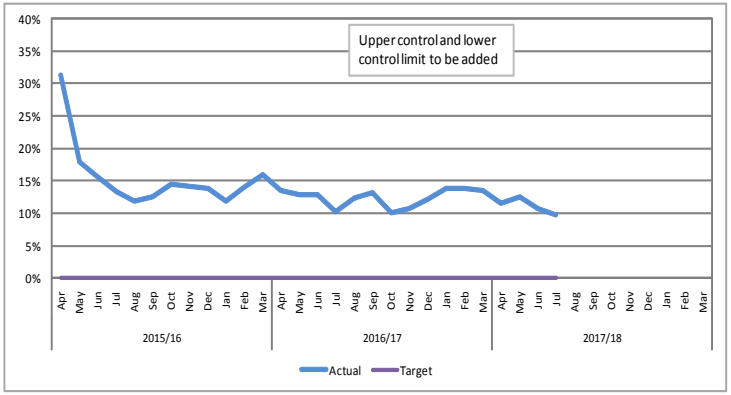
There were no never events in July 2017.

West Hertfordshire Hospitals NHS Trust

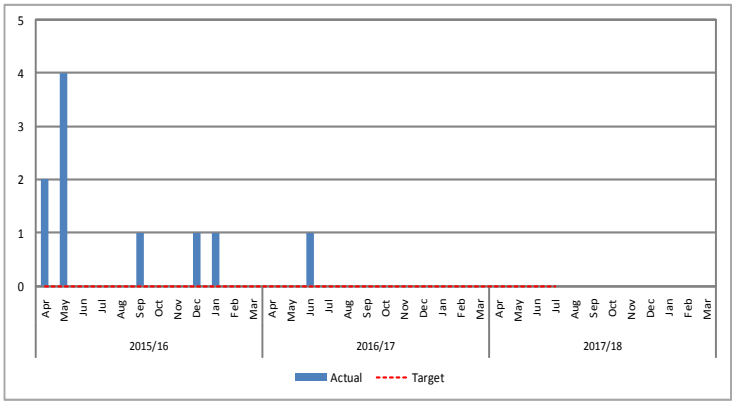
Serious incidents



% of reported patient safety incidents that are harmful



Medication errors causing serious harm*



Serious Incidents

There were 3 Serious Incidents (SI) declared in July 2017, which were as follows:

- 2 in Surgery, Cancer and Anaesthetics
- 1 in Women's & Children's Services

At the end of July there were 8 ongoing SI investigations, one of these was overdue with the estimated date of completion 2 weeks after deadline.

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.
- The SI review group (SIRG), chaired by the Associate Medical Director, review all closed SI action plans and senior divisional representation provides assurance and evidence that actions have been implemented before the SI is formally closed internally.

There were 3 x 45 day review meetings in July 2017.

A SIRG meeting was held on 28 July 2017. Eleven serious incident investigation action plans were reviewed, 5 of which were closed as adequate evidence was provided to the group demonstrating implementation of actions from learning. A further six action plans were closed that had been presented previously to the Group as previously requested evidence of implementation of actions had been provided.

% of patient safety incidents which are harmful

9.69% of incidents reported in July 17 were recorded as harmful, which is consistent with the decreasing trend recorded since March 2017 (13.38%). There has also been a 1.1% decrease of incidents recorded as harmful from June 2017 (10.79%) to July 2017 (9.69%). 18 incidents were scored as moderate or above in July 2017 of which 7 still require harm validation and are therefore subject to change. This is a significant decrease from 30 incidents reported as moderate or above in June 2017.

Medication incidents causing serious harm

There were no medication errors causing serious harm in July 2017

Safe, effective, caring

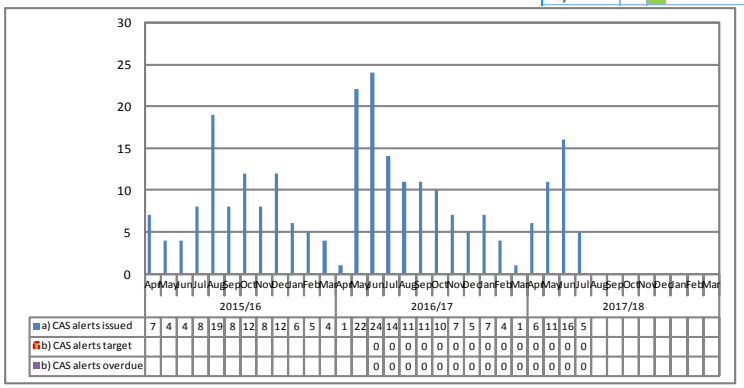
Reporting sub committee - S&C & COEC

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

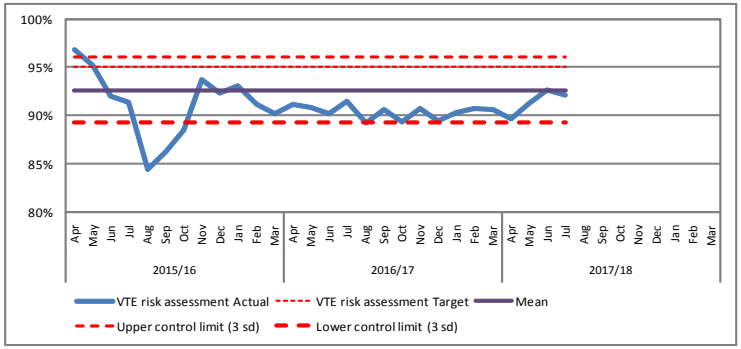
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Jul-17	1	4
Jun-17	1	4
May-17	1	4

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*



There were 5 alerts issued in July 2017, of which 2 were medical device alerts which have been sent to the Divisions and procurement , 2 estates and facilities alerts which have been sent to the Environment Division and 1 patient safety alert for which a designated Trust lead has been appointed.

Issued by CAS	5
Breached in month	0
Currently overdue	0
CAS alerts not acknowledged within 48hrs	0

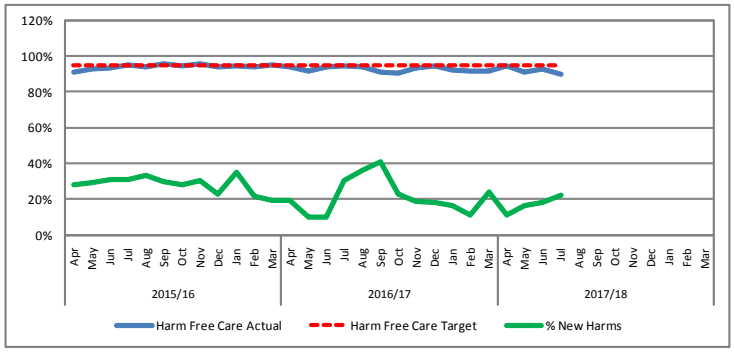
All alerts issued by CAS in July 2017 were acknowledged within the 48hr deadline. There were no breaches during July 2017 and all alerts with deadlines were closed on time.

VTE

VTE risk assessment compliance remains suboptimal. An audit (April 2017) of the VTE risk assessment forms which have been classified as non-compliant, has been undertaken by clinicians in order to gain understanding of the problem and to ascertain whether appropriate thromboprophylaxis was prescribed in these patients. This showed that the majority of patients did receive appropriate thromboprophylaxis despite incomplete risk assessment form completion.

The audit also highlighted groups of patients who should be exempt from VTE risk assessment who were previously included (eg patients on anticoagulation treatment and those who will be started on anticoagulants for acute coronary syndrome). In addition a more “fit for purpose” version of the risk assessment form has been devised for patients with stroke. These new measures should increase compliance figures and improvement over the next 3 months is anticipated. Clinical areas identified with particularly poor compliance will be targeted and juniors will receive regular reminders to complete VTE risk assessments.

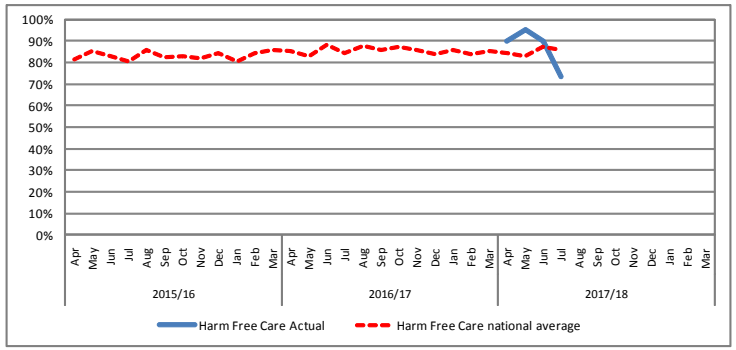
Adult Safety Thermometer: Harm Free Care and New Harms



Adult Safety Thermometer: Harm Free Care and New Harms

July 2017	National	WHHT	Milton Keynes	East and North	The Hillingdon
Pressure Ulcers - New	0.96	0.65	1.42	0.19	0.49
Catheter & New UTI	0.30	0.82	-	0.19	-
Catheters	13.42	19.09	19.67	18.41	19.46
Falls with Harm	0.51	0.33	-	-	0.24
All New VTEs	0.40	0.49	-	1.52	0.97
New Harm Free	97.83	97.72	98.58	98.10	98.54

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 July Harm Free Care was 89.7%, below the national average of 94.2%. This includes harms acquired both inside and outside of the Trust..

New Harm Free care (harms acquired in the Trust) for July 2017 was 97.72%, below the national average of 97.83%.

Children and Young People's Services Safety Thermometer

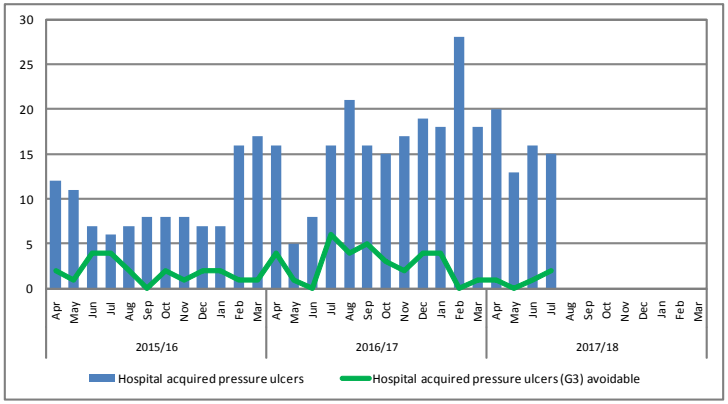
Harm includes patients with an EWS completed, triggered and not escalated, extravastion, patients in pain at point of survey, any pressure ulcer or any moisture lesion

Harm free care was 73.3% in July compared to 83.0% nationally. An analysis of the July 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 observed in 6.7% of patients from an IV device in the last 24 hours, including any device in situ or one removed within the last 24 hours. No patients had a pressure ulcer or moisture lesion at the point of the survey. Twenty percent of patients reported being in pain at the point of the survey, compared to 7.0% nationally.

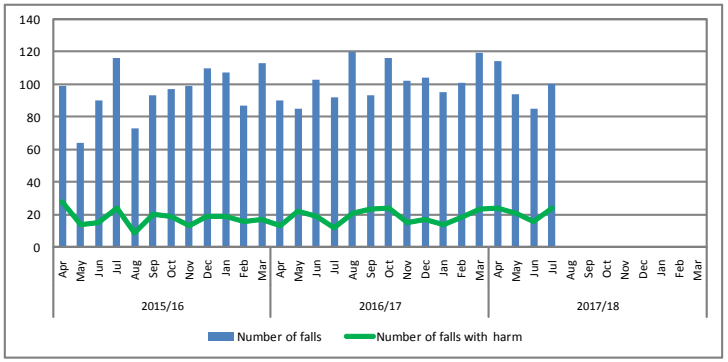
Harm Free Actions

- 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.
- Relaunch of protected mealtimes
- 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 July there were 17 new pressure ulcers, 13 grade 2 and 3 grade 3 of which 1 was deemed unavoidable. 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 increase in July with the avoidable Grade 3 pressure ulcers . When compared to July 16 an improvement can be seen in the total amount of hospital acquired pressure damage .

An improvement plan is in place to continue the focus on reducing pressure damage as part of harm free care.

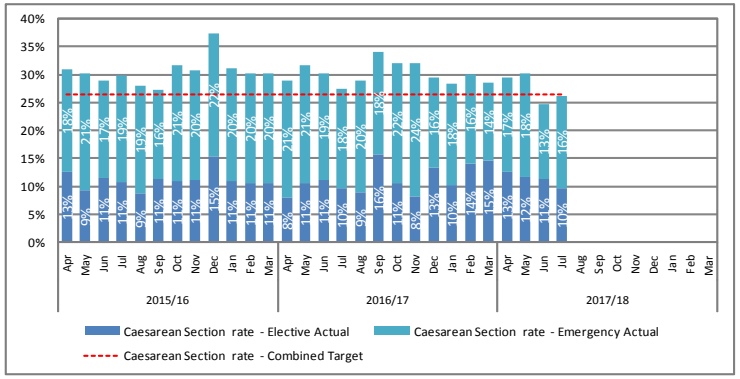
Falls and falls with harm

In July there were 99 falls with 29 resulting in harm – 28 low harm, and 1 moderate harm which was fractured finger on an inpatient ward.

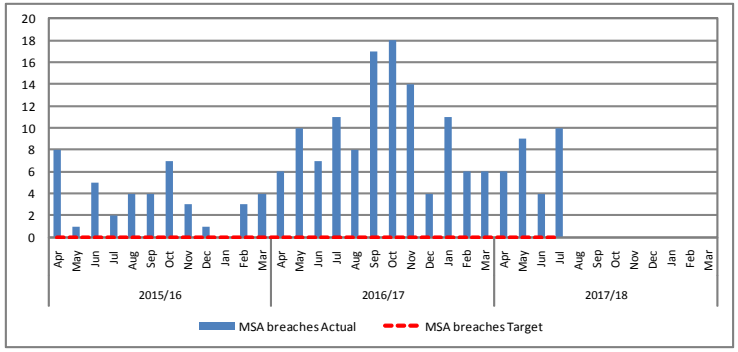
In relation to the numbers of falls – falls with harms remains low.

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

C-section rate



Mixed sex accommodation



C-section rate

Women are offered greater choice for VBAC and greater access to the Alexander Birthing Centre. Workshops rolling out the C-section toolkit are underway.

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

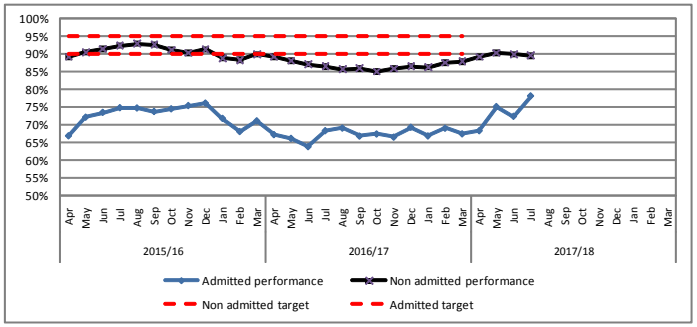
Access indicators - RTT, diagnostics, cancelled operations and outpatient appointments

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

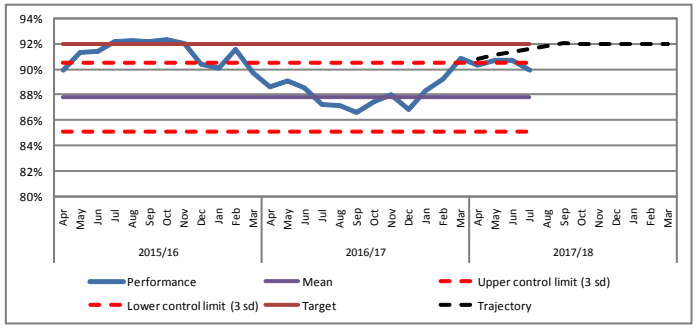
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Jul-17	5	2
Jun-17	5	2
May-17	5	2

West Hertfordshire Hospitals NHS
NHS Trust

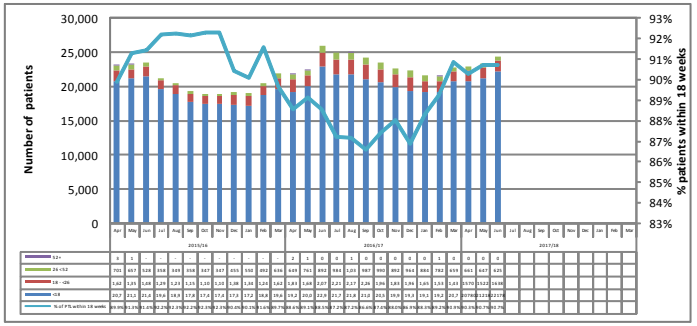
Completed pathways within 18 weeks



Incomplete pathways within 18 weeks



Incomplete pathways WL profile



RTT

Performance for July was 90%, a slight decrease on the previous month (90.7%). The most recent national data available (June) shows that the Trust's performance in June at 90.7%, remained better than the national average (90.4%) with 92% achieved at RFH and L&D but not E&NH (88.9%). The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was better than the national position (6.4 weeks vs 6.6 weeks) and better than the 92 percentile wait time (18.4 vs 19.5 weeks).

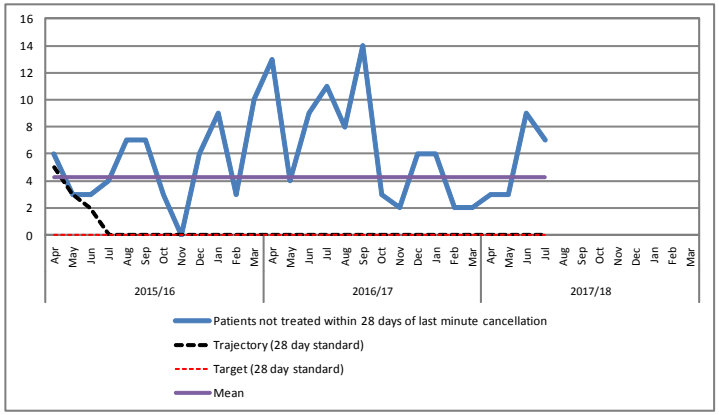
Operational challenges including the requirement to accommodate unplanned theatre ventilation works have severely impacted performance within the Surgical division, with a drop of 1.3% to 85.6%. Elective Medicine remains compliant at 95.78%, with slight improvement in WACS performance at 96.62%.

The backlog has increased slightly and currently represents 10% of the total PTL.

Service	18 Weeks Plus	% Under 18 Weeks
ORTHODONTICS	35	78.13%
ENT	436	79.89%
OPHTHALMOLOGY	497	80.82%
PAIN MANAGEMENT	105	84.42%
UROLOGY	178	85.13%
TRAUMA & ORTHOPAEDICS	542	85.70%
VASCULAR SURGERY	21	86.71%
GENERAL SURGERY	168	89.86%
PAEDIATRIC EPILEPSY	4	90.24%
UPPER GI SURGERY	5	90.74%
NEUROLOGY	74	92.56%
ORAL SURGERY	68	93.33%
PAED CLINICAL HAEMATOLOGY	1	94.44%
COLORECTAL SURGERY	29	94.60%
RESPIRATORY MEDICINE	34	94.86%
ORTHOTICS	8	94.90%
PAEDIATRICS	39	95.14%
CARDIOLOGY	79	95.23%
PAEDIATRIC UROLOGY	6	95.42%
DERMATOLOGY	97	95.89%
DIABETIC MEDICINE	3	96.15%
RHEUMATOLOGY	15	96.42%
PAEDIATRIC CARDIOLOGY	1	97.37%

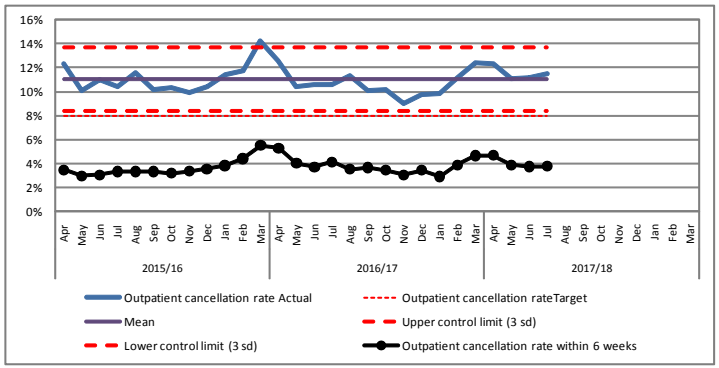
Service	18 Weeks Plus	% Under 18 Weeks
GASTROENTEROLOGY	24	97.70%
CLINICAL HAEMATOLOGY	6	97.81%
PAEDIATRIC ENDOCRINOLOGY	1	97.83%
BREAST SURGERY	7	97.93%
GYNAECOLOGY	18	98.14%
PAEDIATRIC DERMATOLOGY	1	98.18%
ENDOCRINOLOGY	5	98.25%
PAED GASTROENTEROLOGY	1	98.65%
NEPHROLOGY	1	98.67%
PAEDIATRIC OPHTHALMOLOGY	1	98.86%
GYNAECOLOGICAL ONCOLOGY	1	99.24%
GENERAL MEDICINE	0	100.00%
GERIATRIC MEDICINE	0	100.00%
HEPATOLOGY	0	100.00%
STROKE MEDICINE	0	100.00%
TRANSIENT ISCHAEMIC ATTACK	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
OBSTETRICS	0	100.00%
MIDWIFE EPISODE	0	100.00%
ORTHOPTICS	0	100.00%
CLINICAL ONCOLOGY	0	100.00%
Total	**2511**	**90%**

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

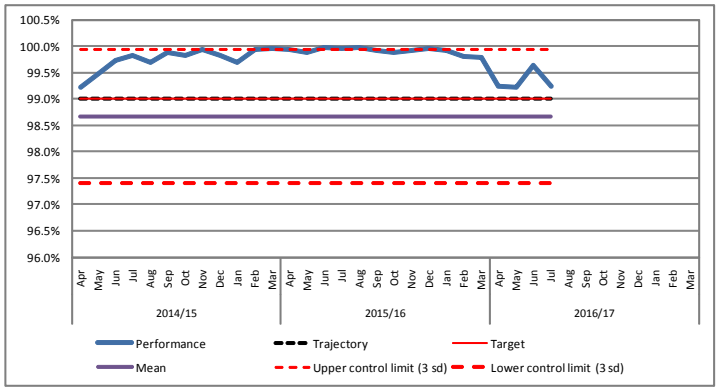


Hospital outpatient cancellations all and % cancelled* within 6 weeks

*(*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 7 breaches of the 28 day rebooking requirement, an improvement on June (9) –Ophthalmology (4), General Surgery ( ) and Urology (1). Two breaches were the result of lack of anaesthetic cover, three were not booked within the 28 day window, one was cancelled for a second time because equipment was unavailable, and one was cancelled because of bed capacity.

Hospital cancellations – patients cancelled within 6 weeks and overall

Short notice, hospital initiated cancellation is consistently below the Trust tolerance (5%) at 3.8% (excluding valid cancellations and patient initiated cancellations).

Total cancellations: 25.0%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
11.5%	3.8%	13.5%	10.7%

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.

Consistently strong performance against this standard continues and remains better than the national position, although increased demand continues in Cardiology.

Responsive

Reporting sub committee - TEC

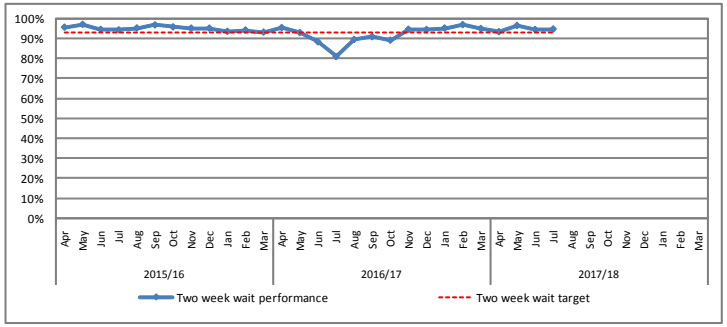
CWTs

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

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

West Hertfordshire Hospitals NHS
NHS Trust

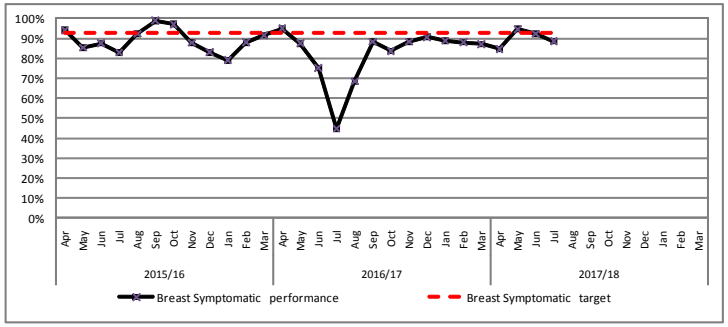
Two week standard



2ww

The provisional position for July is compliant at 94.6%

Breast symptom two week standard

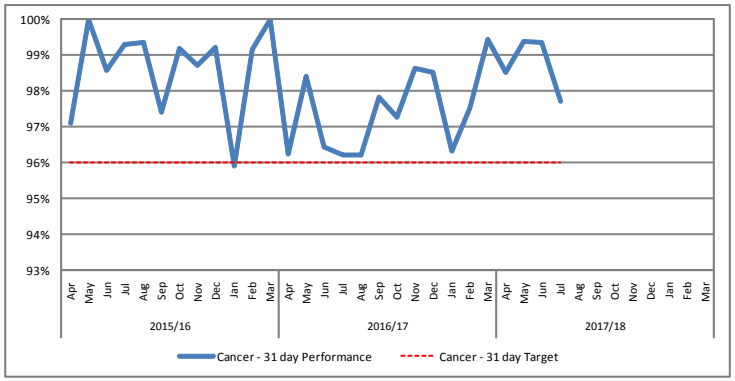


Breast symptomatic

The provisional position for July is non-compliant at 88.6% . The month saw the second highest number of referrals, with 20 breaches against the standard.

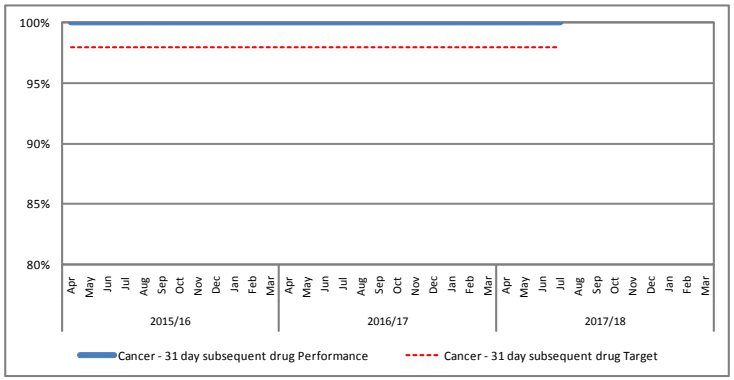
Work to reduce the wait between referral and first offered appointment is underway, with a reduction to day 9 (from day 11 in June) and further improvement is anticipated.

31 day standard



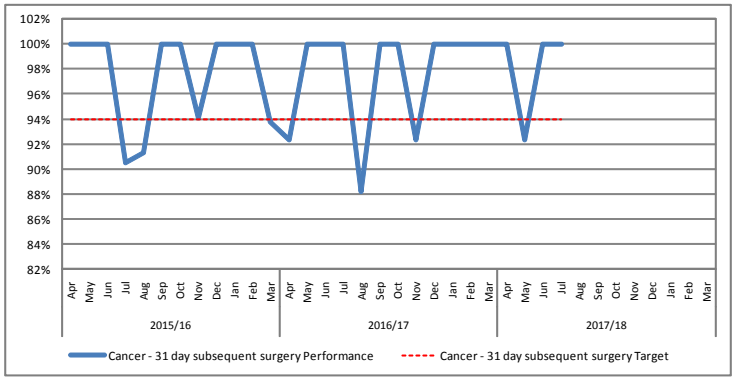
31 day first
June is compliant at 97.7%

31 day subsequent drug standard



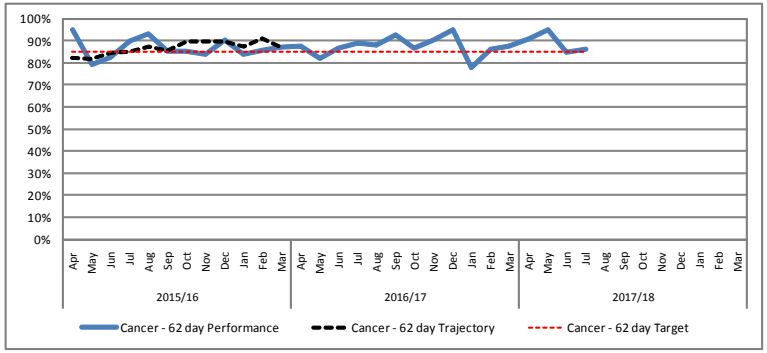
31 Day subsequent Drug, Palliative Care & Other
June is compliant at 100%

31 day subsequent surgery standard

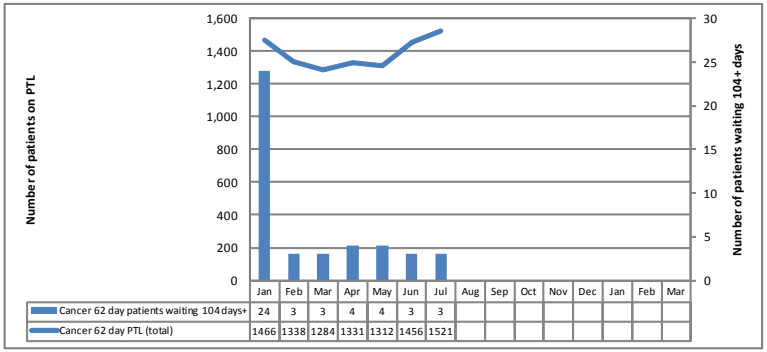


31 day subsequent –Surgery
Performance has recovered to a compliant position at 100%.

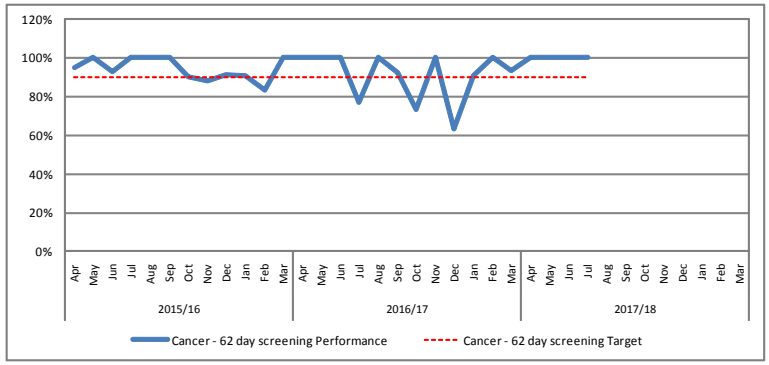
62 day standard



62 day standard number of 104+ day waiters



62 day screening standard



62 day GP – urgent

The provisional position for July is compliant at 86.4% (target 85%) with 10.5 breaches. Performance and breach counts across the tumour types is as follows:

Tumour type	July (prov.)
Breast	96.6
Gynaecological	87.5
Haematological	
Head and Neck	100
Lower GI	80
Lung	55.6
Skin	95
Upper GI	85.7
Urological	78
Total	**86.4**

TumourType	Breach count
Breast	0.5
Gynaecological	0.5
Lower Gastrointestinal	0.5
Lower Gastrointestinal	0.5
Lung	0.5
Lung	0.5
Lung	0.5
Lung	0.5
Other	0.5
Skin	1
Upper Gastrointestinal	0.5
Urological	0.5
Urological	0.5
Urological	0.5
Urological	0.5
Urological	0.5
Urological	1
Urological	0.5
Urological	0.5

104 day waits

There are 3 open pathways, of which 2 patients are awaiting clinical review following several DNAs and cancellations causing overall pathway delays. One patient has had an admission and the outcome is awaited.

The provisional number of 104 day breaches (pathways closed) in July is 9, the breakdown of which is as follows:

- In General Surgery there was one pathway delayed by patient choice.
- There were two patient choice and one tertiary centre capacity delays in Urology, and a further pathway breach where information is awaited.
- In respiratory medicine there were three complex pathway breaches.
- In Gynaecology there was one breach due to a delay in referral from another trust.

62 day screening

100% compliance achieved in July.

Responsive

Reporting sub committee - TEC

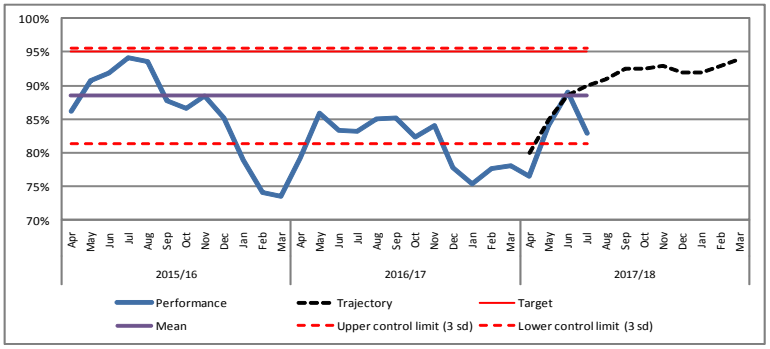
Unscheduled care indicators - A&E, ambulance turnaround and DToC

West Hertfordshire Hospitals NHS Trus

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

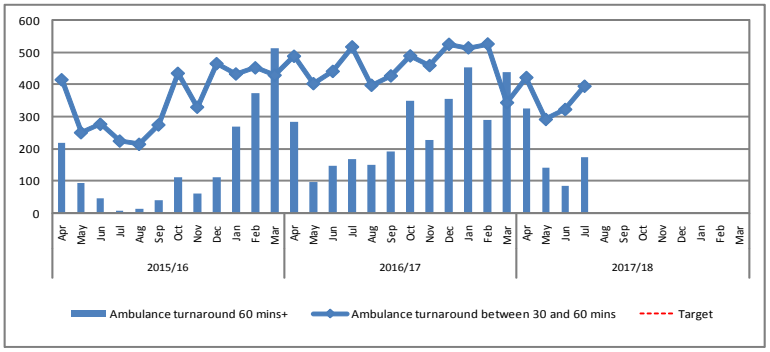
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Jul-17	1	4
Jun-17	1	4
May-17	1	4

A&E



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

Ambulance turnaround time



A&E performance in July was 82.9%, compared with June's performance of 89%. This was a similar level to performance in May (84%), and has fallen below the revised trajectory to meet compliance. Minors performance achieved 90.6%, CED maintained performance at 93.2%.

The percentage of A&E attendances that were admitted increased to 40% in July, compared with an average of 35% in the previous three months, and can be linked to the acuity of patients.

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, there were days in July when there were a number of overnight patients in Ambulatory Care and ESAU.

An external turnaround team to support the Trust in improving emergency care performance commenced in July.

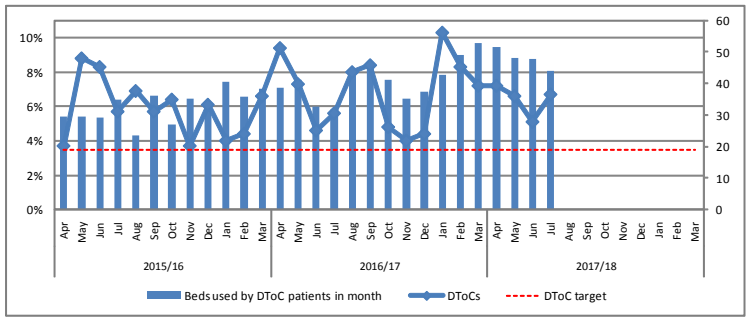
Performance continues to be monitored through the Emergency Department Transformation Meeting chaired by the Medical Director.

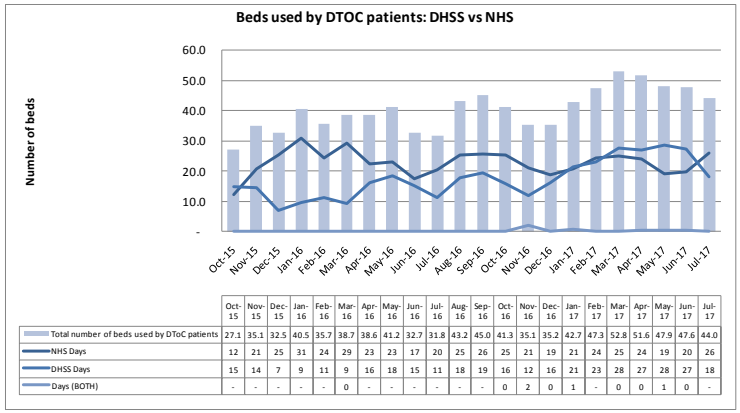
In line with performance against the 95% 4 hour standard, the improvement in ambulance turnaround times was not sustained. WHHT has increased the resource available to care for patients in the corridor so it can respond flexibly to any queue of ambulances to enable earlier release of crews.

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 -3.3%.
- Admission rate from A&E (excluding ambulatory and frailty) is up by 9.8%.

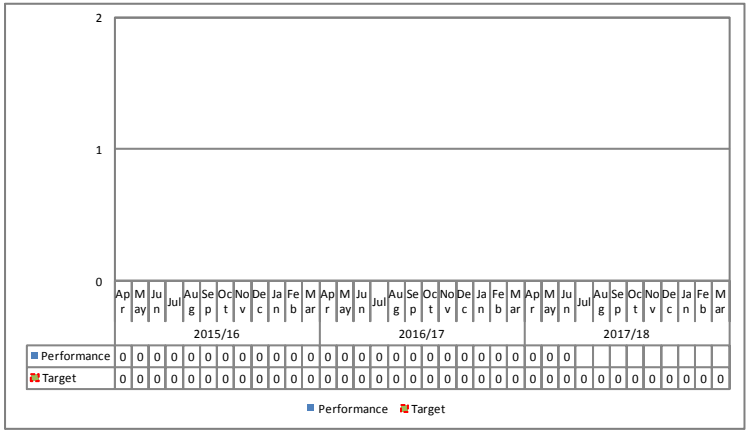
Delayed Transfers of Care (DToC)





	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
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
NHS Days	12	21	25	31	24	29	23	23	17	20	25	26	25	21	19	21	24	25	24	19	20	26
DHSS Days	15	14	7	9	11	9	16	18	15	11	18	19	16	12	16	21	23	28	27	28	27	18
Days (BOTH)	-	-	-	-	-	0	-	-	-	-	-	-	0	2	0	1	-	0	0	1	0	-

12 hour trolley waits



	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									
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

Delayed Transfers of Care

DToC patients represented 6.7% of occupied beds in July, 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 July DToC patients consumed 1364 bed days, the equivalent of 44 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.

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

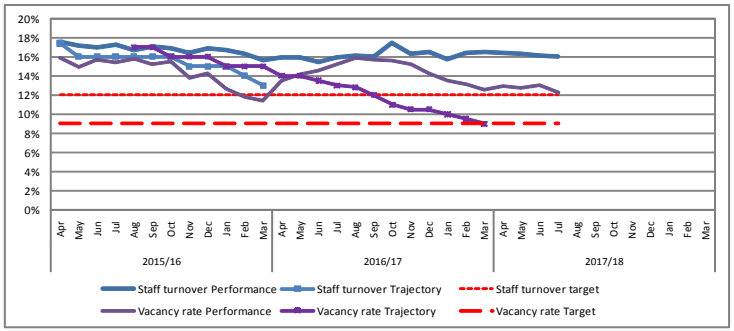
Reporting sub committee - PSE

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

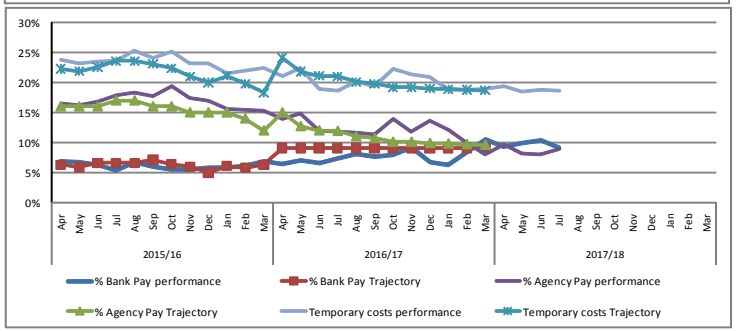
Executive lead	Clinical lead	Operational lead
Paul da Gama		

Performance relative to targets/ thresholds		
	Achieving	Not achieving
Jul-17	3	4
Jun-17	3	4
May-17	2	5

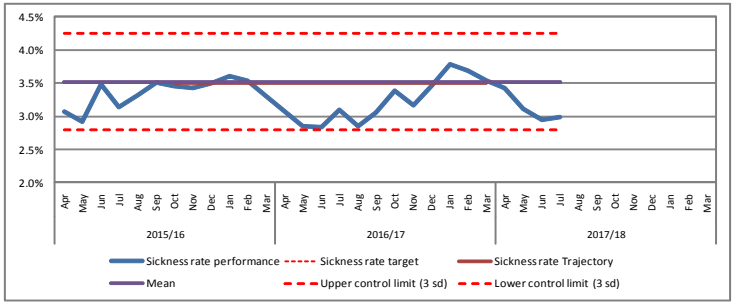
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate



Turnover and Vacancies

At the end of July the overall Trust vacancy rate decreased slightly from 13.0% to 12.3%. 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 12. Staff-in-post remains virtually unchanged from May, a month in which we saw the highest ever figure for the Trust, at 4,196 wtes. Within the overall figure, the vacancy rate for qualified Nursing & Midwifery posts rose marginally, from 17.5% to 17.6%. Recruitment activity has built up a large pipeline of new N&M recruits (currently 307 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 the same at 16.1%; 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 has a 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.

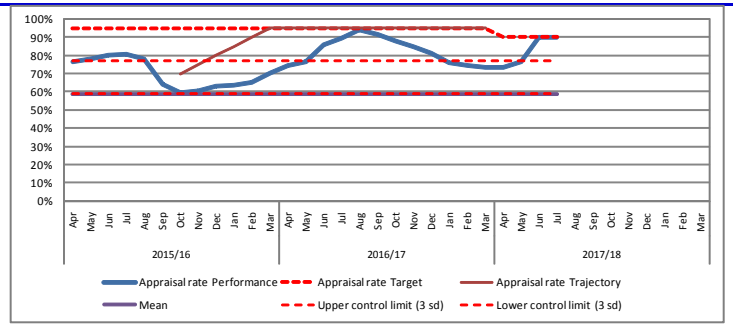
% Bank and Agency Expenditure

Agency spend in July increased from £1.56m to £1.75m and July spend represented 9.0% of the overall pay-bill compared to 8.0% in June. Agency spend had 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 decreased from 10.3% to 9.1%.

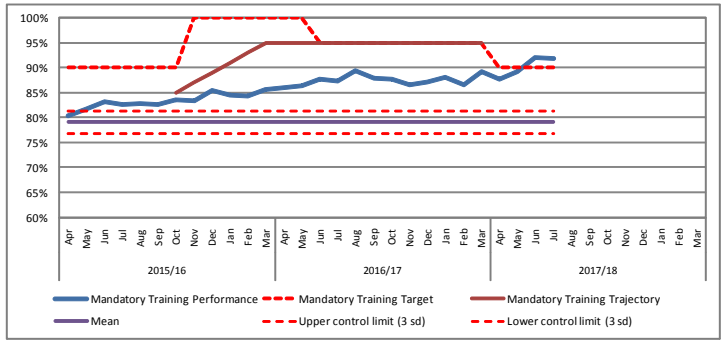
Sickness rate

The sickness absence rate rose from 2.9% in June to 3% in July, but is comfortably below the Trust target of 3.5%. The Trust is currently well below the Herts & Beds average, which stood at 3.8% at the end of Quarter 4. 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 3.1% in the current year to date.

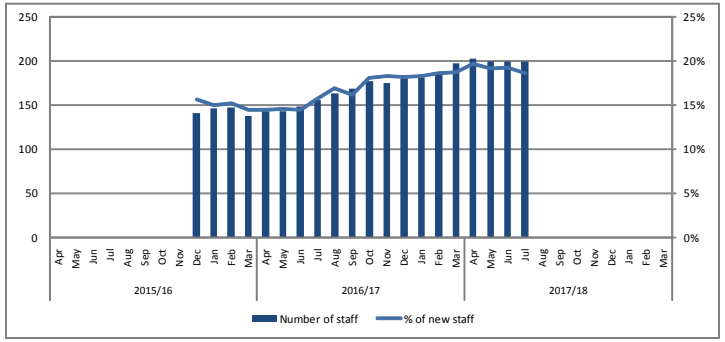
Appraisal rate
(non medical staff only)



Mandatory training



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



Appraisal – non medical staff

Appraisal rates have remained static at 90% 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. HR Business Partners are working with managers 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 has remained static at 92%. Retained focus is required to sustain and better compliance rates. The Trust has moved to more 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. 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.

Workforce BAF scorecard

Workforce Indictors - Progress Table
Progress against target - July 2017

KPI	Benchmark average	Performance 12 months ago	Performance 3 months ago	Current performance	Target	Distance to target	Better / worse than 3 months ago	Remaining Progress to target needed (%)
Vacancy	12%	15.2%	13.0%	12.3%	9.0%	3.3%	↘	37%
Turnover	16%	16.3%	16.4%	16.1%	12.0%	4.1%	↘	34%
Total Sickness	3.8%	3.1%	3.4%	3.0%	3.5%	-0.5%	↘	-14%
Sickness Short Term		1.4%	1.5%	1.3%	1.75%	-0.5%	↘	-26%
Sickness Long Term		1.7%	1.9%	1.7%	1.75%	-0.1%	↘	-3%
Non-Medical Appraisal	82%	89.0%	73.0%	90.0%	90.0%	0.0%	↗	0%
Medical Appraisal		99.0%	99.0%	99.0%	99.0%	0.0%	→	0%
Core Skills Framework	88%	87.0%	88.0%	92.0%	90.0%	2.0%	↗	-2%
Agency as a % of Paybill	8%	11.9%	9.7%	9.1%	8.0%	1.1%	↘	14%
Friends and Family Test	60.00%	57.0%	59.1%	53.7%	66.0%	-12.3%	↘	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 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 are 2 indicators that are within 60% to 80% of the target. (Turnover and Vacancies). 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.

For appraisals and core Training, the Trust has achieved its target of 90% for the second 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 9%, slightly higher than the 8% target.

Turnover rates have reduced to 16.1%.

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

Safe, effective, caring

Well led

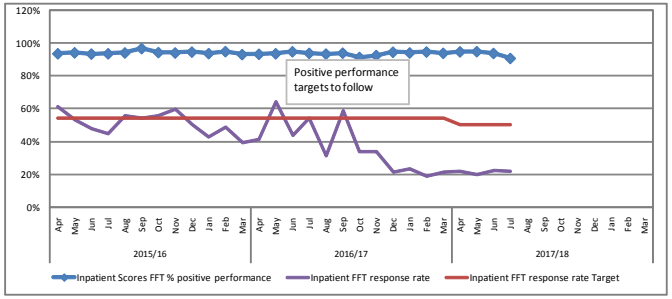
Reporting sub committees - PSQ and PSE

Friends and family

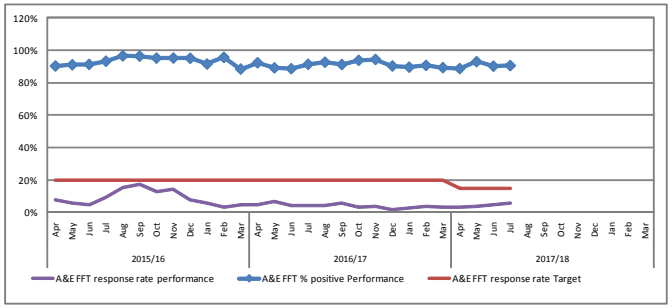
Executive lead	Clinical lead	Operational lead
Tracey Carter and Paul Da Gama		

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

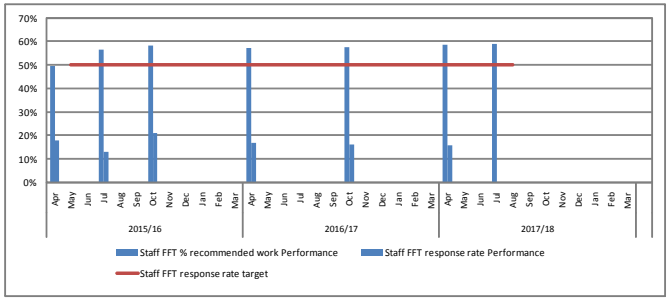
Inpatient scores (% positive and negative) and response rate



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 0.5% this month with a reduction in the positive rate of responses and an increase in negative responses. The 3 areas with the highest response rates were AAU Level 3 Blue & Yellow at 93.7%, Winyard at 88.1% and Aldenham at 77.6%.

A&E

The response rate has improved again this month, by 1.0%. The positive rate of response increased by 0.3% and the negative rate of response increased by 0.5%.

Maternity Question 2

The rate of response has increased again this month with a further reduction to the positive rate of response but improvement in the negative response rate.

A review of feedback for all areas has been completed to identify any themes in responses.

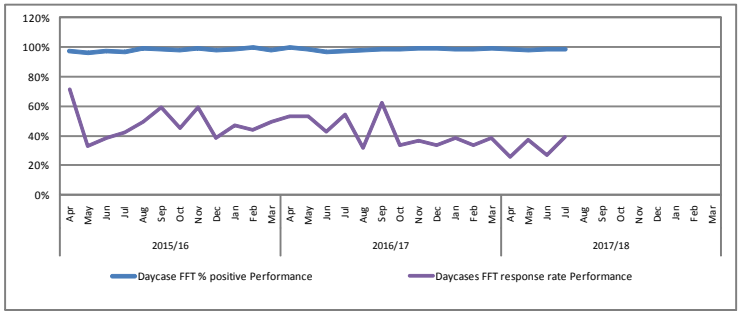
Staff

The Staff Friends and Family Test ran from 22 June to 9 July 2017. There were 541 electronic (e-mail) returns and 14 paper returns, a total of 555. The number of staff that would recommend this organisation as a place to work was 53.71%. The number of staff that would recommend this organisation if friends and family needed care was 63.11%. The overall trust engagement score is shown first followed by each division's engagement score (out of 5).

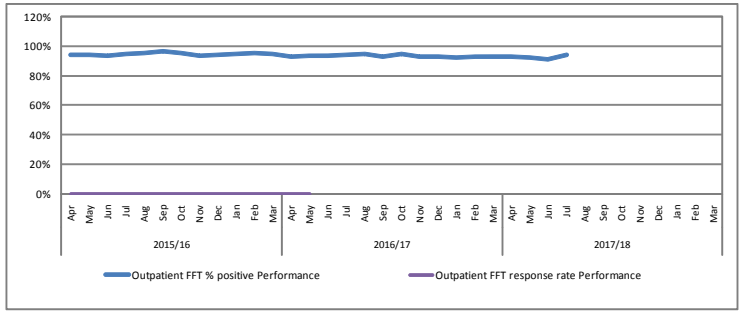
Trust Totals - FFT Questions - Work Q1 17/18

Question	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Total	Engagement Score Q4 16/17	Engagement Score Q1 17/18	Change on Last Quarter
Q1. How likely are you to recommend this Trust to friends and family if they needed care or treatment?	87	262	127	47	26	553	3.70	3.59	↓
Q3. How likely are you to recommend this Trust to friends and family as a place to work?	65	232	131	68	52	553	3.49	3.32	↓
Q5. I am able to do my job to a standard I am personally pleased with?	106	296	59	80	13	554	3.75	3.73	↓
Q6. My manager asked for my opinion before making decisions which affect my work?	118	218	97	93	28	554	3.56	3.55	↓
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?	37	159	157	149	51	553	3.15	2.97	↓
Q8. I generally feel well informed about what's going on within the Trust	70	283	128	60	13	554	3.52	3.61	↑
Q9. I generally feel well informed about what's going on in my local place of work	99	259	103	67	26	554	3.63	3.61	↓
Q10. I feel proud to work for WHHT	106	256	139	43	10	554	3.79	3.73	↓
Q11. I feel proud to work within my local place of work	153	244	106	41	10	554	3.94	3.88	↓
Overall Engagement Score						4983	3.62	3.55	↓

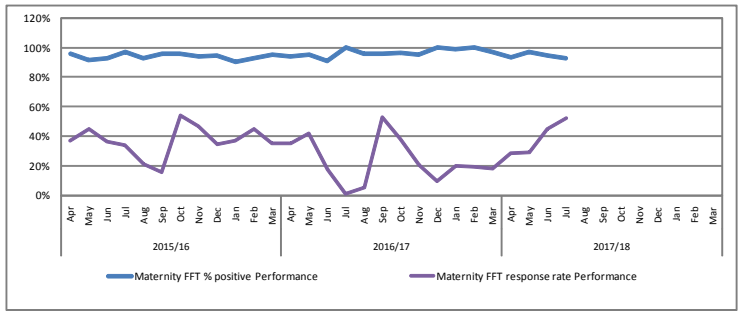
Daycases scores (% positive and negative) and response rate



Outpatient scores (% positive and negative) and response rate



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



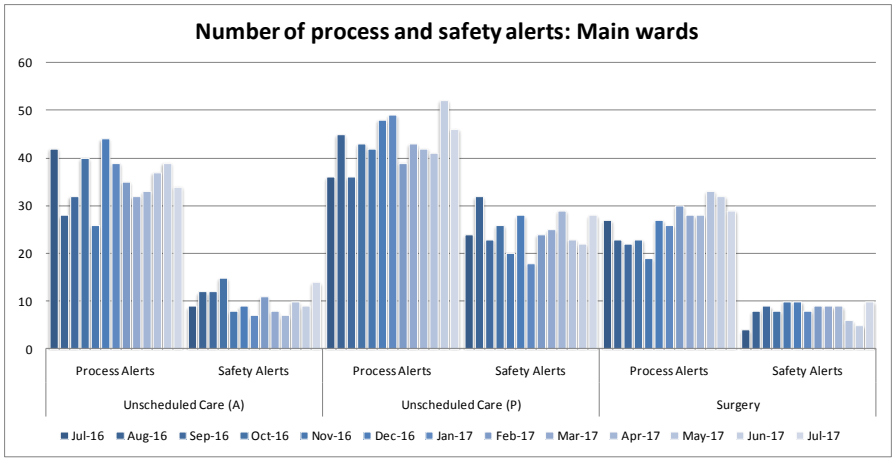
Day case
The Trust is now measuring both the main DSU at SACH and also the Surgical admission lounge at WGH.

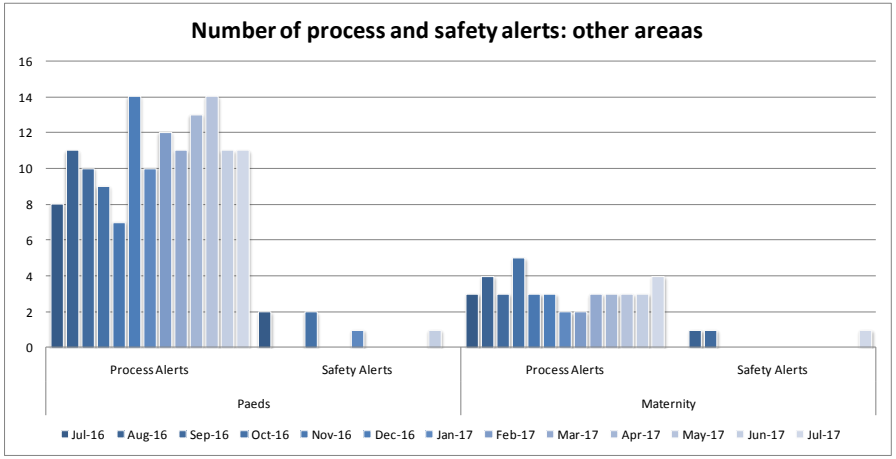
Outpatients
The total number of responses has reduced slightly this month.

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

Ward scorecard

Indicator	Performance (July)	Last month
Number of areas with safety alerts	53	37
Number of areas with process alerts	124	137





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- These are numbers of Falls, falls with harm and the response of 'extremely likely' to FFT being under 90%. Avoidable Pressure Ulcers.

Paediatrics have no safety alerts
Maternity safety alert is % extremely likely response rate for FFT.
There are less safety alerts occurring in Surgery.
There are less Process Alerts across the Trust this month.

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, Trolley dashes and use of simulation.

West Hertfordshire Hospitals NHS Trust

Ward Scorecard July 2017

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	9 / 26	1 / 26	11 / 35	7 / 32				1 / 28	5 / 36				27 / 34		30 / 33	23 / 28	11 / 30	n/a		
	Safety					14 / 35	9 / 30	15 / 30			0 / 37	0 / 37	15 / 35		0 / 33						
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 accquired C.diff	Hopsital accquired 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	Not Done	Not Done	! 88%	! 86%	✗ 1	✗ 5	✗ 2	✓ 100%	! 85%	✓ 0	✓ 0	✓ 92%	✓ 94%	✓ 0	✗ 25	! 86%	! 94%	7.39	3	6
	AAU B1	! 89%	✓ 91%	! 87%	✓ 100%	✗ 2	! 2	✓ 0	✓ 100%	✓ 90%	✓ 0	✓ 0	✓ 92%	✗ 13%	✓ 0	✗ 12	✗ 0%	! 92%	8.27	1	6
	AAU G1	! 88%	✓ 91%	! 88%	✓ 93%	✓ 0	✗ 5	✗ 2	✓ 100%	✓ 90%	✓ 0	✓ 0	✗ 64%	✗ 9%	✓ 0	✗ 3	✗ 71%	✓ 97%	8.67	3	5
	AAU P1	! 88%	✓ 93%	✓ 95%	✓ 98%	✓ 0	✓ 0	✓ 0	✓ 100%	✓ 92%	✓ 0	✓ 0	✗ 76%	✗ 14%	✓ 0	✗ 3	! 82%	✓ 98%	11.00	1	4
	AAU Y1	! 85%	✓ 93%	✓ 91%	✓ 90%	✗ 1	✗ 5	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 81%	✗ 27%	✓ 0	✗ 19	✗ 72%	! 93%	8.17	4	5
	CCU/ P/G 3	✓ 91%	✓ 100%	✓ 99%	✓ 99%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 91%	! 50%	✓ 0	✗ 8	✓ 100%	✓ 98%	6.94	0	2
	A&E	✓ 93%	✓ 92%	✓ 93%	✗ 67%	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 83%	✗ 3%	✓ 0	✗ 6	NA	NA	NA	1	3
	MIU	Not Done	Not Done	✓ 96%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	! 88%	✗ 2%	✓ 0	✓ 0	NA	NA	NA	1	1
	UCC	Not Done	Not Done	✓ 94%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✓ 93%	✗ 11%	✓ 0	✓ 0	NA	NA	NA	0	1
	Frailty	Not Done	Not Done	✓ 96%	✓ 100%	✓ 0	! 1	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 90%	✗ 6%	NA	NA	NA	NA	NA	0	1
Medicine	Aldenham	✓ 95%	✓ 100%	✓ 93%	✓ 98%	✓ 0	! 2	✗ 1	✓ 100%	✗ 70%	✓ 0	✓ 0	✓ 94%	✓ 78%	✓ 0	✗ 41	✗ 43%	✓ 96%	6.61	1	3
	Bluebell	Not Done	Not Done	! 80%	✗ 66%	✗ 1	✗ 9	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 26%	✓ 0	✗ 61	✗ 57%	✓ 97%	11.53	3	5
	Cassio	✓ 94%	✓ 100%	✓ 96%	! 88%	✗ 2	! 3	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	! 51%	✓ 0	✗ 24	! 76%	✓ 108%	5.90	3	4
	Croxley	✓ 97%	✓ 97%	✗ 69%	✗ 78%	✓ 0	✗ 5	✓ 0	✓ 100%	! 85%	✓ 0	✓ 0	✗ 64%	✗ 24%	✓ 0	✗ 4	! 76%	✓ 107%	6.83	2	6
	Heronsgate & Gade	✓ 91%	✓ 97%	✓ 92%	✓ 98%	✗ 1	✗ 6	✗ 2	✓ 100%	✓ 95%	✓ 0	✓ 0	✗ 77%	✗ 13%	✓ 0	✗ 17	! 75%	! 94%	5.63	4	4
	Oxhey	Not Done	Not Done	! 88%	✗ 79%	✗ 1	! 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 67%	✓ 0	✗ 2	✗ 74%	✓ 100%	7.70	1	4
	Red	Not Done	Not Done	✓ 98%	✓ 97%	✓ 0	✗ 7	✗ 5	✓ 100%	✓ 100%	✓ 0	✓ 0	! 81%	✗ 38%	✓ 0	✗ 5	! 86%	✓ 115%	7.01	3	3
	Sarratt	✓ 95%	✓ 100%	✓ 90%	✓ 91%	✗ 3	✗ 5	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 33%	✓ 0	✗ 13	✗ 56%	✓ 100%	6.53	3	3
	Simpson	✓ 96%	✓ 96%	! 85%	! 81%	✓ 0	! 4	✗ 1	na	✓ 100%	✓ 0	✓ 0	✓ 94%	✓ 62%	✓ 0	✗ 6	✗ 65%	✓ 106%	6.21	1	4
	Stroke	✓ 96%	✓ 97%	✓ 100%	✓ 99%	✗ 1	! 4	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 94%	✓ 56%	✓ 0	✗ 11	! 81%	✓ 98%	7.73	2	2
	Tudor	Not Done	Not Done	✓ 90%	✓ 92%	✓ 0	✗ 8	✗ 2	! 80%	✓ 100%	✓ 0	✓ 0	✗ 75%	✗ 1%	✓ 0	✗ 62	✗ 62%	✗ 67%	7.21	3	5
	Winyard	Not Done	Not Done	! 88%	✓ 96%	✓ 0	! 2	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 70%	✓ 88%	✓ 0	✗ 8	! 81%	✓ 100%	6.20	2	3
Surgery	Cleves	! 81%	✓ 99%	✓ 99%	✓ 100%	✓ 0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 91%	! 49%	✓ 0	✗ 14	✓ 95%	✓ 98%	6.14	1	3
	DLM	✓ 100%	✓ 98%	✓ 99%	✓ 99%	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 98%	✗ 47%	✓ 0	✗ 35	✓ 113%	✓ 97%	11.64	0	2
	Flaunden	! 85%	Not Done	! 85%	✓ 100%	✗ 1	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 34%	✓ 0	✗ 15	✗ 48%	! 95%	4.98	2	6
	ICU	✓ 98%	✓ 96%	✓ 95%	✓ 95%	✗ 1	✓ 0	✓ 0	✓ 100%	✓ 93%	✓ 0	✓ 0	No Resp	✗ 0%	✓ 0	✗ 14	✓ 99%	✓ 99%	25.47	1	2
	Langley	! 82%	✓ 98%	✓ 97%	✓ 100%	✗ 2	✓ 0	✓ 0	✓ 100%	! 89%	✓ 0	✓ 0	✓ 91%	✗ 27%	✓ 0	✗ 21	! 86%	✓ 99%	5.91	1	5
	Letchmore	✓ 100%	✓ 97%	✓ 97%	✓ 96%	✗ 1	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 27%	✓ 0	✗ 17	✗ 74%	✓ 111%	5.92	2	3
	Ridge	! 82%	✓ 97%	✓ 92%	✓ 91%	✓ 0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 91%	✗ 44%	✓ 0	✗ 26	✗ 67%	✓ 96%	5.46	1	4
	Elizabeth	✓ 98%	✓ 99%	✓ 97%	✓ 100%	✗ 1	! 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	✗ 41%	✓ 0	✗ 23	✗ 53%	✗ 87%	4.74	2	4
Paeds	SCBU	✓ 92%	✓ 100%	✓ 95%	✓ 95%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 25%	✓ 0	✗ 38	NA	✗ 82%	10.07	0	3
	Starfish	✓ 96%	✓ 93%	! 87%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 10%	✓ 0	✗ 10	! 76%	! 91%	10.73	0	5
	CED	✓ 97%	✓ 96%	! 87%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 4%	✓ 0	✗ 25	NA	NA	NA	0	3
	Safari	✓ 100%	✓ 96%	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 56%	✓ 0	✓ 0	✓ 100%	NA	NA	0	0
Maternity	Delivery Suite	✗ 78%	✗ 75%	✓ 91%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 93%	NA	NA	NA	NA	✗ 86%	22.81	0	3
	Katherine	NA	NA	✓ 91%	NA	✓ 0	NA	NA	NA	✓ 93%	NA	NA	! 88%	NA	NA	NA	NA	✗ 87%	5.03	1	1
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
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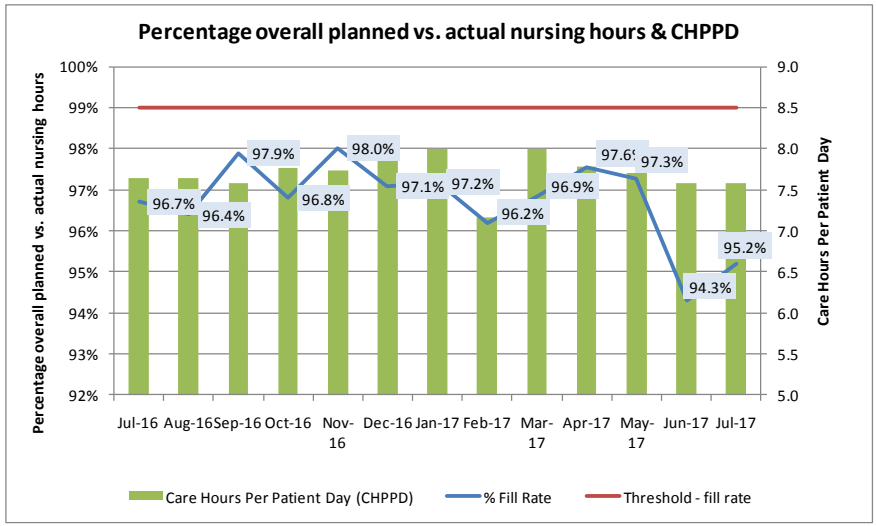
Ward Scorecard (Other/ Non Adult Inpatient) July 2017

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	4 / 30	1 / 5				0 / 4	0 / 13				6 / 7		4 / 7	1 / 2	4 / 4	n/a		
	Safety			0 / 9	0 / 3	0 / 3			0 / 15	0 / 15	7 / 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	✓ 93%	✗ 67%	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 83%	✗ 3%	✓ 0	✗ 6	NA	NA	NA	1	3
	MIU	✓ 96%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	! 88%	✗ 2%	✓ 0	✓ 0	NA	NA	NA	1	1
	UCC	✓ 94%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✓ 93%	✗ 11%	✓ 0	✓ 0	NA	NA	NA	0	1
Paeds	SCBU	✓ 95%	✓ 95%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 25%	✓ 0	✗ 38	NA	✗ 82%	10.07	0	3
	Starfish	! 87%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 10%	✓ 0	✗ 10	! 76%	! 91%	10.73	0	5
	CED	! 87%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 4%	✓ 0	✗ 25	NA	NA	NA	0	3
	Safari	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 56%	✓ 0	✓ 0	✓ 100%	NA	NA	0	0
Maternity	Delivery Suite	✓ 91%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 93%	NA	NA	NA	NA	✗ 86%	22.81	0	1
	Katherine	✓ 91%	NA	✓ 0	NA	NA	NA	✓ 93%	NA	NA	! 88%	NA	NA	NA	NA	✗ 87%	5.03	1	1
	Community	✓ 94%	NA	✓ 0	NA	NA	NA	NA	✓ 0	✓ 0	✓ 96%	NA	NA	NA	NA	NA	NA	0	0
	ABC	✓ 98%	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
clinical support	Radiology WGH	✓ 91%	NA	NA	NA	NA	NA	NA	NA	NA	! 89%	NA	NA	NA	NA	NA	NA	1	0
	Radiology HHGH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Radiology SACH	✓ 90%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Radiology AAU	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
Medicine	Outpatient WGH	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 93%	NA	NA	NA	NA	NA	NA	0	0
	Outpatient SACH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 91%	NA	NA	NA	NA	NA	NA	0	0
	Outpatient HHGH	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	! 90%	NA	NA	NA	NA	NA	NA	1	0
	Endoscopy HHGH	! 85%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	1
	Endoscopy WGH	✗ 79%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 99%	NA	NA	NA	NA	NA	NA	0	1
	Cath lab WGH	not done	NA	NA	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 97%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology WGH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 93%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology SACH	✓ 97%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 91%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology HHGH	✓ 97%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 93%	NA	NA	NA	NA	NA	NA	0	0
	Helen Donald WGH	✓ 100%	NA	NA	NA	NA	✓ 100%	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
Surgery	Day surgery SACH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Opthalmology WGH	✓ 98%	NA	NA	NA	NA	NA	NA	NA	NA	✗ 60%	NA	NA	NA	NA	NA	NA	1	0
	Pre Op HHGH	✓ 95%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Theatres WGH	✓ 97%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres SACH	✓ 99%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres Delivery WGH	✓ 96%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Pre Op WGH	✓ 90%	NA	NA	NA	NA	NA	NA	NA	NA	! 83%	NA	NA	NA	NA	NA	NA	1	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

Safer staffing

Indicator	Performance (July)	Threshold	Trend	Forecast next month
% Nursing hours versus planned	95.2%	>95%	Up	>99%
Care hours per patient day	7.6	n/a	Stable	7.2



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	89.3%	103.7%
	Night	93.6%	101.0%
Care hours per patient day	All	4.7	2.9

What actions have been taken to improve performance

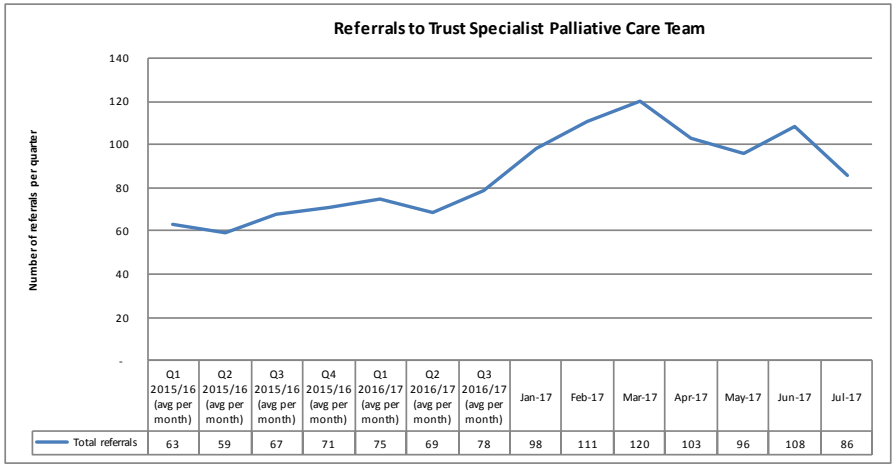
- Enhanced care needs team commenced 13 May 2017
- Castle – 12 beds as a surge area closed 15th June
- Local and international recruitment initiatives continue.
- Trust Recruitment Group formed chaired by Exec HR
- Use of Bank/Agency to cover enhance care whilst recruitment and evaluation of the impact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

What is causing the variance

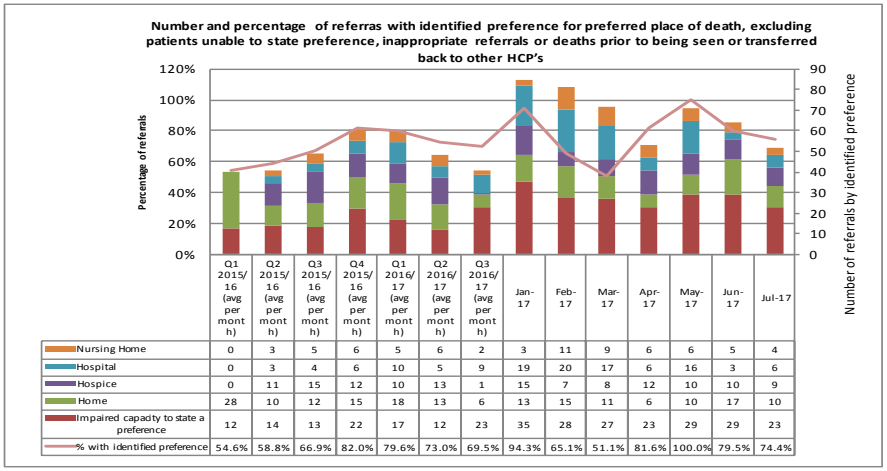
Overall the Trust % fill rate for July was 95.2%, which was an increase in the fill rate compared to June. The July fill rate was above the national threshold of 95%. The fill rate within the Medicine/USC division was 97.4%, a decrease of 1.3 percentage points from last month. Within the division of Surgery, the fill rate was 97.2%, an increase of 2.5 percentage points. The fill rate within WACS was 89.6% with maternity reporting fill rates of 95%. In July there 7141 shifts requested to be filled via NHSP through bank and agency ; and of the requests 1124 shifts were not filled. The current band 5 turnover rate between 28-29% in this group of staff however, this is also due to a number of band 5s moving to speciality areas in the Trust such as AE; ITU and theatres. The wards indicating fill rates below 90% include AAU Blue Level 1, Tudor, Cassio, Heronsgate and Gade, Ridge and Flaunden and Letchmore. Areas indicating fill rates below 80% include AAU Yellow Level 1, Bluebell, De La Mare/Beckett and Langley. Recruitment is ongoing with an overseas recruitment plan with skype interviews in Europe and a scheduled visit to the Phillipines. The Trust Enhanced Care Team began working in May, during July the number of patients requiring enhanced care needs ranged from `10-22 throughout the month. There were no red flags for July. The % Trust shifts days and night RAG Rated Green = 77.8% a decrease of 7.3% from last month, % Trust shifts day and night RAG rated amber = 22% an increase of 5.1 %. Trust shifts day and night RAG rated red were 3 shifts on the following wards Level 3 Blue and Yellow and Winyard and Flaunden. Mitigations were put into place ranging from the ward sisters working long days and the movement of staff. No harms were recorded due to RED shifts. Total of 568 (increase 129 shifts Red Flag more than 8 hours less than planned equates to 22.7%, an increase of 3.4% from last month. Maternity Fill Rates following review with HOM have now increased except Katherine at night for HCSW's and Maternity Delivery Suite % shifts amber = 32% a decrease of 3% from last month, Katherine Ward 69% shifts amber an increase from 16% last month, Victoria 10% a decrease of 2% from last month. Maternity RED shifts and Flags are reported via daily email on the staffing report . Birth Rate Plus findings are being analysed and will be reported through the Trust governance processes. SITREP template reviewed with HOM and amended to reflect maternity daily staffing. CHPPD as a staffing indicator is being used in the adult inpatient establishment and this month's performance is 7.6 which is the same as last month. The following surge areas were open in July , Ambulatory 10 days, Elizabeth 14 days, Oxhey increased to 12 patients 4 days. The overall Trust Supervisory Hours Lost in July was 20.1% an increase of 2.1% 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
Total referrals	63	59	67	71	75	69	78	98	111	120	103	96	108	86



	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
Nursing Home	0	3	5	6	5	6	2	3	11	9	6	6	5	4
Hospital	0	3	4	6	10	5	9	19	20	17	6	16	3	6
Hospice	0	11	15	12	10	13	1	15	7	8	12	10	10	9
Home	28	10	12	15	18	13	6	13	15	11	6	10	17	10
Impaired capacity to state a preference	12	14	13	22	17	12	23	35	28	27	23	29	29	23
% 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%	74.4%

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 July, the number of referrals to the Trust Specialist Palliative Care Team was 86. The number of patients seen by the Specialist Palliative Care Team with an identified preferred place of death (PPD) was 29 out of the 39 patients who had capacity and were appropriate to have this discussion. This equates to 74.4%.

There was one patient 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.

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	Discharges between 8am and 12pm* (main adult wards excl AAU)	A			
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	Serious incidents - number*	A			
Safe, Effective, Caring	Serious incidents - % that are harmful*	A			
Safe, Effective, Caring	% of patients safety incidents which are harmful*	A			
Safe, Effective, Caring	Medication errors causing serious harm *	A			
Safe, Effective, Caring	CAS Alerts: Number issued each month	A			
Safe, Effective, Caring	CAS alerts not acknowledged within 48 hours	A			
Safe, Effective, Caring	Hospital Acquired Pressure Ulcers - Grade 3	A			
Safe, Effective, Caring	Number of Falls*	A			
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
07 September 2017

Title of the paper	**NHS England's Emergency Preparedness, Resilience & Response Annual Assurance**
Agenda item	**10/51**
Lead Executive	**Sally Tucker, Chief Operating Officer**
Author	**James Mason, Head of Emergency Planning**
Executive summary	Emergency preparedness, resilience and response (EPRR) is a Trust wide requirement. It requires the development of enhanced processes to achieve a consistent and effective response, providing assurance, confidence and effective management of any incident that threatens to impact or overwhelm services. The NHS England (NHSE) EPRR core standards set out the minimum standards in which NHS organisations must meet, these standards are assessed annually by NHS England through the annual assurance process. The Trust achieved a fully compliant status for 2016. The first element of the annual assurance process is the self-assessment process against the 52 core standards. The deep dive element for 2017 focuses on EPRR governance arrangements. The Trust must also provide assurance as to arrangements to respond to Chemical, Biological, Radiology, Nuclear & Explosive (CBRNe) incidents. As part of the annual return, a subject specific deep dive is identified by NHSE, for 2017 this was identified as governance. This deep dive has highlighted the requirement for an identified Non-Executive Director lead for EPRR. Following submission of this return to Safety & Compliance Committee for approval it has been confirmed that Phil Townsend will be the identified Non-Executive Director lead for EPRR. The 2017 self-assessment process has demonstrated that the Trust has maintained a fully compliant status pending the Local Health Resilience Partnership confirm and challenge session.
Where the report has been previously discussed	Safety & Compliance Committee – Approved Emergency Planning Group

Action required:

- The Board is asked to approve the submission to NHS England.

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

Assurance of the Trust major Incident response and recovery providing improved effectiveness of resilience and business continuity, maintaining and protecting critical services and infrastructure

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

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017 -18(blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

- Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	**Green**	Chief Operating Officer	**AEO**	Current
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y		**Green**	Annual program delivered including exercise plan locally & LHRP Exercise Plan - Risk register, Incident assessment & Review including reporting process. Reports communicated to following Group: Emergency Planning Group (EPG) EPG Action logs/Minutes and via minutes to Quality Safety Group (QSG)	**EPR**	Current
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y		**Green**	Major Incident Plan Business Continuity Plan (Corporate, Divisional, Service) Bomb Threat Pandemic Flu Lockdown IT Disaster/Cyber Attack Heatwave Cold Weather / Snow Evacuation Mass Casualty Mass Fatality CBRNe/HazMat All following Trust governance process including approval at EPG & reporting of ratficiation to Trust board	**EPR**	Current
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y		**Green**	6 monthly Minutes	**AEO**	Current
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites)	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	**Green**	Departmental Risk Register Emergency Planning Group Minutes LRF minutes	**EPR**	Current
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y		**Green**	Departmental Risk Register Emergency Planning Group Minutes LRF minutes	**EPR**	Current
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y		**Green**	Departmental Risk Register Emergency Planning Group Minutes LRF minutes Quality & Safety Group - minutes	**EPR**	Current
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or	**Green**	Major Incident Plan, ratified and	**EPR**	Current
9		corporate and service level Business Continuity (aligned to current nationally recognised	Y		**Green**	BCPs, ratified and circulated at	**EPR**	Current
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y		**Green**	CBRNe/HazMat Plan, ratified and circulated	**EPR**	Current
11		Severe Weather (heatwave, flooding, snow and cold weather)	Y		**Green**	Heatwave & Cold Weather Plan (incl Snow), ratified and circulated, reviewed annually	**EPR**	Current
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y		**Green**	Pandemic Flu, ratified and circulated	**EPR**	Current
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y		**Green**	Plan, ratified and circulated	**EPR**	Current
14		Mass Casualties	Y		**Green**	Mass Casualty Plan ratified and circulated	**EPR**	Current
15		Fuel Disruption	Y		**Green**	Fuel Disruption Plan ratified and circulated	**EPR**	Current
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns,	Y		**Green**	Surge Plan ratified and	**EPR**	Current
17		Infectious Disease Outbreak	Y		**Green**	Outbreak Plans ratified and circulated	**EPR**	Current
18		Evacuation	Y		**Green**	Evacuation Plans ratified and circulated	**EPR**	Current
19		Lockdown	Y		**Green**	Lockdown Plan ratified and circulated	**EPR**	Current

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20		Utilities, IT and Telecommunications Failure	Y	emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone	**Green**	Utility Failures incorporated within plans	**EPR**	Current
21		Excess Deaths/ Mass Fatalities	Y		**Green**	Mass Fatality Plan, ratified and circulated	**EPR**	Current
22		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			*Not Applicable*	*Not Applicable*		*Not Applicable*
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			*Not Applicable*	*Not Applicable*		*Not Applicable*
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be	**Green**	Attendance at LHRP, LRF, SAG, London EPR Network, London Borough Resilience Forums Plans updated upon receipt of national guidance Annual plans (Heatwave, Flu etc.) updated accordingly Governance process for approval established, minutes EPG, QSG, SQC Plans ratified & circulated EPR Intranet page	**EPR**	Current
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	**Green**	On-call Structure On-call Manual Major Incident Plan Business Coninuity Plans 24/7 cascade process	**EPR**	Current
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business	Y		**Green**	BIA, BCP at corporate, divisional & service levels EPG Trust stakeholder engagement	**EPR**	Current
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y		**Green**	VIP Policy Major Incident Plan	**EPR**	Current
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	**Green**	EPG Plans contribution lists SAG, LRF, LHRP, London forums Partner agency engagement	**EPR**	Current
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.	Y		**Green**	All incident plans incorporate de-brief process	**EPR**	Current
Command and Control (C2)								
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	**Green**	On-call Structure On-call Manual Major Incident Plan Business Coninuity Plans 24/7 cascade process Dedicated contact numbers	**EPR**	Current
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and	**Green**	Training Records MAGIC Training as part of LRF (SLIAC)	**EPR**	Current
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all	**Green**	Major Incident Plan / other incident plans Alternative ICCs on-site and at	**EPR**	Current
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y		**Green**	Loggist Training Log records from incidents Major Incident Plan	**EPR**	Current
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y		**Green**	Major Incident Plan Template records Action Cards	**EPR**	Current
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		**Green**	CBRNe/HazMat Plan, ratified and circulated PHE National Advice Lines	**EPR**	Current
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		**Green**	Trust RPS in place via ENH Trust CBRNe/HazMat Plan, ratified and circulated	**EPR**	Current
Duty to communicate with the public								

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns	**Green**	Communications Action Cards Major Incident Plan 24/7 Comms on-call Communications methods, MTPAS, Email, BSM Remedy Alerts	**EPR**	Current

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	**Green**	Trust mobile, Pager, MTPAS, Internal Lines, Personal Mobiles held, Long Range Pagers, Bleeps, Analogue Phones, Emergency Phone Network, Multisite radio BCP/IT Disaster Recovery Plan	**EPR**	Current
Information Sharing – mandatory requirements								
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience	**Green**	LRF, LHRP Minute/Actions London BRF, Health EPR Network MIP/BCP	**EPR**	Current
Co-operation								
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience	**Green**	Hertfordshire LRF & BRF Sub-Groups London - Minutes	**EPR**	Current
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y		**Green**	Hertfordshire LRF & BRF Sub-Groups London & SAG - Minutes Multi-Agency exercising	**EPR**	Current
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services a	Y		**Green**	Major Incident Plan / BCP LHRP , London EPO Network	**EPR**	Current
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				**Not Applicable**	Not Applicable		Not Applicable
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				**Not Applicable**	Not Applicable		Not Applicable
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y		**Green**	LHRP, LHRP Sub-Group, Returns, Supporting	**EPR**	Current
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared				**Not Applicable**	Not Applicable		Not Applicable
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months				**Not Applicable**	Not Applicable		Not Applicable
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y		**Green**	AEO = COO LHRP - Minutes	**AEO**	Current
Training And Exercising								
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave	**Green**	TNA Major Incident Awareness drop-in sessions e-Learning package - all staff CBRNe/HazMat Departmental specific training On-call Structure Training Records	**EPR**	Current
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y		**Green**	Exercise Plan (Local & LHRP - WHHT Leads on LHRP exercise plan) Exercise Reports Multi-Agency Exercises Exercises conducted above minimum standards within framework	**EPR**	Current
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y		**Green**	Exercise Reports	**EPR**	Current
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y		**Green**	Exercise Reports Training Records	**EPR**	Current

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2017 Deep Dive								
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS	Y	• Organisation's public Board/Governing Body report • Organisation's public website	**Green**	Public Board presentation of EPRR & Core Standard outcomes	**EPR**	Current
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	• Organisation's Annual Report • Organisation's public website	**Green**	Report due to be published August 2017	**EPR**	Current
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body	Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings	**Green**	Minutes of meeting Safety & Compliance Committee NED Identified	**NED**	Current
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function	Y	• Minutes of meetings	**Green**	Emergency Planning Group Terms of Reference Minutes/Agenda	**EPR**	Current
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program.	Y	• Minutes of meetings	**Green**	Emergency Planning Group Minutes	**EPR**	Current
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has	Y	• Minutes of meetings	**Green**	Minutes of meeting	**AEO**	Current

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
	Preparedness							
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	**Green**	CBRNe/HazMat Plan, ratified & circulated CBRNe Action Cards	**EPR**	Current
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	• Site inspection • IT system screen dump	**Green**	Intranet Policy Database Hard Copies within	**EPR**	Current
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	**Green**	CBRNe Risk Assessment CBRNe/HazMat Plan	**EPR**	Current
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y	• Resource provision / % staff trained and available • Rota / rostering arrangements	**Green**	Training Records ED Roster	**EPR**	Current
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	• Provision documented in plan / procedures • Staff awareness	**Green**	CBRNe Action Cards CBRNe/HazMat Plan PHE Advice Centre	**EPR**	Current
	Decontamination Equipment							
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	**Green**	Asset Register	**EPR**	Current
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		**Green**	Asset Register	**EPR**	Current
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		**Green**	Monthly Inspection Record Asset Register Training Sessions	**EPR**	Current
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		**Green**	Monthly Inspection Record Asset Register Training Sessions Testing Records -Tent Ram-Gene	**EPR**	Current
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		**Green**	CBRNe/HazMat Plan, ratified & circulated CBRNe Action Cards	**EPR**	Current
	Training							
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		**Green**	Clinical CBRNe Lead Dedicated Training Package PHE e-Learning	**EPR**	Current
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	**Green**	Clinical CBRNe Lead Dedicated Training Package PHE e-Learning	**EPR**	Current
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		**Green**	Clinical CBRNe Lead Dedicated Training Package PHE e-Learning	**EPR**	Current

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y		**Green**	IOR / CBRNe Training for Reception Staff Training Records	**EPR**	Current

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame	Not Applicable	Not Applicable
E1.1	Liner	Not Applicable	Not Applicable
E1.2	Air inflator pump	Not Applicable	Not Applicable
E1.3	Repair kit	Not Applicable	Not Applicable
E1.2	Tethering equipment	Not Applicable	Not Applicable
	OR: Rigid/ cantilever structure		
E2	Tent shell	Immediate response Technology - Shelter / decon / T8/ 2L CSTM GRN / WHT	**Green**
	OR: Built structure		
E3	Decontamination unit or room	Not Applicable	Not Applicable
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)	SETOLITE - GMBH - ALDERBAN x 2	**Green**
E5	Shower heads	Part of tent integrated installation	**Green**
E6	Hose connectors and shower heads	Yes - additional shower equipment	**Green**
E7	Flooring appropriate to tent in use (with decontamination basin if needed)	Palletise - PLASTIC / HV DUTY GRID FLOOR	**Green**
E8	Waste water pump and pipe	NBC Group / TSURUMI - LSC-4 Pumps	**Green**
E9	Waste water bladder	NBC Group 1000Ltrs (S/ 41287/1)	**Green**
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).	24 suits tested , certificated and operationally ready	**Green**
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme	24 suits tested , certificated and operationally ready	**Green**
	Ancillary		
E12	A facility to provide privacy and dignity to patients	Allocated space provided / clothing	**Green**
E13	Buckets, sponges, cloths and blue roll	yes	**Green**
E14	Decontamination liquid (COSHH compliant)	yes	**Green**
E15	Entry control board (including clock)	yes - 1	**Green**
E16	A means to prevent contamination of the water supply	Drain Block	**Green**
E17	Poly boom (if required by local Fire and Rescue Service)	Not Applicable	Not Applicable
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)	40	**Green**
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)	40	**Green**
E20	Waste bins	Yes	**Green**
	Disposable gloves	Yes	**Green**
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe	Yes	**Green**
E22	FFP3 masks	easimasks	**Green**
E23	Cordon tape	SKU - 76107(R/W)	**Green**
E24	Loud Hailer	Manacor TM22	**Green**
E25	Signage	8 signs	**Green**
E26	Tabbards identifying members of the decontamination team	5 tabbards	**Green**
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.	Yes - on request	**Green**
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)	Pelican - Rotem RAM GENE -1 S/ 2305-740 Pelican - Rotem RAM GENE -1 S/ 2305-743 Annually Tested	**Green**
E29	Hooded paper suits	Yes	**Green**
E30	Goggles	Yes	**Green**
E31	FFP3 Masks - for HART personnel only	Not Applicable	Not Applicable
E32	Overshoes & Gloves	Yes	**Green**

Trust Board meeting

07 September 2017

Title of the paper	**Quality improvement plan progress update**
Agenda item	**11/51**
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 16 projects reported through the QIP reporting cycle this month. The overall status for the QIP at the end of July is green; the forecast status for August is also green. Two projects are rated red (ICT), with nine red actions (largely relating to the ICT projects). For the months of June/July, 15 actions were closed, resulting in a total of 43 open actions for this reporting period. The progress updates and indicators contained in this report reflect June and July data, to provide the Board with the most up to date information.
Where the report has been previously discussed, i.e. Committee/Group	Strategy Delivery Board (TEC) 09 August 2017 Safety and Compliance Meeting 10 August 2017 Oversight Meeting 17 August 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.	

Agenda Item: 11/51

Trust Board – 07 September 2017

Quality Improvement Plan Progress Update (June/July data)

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) which was previously closed has reopened and will be reported on from this month.

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 July 2017 and is reported using the Red, Amber and Green (RAG) rating.

2.4 There are 16 projects reported through the QIP reporting cycle this month. The overall status for the QIP at the end of July is green; the forecast status for August is also green.

2.5 This reporting period both June and July data have been combined into one report to bring the QIP report up to date so that the report reflects the most up to date information with regards to the QIP Programme delivery.

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.

3.1 Activity Trends

3.1.1 In the current reporting period there are 16 active plans. Of the 16 live projects in this reporting period, one project has been closed in July following the completion of their actions. The closed project is Patient Flow.

3.1.2 Of the 15 active live projects reported against in June/July 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).

3.1.3 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.

3.1.4 Two change requests have been drafted for review and approved by the Trust Executive Committee (TEC) in the month of July. One further Change request, (Paediatrics) is due to be submitted to TEC for approval on 9th August 2017.

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

3.2 Key Milestones – Status Trends

3.2.1 There are 43 open actions within the QIP in this reporting period, this is a reduction from the 58 open actions last reporting period. 30 of the 43 actions are currently rated as green and are on track to deliver as agreed in the milestones, 4 milestones are rated amber, and 9 of the 43 open actions are rated as red (these largely relate to the ICT project); compared to 6 amber actions and 8 red actions in the previous reporting period. 15 actions have been completed in the months of June/July and closed.

3.2.2 All red rated milestones for each project have been reviewed by the TEC as part of the Project Review Deep Dive Process. This took place fortnightly as part of the CQC countdown plan.

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	Aug	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. A number of high scoring risks and issues associated w ith the project	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	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 on Track	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 projects or projects that have actions with no planned completion date detailed in their plan, work continues to deliver the approved actions. The PMO will work closely with project leads to agree planned completion dates.

5.0 CQC preparation

5.1 The date of the inspection has been confirmed as 30 August – 1 September 2017. Preparation for the CQC inspection is part of our ongoing journey to drive improvement in quality across the Trust and so this work will be delivered as part of Quality Transformation work. A CQC mobilisation team is in place as previously reported.

6.0 Recommendation

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

Tracey Carter

Chief Nurse and Director of Infection Prevention and Control
August 2017

Appendix 1

Oversight Metrics Performance Challenges

A&E performance *(WGH time to initial assessment % within 15 mins) No baseline however, performance continues to improve from May 87.3%, June 91.4% and 89.0% in July. This is still below the target of 95%.*

Mandatory training compliance has improved with performance at 89.2% in May, 92.1% in June and 91.7% in July (now compliant for the last two months).

Outpatients Appointments:

Cancelled appointments with less than 6 weeks' notice, continues to improve from 4.0% in May to 3.8% in both June and July.

Vacancy rate:

The vacancy rate has again declined for the reporting period, from 12.7% in May, 13.0% in June to 12.3% in July. 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 96.5% in May, 94.0% in June and 93.7% in July.

Accurate Record Keeping has declined slightly from 94.2% in May to 90.8% in June and 92.0% in July.

Number of SI's submitted to the CCG within time:

Compliance was 100% for June and 25% for July (low numbers and submitted within month).

Appendix 1 – Oversight Metrics – June/July 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	
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%	
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%	
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%	
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%	
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	
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	
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%	
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%	
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	
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%	
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%	
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%	
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%	
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%	
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%	

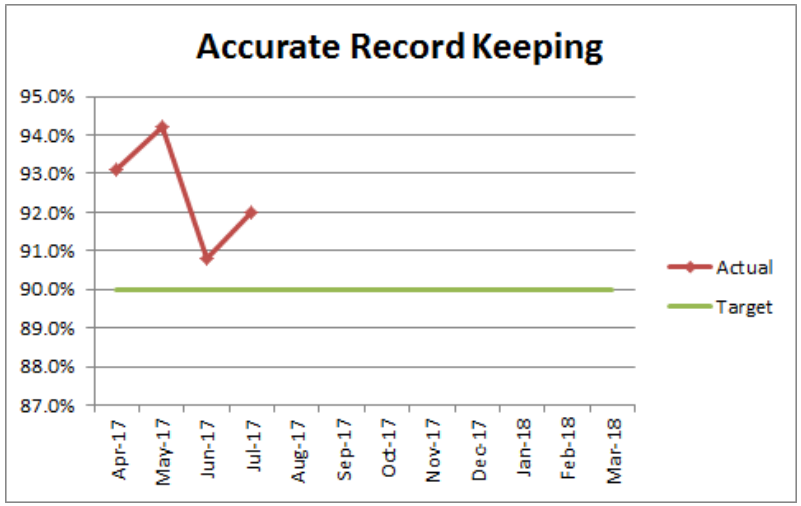
^ Excluding valid cancellations (cancellations to provide earlier appointments, cancellations due to where patients have died and cancellations to appointments made in error)

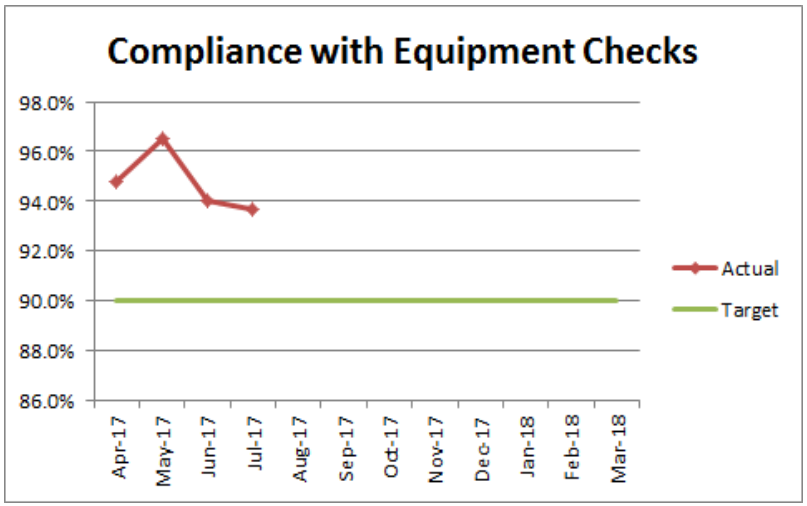
NB. Where national avg. blank - information not currently available

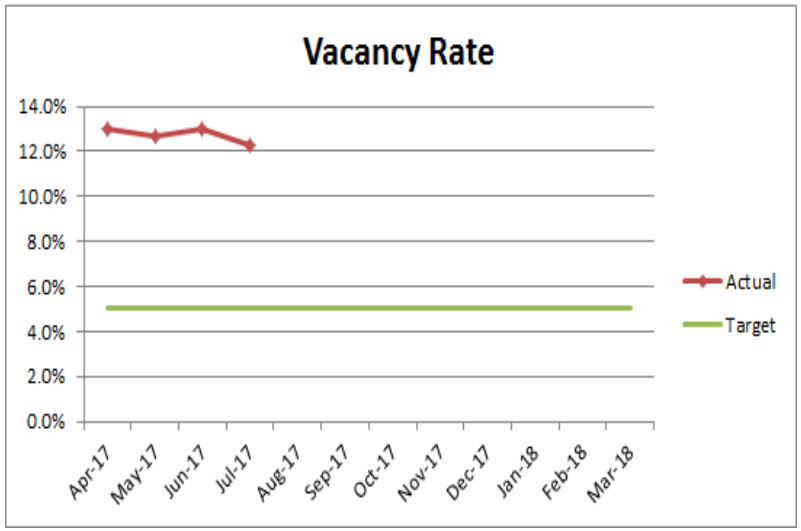
** Indicator measured using response sections: Infection Control, Privacy and Dignity and Resuscitation Trolley. Community Midwifery and Maternity Delivery Suite Care Indicators excluded along with new wards included on TYC in 16/17, Oxhey and Gade.*

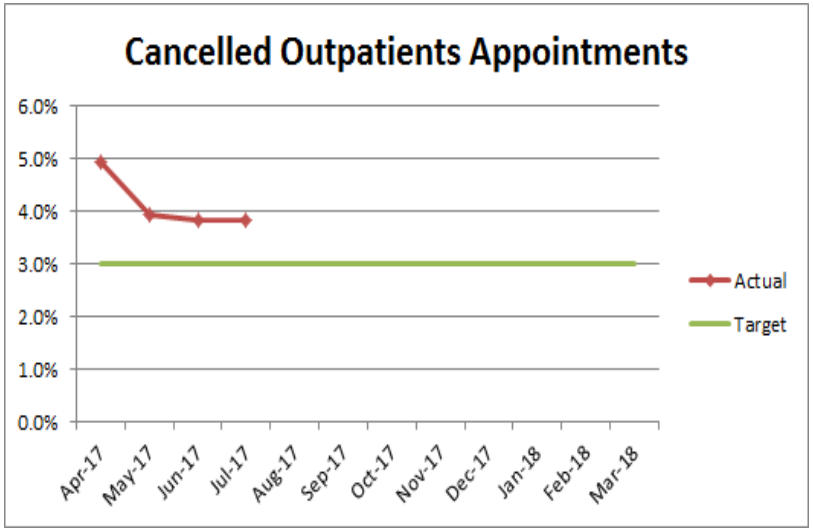
** Note that targets for mandatory training, appraisal and vacancy rate have been amended to reflect new Board-agreed levels*

Oversight Metrics Target v Actual – June/July Data


Accurate Record Keeping
95.0%
94.0%
93.0%
92.0%
91.0%
90.0%
89.0%
88.0%
87.0%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Actual
Target


Compliance with Equipment Checks
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Actual
Target


Vacancy Rate
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Actual
Target


Cancelled Outpatients Appointments
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Actual
Target

Appendix Two

REFERRAL TO TREATMENT PERFORMANCE IMPROVEMENT

June/July 2017

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

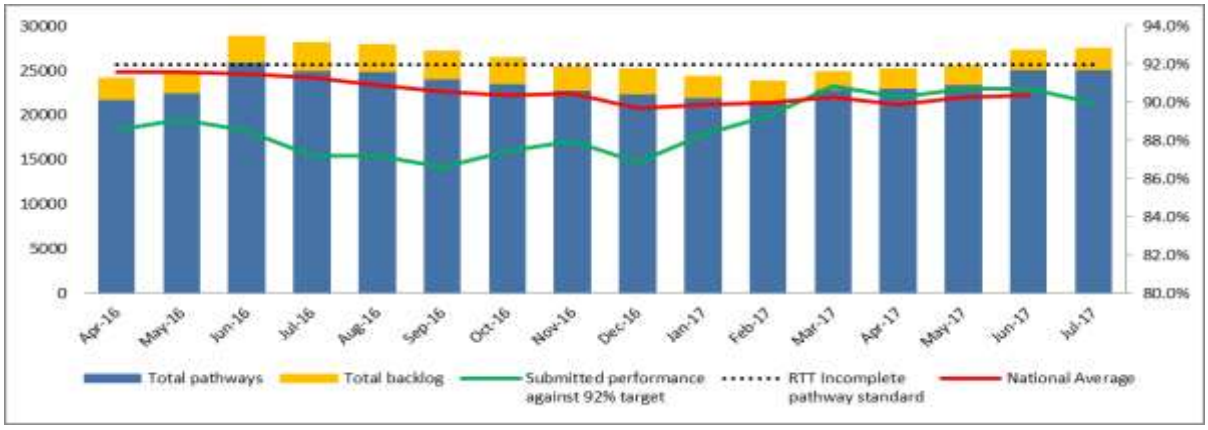
…to improve the percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment

Submitted performance

RTT performance for May was 90.7%, June 90.7% and July 90.0%. Recovery has slowed, largely as a result of several simultaneous operational challenges which have impacted elective theatre and bed capacity.

However, WHHT at 90.7% continues to perform above the latest available (June) national average of 90.3%.

Figure 1: RTT PTL changes & performance



Trust Board Meeting
07 September 2017

Title of the paper	**End of Life Care Annual Report**
Agenda item	**12/51**
Lead Executive	**Tracey Carter, Chief Nurse**
Author	**Michelle Sorley, Macmillan Cancer & Palliative Care Lead Nurse**
Executive summary	This annual report gives an account of End of Life Care across the Trust and relates to the period April 2016 – March 2017. This paper outlines the progress made with regards to the implementation of the End of Life Care Strategy and demonstrates the organisations commitment to its patients over the last twelve months, supporting the delivery of high quality, timely, effective, individualised care for our patients with end of life care needs, to ensure support for their families as well as support for our staff providing these services. This improvement work continues, to support our staff in providing compassionate, holistic, patient centred care. End of Life Care is everyone's responsibility and is being recognised more promptly across our clinical areas. Key achievements during this period include: • Our CQC rating improving from "requires improvement" to "Good". • Development of a Trust wide action plan to ensure all issues and necessary actions are captured. • End of Life training now part of the core essential skills training for all new starters. • Successful recruitment of a Macmillan EOLC Educator • Roll out of the individualised plan of care for the dying person on the acute site. • End of Life Clinical Lead recruited. • Inaugural Memorial Service held onsite. The paper also sets out the priorities for 2017-18 to enable us to deliver the Strategy.
Where the report has been previously discussed, i.e. Committee/Group	Surgical Divisional Committee Meeting Cancer Committee Clinical Outcomes and Effectiveness Committee
ion required: • The Board are asked to receive the report for information and assurance of end of life care strategy progress.	

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 To improve end of life care in the hospital for patients and supporting relatives, families, friends and carers.	
Risks attached to this project/initiatives and how these will be managed: Sustaining progress against Key performance indicators to ensure transition of established best practice in specialist palliative care to end of life. Mitigation is to develop a reporting framework, to monitor trajectory against agreed milestones. An operational working group has been established which is monitored by the Compassionate End of Life Care panel to ensure successful delivery of the Strategy.	

Agenda Item: 12/51

Trust Board meeting – 07 September 2017

End of Life Care Annual Report

Presented by: Tracey Carter, Chief Nurse

1. Executive Summary

This twelve month report gives an account for End of Life Care across West Hertfordshire NHS Hospitals Trust (WHHT). The report covers the period April 2016 – March 2017. This report demonstrates the organisations continued commitment to our patients over the last twelve months, supporting the delivery of high quality, timely, effective, individualised care for our patients with end of life care needs, to ensure support for their families as well as support for our staff providing these services. This improvement work continues, to support our staff in providing compassionate, holistic, patient centred care. End of Life Care is everyone's responsibility and is being recognised more promptly across our clinical areas.

2. Indicators of activity for this reporting period

- Continued significant increase in the number of referrals to the Specialist Palliative Care team
- 1012 referrals were received by the palliative care team for 947 patients of which 928 were new patients to the service.
- 419 referrals to the Marie Curie Discharge Liaison Nurse between April 2016 – March 2017
- Increased number of discharges to patients preferred place of care
- Increase in the number of referrals for patients with a non cancer diagnosis
- Increased number of staff completed end of life training –we have exceeded the number of staff trained by 26% the target set was 40%.

3. Achievements within the reporting period

- End of Life Clinical Lead appointed
- End of Life Care improved from receiving a rating of "requires improvement" to receiving a "Good" rating from the CQC.

- Operational End of Life Group established which will enable delivery of the key objectives across the Divisions and for this group to report to the CEOLCP
- Development of a Trust wide End of life Care Action plan to ensure all issues and necessary actions are captured centrally
- The team has been successful in securing a place as one of the core essential teaching sessions that must be attended by new starters to the Trust and this commenced in April.
- The roll out of the Individualised plan of care for the dying person has now been completed across the acute Trust.
- End of Life Strategy ratified and presented to various forums including the Herts Valley Clinical Commissioning Group (HVCCG) Palliative and End of Life Forum.
- Achieving compliance with CCG target for ensuring our patients if appropriate have an Advance Care Plan in progress and achieve their Preferred Place of death (PPD).
- Trust a member of the UCLP EoLC Community of Practice
- Bereavement Focus Groups have been held locally working in conjunction with our Patient and Public Involvement Lead and our Carers Lead as well as external agencies.
- Inaugural Trust Memorial Service took place on November 20th 2016.
- Recruited into the Macmillan End of Life Care Nurse Educator post and post holder commenced February 2017.
- Continued partnership working across the locality with Herts Valley Clinical Commissioning Group (HVCCG) and other Local providers to enhance the care and support our end of life patients receive.
- Continued representation at the University College London Partnership EoLC Community of Practice.
- Worked jointly with local providers in the implementation of the Electronic Palliative Care Coordination System (EPaCCS) the Trust gained access to the viewing part of this in February 2017.
- Working collaboratively with our local providers in the establishment of a coordination centre which will provide a single point of referral for all palliative and end of life referrals
- Ensure continued compliance with National and local recommendations with audits and service reviews.
- Continued to raise awareness off end of life care across the Trust.
- Trust funding obtained for Discharge Liaison Nurse post
- Ensuring the mental capacity assessment stamp is present on all Do Not Attempt Cardio-Pulmonary Resuscitation forms in the Trust
- Continued education of medical staff with regards to mental capacity assessment (MCA) form completion specific to Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions.
- At the beginning of this reporting period we had identified and commenced training of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Champions across the Trust
- Completion of the pan-Hertfordshire project to improve the system of paperwork for administration sent with patients when discharged with end-of-life medicines.
- End of Life updates published in the Trust Herts and Minds newsletter as well as the Chief Nurse's Newsletter and regular e-updates.
- Involvement in the EOLC work stream of the STP framework working closely with East and North Hertfordshire NHS Trust and Princess Alexandra Hospital, Harlow.

- Completion of Pain audit, this was identified during the recent CQC inspection.
- Initial meetings have been held with local hospices in relation to the establishment of End of Life volunteers (Rose volunteers)
- Mortuary floor has been replaced.
- Audit schedule continues to be implemented.

4. Future Priorities for 2017-18

- We will focus on delivering our action plan which underpins our End of Life Care strategy and will focus on delivering this in 2017-18
- Continuing to embed our education programme
- Embedding compliance with the Mental Capacity Act 2005 and associated code of practice when completing 'do not attempt cardiopulmonary resuscitation' forms.
- We will improve use of Treatment Escalation Plans to support effective care planning, through embedding these and training clinical staff in their use
- Identification of our Trust Compassionate Care Champions
- We will work with the Trust Care of the Elderly team to improve the End of Life Care that is delivered, including earlier referrals into End of Life Care team
- We will be part of an NHS Improvement End of Life collaborative to share learning, best practice and learn more about improvement methodology and how it can be applied to End of Life Care
- Recruit End of Life volunteers to support patients and their families at this difficult time.

1.0 Purpose

The purpose of this report is to provide an account and an overview of End of Life Care across West Hertfordshire Hospitals NHS Trust (WHHT). The report aims covers the period April 2016 –March 2017 in relation to end of life care service improvement work at WHHT that supported the local and national priorities, over the last twelve months (April 2016 – March 2017) and the progress that has been made at West Hertfordshire Hospitals NHS Trust (WHHT), to support the delivery of high quality, timely, effective, individualised services for our patients with end of life care needs, support for their families as well as support for our staff providing these services. Much of this is in line with the priorities of care set out in "One Chance to get it Right" Leadership Alliance for Care of Dying People (2014).

The 5 Priorities are:

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them

3. The dying person, and those identified as important to them, are involved in the decisions about treatment and care to the extent that the dying person wants

4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible 5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Caring for people nearing the end of life is one of the most important things we do in hospital and is everyone's responsibility. As a Trust we supported 1430 over the age of 18 that died during the period April 2016 – March 31st 2017. This is a slight increase from the same period in 2015 – 16 when we supported 1288 patients.

End of life care continues to be supported by all divisions within the Trust through membership of the Compassionate End of life Care Panel, which is chaired by the Chief Nurse who is the Executive Lead for End of Life Care.

An End of Life Care Work plan was developed in June 2016 which was an amalgamation of all previous action plans from previous audits, external reviews and inspections therefore this plan underpins and leads the activity across the Trust. Actions from audits and external reviews and inspections are added to the plan and progress against these actions is reviewed bimonthly. The work plan is overseen, monitored and reviewed by the Compassionate End of Life Care Panel.

2.0 End of Life Care Leadership and Accountability

We have had continued support from the Trust Executive Lead with responsibility for end of life care who is the Chief Nurse and Chair of the Compassionate End of Life Care Panel (CEOLCP), and from the Trust Board with the appointment of a non-executive director for End of Life Care. The Trust Medical Director continues to be supportive particularly in our work to improve conversations in relation to resuscitation and Treatment Escalation Plans (TEPs) and the documentation of these.

An End of Life Care Lead was also appointed.

Key Achievement – End of Life Care Clinical Lead appointed

3.0 Compassionate End of Life Care Panel

This panel oversees all end of life work across the Trust. The panel reports end of life activity to the Quality and Safety Group.

The panel meets bi monthly with representation from across all the Trust Divisions as well as external representation for the Clinical Commissioning Group and East of England Ambulance Service.

4.0 CQC Inspection

Following the 2015 inspection considerable work has taken place and a monthly Highlight Report (HLR) is completed as part of the Trust Quality Improvement Plan (QIP). The Organisations' commitment and the hard work of the team and staff across the Trust has resulted in End of Life Care improving from a "Requires improvement" to a "Good" rating from the September 2016 inspection.

Key Achievement – CQC Improved rating from "Requires Improvement" to "Good"

5.0 Specialist Palliative Care Team

5.1 Referrals/ Activity

The specialist palliative care team have received a total of 1012 referrals for 947 patients of which 928 were new patients to the service in the reported period. This compares with a total of 826 referrals for 774 new patients to the service for the same period in 2015-16. This is an increase of 186 referrals and 102 patients.

Table 1 shows the distribution of the number of referrals received and the number of new patients reviewed over this period of April 2016-17 compared with the same period in 2015-16.

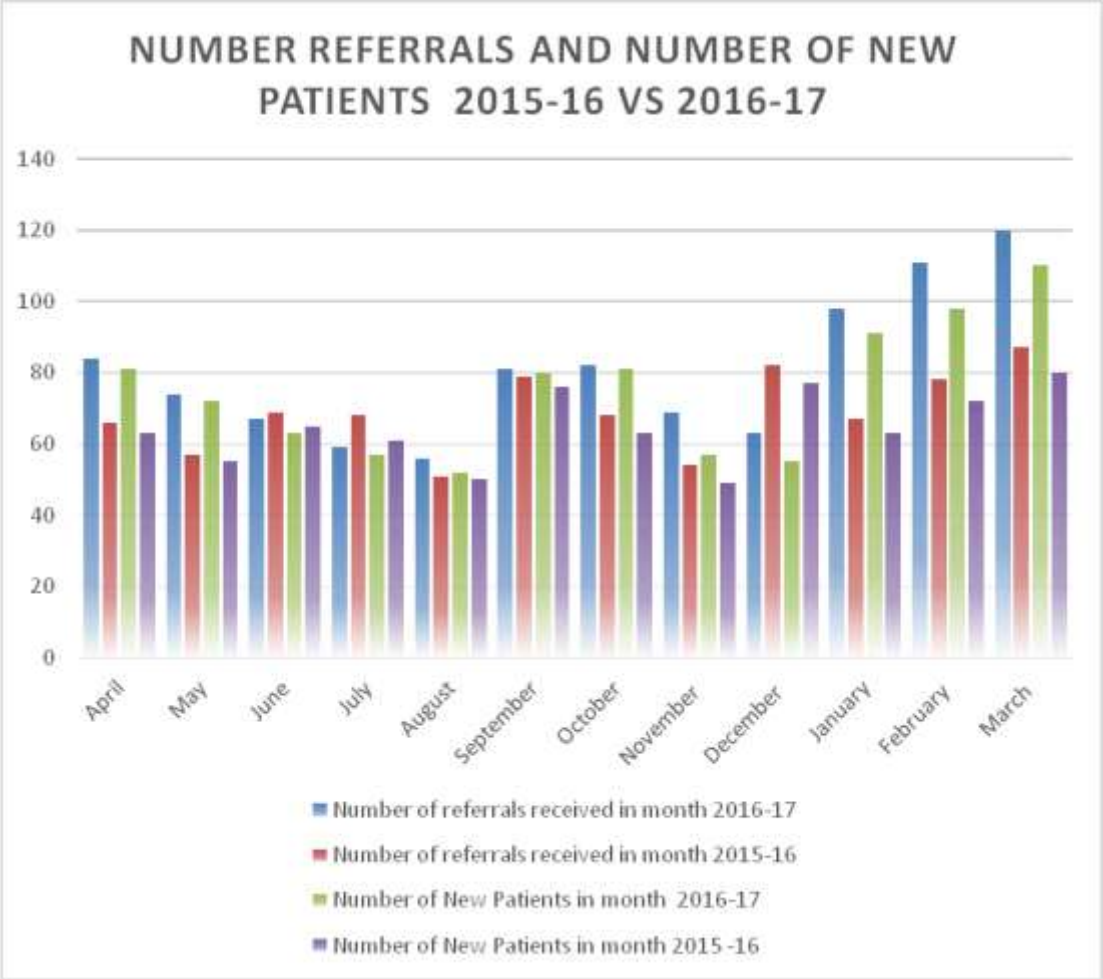
Referrals continue to be received from all wards in the Trust. The team continue to support patients in A&E Resus, Intensive Care Unit and the following ward areas - Care of the Elderly, Surgery, Gynaecology and the Medical wards as well as the Acute Admissions Unit.

As well as an increase in the number of patients there has been an increase in the complexity of patient need as well as an increase in referral for patients with a non-malignant condition.

The team provide symptom control advice and psychological support to those patients that need it the most. They ensure that patients have choices by undertaking Advance Care Planning conversations with them and ensuring that these are documented.

During the previous reporting year as a Trust we were included in the returns for the Minimum Data Set for Palliative Care as a large unit as we see more than 749 patients. Nationally there are 66 other large units. It has now been decided that this report will no longer be produced therefore we can no longer benchmark ourselves against others.

Table 1 Number of referrals received and number of patients seen by SPC Team.



5.2 Establishment

During this period three new members of staff commenced with the specialist palliative care team, in August an administrator joined the team, a Clinical Nurse Specialist commenced in October 2016 and in February 2017 our Macmillan End of Life Care Nurse Educator which now means that the team will have increased capacity to educate our staff both medical and nursing and the educator will be in a position to work alongside staff on the ward as appropriate.

Seven day working recommenced at the beginning of April 2016 and this has continued throughout the reporting period. As a Trust a seven day service was achieved 361 days out of 364 which equates to 99.1%. Out of hours clinical advice continues to be provided by the 24 hour palliative care advice line which is supported by the local hospices.

Table 3 below shows the team establishment at the beginning of the reporting period and at the end of the period.

Table 3: Trust Specialist Palliative Care Establishment

Role	Funded WTE Establishment	In post WTE April 1st 2016	In post WTE March 31st 2017
Macmillan SPC Team Leader (Band 8A)	1.0	0.8	0.8
Macmillan Hospital Palliative Care Nurse Specialists (Band 7's)	5.3	4.3	5.3
Macmillan End of Life Care Nurse Educator	1.0	0	1
Palliative Medicine Consultants	0.9	0.8	0.8
Marie Curie Discharge Liaison Nurses	1.0	1.0	0 (recruitment in place)
MDT Coordinator (Band 4)	1.0	1.0	(recruitment in place)
Team Administrator (Band 4)	1.0	0.0	1.0

Key Achievement – a seven day Specialist Palliative Care Service was provided 361 days out of 364 which equates to 99.1%

5.3 Marie Curie Discharge Liaison Nurses

The Marie Curie Discharge liaison nurse (MCDLN) has continued to do invaluable work helping those patients who are thought to be imminently dying achieve their preferred place of care, by undertaking fast track continuing health care funding applications and securing care packages, equipment, nursing homes or Hospice places when appropriate. The MCDLN also communicates with the Health and social care providers in the community to ensure a smooth transition for the patient out of the Trust.

The Marie Curie DLN received 419 referrals during the period of April 2016 – February 2017. Out of those 115 patients died prior to discharge thus not discharged to their preferred place of care. A further breakdown is available in Appendix 1
The joint funding for the two posts comes from Marie Curie and the Clinical Commissioning Group (CCG) who each pay 50%. There has been a vacancy of 1 WTE over this reporting period. Confirmation was received from Marie Curie that their funding would cease at the end of the financial year 16/17. This was addressed as a matter of urgency by the service and CCG, funding for the one WTE post has now been agreed by us as a Trust and the CCG and we are in the process of recruitment, moving forward this post will be known as the Palliative Care Discharge Liaison Nurse (PCDLN).

6.0 Improvements made during the reporting period

- End of Life Clinical Lead appointed
- End of Life Care improved from receiving a rating of “requires improvement” to receiving a “Good” rating from the CQC.
- Operational End of Life Group established which will enable delivery of the key objectives across the Divisions and for this group to report to the CEOLCP
- Development of a Trust wide End of life Care Action plan to ensure all issues and necessary actions are captured centrally
- The team has been successful in securing a place as one of the core essential teaching sessions that must be attended by new starters to the Trust and this commenced in April.
- The roll out of the Individualised plan of care for the dying person has now been completed across the acute Trust.
- End of Life Strategy ratified and presented to various forums including the Herts Valley Clinical Commissioning Group (HVCCG) Palliative and End of Life Forum.
- Achieving compliance with CCG target for ensuring our patients if appropriate have an Advance Care Plan in progress and achieve their Preferred Place of death (PPD).
- Trust a member of the UCLP EoLC Community of Practice
- Bereavement Focus Groups have been held locally working in conjunction with our Patient and Public Involvement Lead and our Carers Lead as well as external agencies.
- Inaugural Trust Memorial Service took place on November 20th 2016.
- Recruited into the Macmillan End of Life Care Nurse Educator post and post holder commenced February 2017.
- Continued partnership working across the locality with Herts Valley Clinical Commissioning Group (HVCCG) and other Local providers to enhance the care and support our end of life patients receive.
- Continued representation at the University College London Partnership EoLC Community of Practice.
- Worked jointly with local providers in the implementation of the Electronic Palliative Care Coordination System (EPaCCS) the Trust gained access to the viewing part of this in February 2017.
- Working collaboratively with our local providers in the establishment of a coordination centre which will provide a single point of referral for all palliative and end of life referrals
- Ensure continued compliance with National and local recommendations with audits and service reviews.
- Continued to raise awareness off end of life care across the Trust.
- Trust funding obtained for Discharge Liaison Nurse post
- Ensuring the mental capacity assessment stamp is present on all Do Not Attempt Cardio-Pulmonary Resuscitation forms in the Trust
- Continued education of medical staff with regards to mental capacity assessment (MCA) form completion specific to Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions.
- At the beginning of this reporting period we had identified and commenced training of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Champions across the Trust

- Completion of the pan-Hertfordshire project to improve the system of paperwork for administration sent with patients when discharged with end-of-life medicines.
- End of Life updates published in the Trust Herts and Minds newsletter as well as the Chief Nurse's Newsletter and regular e-updates.
- Involvement in the EOLC work stream of the STP framework working closely with East and North Hertfordshire NHS Trust and Princess Alexandra Hospital, Harlow.
- Completion of Pain audit, this was identified during the recent CQC inspection.
- Initial meetings have been held with local hospices in relation to the establishment of End of Life volunteers (Rose volunteers)
- Mortuary floor has been replaced.
- Audit schedule continues to be implemented.

Key Achievement - AAUL1 Green were nominated for Team of the Month for working closely together to ensure a patient and their family were well looked after and cared for at end of life.

7.0 Work streams

7.1 Individualised Plan of Care for the Dying Person

The roll out of the Individualised plan of care for the dying person has now been completed across the acute Trust. A bespoke plan of care for their dying patients has been implemented during the latter part of this reporting period in Intensive Care.

Education and training is pivotal to support the implementation and embedding of the care plan across the Trust. As a team we are in the process of monitoring, auditing and our findings will be presented to the Compassionate End of Life Care Panel.

Key achievement –Roll out of Individualised care plan for the dying person across all clinical wards.

7.2 Education

One of the key achievements for this period is end of life training is now one of the core essential teaching sessions that must be attended by new starters to the Trust and this commenced in April 2016.
The team have continued to deliver a significant amount of education over the last twelve months which includes the following:

- Teaching on the Individualised Plan of Care for the Dying Person
- Teaching to Acute Medicine, Medicine and Care of the Elderly teams on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussions and how to document and correctlycompletethe forms.
- Teaching to FY1s and FY2s on symptom control, breaking bad news and DNACPR discussions
- Teaching to Joint medical governance meeting on DNACPR and Treatment Escalation Plans (TEPs).
- Teaching on the rose project to all staff
- External teaching has been provided to the Mortuary and patient affairs staff on communication and training in how to recognise those at high risk of a complicated bereavement has been provided to the staff in patient affairs.

- The Specialist Palliative Care Team continues to have final year medical students from Imperial College shadowing them as part of their Long Term Conditions Placement and this has had good feedback. Following the success of these placements the team have been approached for the students to have longer placements with the team.
- Teaching to Allied Health Professionals by MCDLN and palliative care CNS's.

768 staff members which equates to 66% of the staff identified as being appropriate through the Training Needs Analysis have undertaken end of life training this exceeds the target set of 40%.

Key Achievement –768 staff members which equates to 66% of the staff identified as being appropriate through the Training Needs Analysis have undertaken end of life training this exceeds the target set of 40%.

7.3 Mortuary

As part of the Trust improvement plan, work continues in the mortuary with new fridge alarms installed on both Mortuary sites. This new system alerts the on call estates team and the senior Mortuary staff if the fridge temperature variates outside of the acceptable range.

Two of the Trainee APT's completed and passed all written exams as part of their Level 3 Diploma in Anatomical Pathology Technology. Both staff are now working on completing their portfolio of evidence in preparation for their practical assessment later in 2017.

The Senior APT attended the AAPT Consent Training day and is now trained to assist with obtaining consent for Post Mortem examinations.

7.4 Syringe pumps

One of the challenges over the last twelve months has been the reduction in the number of syringe pumps available across the Trust for our end of life patients, the palliative care team have worked closely with the Clinical Engineering Department and implementing other methods of tracking. The reduction in pumps has been highlighted to ward areas and divisions and has been discussed at the CEOLCP. This is on the risk register ref 3152.

Members of the Senior Clinical Nurses rota now have access to the equipment library and a business case has been submitted for additional pumps.

7.5 Advance Care Planning and EPaCC

During this period, work has started to implement more advance care planning discussions and documentation in the Trust.

Alongside this there has been cross organisational working to implement the Electronic Palliative Care Coordination System (EPaCCS) which is principally an end of life register on which details of Advance Care Planning can be recorded. This has been a large project as it has involved all the local providers and has required access to SystmOne. There have been many practical as well as governance issues that have needed to be addressed across the local providers. Work has been completed to enable the Trust specialist palliative care team to access SystmOne.

The Palliative care team have also worked with the Infloflex team to create an EPaCCs proforma which enables the information to be sent electronically from the system to the coordinator to ensure the safe transfer of data.

This work has been supported by a cross organisational CQUIN for 2016 -17.

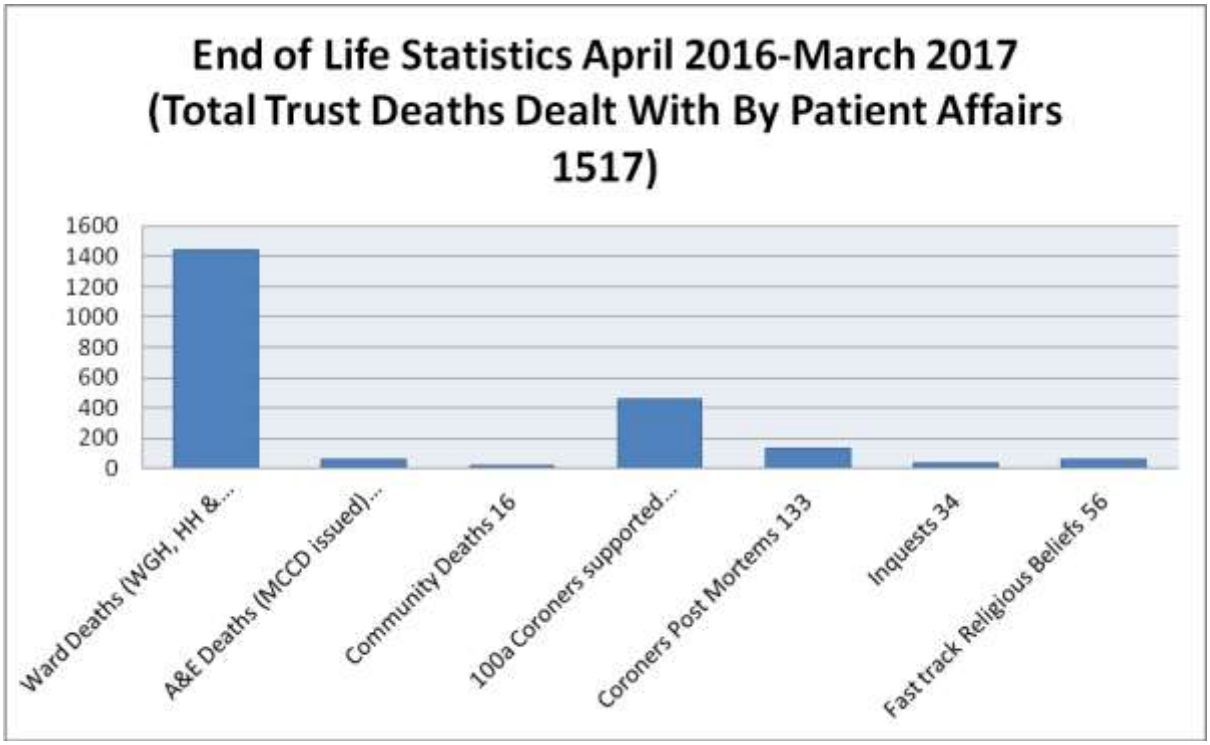
Key Achievement - Working jointly with local providers in the implementation of the Electronic Palliative Care Coordination System (EPaCCS).

7.6 Patient Affairs

The team provide a full service Monday to Friday between 9am to 4pm with additional support provided on a Sunday between 10am and 4pm to support deaths that have occurred over the weekend/bank holiday period. During this reporting period April 2016 – October 2017 the Patient Affairs team dealt with 1517 deaths and 368 deaths of these were over a weekend/BH with 7 fast tracked/certificates issued.

(It is important to note that Patient Affairs activity in relation to deceased patients April 2016 - Mar 2017 is different to the reported number of Trust deaths; this is due to the departmental activity including children deaths, community deaths and patients who have died in ED and have had to have a death certificate issued). Table 4 shows a breakdown of the number of patients deaths dealt with by patient affairs.

Table 4



The Patient Affairs team have continued to

- Provide a service for all staff and bereaved relatives and carers involved in the death of a patient, adult or child.
- Support the medical staff, included assisting and advising on the issuing of any legal documentation necessary for registering a death and to allow a cremation or burial to take place.
- Liaise with the Coroner‘s office for complex cases and/or those requiring a post mortem examination.
- Give information, support and guidance to relatives or carers on funeral arrangements.
- Contract funeral service in the event that there is no next of kin; the team will register the death, arrange the funeral and liaise with any internal or external agencies.
- Assist with viewings of the deceased patient in hours.
- Information on organ/tissue donation if required
- Facilitate the donation of tissues for retrieval, which are used to help many hundreds of people every year.
- Every effort to observe and respect the cultural and religious needs of every family
- Initiate a fast track process to ensure burial takes place quickly for families who require a funeral in a set timescale.
- Oversee the process when patients request to leave their body to a school of anatomy.
- Assist with any documentation required for repatriation.
- Advise on registering a death.
- Work closely with the Spiritual and Pastoral team, who provide additional support for those who wish to receive it.
- Work closely with the Specialist Palliative Care Team
- Work closely with the local hospices to signpost bereaved relatives to ensure that they receive appropriate support.
- Collaboration with Intensive Care to provide a streamlined service to enable the prompt identification of any case that needs referral to the Coroner.
- Involved in the training for Nurses and HCA’s in regards to what happens after death.

In September 2016 the League of Friends donated £5031.74 to the Trust for the sole purpose of replenishing the Rose Project stock which has allowed Patient Affairs to continue supplying the wards with cloth and plastic rose property bags for placing deceased property in before handing to the family and for stationery items needed by the ward when a patient approaches end of life.

Key achievement – Successful bid to League of Friends for funding to continue the Rose project.

7.6 Bereavement Service

As a Trust, it is recognised that we do not provide a bereavement service however we continue to signpost people to local bereavement services as appropriate. This was put in place following a service review and it was agreed that the Patient Affairs Department would continue to be the main contact point for bereaved relatives for information and signposting

as required to local agencies. If there are complex bereavement needs the patient affairs staff liaise with the Specialist Palliative Care Team for additional support if required for any bereaved relatives and the Spiritual and Pastoral Care team in respect of any family viewings. Supervision is provided for the team by the Lead Nurse for Patient Experience. The team have also undertaken training in compassionate communication and bereavement care. Two new members of staff joined the team in December 2016 and will attend training in July 2017 which was one of the recommendations from the 2015 CQC inspection.

Key achievement – All staff in the Patient Affairs have completed compassionate communication and bereavement training.

7.7 Surveys/ Feedback

As a Trust, we survey our bereaved families /carers of those who have died and if they want to, allow them to complete these in their own time. These questionnaires provide us with feedback both positive and negative that we can learn from. The results from these surveys are shared with the CEOLCP, the Trust Patient Experience Group as well as the Ward Managers, Matrons and Heads of Nursing. Learning from the feedback has been used to support improving care across the Trust.

The number of completed questionnaires continues to increase however as a Trust the response rate is approximately 10% and this was raised by the CQC in our most recent report following our 2016 inspection. Appendix 2 shows a breakdown of results. We are part of the University College London Partners (UCLP) Community of Practice (CoP) and Trust response rates have been discussed at this forum. There has been work undertaken by the CoP members to use a questionnaire which can be used across all partner Trusts which will enable us all to benchmark ourselves with others due to the recognition of the low response rates. One of the main issues of concern for us is as a Trust our questionnaire is more detailed.

To enable us to understand further how we can improve end of life care in the Trust the Palliative care team are working closely with the Trust Patient and Public Involvement Lead and the Trust Carer Lead and we have held two Bereavement Focus Groups this year. The aim of these is to capture and learn from both positive and negative feedback, whilst allowing the families and carers in addressing issues in an informal setting away from the Trust and this feedback will enable us to drive forward improvements. The themes from these two focus groups are fedback to the CEOLCP. Some examples of those discussed have been in relation to communication issues, organ and tissue donation, advance care planning.

Key Achievement - The Palliative care team have worked closely with the Trust Patient and Public Involvement Lead and have held two Bereavement Focus Groups this year.

7.8 Memorial Service

An inaugural memorial service was held in November 2016 at the Trust for the families of those with loved ones who had died in the Trust.

Over 50 people attended this very special, emotional and intimate multi faith service which was held in the Executive meeting room at Watford General Hospital to remember the life's of those who had died on our wards across the Trust, it was a time of reflection and of remembering those whom they loved.

Each person attending was given the opportunity to light a candle and was also given a pink rose in remembrance of their loved one.
This event was supported by the Trust Organ Donation team.

Key Achievement – Inaugural Trust Memorial Service held in November 2016.

8.0 Governance and Risk

8.1 End of Life Strategy

Our Trust Strategy sets out the vision and ambitions for End of Life Care in West Hertfordshire Hospitals NHS Trust (WHHT). It is informed by the national framework and the earlier NHS End of Life Care Strategy.

The trust vision is to deliver **the very best care for every patient every day** and for patients at the end of their lives the aim is to deliver **the care I want, where I want and when I want during my life and after death for myself and my family/carer(s) delivered by competent, confident and compassionate professionals.**

This strategy covers all those under the care of the trust who are at the end of their lives, their carers and family members and others who are close to them. This includes care given in bereavement. It is applicable to all trust employees. Delivery applies to anyone, irrespective of their age, their gender, their race, their religion, their sexuality or whether they have a disability or sensory impairment.

It is based on the national framework which identifies six ambitions for locally delivered care which are:

Each person is seen as an individual
Each person gets fair access to care
Maximising comfort and wellbeing
Care is coordinated
All staff are prepared to care
Each community is prepared to help

The six local priorities that we have identified will help us achieve the national ambitions for end of life care and these can be found below. We as a Trust are measuring our success in delivering this three year strategy against the achievement of our six ambitions and local priorities. These are recorded on the Trust wide End of life Care Action plan which is monitored by the CEOLCP. Our progress against these ambitions and priorities can be found in Appendix 3.

8.2 Audit

An internal audit programme has been commenced. During this reporting period the following audits have been undertaken:

- Patients who died in hospital and whether they were on an EOL care register and had an ACP in place.
- Audit of Documentation of Spiritual Care, Advanced Care Planning and Individualised Care Plan for the Dying Person
- Auditing the time from prescribing to starting syringe pumps
- Re-audit of time from referral to time seen by the specialist palliative care team
- Audit the compliance of the seven day CNS service
- Audit of pain assessment in new referrals to SPCT

8.3 CQUIN

As a Trust we were part of a system-wide CQUIN to promote improved collaboration and co-ordination across the EoLC pathway. The aims were, to increase the numbers of patients being treated in their preferred place or care and dying in their preferred place of death and to improve the patient experience enabling patients to remain in the community by following patient centred care planning by:

- **Improving the identification** of those who are likely to be in their last year of life to 1%, in line with national guidance.
- **Improving the quality of care** experienced received by patients and their carers.
- **Reducing emergency admissions and A&E attendances** in the last 90 days of life by 10%.
- **Improving the speed of discharges** for patients who are at the end of life. Reducing health delayed transfer of cares for domiciliary care and residential and nursing care.
- Giving more **choice and control** for those approaching the end of their life by increasing the number of Advance Care Plans where possible
- Implementing the Care Co-Ordination Hub with support from across EoLC providers
- Implementation of EPaCCs.

The following targets were set specifically for the Trust by the CCG:

75% of EoLC patients known to palliative care have or have been offered an ACP
60% of patients with an ACP have documented their preferred place of death
65% of patients to have reason documented as to why PPD was not achieved (for those patients with an ACP, with a PPD documented and that died within the hospital)
40% of staff (identified as appropriate for EoLC training through the TNA) has had appropriate EoLC training
To have implemented system 1 and EPaCCs

Key Achievement – Achieved compliance with CCG CQUIN target for ensuring our patients if appropriate have an Advance Care Plan in progress and achieve their Preferred Place of death (PPD).

8.4 Risk Register

The End of Life risk register is discussed at the CEOLCP meetings, actions are monitored. The risks sit as part of the Surgery, anaesthetics & cancer division risk register.

The Lack of Trust wide documentation for our patients who are recognised to be dying is on the risk register ID Number 3709 and scores 9. These have now been implemented across the Trust and documentation and plans of care have now been designed specifically for patients in our Intensive Care unit.

The reduction in the number of available syringe pumps across the Trust for our patients requiring symptom management subcutaneously is on the risk register ref 3152.

8.5 Complaints

As a specialist palliative care team we work very closely with the Head of Litigation and Claims, SIs, Complaints and PALS, who is a core member of the CEOLCP and produces a report for each meeting. We work closely to identify any recurrent themes and learn from these. Some examples of this are ensuring that we communicate with the patient and their families as appropriate when they are deteriorating, allowing relatives to stay with their family member if wished.

9.0 Future priorities for 2017 -18

- We will focus on delivering our action plan which underpins our End of Life Care strategy and will focus on delivering this in 2017-18
- Continuing to embed our education programme
- Embedding compliance with the Mental Capacity Act 2005 and associated code of practice when completing 'do not attempt cardiopulmonary resuscitation' forms.
- We will improve use of Treatment Escalation Plans to support effective care planning, through embedding these and training clinical staff in their use
- We will work with the Trust Care of the Elderly team to improve the End of Life Care that is delivered, including earlier referrals into End of Life Care team
- We will be part of an NHS Improvement End of Life collaborative to share learning, best practice and learn more about improvement methodology and how it can be applied to End of Life Care
- Compassionate Care Champions to be identified and trained.
- Recruit End of Life volunteers to support patients and their families at this difficult time.
- Business case to be completed for Trust Consultant post.

10.0 Recommendations

The Board are asked to receive the report for information and assurance of progress of the end of life care strategy.

Michelle Sorley
Macmillan Lead Nurse Cancer and Palliative Care
July 2017

Appendix 1 Discharge Liaison Nurse Service Data

Watford General Hospital
Discharge Liaison Nurse Service
April 2016 - March 2017

0	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Total %
Referrals to Service	45	30	25	44	40	31	14	48	41	47	54		419	
Inappropriate Referrals													0	0%
Died Before Discharge	15	10	6	15	11	6	3	14	10	10	15		116	27%
Discharged from DLN Service	45	30	25	44	40	31	14	48	41	47	54		419	
to preferred place of care	24	20	15	24	26	22	7	25	29	30	40		282	63%
to other place of care	21	10	10	20	14	9	7	23	12	17	14		157	37%
Average days between admission and referral to service	12.68	16.83	14.44	14.15	17.42	15.45	12.42	14.50	13.24	16.29	12.98		YTD 14.82	14.59
Average days between referral date and actual date of discharge	7.04	9.03	6.56	8.00	11.02	7.35	5.21	7.00	4.87	5.46	2.83		YTD 7.87	6.66
Average bed days between admission and discharge from service	19.73	25.86	21.00	22.14	28.45	22.80	17.64	21.50	18.12	21.76	15.81		YTD 22.89	21.25

RAG	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Total %
Red	13	7	6	22	13	12	6	19	21	22	21		162	39%
Amber	19	13	13	13	18	11	3	17	14	16	20		157	37%
Green	13	10	6	9	9	8	5	12	6	9	13		100	24%
Total	45	30	25	44	40	31	14	48	41	47	54	0	419	100%

Diagnosis	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Total %
Cancer	23	17	11	25	25	17	10	17	20	14	24		203	48%
Non-cancer	22	13	14	19	15	14	4	31	21	33	30		216	52%
Total	45	30	25	44	40	31	14	48	41	47	54	0	419	100%

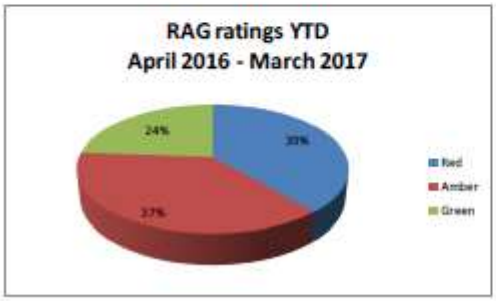
POD (if known)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Total %
Home	0	2	1	2	0	1	0	0	1	2	0		9	2%
Hospice	2	1	0	2	3	1	0	4	2	3	0		18	6%
Hospital	13	11	6	18	10	5	4	14	11	12	13		117	30%
Nursing Home	0	0	0	2	0	0	1	1	0	2	2		8	2%
Residential Home	0	0	0	0	0	0	0	1	0	0	0		1	0%
Other	0	0	0	0	0	0	0	0	1	0	0		1	0%
Data not recorded	30	16	18	20	26	24	9	0	26	28	39		236	61%
Total	45	30	25	44	39	31	14	20	41	47	54	0	390	100%

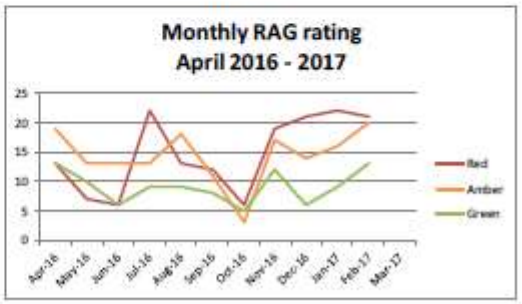
Discharge Location	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Total %
Home	8	6	6	11	6	8	2	7	10	8	10		81	19%
Hospice	3	1	1	4	6	4	0	4	2	6	2		32	8%
Hospital (Inapropriate Ref)	2	0	0	3	2	1	0	1	0	3	3		15	4%
Nursing Home	12	13	6	9	16	11	2	15	16	16	19		137	33%
Residential Home	5	0	4	1	0	2	0	4	2	1	3		22	5%
Data Not Recorded	15	10	8	16	11	6	10	17	11	12	17		132	32%
Total	45	30	25	44	40	31	14	48	41	47	54	0	419	100%

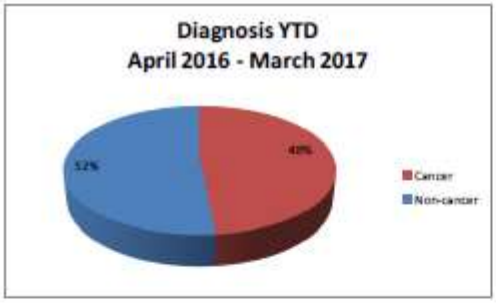
Died before Discharge v's Barriers to Discharge	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Total %
Care Package	0	1	0	0	0	0	0	1	0	0	0		2	2%
Equipment	0	0	0	0	1	0	0	0	1	0	0		2	2%
Funding/CHC	0	2	0	2	3	0	0	1	1	0	0		9	8%
Patient Condition	0	0	1	3	6	2	1	3	1	2	4		23	20%
Personal/Family	0	1	1	0	0	1	0	0	0	0	1		4	4%
Placement Issues	0	0	1	3	0	0	0	3	1	1	0		9	8%
Other	0	0	0	6	0	0	2	0	2	3	1		13	12%
None recorded	15	6	3	2	1	3	0	4	4	4	9		51	45%
Total	15	10	6	15	11	6	3	12	10	10	15	0	113	100%

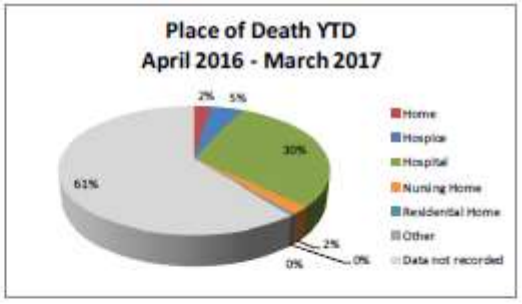

Discharged to Preferred Place of Care
April 2016 - March 2017
Discharged from Service
60
50
40
30
20
10
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Discharged to Preferred Place of Care
Discharged to Other Place of Care

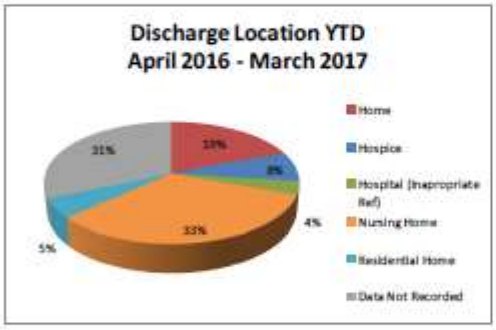

Monthly Average Bed Days
April 2016 - March 2017
Total average bed days
30.00
25.00
20.00
15.00
10.00
5.00
0.00
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Average days between referral and discharge
Average days between admission & referral

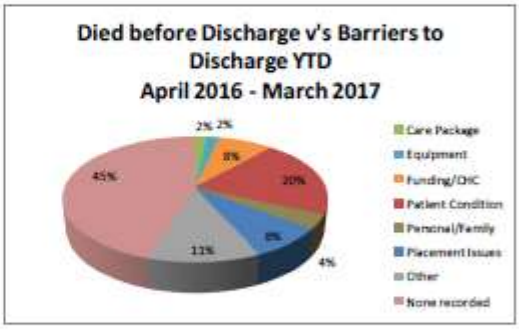

RAG ratings YTD
April 2016 - March 2017
24%
39%
37%
Red
Amber
Green


Monthly RAG rating
April 2016 - 2017
25
20
15
10
5
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Red
Amber
Green


Diagnosis YTD
April 2016 - March 2017
52%
48%
Cancer
Non-cancer


Place of Death YTD
April 2016 - March 2017
2%
5%
30%
61%
2%
0%
0%
Home
Hospice
Hospital
Nursing Home
Residential Home
Other
Data not recorded


Discharge Location YTD
April 2016 - March 2017
19%
8%
4%
33%
5%
31%
Home
Hospice
Hospital (Inappropriate Ref)
Nursing Home
Residential Home
Data Not Recorded


Died before Discharge v's Barriers to Discharge YTD
April 2016 - March 2017
2%
2%
8%
20%
4%
11%
8%
45%
Care Package
Equipment
Funding/CHC
Patient Condition
Personal/Family
Placement Issues
Other
None recorded

Appendix 2 Bereavement Questionnaire Feedback

Export from the Meridian Desktop - Page: Patient Experience >> Bereavement >> Question Analysis

Question Analysis

View the breakdown of responses received, the question text and overall score.
More information

Please use the filters below to change the reporting criteria for Question Analysis

Start Date:	01 Apr 2016
End Date:	31 Mar 2017
Display Black and White:	No
Result Type:	Percentage

Combined result from all questionnaires submitted between 01/04/2016 and 31/03/2017	Number of questionnaires submitted between 01/04/2016 and 31/03/2017
77.60%	119

Results

1. Aware they were dying

Non Scoring, 119 responses

2. Given spiritual or pastoral and emotional support

Overall Meridian score for this question: 52.56%
(based on 117 responses)

3. As comfortable as possible in their last few days

Overall Meridian score for this question: 84.75%
(based on 119 responses)

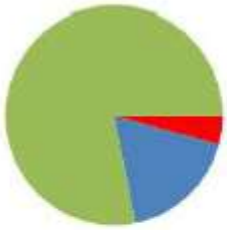
4. Given help to alleviate pain and other symptoms

Overall Meridian score for this question: 93.97%
(based on 119 responses)

Export from the Meridian Desktop - Page: Patient Experience >> Bereavement >> Question Analysis

5. Given enough physical and hygiene care

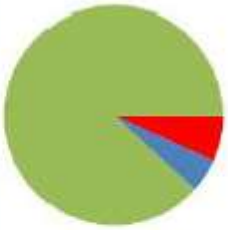
Overall Meridian score for this question: 86.97%
(based on 119 responses)



Distribution of results
4.2% 1 Disagree
17.65% 2 Neither agree / Nor...
78.15% 3 Agree
0% Not Applicable

6. Treated with dignity and respect

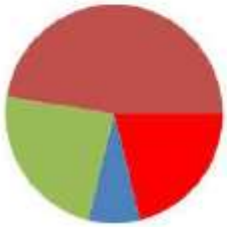
Overall Meridian score for this question: 90.76%
(based on 119 responses)



Distribution of results
6.72% 1 Disagree
5.04% 2 Neither agree / Nor...
88.24% 3 Agree
0% Not Applicable

7. Given / involved in an individualised end of life care plan

Overall Meridian score for this question: 52.42%
(based on 118 responses)



Distribution of results
21.19% 1 Disagree
7.63% 2 Neither agree / Nor...
23.73% 3 Agree
47.46% Not Applicable

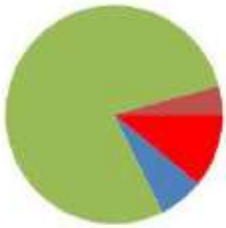
8. Well informed of the patient's condition

Overall Meridian score for this question: 83.47%
(based on 119 responses)

Distribution of results
10.08% 1 Disagree
12.61% 2 Neither agree / Nor...
76.47% 3 Agree
0.84% Not Applicable

9. Given enough opportunity to ask questions and provide important information about the wishes of the patient

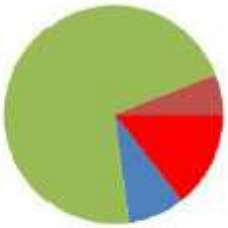
Overall Meridian score for this question: 85.09%
(based on 119 responses)



Distribution of results
10.92% 1 Disagree
6.72% 2 Neither agree / Nor...
78.15% 3 Agree
4.2% Not Applicable

10. Asked how and when you would like to be contacted if there was any change in the patient's condition

Overall Meridian score for this question: 80.18%
(based on 118 responses)



Distribution of results
14.41% 1 Disagree
8.47% 2 Neither agree / Nor...
71.19% 3 Agree
5.93% Not Applicable

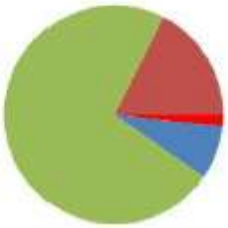
11. Were you given the opportunity to discuss resuscitation of the patient?

Overall Meridian score for this question: 92.63%
(based on 118 responses)

Distribution of results
5.08% 1 Disagree
1.69% 2 Neither agree / Nor...
73.73% 3 Agree
19.49% Not Applicable

12. If you were, was this provided in a sensitive way?

Overall Meridian score for this question: 93.09%
(based on 114 responses)

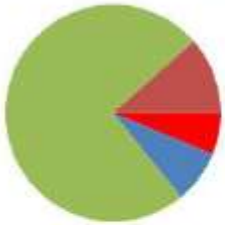


Distribution of results
1.75% 1 Disagree
7.89% 2 Neither agree / Nor...
72.81% 3 Agree
17.54% Not Applicable

Export from the Meridian Desktop - Page: Patient Experience >> Bereavement >> Question Analysis

13. Given support at the time of death If agree, please state by whom:If disagree, please state who you would have liked to have been there:

Overall Meridian score for this question: 88.50%
(based on 113 responses)



Distribution of results
6.19% 1 Disagree
7.96% 2 Neither agree / Nor...
74.34% 3 Agree
11.5% Not Applicable

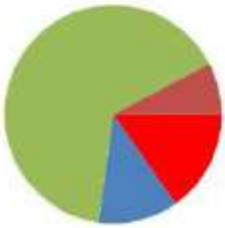
14. Offered refreshments

Overall Meridian score for this question: 89.22%
(based on 119 responses)

Distribution of results
7.56% 1 Disagree
5.88% 2 Neither agree / Nor...
84.03% 3 Agree
2.52% Not Applicable

15. Offered a quiet room

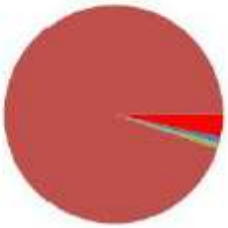
Overall Meridian score for this question: 77.06%
(based on 118 responses)



Distribution of results
15.25% 1 Disagree
11.86% 2 Neither agree / Nor...
65.25% 3 Agree
7.63% Not Applicable

16. Offered interpreting and translating services

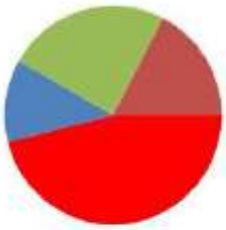
Overall Meridian score for this question: 25.00%
(based on 118 responses)



Distribution of results
3.39% 1 Disagree
0.85% 2 Neither agree / Nor...
0.85% 3 Agree
94.92% Not Applicable

17. Advised appropriately about the use of the rose symbol

Overall Meridian score for this question: 36.84%
(based on 115 responses)



Distribution of results
46.09% 1 Disagree
12.17% 2 Neither agree / Nor...
24.35% 3 Agree
17.39% Not Applicable

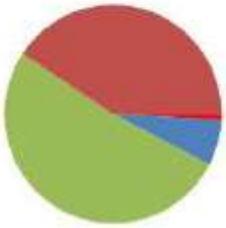
18. Treated with respect and dignity following death?

Overall Meridian score for this question: 92.31%
(based on 119 responses)

Distribution of results
1.68% 1 Disagree
11.76% 2 Neither agree / Nor...
84.87% 3 Agree
1.68% Not Applicable

19. Treated according to his / her wishes (if known, ie religious beliefs, organ / body donation)

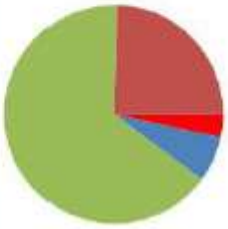
Overall Meridian score for this question: 92.86%
(based on 118 responses)



Distribution of results
0.85% 1 Disagree
6.78% 2 Neither agree / Nor...
51.69% 3 Agree
40.68% Not Applicable

20. Appropriately prepared for viewing on the ward

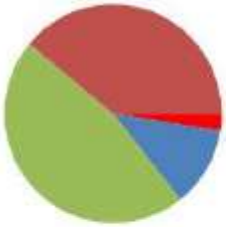
Overall Meridian score for this question: 91.01%
(based on 118 responses)



Distribution of results
3.39% 1 Disagree
6.78% 2 Neither agree / Nor...
65.25% 3 Agree
24.58% Not Applicable

21. Told about the death of your relative / friend in an appropriate place

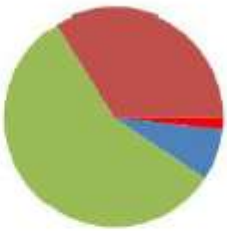
Overall Meridian score for this question: 86.11%
(based on 118 responses)



Distribution of results
2.54% 1 Disagree
11.86% 2 Neither agree / Nor...
46.61% 3 Agree
36.98% Not Applicable

22. Told in a sensitive way

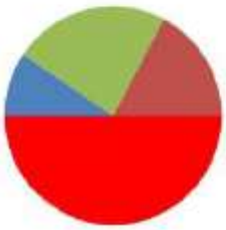
Overall Meridian score for this question: 91.67%
(based on 118 responses)



Distribution of results
1.69% 1 Disagree
7.63% 2 Neither agree / Nor...
56.78% 3 Agree
33.9% Not Applicable

23. Advised appropriately about the use of the rose symbol

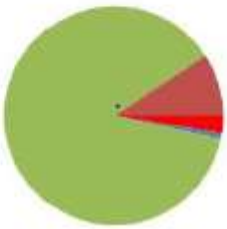
Overall Meridian score for this question: 33.85%
(based on 116 responses)



Distribution of results
50% 1 Disagree
9.48% 2 Neither agree / Nor...
23.28% 3 Agree
17.24% Not Applicable

24. Offered the chance to sit with your relative / friend on the ward

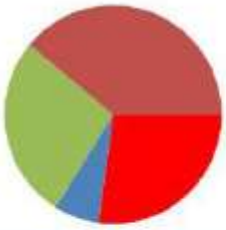
Overall Meridian score for this question: 96.76%
(based on 119 responses)



Distribution of results
2.52% 1 Disagree
0.84% 2 Neither agree / Nor...
87.39% 3 Agree
9.24% Not Applicable

25. Offered the chance to view your relative / friend in the hospital's Chapel of Rest

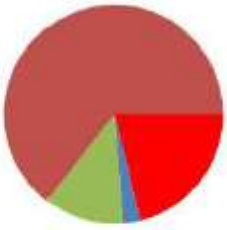
Overall Meridian score for this question: 50.00%
(based on 118 responses)



Distribution of results
27.12% 1 Disagree
6.78% 2 Neither agree / Nor...
27.12% 3 Agree
38.98% Not Applicable

26. Given appropriate support to the hospitals' Chapel of Rest

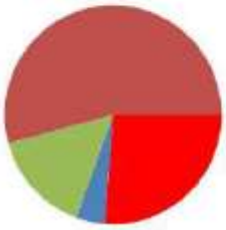
Overall Meridian score for this question: 36.90%
(based on 118 responses)



Distribution of results
21.19% 1 Disagree
2.54% 2 Neither agree / Nor...
11.86% 3 Agree
64.41% Not Applicable

27. Advised of the environment where you would view

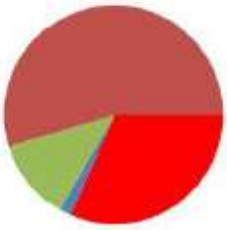
Overall Meridian score for this question: 37.96%
(based on 118 responses)



Distribution of results
26.27% 1 Disagree
4.24% 2 Neither agree / Nor...
15.25% 3 Agree
54.24% Not Applicable

28. Advised how your relative/friend may look prior to viewing

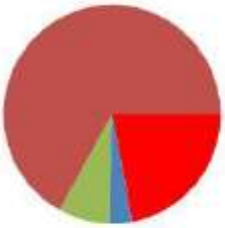
Overall Meridian score for this question: 28.30%
(based on 117 responses)



Distribution of results
31.62% 1 Disagree
1.71% 2 Neither agree / Nor...
11.97% 3 Agree
54.7% Not Applicable

29. Appropriately prepared for viewing in the hospital's Chapel of Rest

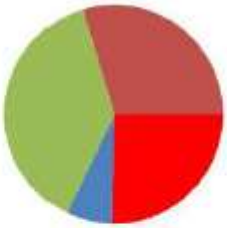
Overall Meridian score for this question: 28.21%
(based on 118 responses)



Distribution of results
22.03% 1 Disagree
3.39% 2 Neither agree / Nor...
7.63% 3 Agree
66.95% Not Applicable

30. Advised that you could view at the Funeral Directors

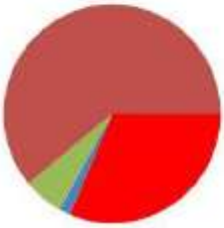
Overall Meridian score for this question: 59.04%
(based on 118 responses)



Distribution of results
25.42% 1 Disagree
6.78% 2 Neither agree / Nor...
38.14% 3 Agree
29.66% Not Applicable

31. Given the opportunity of discussing organ, tissue or body donation by the Clinical staff

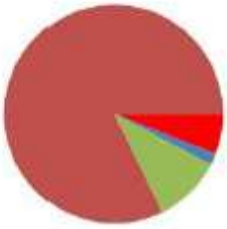
Overall Meridian score for this question: 17.39%
(based on 118 responses)



Distribution of results
31.36% 1 Disagree
1.69% 2 Neither agree / Nor...
5.93% 3 Agree
61.02% Not Applicable

32. Given the opportunity of the patient being released from hospital as soon as possible due to religious or cultural needs

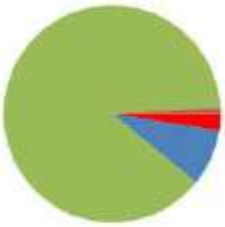
Overall Meridian score for this question: 61.90%
(based on 118 responses)



Distribution of results
5.93% 1 Disagree
1.69% 2 Neither agree / Nor...
10.17% 3 Agree
82.2% Not Applicable

33. Treated with dignity and respect by staff

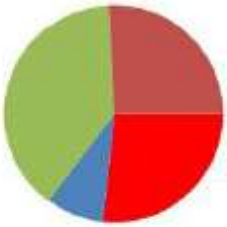
Overall Meridian score for this question: 93.22%
(based on 119 responses)



Distribution of results
2.52% 1 Disagree
8.4% 2 Neither agree / Nor...
88.24% 3 Agree
0.84% Not Applicable

34. Offered spiritual and pastoral support

Overall Meridian score for this question: 58.14%
(based on 116 responses)



Distribution of results
26.72% 1 Disagree
8.62% 2 Neither agree / Nor...
38.79% 3 Agree
25.86% Not Applicable

35. Advised of the Patient Affairs department

Overall Meridian score for this question: 89.66%
(based on 118 responses)

Distribution of results
9.32% 1 Disagree
1.69% 2 Neither agree / Nor...
87.29% 3 Agree
1.69% Not Applicable

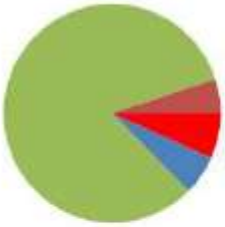
36. Given a bereavement booklet?

Overall Meridian score for this question: 97.90%
(based on 119 responses)

Distribution of results
1.68% 1 Disagree
0.84% 2 Neither agree / Nor...
97.48% 3 Agree
0% Not Applicable

37. Given the Medical Certificate of Cause of Death and patient's property in an appropriate environment

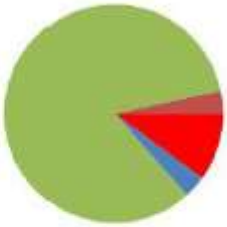
Overall Meridian score for this question: 89.82%
(based on 119 responses)



Distribution of results
6.72% 1 Disagree
5.88% 2 Neither agree / Nor...
82.35% 3 Agree
5.04% Not Applicable

38. Guided on what to do next, i.e. registering a death or making funeral arrangements

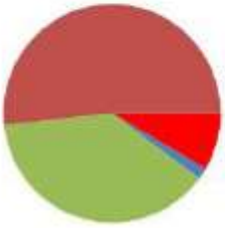
Overall Meridian score for this question: 87.83%
(based on 119 responses)



Distribution of results
10.08% 1 Disagree
3.36% 2 Neither agree / Nor...
83.19% 3 Agree
3.36% Not Applicable

39. Advised of any Coroner's involvement

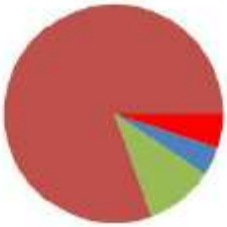
Overall Meridian score for this question: 80.70%
(based on 118 responses)



Distribution of results
8.47% 1 Disagree
1.69% 2 Neither agree / Nor...
38.14% 3 Agree
51.69% Not Applicable

40. Made aware a Coroner's post-mortem was required

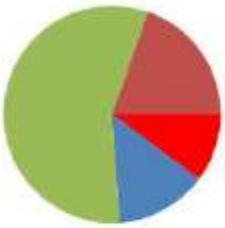
Overall Meridian score for this question: 63.04%
(based on 118 responses)



Distribution of results
5.08% 1 Disagree
4.24% 2 Neither agree / Nor...
10.17% 3 Agree
80.51% Not Applicable

41. Advised of where further support could be obtained

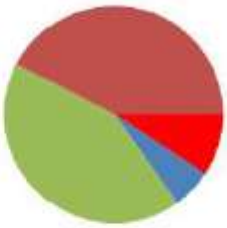
Overall Meridian score for this question: 78.72%
(based on 117 responses)



Distribution of results
10.26% 1 Disagree
13.68% 2 Neither agree / Nor...
56.41% 3 Agree
19.66% Not Applicable

42. Given an opportunity to discuss cause of death with a doctor if you requested

Overall Meridian score for this question: 78.68%
(based on 118 responses)



Distribution of results
9.32% 1 Disagree
5.93% 2 Neither agree / Nor...
42.37% 3 Agree
42.37% Not Applicable

43. I would recommend this ward to others needing end of life care

Overall Meridian score for this question: 78.18%
(based on 118 responses)

Distribution of results
13.56% 1 Disagree
13.56% 2 Neither agree / Nor...
66.1% 3 Agree
6.78% Not Applicable

Appendix 3: Measures of Success Progress from April 2016 – March 2017.

Local Priority	Measure of Success	Progress to date: April 2016 - March 2017
Individualised care plans	By 2019, 100% of appropriate patients to have individualised care plans in place	This continues to be work in progress; the plan of care for the dying person has been implemented across the Acute Trust now we need to ensure that it is embedded in our daily practice. Audit to be performed in 2017-18.
Advance care plans	By 2019, 90% of appropriate patients to have an advance care plan in place By 2019, 90% of patients to have their preferred place of death documented and if preferred place of death was not achieved 100% of patients to have reason documented	This is now recorded monthly for the Trust IPR.
Meeting diverse needs of communities	Evidence of engagement and involvement of local communities and religious leaders	We continue to Work with local communities and religious leaders eg. Bereavement focus groups held locally. Memorial service held in November 2016.
7 day palliative care service	By 2016, Specialist palliative care on site support to be available 364 days per annum and access to out of hours service available 365 days per annum	Of the 364 `days in this period with Christmas Day excluded) 361 days were covered by the Specialist Palliative Care Team = 99.1%. Access to the out of hours service has been available for the 365 days.
Improving care for all	Continue to deliver and audit an equitable service to cancer and non cancer patients ensuring benchmarking against National data	Submission of our Palliative care data set (MDS) Our ratio of non cancer to cancer patient referrals are recorded
Updated policies and clinical guidelines	Each year to have agreed policies and guidelines that impact on end of life care and to review, ratify and reflect best practice	Policies being reviewed which reflect best practice
Supporting carers and families	By 2016, to have a Patient Experience and Carers strategy in place	Patient and Carers Strategy is in place.

Electronic links between care providers	By 2016, electronic links in place between ourselves, primary and community providers are used to co-ordinate care	This work has been undertaken with the CCG and other local providers and since February 2017 we as a SPC team have had viewing access to the system
Leadership	By 2016, appointment of End of life Clinical lead, Non-Executive Director lead and Compassionate End of Life Care panel (CELCP) chaired by Chief Nurse	These posts have been appointed to
Continuity in partnership	Regular attendance and engagement with local, network, Academic health science partnerships, strategic clinical networks and national forums.	Engagement continues & Trust is represented at all forums and now represented at the STP meetings
Core and extended training	In 16/17 to have trained 40% of identified staff, in 17/18 to have trained 75% of high risk staff and 40% of others and in 18/19 to have trained 95% of high risk staff and 50% of others	Core training continues at end of this reporting period members of identified staff who have undertaken training =66%. Target was set for 40%.
Bereavement support	Families and carers have increased levels of Families and carers have increased levels of satisfaction with the care of their dying relatives offering signposting to support. Identifying those families at risk.	Bereavement questionnaire continues and Focus groups held locally.

Trust Board Meeting
07 September 2017

Title of the paper	**Infection and Prevention Control Report Annual Report 2016/17**
Agenda item	**13/51**
Lead Executive	**Tracey Carter, Chief Nurse & DIPC**
Author	**Infection Prevention and Control Team**
Executive summary **(including resource implications)**	This report summarises the work undertaken in the organisation for the period 1st April 2016- 31st March 2017. There was sustained reduction in the rates of *Clostridium difficile* infections achieving our target; however we breached the MRSA bacteraemia target, reporting one case. The improvement in the Infection Prevention and Control training uptake and Hand Hygiene compliance has equipped staff with the knowledge they require for the control and prevention of infections. This has been evidenced by the Norovirus and Flu outbreaks that have been well contained within the affected bay/wards despite high incidences of these in the community and admissions from affected care homes. We received a High Outlier Notice from PHE that our Surgical site infection rate is above the 90th percentile for Total Knee Replacement and Total Hip Replacement. This also needs to be interpreted in the light of the low study population (<100). However we fared better in comparison to trusts in the region. Validation of theatre ventilation was undertaken in both WGH and SACH, which all have had works undertaken since and are fully operational.
Where the report has been previously discussed, i.e. Committee/Group	Infection & Prevention Control Panel Clinical Outcome and Effectiveness Committee

Action required:

- The Trust Board is asked to receive the report for information and assurance of compliance with the Health and Social Care Act 2008 (2015): Code of Practice for health and adult social care on the prevention and control of infections and related guidance (The Hygiene Code).

- Approval for publication on the Trust's website.

Link to Board Assurance Framework (BAF)	☒ **PR1** Failure to provide safe, effective, high quality care ☒ **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care
Trust objectives	☒ To deliver the best quality care for our patients
Benefits to patients/staff from this project/initiatives Compliance with the Hygiene Code will ensure patient will receive safe and effective care with both staff and patient protected against acquiring healthcare associated infections	
Risks attached to this project/initiatives and how these will be managed • Failure to achieve compliance with agreed infection targets will affect the rating for the Trust and CQC Outcome 8: Cleanliness and Infection Control. • Potential financial penalties from Commissioners if infection prevention and control targets are breached	

West Hertfordshire Hospitals NHS Trust

INFECTION PREVENTION & CONTROL

Annual Report
April 2016-March 2017

FOREWORD BY THE CHIEF NURSE AND DIRECTOR OF INFECTION PREVENTION AND CONTROL:

Healthcare associated infections (HCAIs) remains a top priority for the Trust, public, patients and staff. HCAIs increase the patient stay in hospital and thereby increase in the cost of the patient`s care. The reduction of avoidable HCAIs is a priority for our organisation.

This year the Infection prevention and control team has continued to work closely with the divisions attending the monthly divisional governance meetings.

I would like to thank all staff for their efforts, engagement and hard work throughout this year to ensure the safety of our patients

Our continued goal is to deliver 'Harm Free Care' and not a single preventable infection should be allowed to develop in our hospitals.

Tracey Carter
Director of Infection Prevention & Control/Chief Nurse

EXECUTIVE SUMMARY

This was another busy year for the Infection Prevention and Control Team (IPCT) who continued to maintain high visibility and engagement in the clinical areas. The IPCT still faces a challenge due to lack of dedicated electronic Infection Control Surveillance software, using paper system which is time consuming.

We reported 20 *Clostridium difficile* Infection (CDI) cases against a trajectory of 23, achieving this year`s target. 7 of the cases were upheld, where we demonstrated that the acquisition of CDI was unavoidable. Our *CDI* rate is 8.85 per 100, 000 bed days, which is lower than the East of England being 12.39 and 11.08 for England.

Following an outbreak of *Clostridium difficile* infection (2 cases which were linked to time, place and ribotype) on Cassio ward in August 2016, there were no further WHHT acquired cases of CDI on Cassio ward nor any further CDI outbreaks in the Trust.

We reported 1 case of MRSA bacteraemia (MRSAb), our MRSAb rate per 100, 000 bed days is 0.44 which is lower than the national (0.75) and regional (0.64) rates.

Our E. colib figures are lower this financial year than the previous years, though national figures have seen an increase. In November 2016, the Secretary of State for Health launched an ambition to deliver a 50% reduction by March 2021,for Gram Negative Bloodstream Infections**.** The initial focus will be Ecolab which represents 55% of all Gram-negative BSIs.

We received a High Outlier Notice from PHE that our SSI rate is above the 90th percentile. The total population for Watford site is small and the case mix consists of high risk patients i.e. with co-morbidities affecting anaesthetic risk and possibly outcome. In comparison with neighbouring Trusts in 2015-2016, we do not fare badly: 0.7% THR, 0.4% TKR, compared to Luton and Dunstable NHS Trust (1.5% THR, 1.3% TKR), East and North NHS Trust (2.1% THR, 2.9% TKR), Hillingdon NHS Trust (0.7% THR). In 2016/17 our rate of infection for THR was 1.2% and TKR 1.7%. The data for other trusts has not been published yet for comparison.

A 5 year review of SSI rate for both THR & TKR on both sites (WGH & SACH) and of the Root Cause analyses of all cases has been undertaken and from this an orthopaedic surgical site infection prevention action plan has been formulated targeting areas of non-compliance with local policy and national guidance

There were several areas that experienced outbreaks of Norovirus, with the outbreaks well contained within those areas and no transmission to other areas of the hospital.

There were clusters of Pseudomonas in SCBU, the typing results of patients was different to the environmental isolates indicating that the water was not a source of colonisation of the babies.

Validation of theatre ventilation was undertaken in both Watford General Hospital (WGH) and St Albans City Hospital (SACH), which all have since had works undertaken and are fully operational. WGH theatres participated in the 90 day IPC quality improvement program in collaboration with NHS Improvement.

There has been sustained improvement in the IPC training compliance for clinical staff. The IPCT has continued to participate in international and national IPC activities, and continued to deliver extra IPC training to improve training uptake, including drop in sessions and “Power Training” in the clinical areas. There also been has been sustained improvement in hand hygiene compliance.

Future Priorities & Direction - 2017/18

- IPCT to maintain high visibility and engagement in the clinical areas.
- Continue to raise awareness amongst staff regarding the importance of hand decontamination in the prevention and control of infection in all educational sessions and on routine visits to clinical areas
- Deliver the IPC single study days and six day program.
- Improve support to IPC Link Practitioners by undertaking Code of Practice (CoP) audits in conjunction with them to improve understanding of IPC in the clinical area,
- Improvement in CoP audits
- Improve the turnaround of action plans for HCAI RCAs and Clinical audits
- Review Trust Peripheral IV administration study day
- Review assurance audits for Peripheral IV cannula and CVC’s audits
- Training on the use of the IPC admission risk assessment to ensure appropriate management of patients.
- Serious infections CQUIN
- OPAT pathways on antimicrobials and weekly OPAT virtual ward rounds
- Fortnightly MDT –orthopaedics to be re-instated
- Daily antimicrobial rounds on intensive care
- Weekly carbapenem stewardship rounds
- Continue to monitor antibiotic consumption

Contents

1. INTRODUCTION

The purpose of this report is to provide assurance of the Trusts compliance with the Health and Social Care Act 2008 (DH, 2015), The Hygiene Code during 2016/17.

- To keep the Trust Board informed of IPC performance over the year. This is in addition to the monthly Integrated Performance Report.
- To highlight the key areas of focus for 2017/18.

2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

Infection Prevention and Control is everyone `s responsibility within the organisation, as healthcare workers we all play a role in ensuring that our patient are safe from acquiring a preventable healthcare associated infections (HCAI).

The Chief Executive accepts on behalf of the Trust Board responsibility for all aspects of Infection Prevention and Control (IPC) within the Trust. This responsibility is delegated to the Chief Nurse (CN) as Director of Infection Prevention and Control.

- The Chief Nurse as the designated executive lead for IPC, reports directly to the Chief Executive and the Board, and is chair of the Trust Infection Prevention and Control Panel
- As the Executive Director with responsibility for IPC the CN delegates operational responsibility at Divisional level to the divisional triumvirate teams which include the Heads of Nursing/Midwifery and Divisional Managers and Divisional Directors.
- The CN/DIPC leads, and is accountable for the review and communication of the strategy, assessment of milestones and ensures that appropriate planning takes place in order to deliver the objectives.
- The CN/DIPC works in close collaboration with the Infection Control Doctor (ICD) and Assistant Director Infection Prevention and Control (ADIPC) incorporating national guidance into local policy, monitoring key performance indicators (KPIs) and compliance with the Hygiene Code.

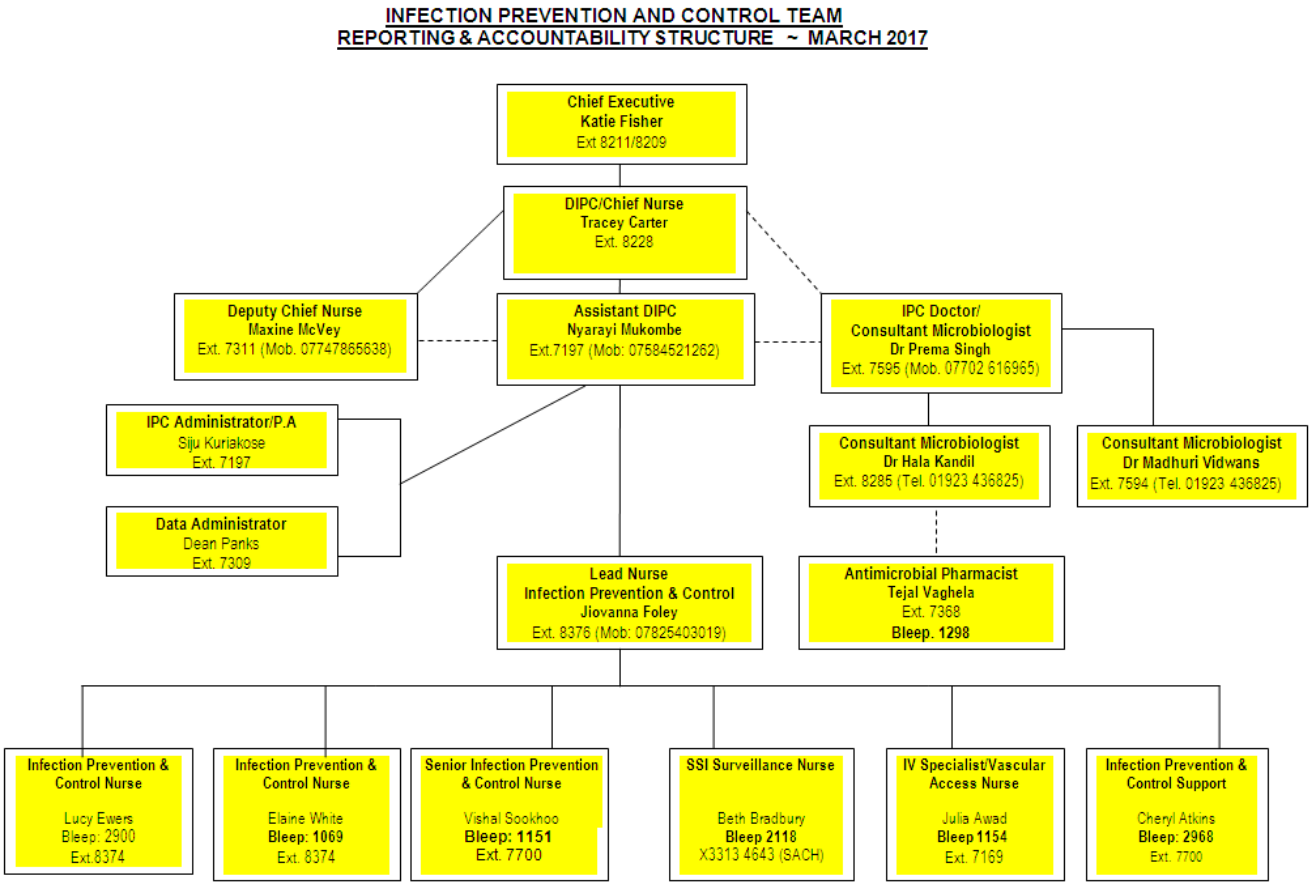
3. INFECTION PREVENTION AND CONTROL TEAM (IPCT)

The IPCT have continued to be busy this year, including challenges with the flow of emergency patients through the hospital, and reduced numbers in the team in the last quarter of the financial year.

The IPC nursing team and administration staff:

Band	Role	WTE	Comments
3	IPC Support	1	
4	IPC PA	1	Started from 1st Jan 2017, (from career break)
4	IPC Data Administrator	1	
6	IPCN	0.69	
6	IPCN	1	1 WTE till 8th Jan 2017. Maternity leave
7	Snr IPCN	1	
8a	Lead IPCN	1	
8b	ADIPC	1	
WIDER IPCT			
6	SSI Nurse	1	
7	Vascular Access Nurse	1	
	Antimicrobial Pharmacist		

	Infection Control Doctor and Microbiologists		



24hr IPC advise:
A comprehensive IPC service is provided Trust-wide. The IPCT provides a ward liaison and telephone consultation service with on-call arrangements. This on call is undertaken by a consultant microbiologist for emergency assistance and advice.

4. IPC ANNUAL PROGRAMME

The annual programme is prepared by the IPCT and agreed by the IPCP and ratified by the QSG. The programme is mapped to the duties of the Hygiene Code, and is monitored by the IPCP. The Health and Social Care Act 2008 provides Trusts with a code of practice for the prevention and control of HCAI and makes clear their statutory responsibilities. Each organisation is expected to have sufficient systems in place to apply evidence-based protocols and to comply with the relevant provisions of the Act so as to minimise risk of infection to patients, staff and visitors. (See appendix 3 for the programme and update for 2016/17.

5. MANDATORY SURVEILLANCE REPORTING OF HCAI

The Department of Health (DH) requires mandatory surveillance of specific categories of HCAI. This allows national trends to be identified and can be used as a measure of progress within a Trust and an indicator of standards.

The Trust is required to report on the alert organisms indicated below:

- MRSA bacteraemia (MRSAb)
- Clostridium *difficile* infection (CDI).

- *Escherichia coli* (E.coli) bacteraemia (E colib)
- Methicillin sensitive staphylococcus aureus bacteraemia (MSSAb)

National mandatory reporting for these organisms is co-ordinated by the Public Health England (PHE) using a Data Capture System (DCS).

The IPC nursing team perform a daily review of all alert organisms and report any alert organisms and conditions that are identified. There is no dedicated electronic Infection Control surveillance software. The IPCT use a manual system which is resource intensive. The surveillance system is of prime concern, it allows the IPCT to identify and assess all the infected patients in the hospital and is essential to the hospitals infection control management.

5.1 Trust assigned MRSAb

The DH began mandatory surveillance of MRSAb in April 2004. The trajectory set for this financial year 2016/2017 by NHS England was zero tolerance on MRSAb for all Trusts. For all cases of MRSAb a Post Infection Review (PIR) is carried out. The purpose of the PIR is to investigate how a case of MRSAb occurred and to identify actions that will prevent it reoccurring

In March 2017, we reported 1 MRSAb. The PIR was attended by the representatives from all the organisations involved in the patient `s care pathway including the Herts Valley Clinical Commission Group (Head of IPC), IPCT and the clinical teams looking after the patient.

Key learning:

- Most likely to be a contaminant, inflammatory markers improved without specific treatment for MRSAb.
- Technique used for collecting the blood culture increases the risk of contamination

Changes, New blood culture bottles and the connection system have now been implemented

Figure 1a, illustrates the MRSA bacteraemia from 2007 to March 2017.

Figure 1 a

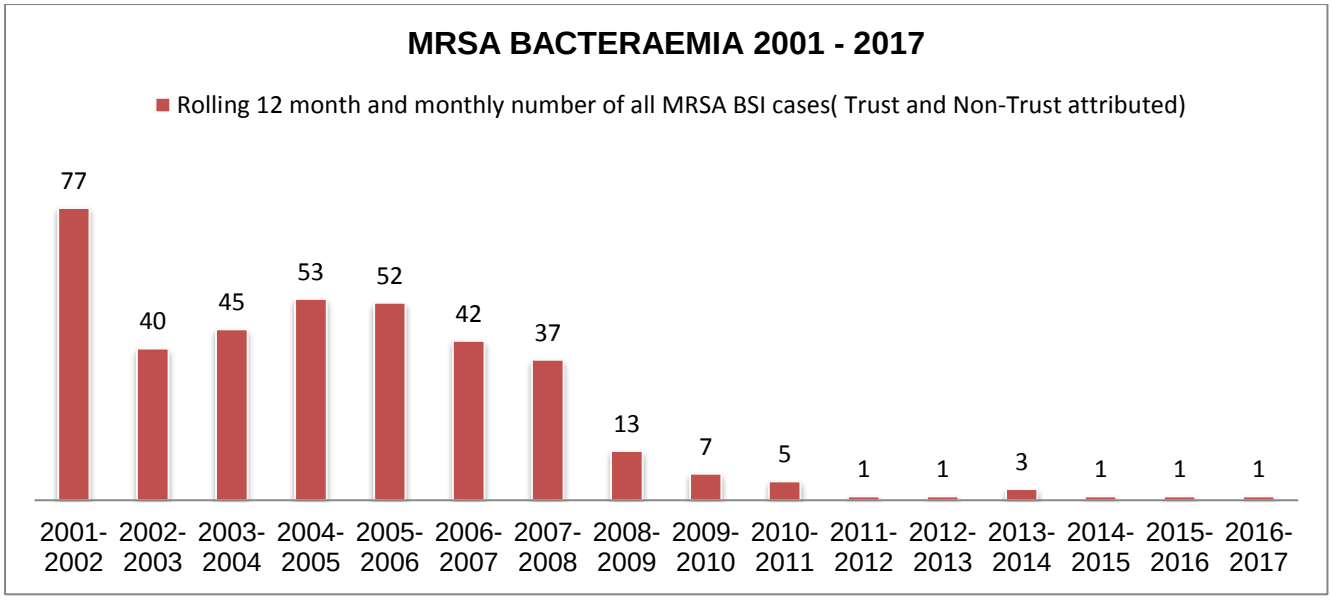
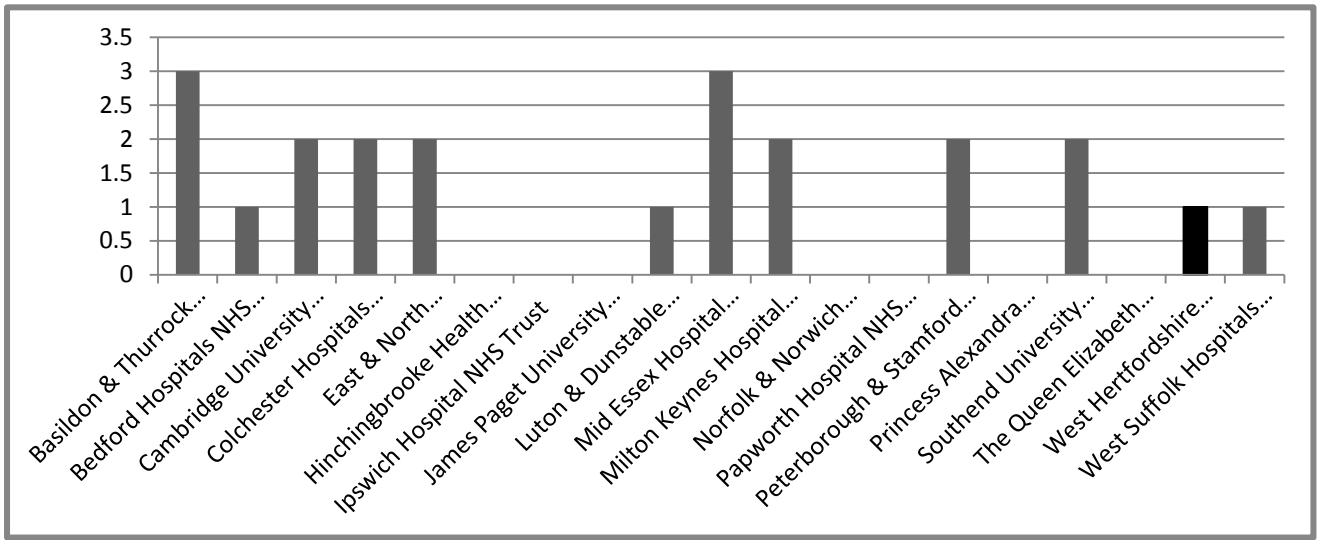


Figure 1 b
The graph below (Figure1b) illustrates the number of MRSA bacteraemia per trust in East of England.



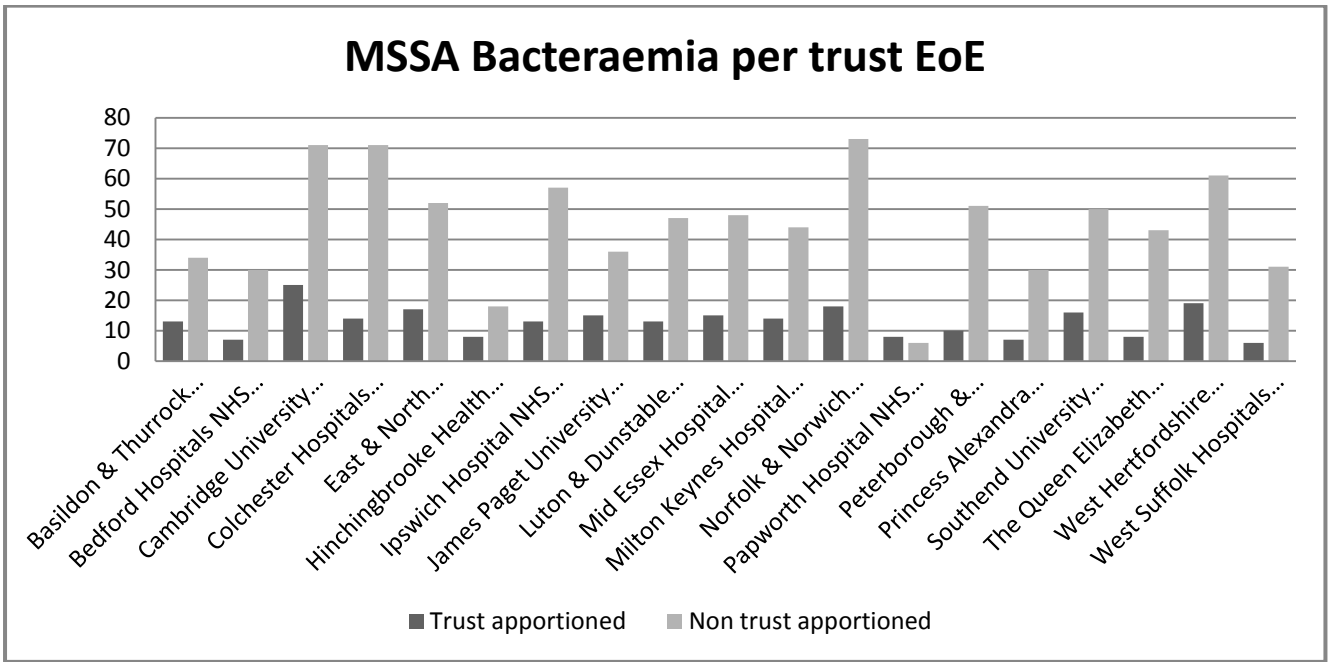
Our rate of MRSAb was 0.44 per 100,000 bed days, the East of England average rate was 0.64 per 100,000 bed days and that of England was 0.75

5.2 Methicillin Sensitive Staphylococcus Aureus Bacteraemia (MSSAb)

Reporting of MSSAb has been mandatory since January 2011. There is no trajectory set for MSSAb. In 2016/17 there were 19 WHHT apportioned MSSAb. This is an increase from last year where we reported 4 cases of MSSA.
Below Table 1 is comparison from the year 2015-2017.

MSSA	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014/15	1	0	0	2	0	2	2	0	2	0	3	0	13
2015/16	0	0	1	0	1	0	0	0	0	0	1	1	4

2016/17	1	1	1	2	1	1	2	1	4	1	1	3	**19**



The graph above illustrates the number of MSSAb per trust in East of England; Trust apportioned cases versus non Trust apportioned.

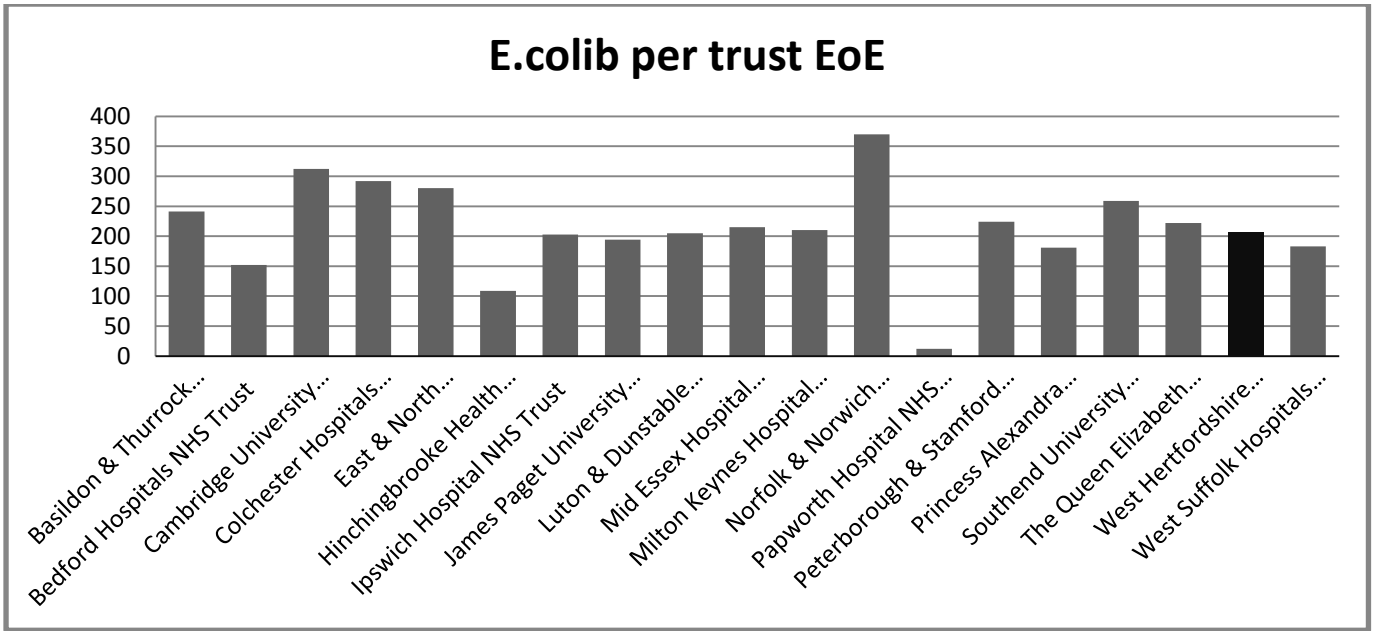
Our rates of MSSAb are lower compared to non-Trust apportioned cases.

5.3 Escherichia *Coli* Bacteraemia (E. colib)

The reporting of Escherichia *colib* became mandatory in June 2011. In this financial year there were no targets set for this condition. 29 E.colib have been identified as WHHT apportioned (that is 48 hours post admission) for April 2016 - March 2017 which is a decrease from previous year which was 33. Common theme for the E.Colib is a catheter associated urinary tract infection.

Table 2

E.coli	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	April	Ma	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014/15	1	2	3	2	4	2	3	0	3	1	1	3	**25**
2015/16	3	3	2	3	2	1	2	2	5	0	3	7	**33**
2016/17	1	1	1	4	2	2	5	1	4	4	2	2	**29**



The increase in Escherichia *coli* bacteraemia is reflected regionally and national, there has been an increase in the counts and rates of Escherichia *coli* bacteraemia. In November 2016, the Secretary of State for Health launched an ambition to deliver a 50% reduction by March 2021, for Gram Negative Bloodstream Infections**.** The initial focus will be E.colib which represents 55% of all Gram-negative BSIs. Our E. colib rates are lower than those for EoE and national.

5.4 WHHT apportioned CDI Cases from April 2016 to March 2017

Reporting for CDI in patients aged 65 and over has been mandatory since 2004 and in 2007 this was extended to include all episodes in patients aged 2 years and over. The trust trajectory for this financial year was 23.

5.4.1 **Root Cause Analysis** (RCA):

All post day 3 cases of CDI (WHHT apportioned CDI cases) are investigated using the RCA process. The expectation is that the RCAs are completed within 14 working days of the notification. Currently this is not always being achieved in the divisions due to various clinical commitments.

The RCA are robust, they involve the IPCT (IPC nurse and or Assistant Director of IPC and consultant microbiologist or Infection Control Doctor and antimicrobial pharmacist), and the Clinical team looking after the patient; (Consultant, Head of Nursing or matron and ward manager).

The responsibility for completion of the RCA rests with the relevant division. The RCA is discussed and an action plan created.

Each RCA, including the associated action plan the expectation is there are monitored at the Divisional Governance meetings. The IPCT have continued to attend the Divisional Clinical Governance meeting. IPC is a standing item on the agenda of these meetings.

*The fully completed RCA with action plan after sign off by the division can be found in the Datix**.***

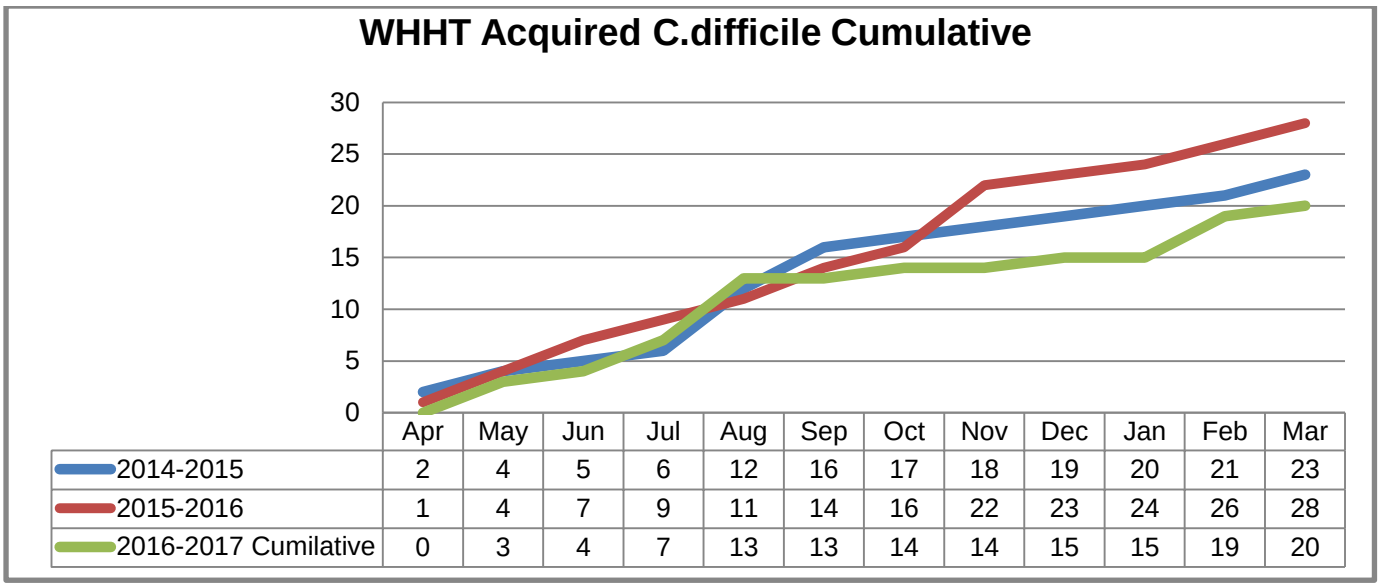
5.4.2 Exclusion from lapses of care:

Negotiation is allowed with the commissioners of acute services to determine if any of the CDI cases could be determined to have been unavoidable. The IPCT submitted 9 cases to the CCG for exclusion from lapses in care. 7 of the cases were upheld, were we demonstrated that the acquisition of CDI was unavoidable.

7 of the cases were upheld, were we demonstrated that the acquisition of CDI was unavoidable.

COMPARISON OF WHHT ATTRIBUTED *CLOSTRIDIUM DIFFICILE* CUMULATIVE CASES; APRIL 2014 TO MARCH 2017

Below is the *Clostridium difficile* graph comparing the last 3 financial years April 2014 to March 2017. This demonstrates that there has been some reduction, compare to the last 3 years.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-2015	2	4	5	6	12	16	17	18	19	20	21	23
2015-2016	1	4	7	9	11	14	16	22	23	24	26	28
2016-2017 Cumilative	0	3	4	7	13	13	14	14	15	15	19	20

WHHT apportioned *Clostridium difficile* April 2007 to March 2016

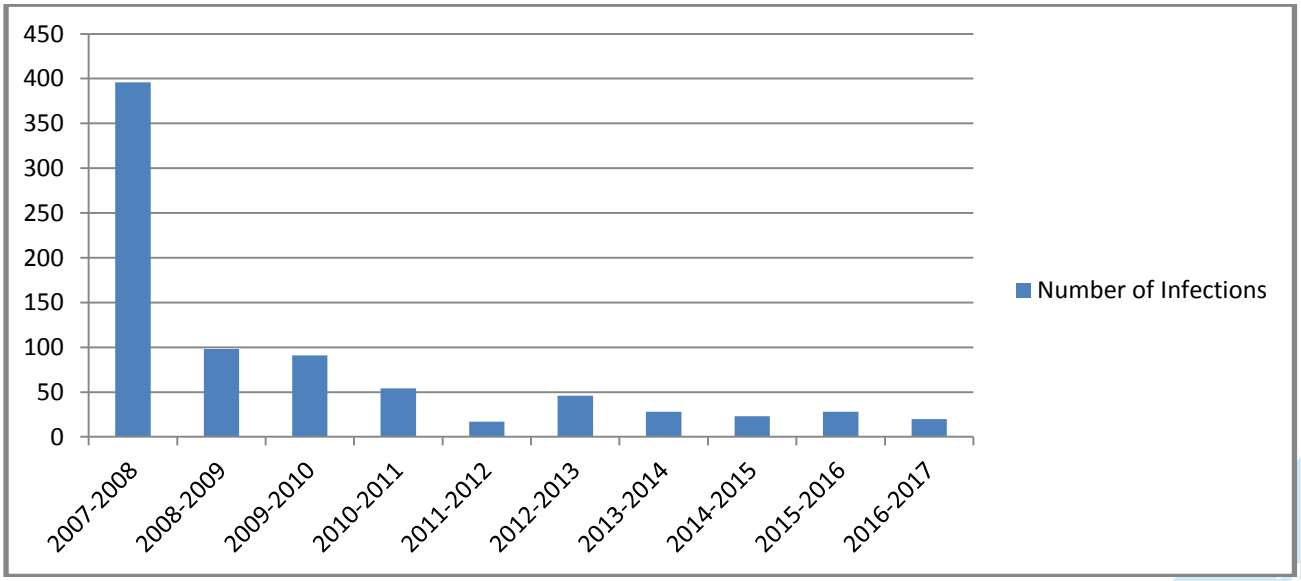
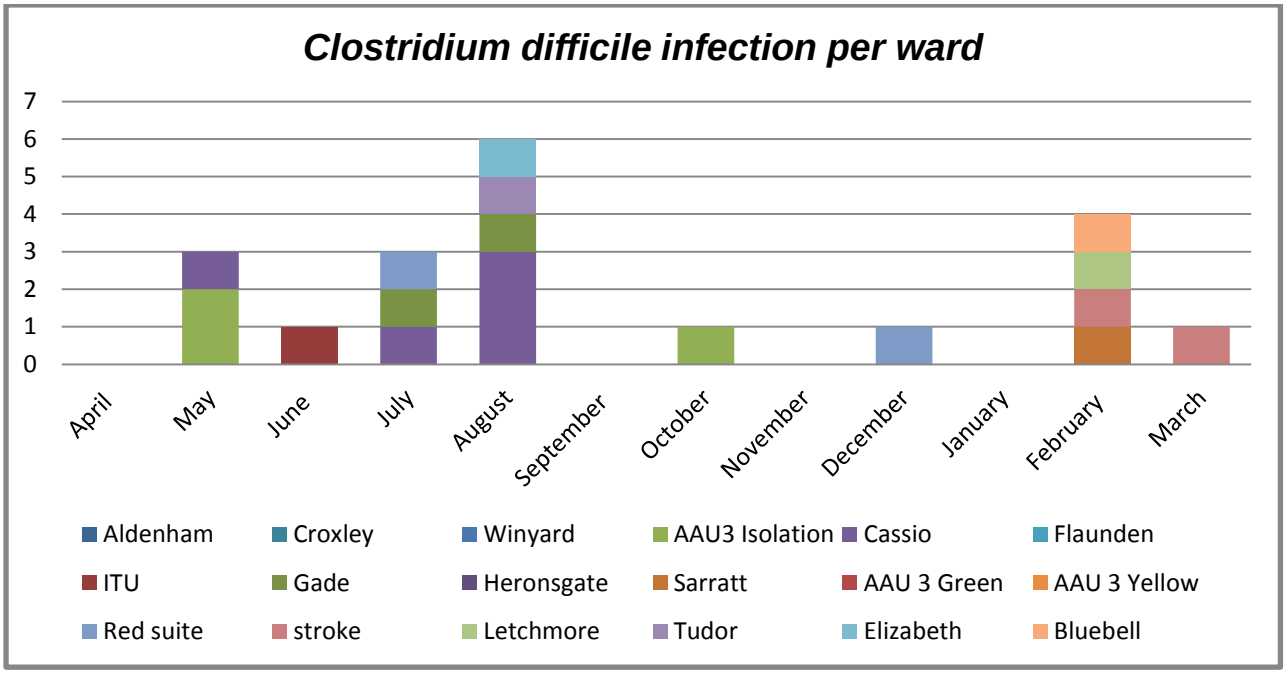


Figure 5: WHHT apportioned *Clostridium difficile* cases per Ward

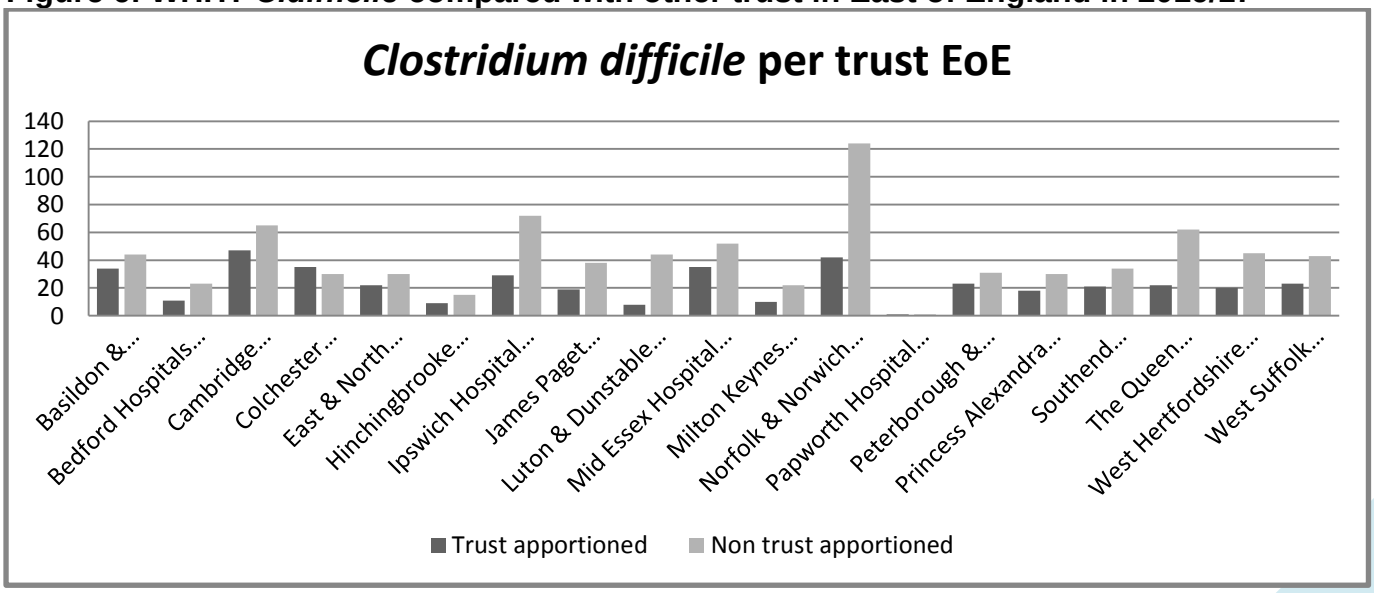
This demonstrates that there were more cases reported on Cassio wad. Cassio ward is our Gastroenterology ward, most patients will have diarrhoea and there is increased sampling on the ward due to this.



In August 2016 we reported 6 cases of CDI, which was higher than the cases we reported last year at the same time, 3 cases from Cassio ward with 2 cases linked by ribotype.:

Cassio has the highest number of CDI cases as this is our Gastroenterology ward where there is also increased testing of stool specimen.

Figure 6: WHHT *C.difficile* compared with other trust in East of England in 2016/17



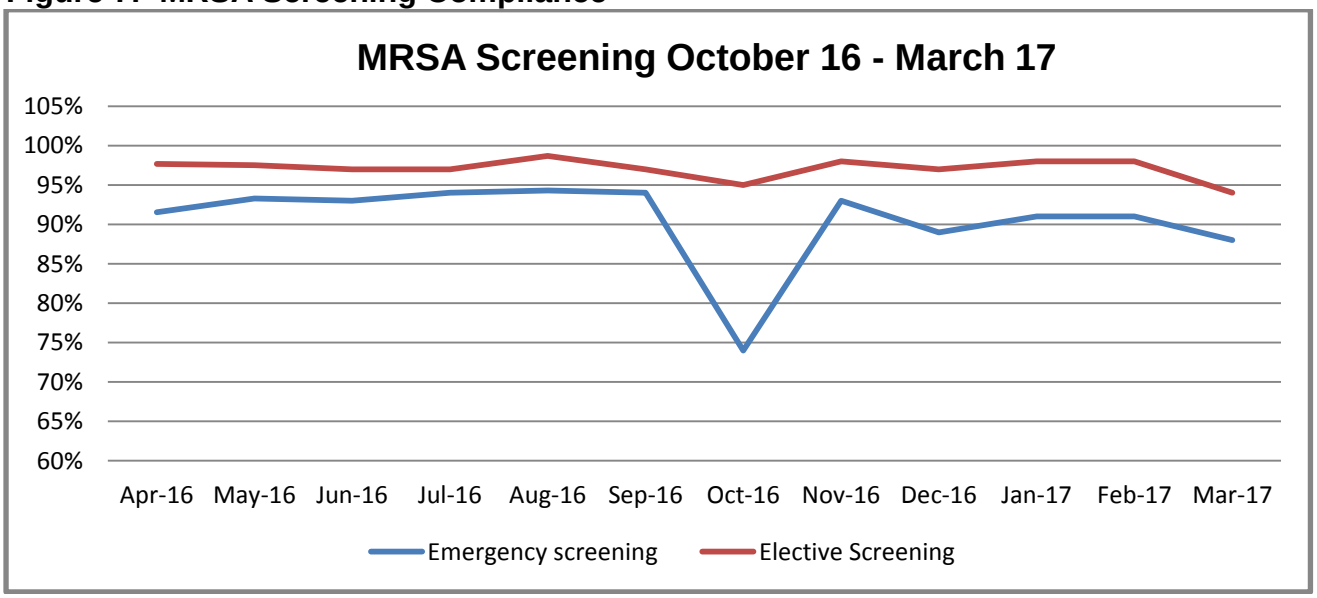
Our rate of CDI was 8.85 per 100,000 bed days, the East of England average rate 12.39 per 100,000 bed days and England rate is 11.06

5.5 MRSA Screening Compliance

In June 2014 the DH published the implementation of modified admission MRSA screening guidance for NHS trusts, where trusts could implement selective screening for MRSA. The Trust has continued to adopt MRSA screening for all planned and emergency admissions with the exception of some low risk areas. The MRSA screening compliance is monitored in the monthly IPCP meetings. Patients identified to be MRSA positive are promptly isolated and commenced on the decolonisation protocol.

Below is the graph that shows MRSA screening compliance for both emergency and elective admission in the trust for 2016/17.

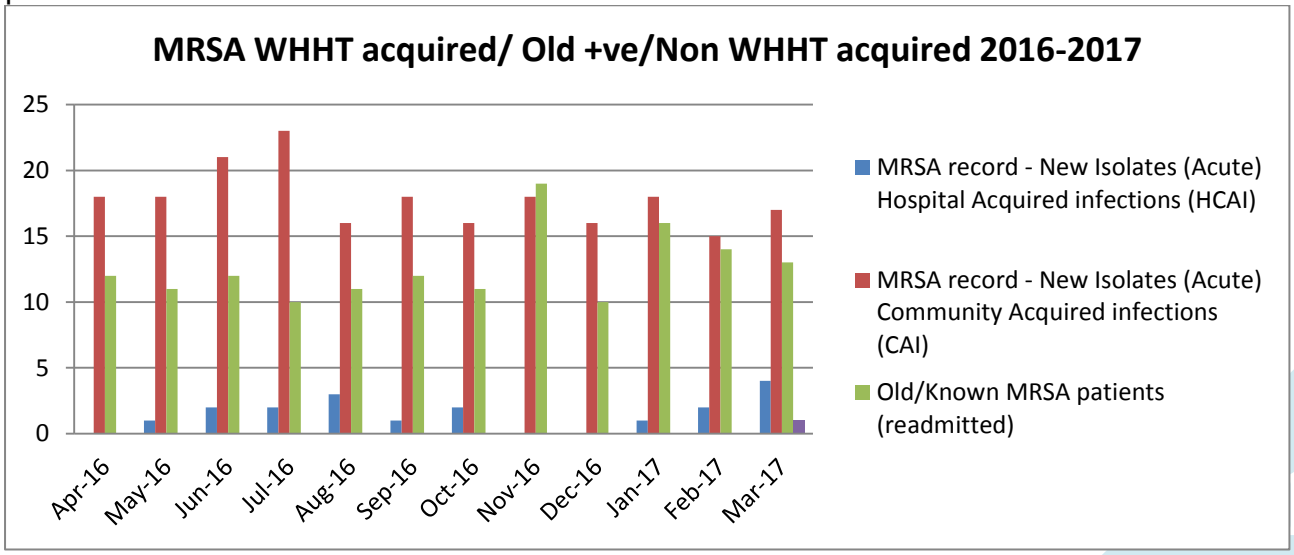
Figure 7: MRSA Screening Compliance



A dip in the Emergency MRSA screening compliance in October 2016. This has improved as demonstrated in the graph.

5.6 MRSA Isolated for April 2016 to March 2017

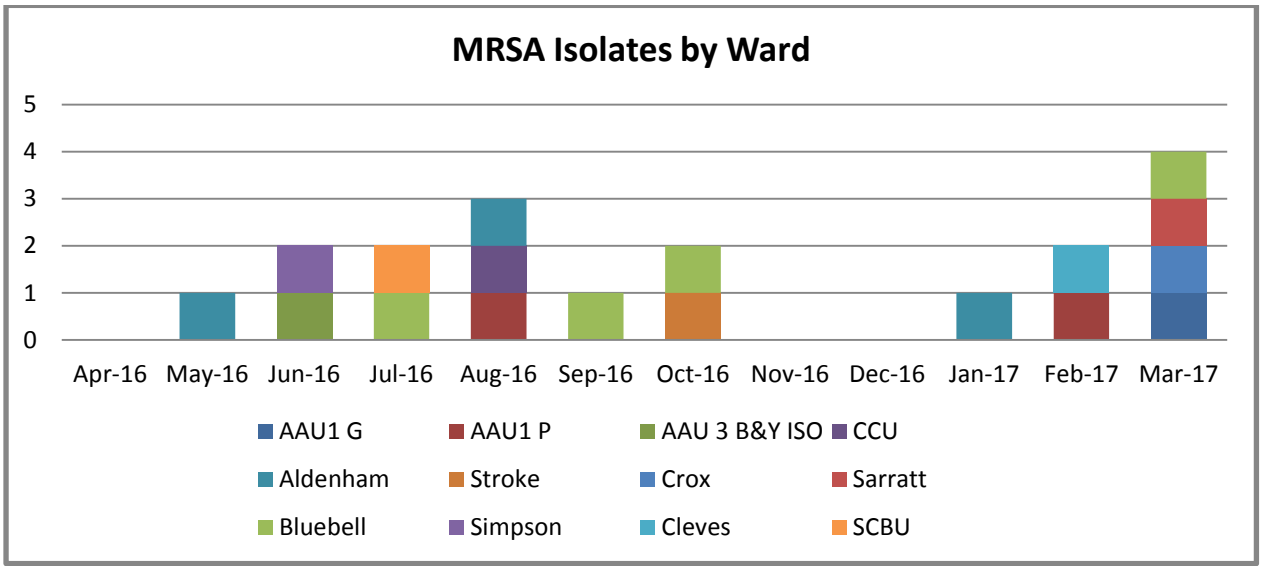
Patients identified to be MRSA positive are promptly isolated and commenced on the decolonisation protocol. All patients admitted undergo an IPC risk assessment as per patient risk assess document.



The WHHT apportioned MRSA (colonisation) has been consistently lower than those that are positive on admission.

5.6.1 MRSA Isolates per ward:

The numbers of cases that are acquired per ward are monitored in the bi monthly IPC panel meetings. The figures are recorded monthly in the IPC dashboard.



6. ANTIMICROBIAL STEWARDSHIP ACTIVITIES

An antimicrobial stewardship programme is a key component in the reduction of healthcare associated infections (HCAI) and contributes to slowing the development of antimicrobial resistance. Antimicrobial team activities have been focussed on supported the delivery of National AMR CQUIN. Antibiotic committee meeting takes place every two months and minutes are submitted to the IPCP.

WHHT antimicrobial strategy document has an antimicrobial stewardship audit plan for each year. This includes monthly antibiotic report, monthly antimicrobial stewardship AMR CQUIN audits and annual point prevalence survey of antimicrobials.

Annual Point Prevalence survey of Antimicrobials was conducted in November 2016. The following is the summary of the survey report

- The percentage of patients prescribed antimicrobials is 40% (250 patients) which is in line with the national survey (38%).
- The percentage of IV antimicrobial courses is 66% (232/352).
- 63% of patients prescribed antimicrobials were over 70 years old.
- 68% (n=169) of patients were prescribed antimicrobials in the unsheduled care division (38% in COE, 12% in Admissions and 18% in medicine)
- Overall compliance to antimicrobial guidelines is 92%
- 94% of antimicrobial courses had documented review at 48-72 hours. However 73% of the documented review was to continue with no further review date.

This year the team also completed the National Point Prevalence Survey of Health Care Infection and Antimicrobial use in acute care hospitals in November 2016. 426 patients were audited for the national survey and the following is the summary of the Trust report.

Number	% total	Has HAI	% HAI	Receives Antimicrobial	% AM
424	100.0%	19	4.5%	176	41.5%

AM-antimicrobials HAI- healthcare associated infections

Peripheral Venous Catheter	% PVC	Central Venous Catheter	% CVC	Urinary Catheter	% UC	Intubation	% Intub
243	57.3%	16	3.8%	78	18.4%	3	0.7%

The AMR CQUIN audits include Antimicrobial stewardship rounds, Meropenem usage audit and total antimicrobial consumption data collection. 2016-2017 data has been submitted to ESPAUR and CCG and the Trust achieved the AMR CQUIN requirements for the year (see below quarterly AMR CQUIN data).

Five posters, two oral presentations and one workshop on “Examples of using surveillance data for quality improvement” were presented at Federation of Infectious Societies (FIS) in Edinburgh in November 16.

The Trust took part in European Antibiotic Awareness Day on 18th November 2016. Staff from pharmacy, infection control and microbiology ran a campaign with quizzes, information sheet on AMR and educational programme throughout the day for public and staff. Grand round session was held on the day where junior doctors presented their audits on “Appropriates of UTI prescribing” and “Appropriateness of Gentamicin prescribing”. These audits were presented as poster for ECCMID 2017 conference in Vienna in April 17. Antimicrobial stewardship rounds abstract was also presented as poster for ECCMID 2017. Orthopaedic MDT abstract on “Evaluation of sonication as a diagnostic tool in orthopaedic implant infections” was given as an oral presentation at ECCMID 2017.

Weekly MDT C-diff rounds with microbiology, gastroenterologist, infection control and antimicrobial pharmacist were implemented in September 2016. MDT rounds sticker has been developed which is completed on each round and attached in the notes. On average 5-7 patients are seen on the round and plans are underway in the development of Faecal Microbiota transplantation service at the Trust.
Weekly virtual OPAT (outpatient antimicrobial therapy) ward rounds are held to review patients who are discharged home on IV antibiotics to ensure high quality of care and safe prescribing.

Quarterly AMR CQUIN Summary Data

Percentage of antibiotic prescriptions reviewed within 72 hours for 40 antibiotic prescriptions

Q1 Milestone	**April 16**	**May 16**	**June 16**	**Q1 average**
25%	78%	93%	98%	90%
Q2 Milestone	**July 16**	**August 16**	**September 16**	**Q2 average**
50%	98%	100%	100%	99%
Q3 Milestone	**October 16**	**November 16**	**December 16**	**Q3 average**
75%	100%	98%	98%	99%
Q4 Milestone	**January 17**	**February 17**	**March 17**	**Q4 average**
90%	100%	98%	98%	99%

Quarterly AMR CQUIN Summary Data

Antibiotics	**Quarter**	**DDD/1000 Admission**	**% Change from baseline March 16**	**YTD%**
Total Antibiotic Consumptions	1	4153	-7	-7
	2	4129	-8	-7
	3	4428	-1	-5.2
	4	4458	-0.3	-4
Carbapenems (exc penicillin allergy pts)	1	53	-41	-41
	2	39	-57	-49
	3	62	-31	-27
	4	74	-18	-29
Piperacillin & Tazobactam	1	175	-31	-32
	2	166	-34	-32
	3	208	-18	-27
	4	229	-9.4	-23

Current actions and Recommendations:

- Assess appropriateness of antimicrobial prescribing through for both treatment and prophylaxis courses. Continue engagement of junior doctors on antimicrobial stewardship audits
- Continue to deliver educational teaching sessions to medical, nursing and pharmacy staff and to re-enforce microbiology clinical aspects in teaching session
- Continue antimicrobial stewardship, meropenem and C diff MDT rounds
- Implement updated antimicrobial guidelines with shorten antimicrobial durations and monitor outcome
- Implement review within 72 hours to include a defined stop/review date if antibiotic course has to continue via antimicrobial stewardship rounds and educational sessions

7. WHHT SURGICAL SITE INFECTION SURVEILLANCE PROGRAMME 2016-2017.

Orthopaedic Surgical Site Infection (SSI) surveillance is a mandatory requirement introduced by the DH in April 2004. The PHE healthcare associated infection and antimicrobial resistance department (HCAI & AMR) run the surgical site infection surveillance service (SSISS). The data collected is forwarded to the PHE for analysis and

reporting. The mandatory requirement is for a three month module of surveillance in one of the following orthopaedic categories:

- Reduction of long bone fracture
- Total hip replacement (THR)
- Total knee replacement (TKR)
- Repair of neck of femur

WHHT has been participating in continuous hip and knee prosthesis SSI surveillance since July 2010 with the addition of other categories of surgery as agreed within the Divisional SSI Surveillance Programme.
For all SSI identified a root cause analysis is undertaken, see appendix 2 for the RCA process.

7.1 Orthopaedic SSIS results published data.

Q2. April-June 2016:

SACH Total Hip Replacement (THR)	**Apr-Jun 16**	**Last 4 periods**
Study population (number of operations)	87	325
Number of inpatient/readmission SSIs	0	1
% infected	**0%**	0.3%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
SACH Total Knee Replacement (TKR)	**Apr-Jun 16**	**Last 4 periods**
Study population (number of operations)	137	456
Number of inpatient/readmission SSIs	4	4
% infected	2.9%	0.9%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Hip Replacement (THR)	**Apr-Jun 16**	**Last 4 periods**
Study population (number of operations)	23	114
Number of inpatient/readmission SSIs	0	1
% infected	0%	0.9%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
WGH Total Knee Replacement (TKR)	**Apr-Jun 16**	**Last 4 periods**
Study population (number of operations)	30	112
Number of inpatient/readmission SSIs	2	5
% infected	6.7%	4.5%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%

Q3 July-September 2016:

SACH Total Hip Replacement (THR)	**July-Sept 16**	**Last 4 periods**
Study population (number of operations)	116	378
Number of inpatient/readmission SSIs	2	3
% infected	1.7%	0.8%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
SACH Total Knee Replacement (TKR)	**July-Sept 16**	**Last 4 periods**
Study population (number of operations)	111	468
Number of inpatient/readmission SSIs	0	4
% infected	0%	0.9%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Hip Replacement (THR)	**July-Sept 16**	**Last 4 periods**
Study population (number of operations)	37	115
Number of inpatient/readmission SSIs	1	2
% infected	2.7%	1.7%

National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
WGH Total Knee Replacement (TKR)	**July–Sept 16**	**Last 4 periods**
Study population (number of operations)	35	121
Number of inpatient/readmission SSIs	2	6
% infected	5.7%	5%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%

Q4 October – December 2016:

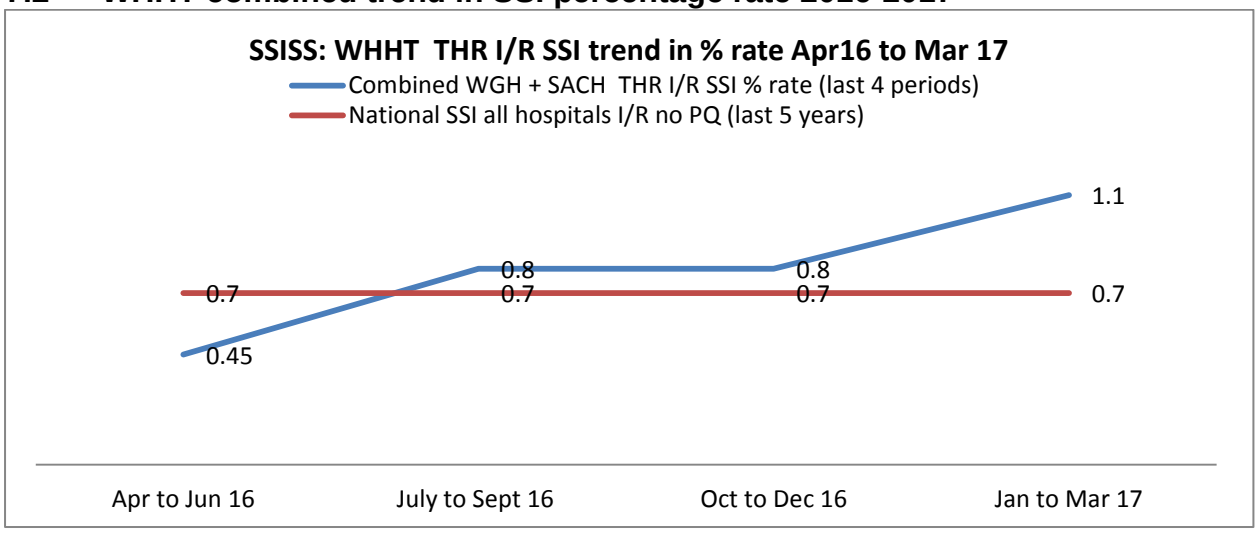
SACH Total Hip Replacement (THR)	**Oct-Dec 16**	**Last 4 periods**
Study population (number of operations)	84	371
Number of inpatient/readmission SSIs	0	2
% infected	0%	0.5%
National baseline: results from all hospitals from the previous 5 yrs *Inpatient + Readmission without PQ)*		0.7 %
SACH Total Knee Replacement (TKR)	**Oct-Dec 16**	**Last 4 periods**
Study population (number of operations)	99	462
Number of inpatient/readmission SSIs	1	5
% infected	1%	1.1%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Hip Replacement (THR)	**Oct-Dec 16**	**Last 4 periods**
Study population (number of operations)	36	125
Number of inpatient/readmission SSIs	1	3
% infected	2.7%	2.4%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
WGH Total Knee Replacement (TKR)	**Oct-Dec 16**	**Last 4 Periods**
Study population (number of operations)	30	121
Number of inpatient/readmission SSIs	0	4
% infected	0%	3.3%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%

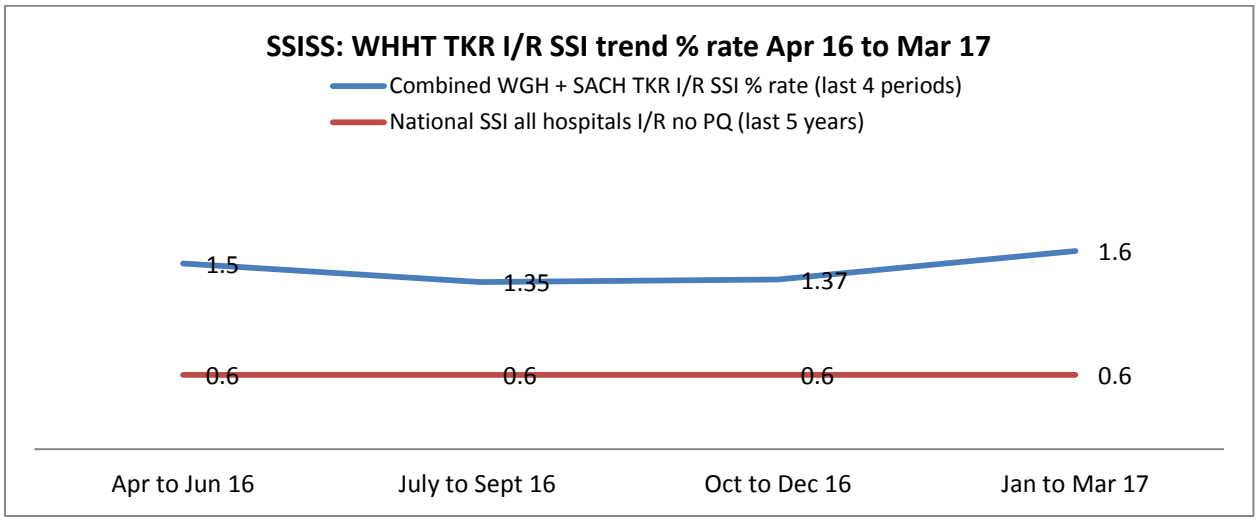
Q1. January – March 2017:

SACH Total Hip Replacement (THR)	**Jan-Mar 17**	**Last 4 Periods**
Study population (number of operations)	97	384
Number of inpatient/readmission SSIs	0	2
% infected	**0%**	0.5%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
SACH Total Knee Replacement (TKR)	**Jan-Mar 17**	**Last 4 Periods**
Study population (number of operations)	79	426
Number of inpatient/readmission SSIs	0	5
% infected	0%	1.2%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Hip Replacement (THR)	**Jan-Mar 17**	**Last 4 Periods**
Study population (number of operations)	27	123
Number of inpatient/readmission SSIs	2	4
% infected	7.4%	3.3%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.7%
WGH Total Knee Replacement (TKR)	**Jan–Mar 17**	**Last 4 Periods**
Study population (number of operations)	17	112
Number of inpatient/readmission SSIs	0	4
% infected	0%	3.6%
National baseline: results from all hospitals from the previous 5 yrs		0.6%

(Inpatient + Readmission without PQ)		
WGH Repair of neck of femur (#NOF)	**Jan-Mar 17**	**Jan-Mar 16**
Study population (number of operations)	99	114
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*	1.3%	1.4%

7.2 WHHT combined trend in SSI percentage rate 2016-2017





High Outlier Notification.

So far this year (2016/17) WHHT has received High outlier notifications from PHE alerting the organization that the SSI rates are above the 90th percentile.

It should be noted that for Oct-Dec 16 TKR at SACH, and for WGH (all periods TKR + THR) a combined SSI rate from the previous four quarters was used to determine outlier status against the national benchmark due to low study population numbers (<100).

In response to this upsurge in orthopaedics SSI's, an orthopaedic surgical site infection prevention action plan has been formulated targeting areas of non-compliance with local policy and national guidance identified following a review of root cause analysis data. This was presented to the SSIPP in January 2017 and is being followed up at all future SSIPP meetings and at Divisional Governance meetings

In comparison with neighbouring Trusts in 2015-2016, we do not fare badly: 0.7% THR, 0.4% TKR, compared to Luton and Dunstable NHS Trust (1.5% THR, 1.3% TKR), East and North NHS Trust (2.1% THR, 2.9% TKR), Hillingdon NHS Trust (0.7% THR). In 2016/17 our rate of infection for THR was 1.2% and TKR 1.7%. The data for other trusts has not been published yet for comparison.

On the WGH site there were 2 cases of SSI that occurred in Q1 (January 2017 to March 2017), both THR both with risk factors (ASA 3, high BMI, type 2 DM, COPD and both were organ-space infections. A thorough RCA investigation has been undertaken as per SSI RCA process. Both cases were also raised and discussed at the Surgical Division Governance meeting.

The main issues addressed by the action plan include:

1) Administration of Antimicrobial Prophylaxis
   - Compliance with NICE CG74 (Timing of antibiotic administration).
   - Compliance with WHHT Surgical Antimicrobial Prophylaxis Policy (choice and dosage of antibiotics).
2) Compliance with DH 'Saving Lives' High Impact Intervention no 4.
   - Review and adaptation of the Surgical Site Infection Prevention care plan.
   - Appropriate use of Surgical Site Infection Prevention care plan at ward and theatre level.
3) Environment
   - Assurance that all surgical areas (Wards/Theatres) are clean, well maintained & fit for purpose.
   - Ring fencing of orthopaedic elective patients at SACH.

8. VASCULAR ACCESS

This is a Nurse Led service, with the Vascular Access Nurse (VAN) being a part of the wider IPCT. The VAN undertakes the insertion of :

- Peripherally Inserted Central Catheter (PICC)
- Midline insertion (short term access)
- Ultrasound guided peripheral cannulation

The VAN also undertakes review of the inpatients with these catheters and provides line management education and training including competency assessment.

8.1 Service improvements undertaken and activities

On-Line referral System

To be implemented in April 2017, the referral pathway has been in development since September 2016. This has been with the involvement of the Lead Microbiologist for Outpatient Parenteral Antibiotic Therapy (OPAT).

The referral form aims to provide integrated care and has recently been modified to include a section for patients require PN and patients who are diabetic.
Access to the system is 24hr via the trust intranet.

The referrals automatically link to the Vascular Access database, which is due for completion Aug 2017.

Device Insertion

Reason for IV Access	PICC	Midline	Peripheral Cannulation (ultra sound)
Antibiotics	154	52	
Chemotherapy	7	N/A	
Parenteral Nutrition	27	N/A	
IV Access	11	6	12
Iloprost	N/A	4	
TOTALS	**199**	**62**	**12**

Ongoing support/advice

Readmission reviews	35
PICC Unblocking	34
Device removal	61
Dressing changes	86
Tip migration	17
Blood cultures	8
Visual Infusion Phlebitis (VIP) Score advice	14

Weekly Reviews

Patients with Midline and CVC devices are reviewed weekly and more frequently when necessary. Assessment focus is on infection control and maintenance of devices.

Peripheral IV access device audit

This was undertaken in conjunction with B Braun.

Summary of recommendations:

- improvements in ongoing care
- documentation,

This has resulted in the formation of a steering group responsible for evaluation and change to the current trust Peripheral IV administration study day. An E- Workbook and test are being developed.

Teaching

Trust Central Venous Catheter (CVC) study day

The need for change was based on completed evaluations from the original course. The day is divided into theory and practical work stations. A pre-course E- module and test have to be completed to secure a place on the study day. There is a time frame of 4 months to complete competencies and successfully finish the course.

Teaching in the clinical areas

This is provided in many forms and concentrates on on-going care and maintenance

MDT Teaching

The aim is to raising aware of the vascular access service and the vital infection prevention and control issues related to all Vascular access devices, talks have been given to

- FY1 & FY2 Doctors
- CT1 & CT2 Doctors
- Trainee Pharmacists

8.2 Future plans

Teaching

- The Trust Peripheral IV administration study day is undergoing major changes to concentrate on practical workshops.
- An E-module workbook and pre-course test is in the process of being developed and the new style course will commence in Jan 2018.
- The CVC IV Administration course will be evaluated in December 17 to determine how many attendees have been signed off as competent, the results will determine future course structure and may involve practical days being built into the course, to ensure competencies are met.
- A bi-annual rolling programme for ward based teaching,

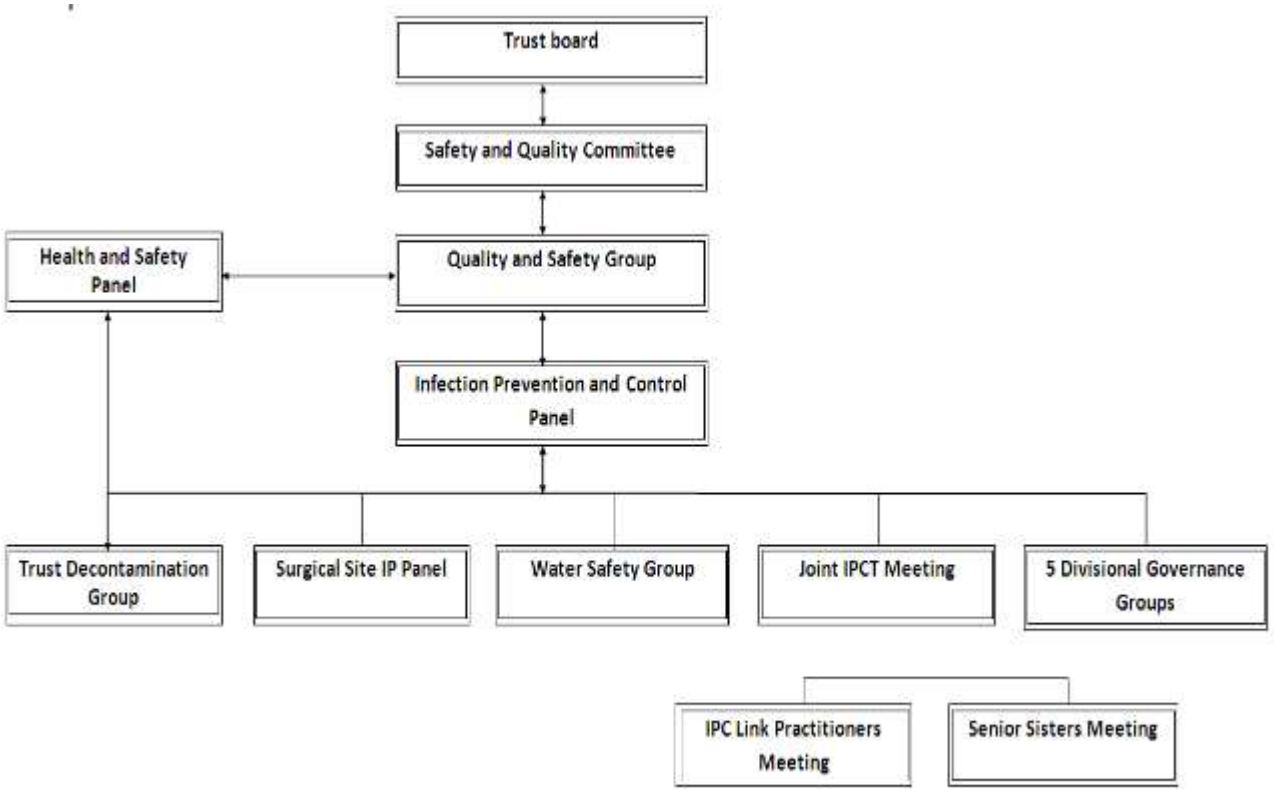
Audits

- Assurance audits for Peripheral IV cannula and CVC's using High Impact Intervention (HII) guidelines have been further developed. The audits will commence in July 2017, each division will undergo 2 audits per year
- The data base linked to the on-line referral pathway is being developed to include follow on reviews, the data from which will direct improvements in patient care and staff teaching programmes

9. SYSTEMS TO MANAGE AND MONITOR THE PREVENTION AND CONTROL OF INFECTION

The following explains the systems and processes that are in place in the Trust IPC

BELOW IS THE IPC REPORTING ARRANGEMENTS.



9.1 The Infection Prevention and Control Panel (IPCP)

The IPCP has an assurance and management role. It meets bi-monthly. The IPC reports to the Board via the quality and safety group (QSG) The meeting is chaired by the DIPC. A patient representative, the CCDC (PHE) and the Head of IPC Herts Valley Clinical Commission Group (CCG) are members of the IPCP. The IPCP reported to the Quality and Safety Group (QSG) and Safety and Quality committee. The DIPC is a member of both the QSG and Safety and Quality committee. The Terms of Reference for the IPC Panel can be found in Appendix 1. These are reviewed annually.

The IPC Panel receive reports and minutes from the groups below:

A. Water Safety Group (WSG)

The group met monthly however as from September 2016, the group now meets bi monthly. Any issues from the meeting are escalated to the QSG via the IPCP meetings. The WSG meeting is chaired by the DIPC. There is also an External appointed independent water safety consultant who supports and advises the group.

B. Surgical Site Infection Prevention Panel (SSIPP)

The group meets monthly and reports to the Surgical Division Governance Group and the minutes IPCP receiving the minutes. SSIPP is led by the Surgical division, with meetings chaired by an Orthopaedic surgeon.

C. Trust Decontamination Group

The executive lead for the trust is the Director of Environment, who chairs the meetings.

D. Joint IPCT meetings

This is a monthly meeting for the IPCT (antimicrobial pharmacist, consultant microbiologist, ICD and the Infection prevention and Control nurses and support). This meeting is chaired by the ADIPC. This group reviews IPC work plans and progress.

9.2 Divisional Governance Meetings

The IPCT attends the monthly divisional governance meetings, a report for the division is presented by the IPCT with the Mandatory surveillance, IPC training compliance, results of various audits, root cause analysis (RCA)s and any clinical issues are discussed.

10. INCIDENTS AND OUTBREAKS OF INFECTION

Outbreaks of infection continue to be the major cause of infection related incidents in any hospital in the United Kingdom. Outbreaks occur when there are two or more linked infections which may or may not be preventable. These events are recognised through surveillance, reporting or routine IPCT activities and are by definition unpredictable.

10.1 Outbreaks Of Infection

There were a number of outbreaks recorded in Hertfordshire in January 2017 with a higher proportion coming from homes in West Hertfordshire. The IPCT continued to inform key areas e.g A&E , operations team about the closed homes to ensure that patients admitted from these homes were immediately isolated on admission. Outbreak meetings were held with key staff with the minutes from the outbreaks tabled at the IPCP.

10.1.1 Influenza A Outbreak:

CLEVES WARD.

Influenza A outbreak was declared on Cleves ward with the Outbreak Control meetings held. There were 3 confirmed cases. The confirmed positive and symptomatic cases were contained within the 3 bays and the side rooms remained unaffected. Confirmed positive cases were offered treatment and prophylaxis for contacts. Only 2 members of staff on Cleves were symptomatic.

10.1.2 Norovirus:

April 2016
Stroke Unit
In April, there was an outbreak of Norovirus on the Stroke unit which affected one bay with two confirmed cases. All other bays in the ward continued to function as normal. Only the affected bay was closed to admissions and discharges. The outbreak lasted for 7 days, after which the bay was deep cleaned and curtains changed prior to opening.

AAU3 Purple
The male bay on AAU3 Purple was closed with three confirmed cases.

AAU3 Yellow:
The female bay on AAU3 Yellow had three confirmed cases and the bay was closed to admissions and discharges. The male bay was unaffected and continued to function as normal**.**
AAU3 Green:
Both the male (three confirmed cases) and female bays (one confirmed case) on AAU3 Green were also closed to admissions and discharges due norovirus outbreak.

November: 2016:

Sarratt ward
There was an outbreak of Norovirus with three confirmed cases in Bay 1 in November 2016. No staff were affected. The outbreak was well contained with the outbreak being declared over within a week, 2 outbreak control meetings were held and the minutes tabled at the IPC panel. Once the outbreak was declared over the bay was deep cleaned and curtains changed.

Croxley ward:
There was one confirmed case of Norovirus from a patient admitted from a Nursing Home closed due to an outbreak of gastro enteritis.

AAU1 Purple and AAU1 Green- One case of Norovirus confirmed from each of the areas.
The control measures that were implemented:

- A pre-recorded message is used at time of outbreaks and removed once they are over
- The Trust continues to use the switchboard as mechanism for informing the public at these times.
- Restricted visiting in affected areas.
- Restriction of movement of staff and patients,
- Allocated staff to affected areas for the duration of their shift.
- The bays/ward were closed to admissions and discharges unless there were discharged to their own homes with no package of care
- Hand hygiene with soap and water at all times.
- Use of PPE when in contact with patients or their surroundings.
- Use Norovirus Action cards
- Increased frequency of decontamination of the environment/equipment with Chlorclean.

The Norovirus cases in these areas were well contained within the affected areas with no transmission to other areas in the hospital.

10.1.3 Clostridium Difficile Outbreak:

Cassio Ward
Cassio Ward is a 20 bedded Gastroenterology unit.
There were 3 of the cases of CDI in the month of August on Cassio ward. 2 of the cases had the same ribotype. A period of increased incidents (PII) of CDI meeting was convened for the 3 cases that had been on the same ward within 28 days. The meeting involved the

IPCT, HoN, matron, sister and consultant of the ward, facilities team including the cleaning contractor As per local policy, all isolates from samples tested in WHHT are sent for typing.

An outbreak meeting was convened following the receipt of the typing results. This involved the Head of IPC for Herts Valley CCG. The outbreak was reported to the CCG, NHS Improvement and PHE. Prior to the declaration of an Outbreak several actions had been in place following the PII meeting which were: Weekly IPC support audits for the ward looking at hand hygiene, equipment and environmental cleanliness, weekly antimicrobial audit, increased frequency of cleaning and deep cleaning of the ward. Up until the end of the year, there were no further CDI cases on Cassio. See Appendix 4 for the progress of the CDI reduction action plan.

Up until end of March there were no further cases of CDI on Cassio, with the last case on Cassio reported in August 2016.

Actions taken following the increased incidence of CDI and the Cassio outbreak:
Production of a Trust wide CDI reduction plan (See appendix 4) to assist clinical staff to focus on patients with diarrhoea and to assess their risk of *Clostridium difficile*.

- Review of the Management of *Clostridium difficile* policy focusing on the flow chart
- for sending samples.
- Targeted training and education which has been informed by the learning identified from the RCAs
- Weekly *Clostridium difficile* ward rounds with Gastroenterologist joining the rounds bi weekly
- Wider sharing of key issues from the RCAs in the Divisional Governance, IPCP, CAG meetings

10.2 IPC Related Incidents

In February 2017, we reported 4 cases of CDI. All the 4 cases were from different wards. However two of the cases had the same ribotype and also some association with Sarratt ward. As per local policy, all isolates from samples tested in WHHT are sent for typing and a timeline for all the positives.

10.2.1 Sarratt Ward

Two patients had had been on Sarratt ward part of December 2016 and part of January 2017) before the positive samples in February 2017. After through investigations and review of the cases, it was agreed that there was no evidence to suggest transmission because of the following reasons:

- Neither was symptomatic (not consistent with *clostridium difficile* associated diarrhoea) while there were on the same ward
- Both positive and developed symptoms while on different wards , 22 days after being on the same ward, incubation too long not consistent with CDI.
- No evidence of sharing equipment
- Both in different bays (bay 5 and 2/ male and female)
- Dedicated staff for each bay
- No overlap in bed spaces
- Same ribotype, which however is a very common strain.

10.2.2 Stroke Ward

In February and March Stroke reported WHHT apportioned CDI case each month. According to the DH guidance this is classified as a period of increased incidence (PII). A PII of CDI meeting was convened for the cases that had been on the Stroke unit. There was no evidence of transmission and both cases had different ribotypes within 28 days. The meeting involved the IPCT, HoN, matron, sister and consultant of the ward, facilities team including the cleaning contractor

Actions taken

- Continued with targeted training and education which has been informed by the learning identified from the RCAs
- Weekly *Clostridium difficile* ward rounds with Gastroenterologist joining the rounds bi weekly

  Wider sharing of key issues from the RCAs in the Divisional Governance, IPCP, meetings

Weekly *Clostridium difficile* ward rounds, Gastroenterologist joining bi weekly

10.2.3 Pseudomonas In SCBU

2 clusters of Pseudomonas aeruginosa on SCBU in May and August 2016. Several meetings were held to investigate the cases, none of them were infections.

1ST Cluster: May and June 2016.

Involved 2 cases. All the clinical areas were clear following re sampling, some non-clinical areas were positive (staffs lounge, expressing room, sluice hand wash basin and parents' shower room). The positive outlets were disinfected and chlorinated, which came back as low count.

2ND Cluster: August 2016.

This involved four cases of colonisation of babies (including one set of twins). Sampling of all the water outlets on the unit was carried out in both clinical and non-clinical areas. The results showed that all the clinical areas were clear, nonclinical area was found to be positive. Disinfection and chlorination was undertaken and re sample and results had low count. The typing results of the 4 clinical (patients) isolates showed 3 of them to have same strain, supporting transmission. This was declared as an outbreak.

The typing results of the patients, was different to the environmental isolates, indicating that the water was not a source of colonisation of the babies

Advice was also sought from PHE and the local Health Protection Team (CCDC) in view of the clusters of cases that have occurred. Their view was that the typing of Pseudomonas aeruginosa strains suggests that there is neither a common source nor significant baby-to-baby transmission. For those events of baby colonisation it appears as a series of sporadic events most probably with an assortment of transmission routes. It was acknowledged that the neonatal unit was obviously treating infection prevention as a priority and the team was hugely motivated and well informed.

Weekly screens of the babies on the unit for Pseudomonas aeruginosa has continued.

10.2.4 Measles

There was a case of measles in A+E and the staffs that were involved were contact traced. There were 39 members of staff that were involved and all 39 have been contacted.

10.2.5 Mumps:

An adult case of mumps was reported and no other cases reported.

10.2.6 Meningococcal Septicaemia

In October there were 2 cases of meningococcal septicaemia, an adult patient in Croxley ward, and a baby. There was no link in these cases.

10.2.7 Carbapenemase-Producing Enterobacteriaceae (CPE)

WHHT has adopted a strict policy for the control of these organisms, based on national guidelines and the experiences of other hospitals. There has not been any post 48hr cases of CPE reported from WHHT, though in total 7 cases were reported pre 48hrs with evidence that all had been in contact with Healthcare in the last 12 months. Challenges with timely isolation of the patients due to side room availability and staff not checking for alerts on admission. This has caused a lot of contact tracing of the contacts. Generating a lot of work for the IPCT and clinical staff. The IPCT have placed alerts on all the contacts to enable them to be screened when there are re admitted for those that would not have been screened prior to discharge.

To date there has been no evidence of transmission of CPE from patients that have been contacts of CPE positive patients that had not been isolated prior to results.

10.3 Ventilation Incidents:

The Trust has engaged an expert accountable engineer (AE) to undertake an inspection and Health Technical Memorandum (HTM) verification of the ventilation system. This is part of the yearly inspection and HTM verification of the specialised ventilation system within the 3 sites.

The verification process comprises a series of tests and measurements in accordance with the relevant HTM to determine the performance of the ventilation system(s) serving the clinical area. An inspection of the air handling equipment is undertaken to ascertain whether the performance and general condition of the air handling unit and associated plant complies with the design specification to which they were initially installed.
Following these inspections and verification tests, some of these areas did not achieve the required >75% of the original parameters as set out in HTM 03-01 Part 3. It is worth noting that the guideline recommendation HTM 03-01 is a new guidance for new units.

10.3.1 Theatres WGH and SACH:

There have been ventilation requirements identified across the WGH and SACH site to meet the HTM-03-01 requirements taking into account the guidance when built in line with Public Health England (PHE). Several meetings involving the IPCT, Estates department, AE and the Surgical division were chaired by the DIPC or the COO in the absence of the

DIPC. Mitigations were put in place to laying up in theatres instead of the prep rooms. The Theatres that were not achieving the recommended air changes were also taken out of use to enable works to be undertaken and validation of the theatres for HTM compliance. Advice was also sort from the PHE expert for ventilation by the Trust. All theatre suites are now fully operational.

All the theatres have under gone re balancing and are now fully operational, though laying up is still undertaken in theatres.

10.3.2 Other Areas:

Endoscopy unit at WGH on level 3, May 2016

The Endoscopy unit at WGH did not achieve the required >75% of the original parameters as set out in HTM 03-01 Part 3 (only 50%). The areas highlighted included treatment room 1, treatment room 2 and the recovery area. A meeting was convened to discuss the findings of the report, the associated risks, risk assessment and formalise the interim and long-term control measures to ensure that patient and staff safety is not compromised as a result of the findings. Outside expect advice was sought from PHE, the view was that there was no risk to patients for upper and lower GI endoscopy, and no risk for the majority of bronchoscopies, with the exception of where there is a TB case or a patient with a high clinical index of suspicion for TB. Suspected and confirmed TB patients should not be bronchoscoped in the current facility. The PHE CCDC advised that a retrospective review of patients/staff was not warranted in view of the small risk and relative short period of exposure during a bronchoscopy.

An SOP for bronchoscopy is now in place to ensure all staff are aware and adhere to application of full PPE for bronchoscopy and GI procedures in Endoscopy.

Side-room 1 on Aldenham:

The validation report confirmed that the system was non-compliant with HTM 03-01, with a difference in air pressure differentials meaning that airflow is moving out from the room as opposed to keeping it in. There are also major issues with the design of the room which is not compliant with current HBN 4 Supp 1. Any confirmed or suspected case of PTB a standard side rooms to be used not side room 1 on Aldenham. Any patient with Multi drug resistant (MDR) TB to be transferred to neighbouring trust with facilities. . An SOP is now in place. Any patients without an airborne infectious disease can still be nursed in side room1.

Any patients with an airborne infection cannot be nursed in side room1 on Aldenham.

Starfish Ward

Beach Hut and Marina side rooms:

The review of the ventilation system in the isolation rooms, Marina & Beach Hut, identified concerns regarding pressure differentials between the side rooms and the corridor. Due to the age and condition of the installation, the recommendation was not to use these side rooms for infectious patients. A SOP is currently in place identifying patients that can be nursed in these rooms. Estates are working with the architects to come up with a design specification and capital costs to convert the room into a strictly negative pressure room.

A SOP is currently in place identifying patient that can be nursed in these rooms

Dermatology ops room on Hemel Hempstead (HH) Out Patients Department:
There were reported concerns regarding ventilation (and high temperatures) of minor surgical procedures rooms for Dermatology at HH, Out Patients Department. A meeting was convened to discuss any risks to patients or staff. Advice was also sought from PHE, ventilation expects. Based on the Hospital Infection Society (HIS) guidelines by Hilary Humphreys and P.Hoffman et al 2011, the risk assessment undertaken by IPCT and also based on the discussions with the teams, there was no evidence to support cessation of procedures in their treatment rooms.

There was no evidence to support cessation of procedures in their treatment rooms, natural ventilation is sufficient.

Minor Dermatology Ops room at WGH
IPC issues related to procedure rooms and ventilation in Dermatology were raised during the CQC planned visit in September 2016. Several meetings were convened. Remedial and maintenance work has been carried out on the ventilation system in the Minor ops room at WGH which has involved filter changes and deep cleaning of the air handling units and duct work. Deep cleaning of the minor ops rooms has taken place including removal of the old blinds. The currently available evidence published by the British Society of Dermatological Surgery supports the skin grafts and the flaps that are being done can be regarded as part of minor dermatological surgery as they are small, superficial and do not breach any body cavity or joints and therefore do not require conventional theatre facilities and can be performed in minor ops room or in an outpatient setting. The local team has also audited their infection rates and though there is no national surveillance programme to benchmark it against they were below the rates quoted in published literature.

11. WATER SAFETY:

Control of Legionella And Pseudomonas

The water supply to a hospital can be a source of infection for patients and staff. The aim of the group is to ensure that risks associated with water systems are recognised, documented and action taken to minimise or control these risks and to ensure that the Trust is compliant with the Health and Social Care Act 2008 (2015) and DH legislation and guidance as they pertain to the safety of hot and cold water systems in Trust premises, with specific reference to:

No Legionella has been identified in clinical area outlets in this financial year.

Sampling regime

The Trust currently undertakes 3 monthly water sampling for legionella and pseudomonas in both Intensive Care Unit and SCBU. The results are monitored via the water safety group.

12. THE INFECTION PREVENTION AND CONTROL 'DASHBOARD'

This is presented at each IPCP meeting. "Red Exception reports" are produced by the division/departments where areas of non-compliance are identified and discussed. The dashboard has Hand hygiene compliance, Commode audits, IPC training compliance, MRSA screening compliance, ward cleaning scores and high impact intervention audits. The actions taken will be explained below under each key performance indicator. The water flushing regimes and temperature are monitored and are available in the monthly infection prevention and control dashboard which are also discussed at the monthly IPCP meetings.

13. ESTATES AND FACILITIES:

13.1 Environmental Cleanliness Joint Monitoring:

The cleaning services are provided by Medirest, the contract is monitored by the facilities team. The standards are audited monthly by the trust monitoring officers. Below are the results, this are discussed at the monthly IPCP and actions of any failures indentified. A trust Cleaning Group has been formed which includes the IPCN's facility team, cleaning contractors, clinical staff, the group discussed the cleaning scores in detail and actions

95-100% = Green <95% = Red			High Risk Areas (e.g ITU, SCBU, Theatres) <98% =Red								
Ward	APR	MAY	JUN	JUL	AUG	OCT	NOV	DEC	JAN	FEB	MAR
A&E, WGH	96	98	96	96	96	96%	97%	98%	94%	97%	77%
Frailty	100	100	93	97	100	ND	ND	86%	ND	ND	94%
AAU-Level-1 Blue	97	96	100	97	99	96%	99%	98%	98%	96%	99%
AAU-Level-1 Green	99	96	ND	96	99	99%	98%	96%	97%	98%	97%
AAU-Level-1 Purple	97	100	83	96	97	95%	100%	98%	96%	95%	95%
AAU-Level-1 Yellow	100	100	ND	96	97	100%	99%	97%	98%	97%	96%
AAU3 Green/Pur/CCU	99	99	98	100	99	100%	100%	98%	97%	95%	96%
AAU Level-2, Cath Lab	97	99	98	98	96	98%	95%	92%	99%	ND	ND
Aldenham Ward,	98	98	97	98	99	96%	ND	98%	90%	96%	ND
Heronsgate/Gade	98	99	99	100	98	97%	85%	98%	95%	98%	ND
Helen Donald Unit	97	98	100	99	100	97%	99%	ND	ND	95%	ND
Cassio Ward, WGH	100	98	ND	98	97	99%	100%	99%	99%	97%	91%
AAU3 Isolation/Blue/Yell	96	97	97	95	98	100%	99%	100%	99%	ND	100%
Stroke Unit, WGH	96	100	96	98	99	99%	ND	97%	99%	ND	ND
Croxley Ward, WGH	91	98	96	98	99	97%	ND	97%	97%	96%	ND
Sarratt Ward, WGH	96	97	93	96	96	98%	95%	96%	98%	98%	ND
Simpson Ward HH	99	100	99	100	100	ND	ND	ND	ND	ND	90%
Red Suite	98	97	97	97	99	99%	98%	99%	100%	98%	
Oxhey Ward, WGH	99	97	99	100	96	100%	99%	98%	99%	97%	96%
Bluebell Ward	99	99	100	ND	99	99%	98%	100%	99%	ND	ND
Winyard Ward	100	ND	100	99	99	98%	98%	99%	100%	ND	98%
Tudor/Castle	99	96	99	93	99	99%	100%	ND	100%	ND	99%
Endoscopy, WGH	99	96	98	97	98	98%	97%	ND	ND	ND	ND
Endoscopy, HHGH	97	99	97	97	98	ND	ND	ND	ND	96%	96%
Beckett, SACH	86	98	86	98	98	98%	97%	ND	98%	98%	95%
De-La-Mare, SACH	92	98	96	97	96	99%	98%	ND	99%	ND	98%
Day Surgery, SACH	86	94	95	98	98	98%	98%	97%	97%	97%	98%
Cleves Ward, WGH	92	99	96	98	99	98%	95%	98%	95%	98%	96%
Flaunden Ward, WGH	100	99	98	98	99	98%	98%	98%	96%	98%	96%
Langley Ward, WGH	92	98	98	98	97	97%	95%	99%	97%	97%	96%
Letchmore, WGH	88	97	98	95	98	99%	99%	97%	95%	98%	95%
Ridge Ward, WGH	88	100	99	99	97	99%	98%	99%	97%	ND	95%
Elizabeth Ward, WGH	98	ND	100	100	98	100%	100%	98%	98%	96%	97%
ITU, WGH	92	97	98	100	99	98%	98%	98%	98%	100%	98%
Theatre SACH	89	100	100	96	99	98%	100%	98%	98%	97%	98%
Theatre/Recovery W	82	96	93	96	96	ND	98%	98%	100%	100%	100%
Antenatal Clinic, WGH	90	100	99	98	100	97%	98%	100%	92%	96%	89%
ABC, WGH	99	100	99	99	99	100%	100%	99%	98%	98%	99%
Katherine Ward, WGH	99	100	100	99	100	99%	99%	98%	99%	97%	100%
Victoria Ward, WGH	99	99	99	98	99	99%	99%	100%	98%	98%	95%
Delivery Suite, WGH	99	98	98	96	97	98%	98%	95%	99%	98%	98%
CED, WGH	99	100	100	100	100	98%	95%	94%	98%	97%	99%
Safari Day Unit, WGH	98	100	99	99	99	100%	99%	95%	100%	ND	98%
Starfish Ward, WGH	99	97	98	100	100	100%	100%	96%	99%	ND	96%
SCBU, WGH	96	98	96	96	96	98%	97%	100%	99%	96%	99%

13.2 Action taken following failures

The Trust, in conjunction with Medirest has put in place procedures to ensure that any 'cleaning failures' encountered during the monitoring programme, or as a result of calls to the Environment Division Help desk or Medirest Help Desk, are acted on immediately. Areas that fail audits are re-audited within the audit period to confirm appropriate action has been taken. The areas that have failed are discussed at the IPCP with the Heads of nursing demonstrating what actions have been undertaken.

13.3 Deep Clean Programme

Operational pressures in the Trust have meant the programme has been conducted on a bay-by-bay, room-by-room basis; and rarely with the opportunity to use the hydrogen peroxide vapour machine routinely except in side rooms. The associated Risk has been included on the Risk Register.

13.4 Informal Monitoring

Clinical Reviews. The Trust has a programme of 'improvement' inspections based on the mock-CQC inspection format. These visits assess, amongst other things, cleaning standards, reporting back to Execs, and Director of Environment.

13.5 Infection Prevention and Control in the Built Environment

The IPCT has been involved in several refurbishments namely:

- Cardiac centre is now fully open since the 26/11/2016.
- Endoscopy expansion
- Theatre door replacement and changing room refurbishments
- Pre op assessment

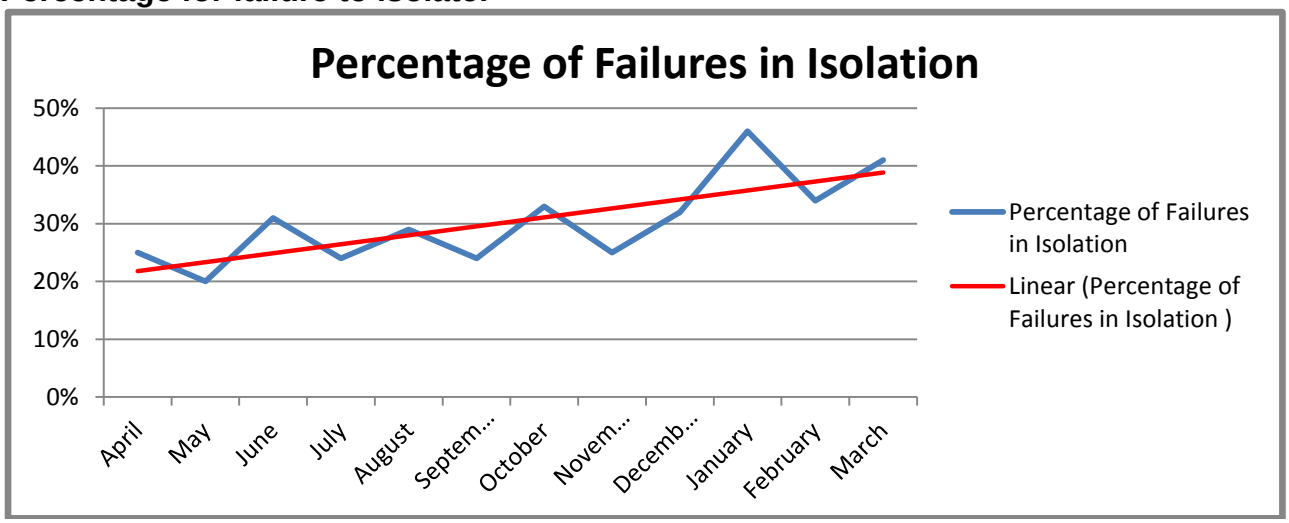
Macerators

Issues with continued blockage and break down of macerators. The Estate are reviewing the way forward due to the current issues.

14. FAILURE TO ISOLATE:

There are challenges isolating patients with the availability of side rooms in the Trust and competing priorities. Failure to isolate within 2 hours is recorded on Datix as an incident and discussed at the bimonthly IPCP. There is no side room availability in the Granger Suite; this is on the trust risk register: Risk number 3436 and scoring is 10. Patients that need isolation in a side room are transferred either to the isolation unit or to another ward where a side room is available. Out of hours and weekends there is a senior nurse to support ward staff in prioritising the side rooms, during the week IPCNs support this. The graph below show the percentage for failure to isolate

Percentage for failure to isolate:



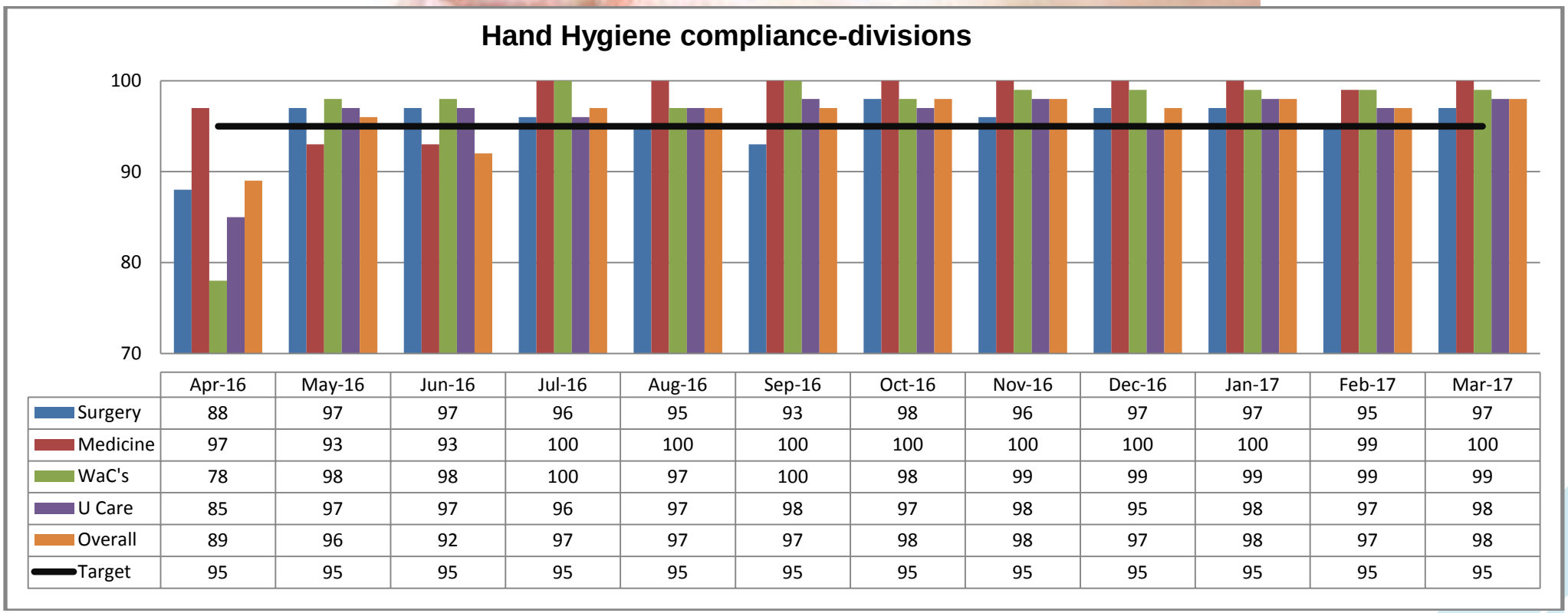
IPCNs continue to support clinical areas that have patients that have not been isolated due to unavailability of side rooms by ensuring appropriate management of these patients. There are regular visits by IPCNs to clinical areas. At times patient are not isolated because due to being medical unfit, in these instances the IPCNs support the nurses to ensure that other patients in the same bay are safe by ensure high standards of standard of control of infection are in place.

15. HAND HYGIENE AUDITS COMPLIANCE: %

Effective hand hygiene remains the single most important intervention in the reduction of HCAI. All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates continue to be calculated, and individual tables for each area within the divisions are produced by the IPCT. The trust Hand hygiene compliance target is 95%. Compliance with hand hygiene is monitored in the bimonthly IPCP meetings, through the IPC dashboard.

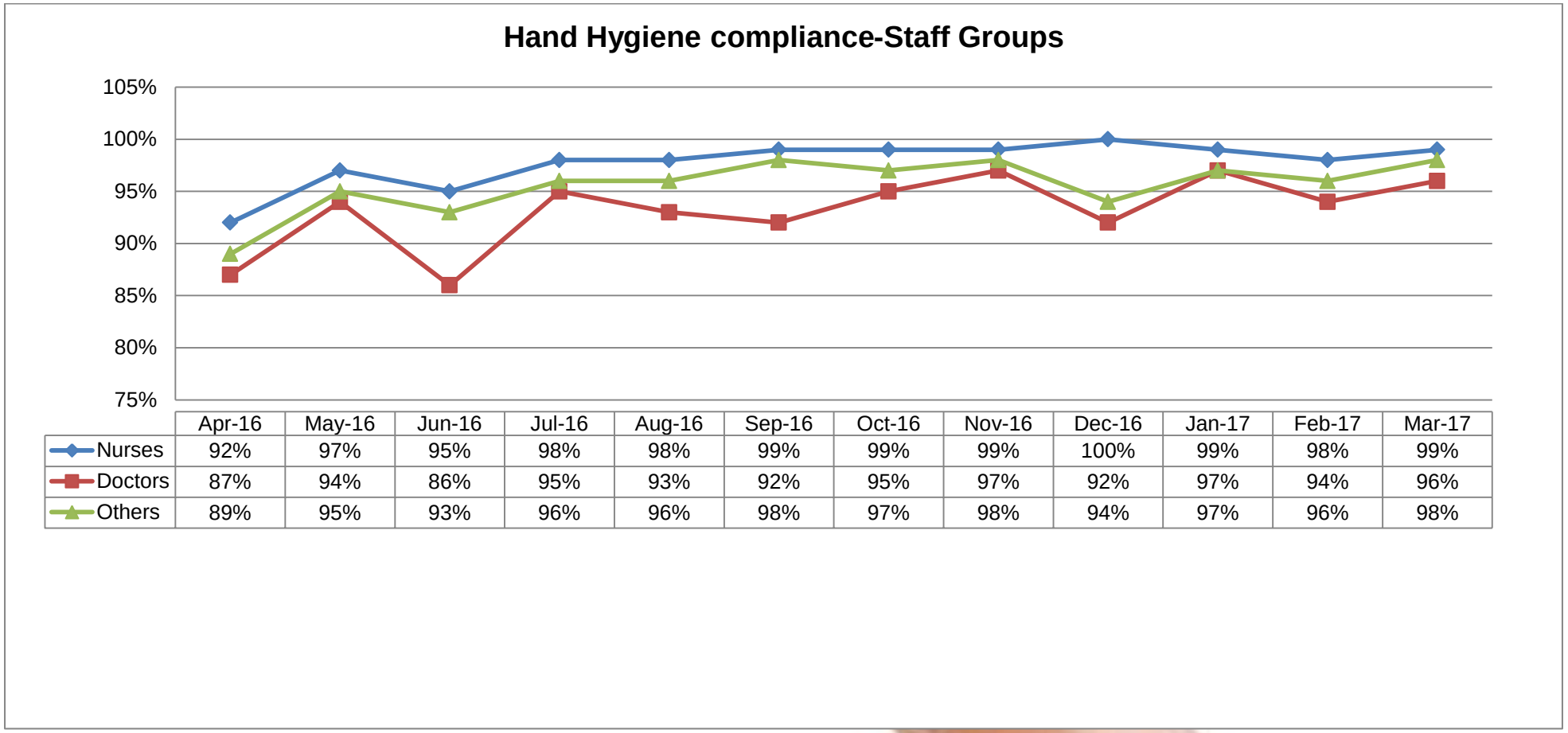
All auditors are trained in undertaking the hand hygiene audits to ensure that there are no variations. The Trust continues to participate in the yearly WHO international hand hygiene awareness day on the 5th of May with different activities undertaken by the IPCNs involving staff and members of the public.

Below is the hand hygiene compliance per division



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Surgery	88	97	97	96	95	93	98	96	97	97	95	97
Medicine	97	93	93	100	100	100	100	100	100	100	99	100
WaC's	78	98	98	100	97	100	98	99	99	99	99	99
U Care	85	97	97	96	97	98	97	98	95	98	97	98
Overall	89	96	92	97	97	97	98	98	97	98	97	98
Target	95	95	95	95	95	95	95	95	95	95	95	95

Below is the hand hygiene compliance per staff group



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Nurses	92%	97%	95%	98%	98%	99%	99%	99%	100%	99%	98%	99%
Doctors	87%	94%	86%	95%	93%	92%	95%	97%	92%	97%	94%	96%
Others	89%	95%	93%	96%	96%	98%	97%	98%	94%	97%	96%	98%

16. IPC AUDITS:

Audit results are disseminated to departmental heads, infection prevention and control link persons and matrons for cascading within their clinical area. Actions to address area of unsatisfactory compliance are taken by the division.

16.1 Code of Practice (CoP) audits

These are undertaken monthly with the IPCNs and the Clinical areas doing them on alternate months.

The key themes

- Availability of macerator posters
- Safe management of sharps
- Availability of wipes on all BP machines.
- IV trays clean and stored appropriately.

Below are the areas that have demonstrated sustained improvements in their CoP audits.

Ward	April	Jun	Aug	Oct	Dec 2016	Feb 2017
AAU Red	96	96	58	83	73	97
Isolation Suite	100	96	89	94	90	97
Oxhey	89	86	97	89	100	100
Stroke	88	97	77	98	88	100
Cleves	96	86	95	88	100	97
Langley	93	100	97	97	100	100
SCBU	95	96	90	93	93	100
CED	100	100	100	100	100	96
ABC	100	100	100	96	100	100
Day Surgery SACH	100		85		97	97
Windsor Unit		100	94	94	91	100
Helen Donald Unit	100	100	97	96	100	100

17. NHS IMPROVEMENT (NHSI) 90 DAY IPC IMPROVEMENT PROGRAMME

WHHT participated in this Quality Improvement (QI) Programme together with other 21 NHS and Foundation Trust across England. The aim of this QI was; better patient outcomes by improving IPC practice by September 2016. The WHHT team consisted of the Facilities, Theatres and IPC Teams. The team was led by the DIPC, Tracey Carter. The area of improvement chosen was equipment and environmental cleanliness in Theatres. The focus was Theatre 4 in WGH. Kevin Swaby (WGH Theatre Manager) and Jason McKee (Surgery Deputy Divisional Manager) drove this QI and presented the progress of work at the 60 day IPC collaborative Improvement event in Birmingham on the 8th July 2016 and also at Clinical leaders‟ day. WGH theatres have worked hard and there has been a big improvement which has been acknowledged by Dr Debra Adams from NHS Improvement.

18. IPC ACTIVITIES

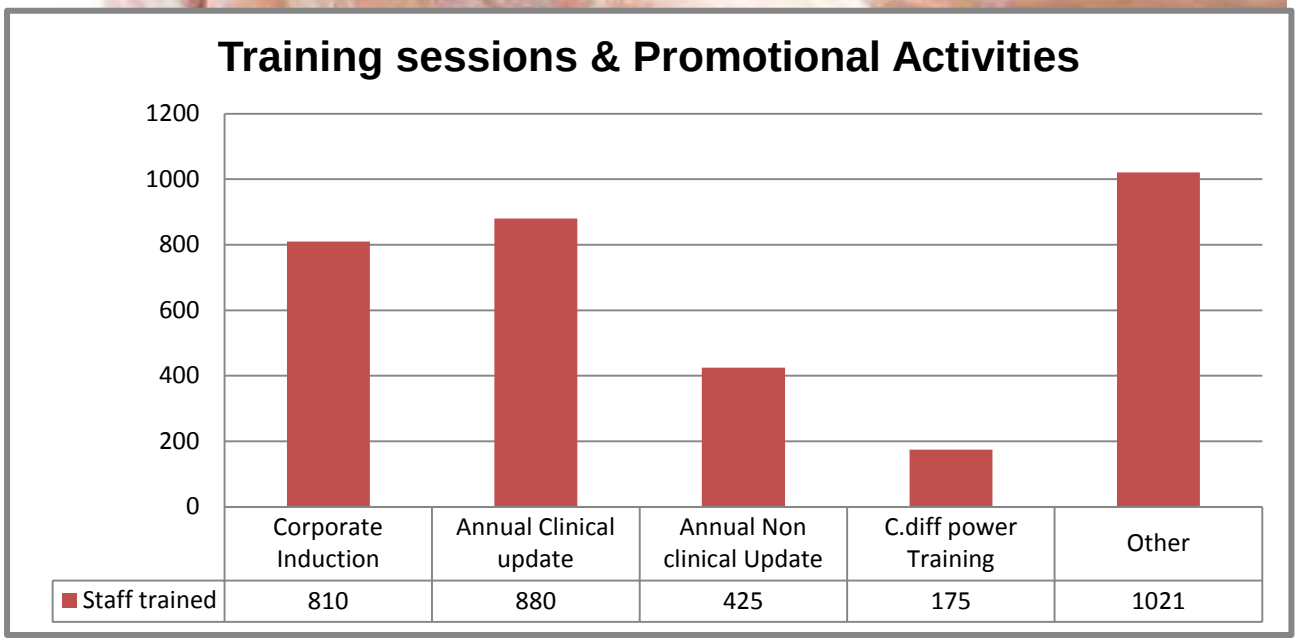
18.1 Training

IPC training and education plays a key role in preventing infections by making staff aware about infection control standards and requirements. It is widely recognised that on-going education activity in Infection prevention and control is required in order to improve healthcare worker compliance with IPC practices. In addition to the Mandatory training discussed below the IPCNs undertake take additional training in response to RCAs, PIRs and audits/surveillance results.

18.2 Power Training:

This is well received by staff, were IPCNs deliver short and quick sessions lasting from 10 minutes to 20 minutes on sealing issues, in clinical areas. Topics covered in Power training so far are Clostridium *difficile*, MRSA, Hand hygiene, Isolation, decontamination, CPE, and PPE. IPCN have introduced a quiz to test staff knowledge of IPC. Norovirus was a key topic in Q3 and Q4 as it was the winter season.

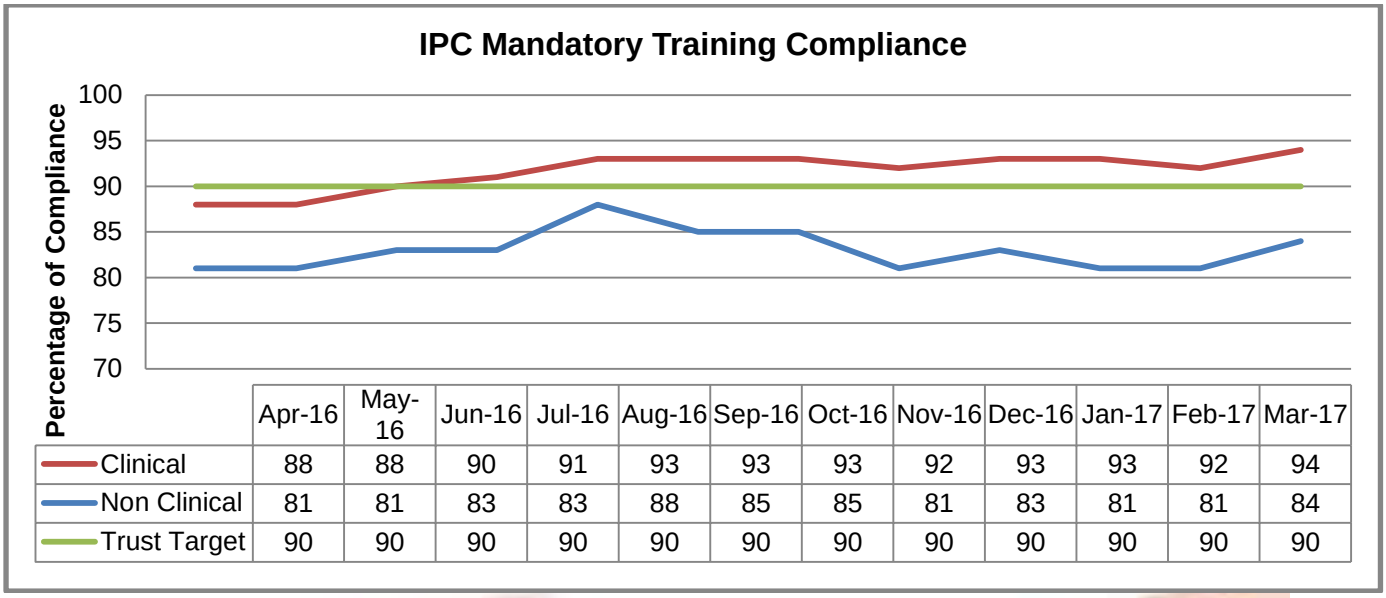
Below are the training activities April 2016 to March 2017



IPCNs have continued with Power Training in clinical areas to support staff when they can't leave the clinical area for training.

Table 5 INFECTION PREVENTION & CONTROL TRAINING COMPLIANCE

The Trust target for IPC mandatory training is 90% for clinical staff. Compliance is monitored via the bimonthly IPCP meetings. Below is the compliance for clinical and non-clinical staff.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Clinical	88	88	90	91	93	93	93	92	93	93	92	94
Non Clinical	81	81	83	83	88	85	85	81	83	81	81	84
Trust Target	90	90	90	90	90	90	90	90	90	90	90	90

18.3 One day IPC study days

There have were 4 IPC study days arranged and attendance was good.

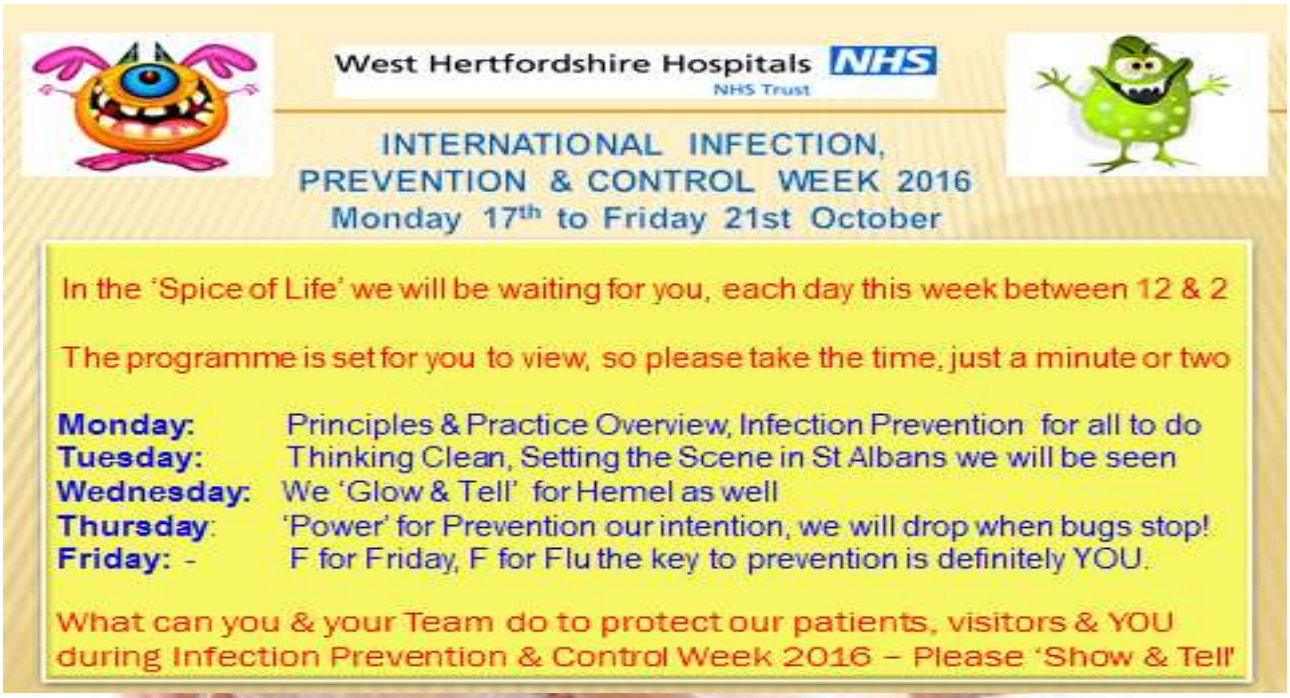
19. IPC PROMOTIONAL ACTIVITIES:

19.1 5th May 2016: WHO International Hand Hygiene Day

The trust observed the WHO international hand hygiene day on the 5th May 2016. There was a stand at the main entrance of WGH. This was to ensure that the team engaged members of the public and staff. There were also visits by the IPCNs to clinical areas to raise awareness on the importance of hand hygiene to staff, patients and visitors. During the visits the IPCNs encouraged patients to ask staff if they have washed their hands. The IPCNs organised various competitions

19.2 International Infection Prevention and Control Week

The IPCT have continued to participate in the international IPC awareness week, raising awareness to staff, patient and visitors. The team had displays, in the canteen and also visited clinical areas. Below is the program for the week.



20. INFECTION PREVENTION AND CONTROL LINK PRACTITIONERS:

The IPCN invite representatives from all departments across the trust to the Infection Prevention Link Practitioners bimonthly meetings. These give an opportunity to discuss IPC matters, in relation to individual areas and trust wide, any new guidance. The expectation is that the link practitioners share the learning in their staff/team meetings within their areas or wards. To date the topics that have been discussed are:

- Audits
- *Clostridium difficile* Infection
- MRSA care plans
- MRSA screening and decolonisation
- Decontamination of patient equipment
- CPE and Screening
- IPC Dashboard
- Norovirus, MRSA , *Clostridium difficile* Infection and documentation
- Dress Code and Infection Prevention and Control

21. POLICIES AND PROCEDURES

All IPC policies, guidelines and leaflets that were due for review were updated to reflect current evidence based best practice. Current policies were also amended when relevant new guidance was published to ensure they remained contemporary and that compliance could be monitored. Refer to appendix 4

22. FLU VACCINATION

The Occupational Health Department continued to work closely with the Clinical and IPC teams to ensure that staffs were protected. Below is the flu uptake.

	Count of Date Given	Count of Date REFUSED	Count of Staff Number	% vaccinated	% refused	% vaccinated & refused
Add Prof Scientific & Technical	64	25	135	47.41%	18.5%	65.9%
Additional Clinical Services	370	151	741	49.93%	20.4%	70.3%
Administrative and Clerical	496	170	1,012	49.01%	16.8%	65.8%
Allied Health Professionals	95	18	179	53.07%	10.1%	63.1%
Estates and Ancillary	34	23	65	52.31%	35.4%	87.7%
Healthcare Scientists	58	38	134	43.28%	28.4%	71.6%
Medical and Dental	261	51	524	49.81%	9.7%	59.5%
Nursing and Midwifery Registered	657	306	1,309	50.19%	23.4%	73.6%
Students	2	1	7	28.57%	14.3%	42.9%
Grand Total	**2,037**	**783**	**4,106**	**49.61%**	**19.1%**	**68.7%**

23. EXTERNAL VISITS

- NHS Improvement- as part of the IPC collaborative on the 23rd May 2016
- Clinical review on the 29th June 2016
- CQC inspection 6-9th September 2016
- UK Accreditation Service (for the laboratory) inspection 16-18th November 2016

24. RECOMMENDATIONS:

The Board is asked to note the IPC annual report for assurance of compliance with the Health and Social Care Act 2008 (2015): Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Hygiene Code).

APPENDIX 1: IPCP TERMS OF REFERENCE

INFECTION PREVENTION & CONTROL PANEL
TERMS OF REFERENCE

PURPOSE:

The purpose of the Infection Prevention and Control Panel is to:

- Strengthen the performance management of Health Care Associated Infections (HCAIs) and cleanliness across the whole of West Hertfordshire NHS Hospitals and to provide assurance to the Board that policy, process and operational delivery of infection prevention and control results in improved patient outcomes.
- Making recommendations, as appropriate, on Infection and Prevention Control matters to the Board.
- To assess and identify risks within the Infection Prevention and Control agenda and escalate this as appropriate.

OBJECTIVES:

West Hertfordshire Hospital NHS Trust is committed to Delivering Safe Clean Care by reducing the risk of harm to patients through pursuing a zero tolerance culture.

The objectives of the Infection Prevention and Control Panel (IPCP) are:

- To advise the Chief Executive and Trust Board on all aspects of infection prevention and control (IPC).
- To provide assurance that the environment within the Trust is safe for patients, visitors and staff in terms of infection prevention and control.
- To provide assurance that all appropriate measures are being taken to assist the Trust with achievement of national and local infection prevention and control targets.
- To ensure corrective action has been initiated and managed where gaps are identified in relation to risks.
- Agree and monitor the annual IPC work program

The panel will receive reports on:

- Mandatory surveillance figures
- Occupational health
- Water Safety (minutes of Water Safety Group)
- Decontamination
- Cleaning monitoring
- Building/Estates development
- Audits undertaken and action plan progress

- Incident reports and investigations

DUTIES:

In particular the Panel will provide assurance, raise concerns (if appropriate) and make recommendations to the Board in respect of :

Infection Prevention and Control

- The six monthly (Hygiene Code paper) Director of Infection Prevention and Control report to Trust Board.
- Undertaking scrutiny and assurance on behalf of Trust Board in relation to IPC
- Monitoring exceptions in the IPC work plan.
- Receiving information about national strategy and discuss how this will impact on the Trust and be operationalised.
- Derive assurance that IPC performance is being delivered.
- Formally review risks related to IPC and ensure risks are addressed and monitored and outcomes provide corporate assurance.
- Monitor by exception Trust delivery plans to deliver targeted reduction and sustainable improvement of HCAIs and cleanliness
- Agree priorities for education and training of all grades and disciplines of staff to ensure reduction of HCAIs
- Review and monitor trust HCAIs and compliance data IPC dashboard.
- Review and monitor Trust performance against national and local targets and standards including MRSA blood stream infections and *Clostridium difficile* reduction.
- Deliver a robust assurance programme that holds directorates to account and provide feedback to the Board.
- To ensure that robust plans for the management of outbreaks of infection are in place and to monitor their effectiveness

MEMBERSHIP:

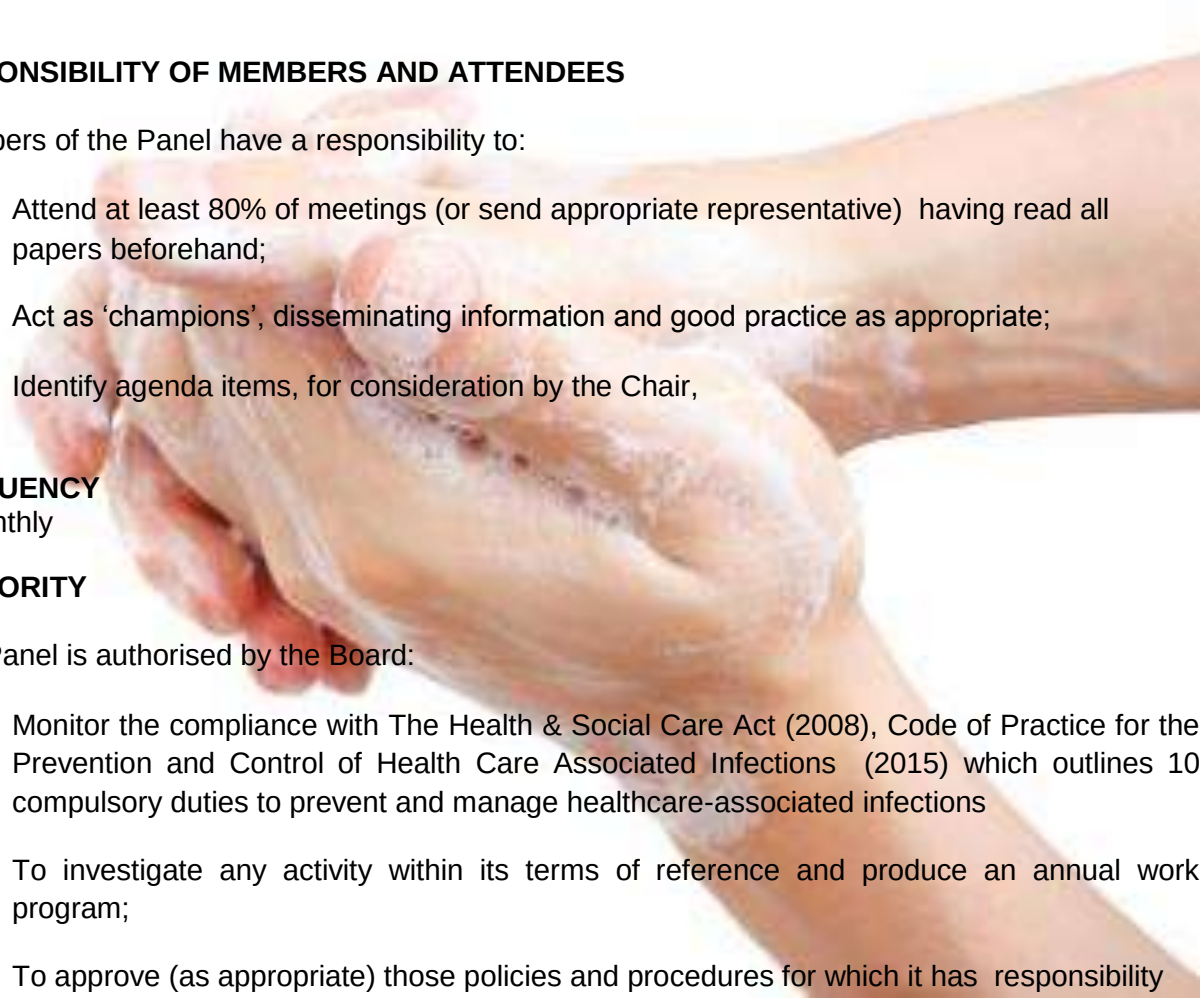
- Chief Nurse/Director of Infection Prevention and Control (Chair)
- Infection Prevention & Control Doctor (Deputy Chair)
- Deputy Chief Nurse (2nd Deputy Chair)
- Assistant Director Infection Prevention & Control / Infection Prevention & Control Nurse / Lead Nurse
- Consultant Microbiologists
- Occupational Health Manager
- Clinical Champions (Doctors)
- Heads of Nursing/Midwifery/ Matron Representatives
- Head of Estates / Head of Facilities

- Trust Decontamination Lead or representative
- Antimicrobial Pharmacist
- Patient & Public Panel Representative
- Head of Infection Prevention & Control – Herts Valley CCG
- PHE - CCDC
- Head of Operations or representative
- Head of Communications or representative

Administrative support is provided by IPCNs PA

QUORUM:

- The quorum necessary for the transaction of business shall be six members, one of which must be the DIPC or Deputy Chair/ICD. Infection Prevention & Control Nurse, and Divisional Representatives



RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Panel have a responsibility to:

- Attend at least 80% of meetings (or send appropriate representative) having read all papers beforehand;
- Act as 'champions', disseminating information and good practice as appropriate;
- Identify agenda items, for consideration by the Chair,

FREQUENCY
Bi monthly

AUTHORITY

The Panel is authorised by the Board:

- Monitor the compliance with The Health & Social Care Act (2008), Code of Practice for the Prevention and Control of Health Care Associated Infections (2015) which outlines 10 compulsory duties to prevent and manage healthcare-associated infections
- To investigate any activity within its terms of reference and produce an annual work program;
- To approve (as appropriate) those policies and procedures for which it has responsibility

DECISION MAKING
Wherever possible members of the Panel will seek to make decisions and recommendations based on consensus.

REPORTING
The Panel will have the following reporting responsibilities:

- To ensure that the minutes of its meetings are formally recorded and submitted to the Quality and Safety Group.

- These minutes shall be accompanied by a summary prepared by the chair of the meeting outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of the Board;

- To produce those assurance and performance management reports listed in the IPC annual work programme which has been agreed with, and are required by, the Board including a six monthly DIPC report (Hygiene Code Paper);

- Any items of specific concern, or which require the Board approval, will be subject to a separate report;

- To provide exception reports to the Board highlighting key developments / achievements or potential issues;

- To produce an annual report for the Board setting out:

a. The role and the main responsibilities of the Panel
b. Membership of the Panel
c. Number of meetings and attendance
d. A description of the main activities during the year and the identification of any development needs for the Panel

REPORTING GROUPS

- Joint IPCT
- Water Safety Group
- Antibiotic Committee
- SSIPP
- Decontamination Group

The groups identified above will be required to submit the following information to the Panel:

- Their terms of reference for formal approval and review;

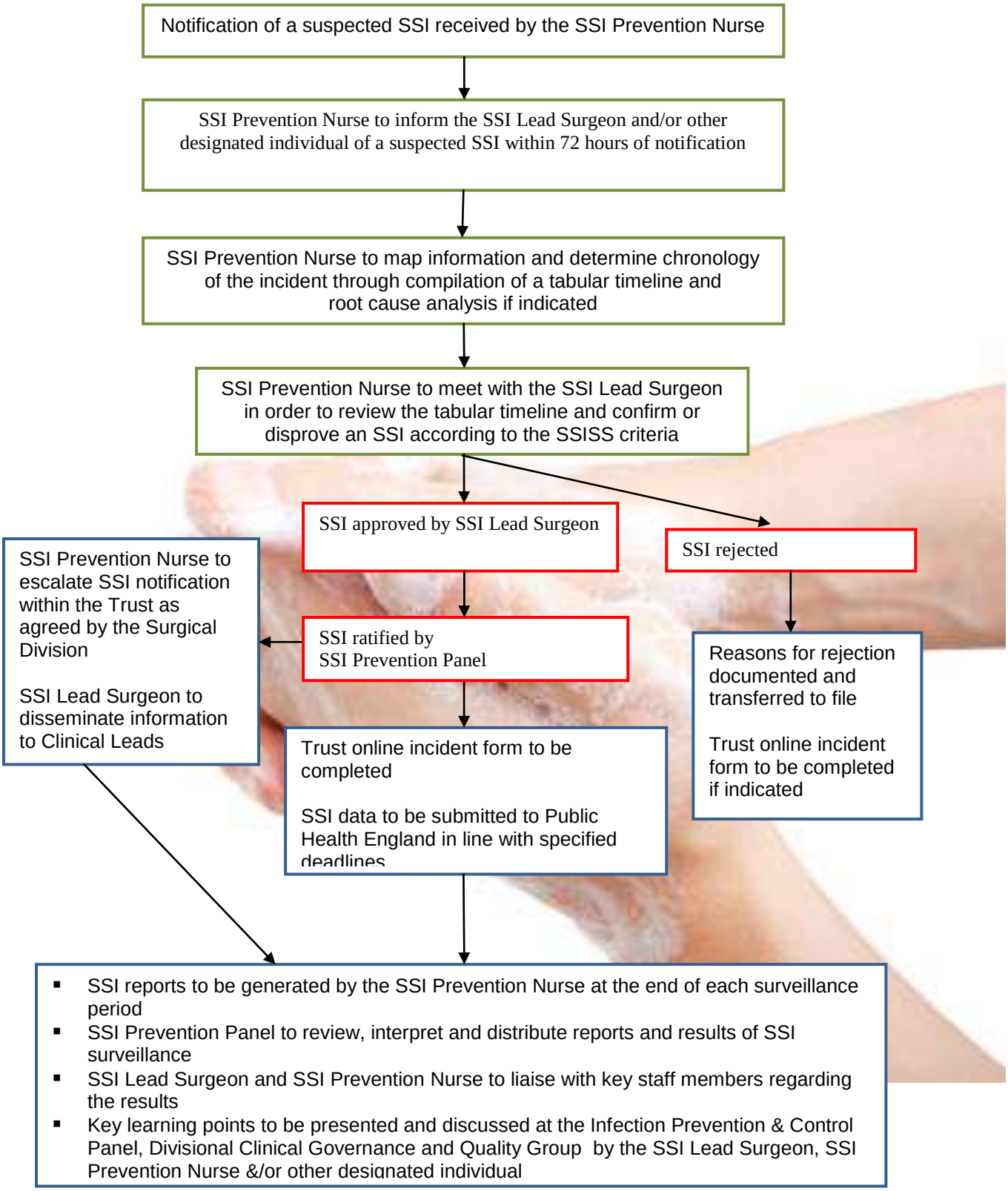
- The minutes of their meetings, together with a summary prepared by the Chair of that group outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of this Panel;

- Any report or briefing requested by this Panel.

REVIEW:

Terms of Reference will normally be reviewed annually
Date Approved and issued
Version Number: Version 1.0
Next Review: 1st May 2017
To be reviewed by: Infection Prevention & Control Panel

APPENDIX 2 SSI INVESTIGATION AND NOTIFICATION PROCESS

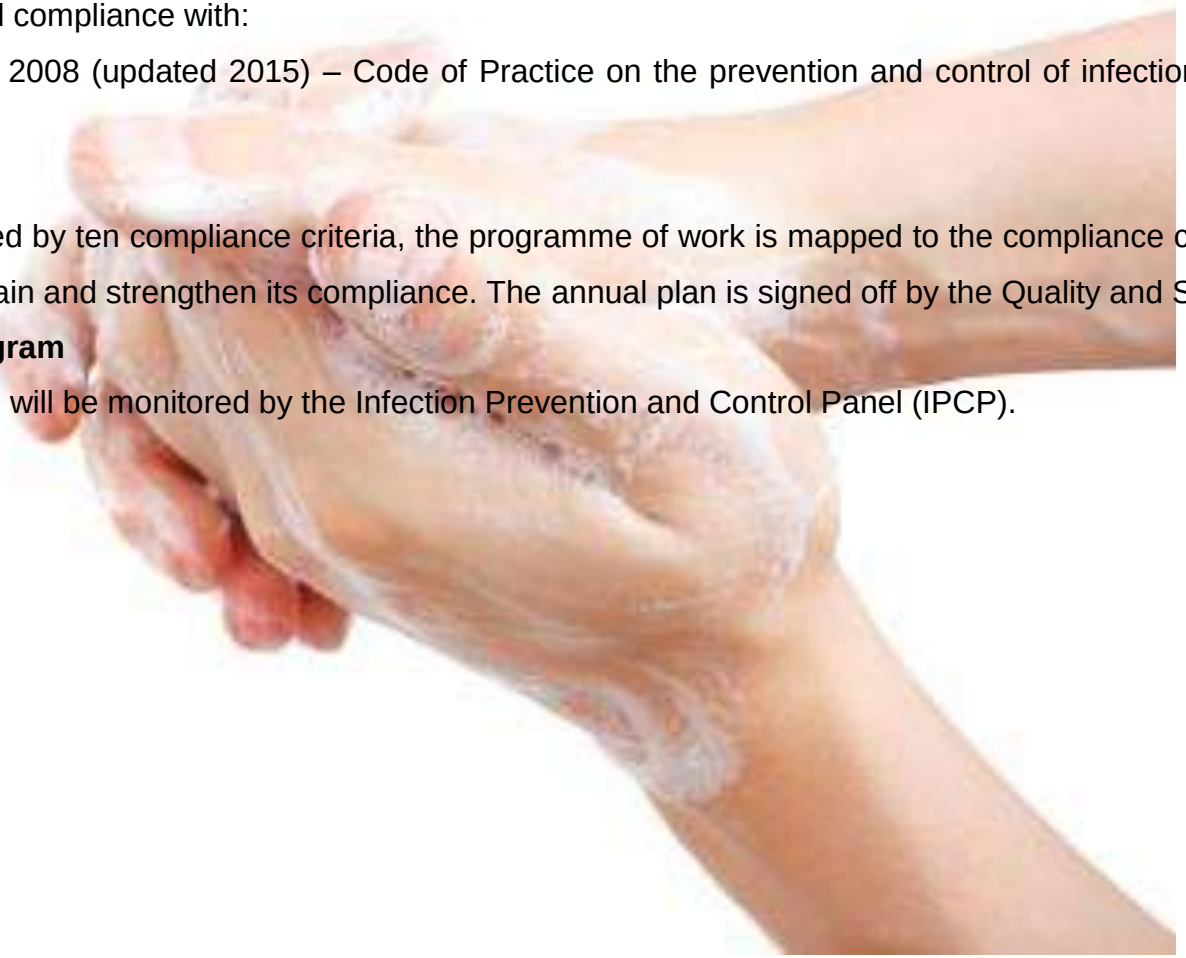


APPENDIX 3: IPC ANNUAL PLAN AND PROGRESS 2016/17

The purpose of the Infection Prevention & Control (IPC) annual plan is to set out the activities the organisation needs to do to ensure that safe quality care is provided. It will also provide assurance to the board that the programme of work if delivered will minimise any risks. The proposed activities of the IPC team, which will ensure that the service meets the statutory requirements.

This programme is based around compliance with:

The Health and Social Care Act 2008 (updated 2015) – Code of Practice on the prevention and control of infections and related guidance also known as The Code.



The Hygiene Code is underpinned by ten compliance criteria, the programme of work is mapped to the compliance criteria, which will ensure that the Trust continues to maintain and strengthen its compliance. The annual plan is signed off by the Quality and Safety Group.

Monitoring delivery of the program

Progress against the programme will be monitored by the Infection Prevention and Control Panel (IPCP).

Issue / Problem	Progress/Assurance	Lead	Timeline	Progress/Assurance
				Q3 and Q4
The Board will monitor the Trust compliance with the Health and Social Care Act 2008.	The Quality and Safety Group (QSG) and Infection Prevention and Control Panel (IPCP) will receive the Annual IPC Report. 2015/20116	DIPC	June 2016	Completed, July 2016 Trust board meeting. This has been signed off and uploaded to the internet.
	The Board will receive Infection Prevention & Control (IPC) updates and any key issues via IPR Instant reporting of any emerging Healthcare Associated issues MRSA BSI annual trajectory is 0 *Clostridium difficile* infection (CDI) annual trajectory is 23	DIPC	Monthly	Monthly IPR submitted to trust board. 1 MRSA bacteraemia 13 CDI cases in Q1 & 2. ; CDI reduction plan in place Q3 & 4; 7 cases reported.
	The Board will receive information relating to assurance on compliance with the Code of Practice, CQC outcome 8 and key indicator targets via the Quality and safety group and challenge concerns in relation to compliance via the DIPC`s Hygiene Code Paper	DIPC	6 monthly:	Q1 and Q2 submitted Q 3 and Q 4 submitted
All divisions to ensure that the reduction of healthcare associated infections is a priority.	Each Division will table clinical issues and exception reports for the Quality and Safety group actions to the IPCP	IPC leads/ HoN/ HoM	Bi monthly	Each Division has submitted their exception reports and action plans at the bi monthly IPCP
	All staff attend Trust induction and mandatory update sessions Trust target for mandatory training is 90%	IPCT/ HoN/HoM	Monthly	The uptake of mandatory IPC training for clinical staff >90%
	Lessons from IC incident/SIs/outbreaks are reviewed monthly, reported to the IPCP and Quality and safety group and acted upon.	HoN/HoM	Monthly	Norovirus, Flu, CDI outbreaks and PII; Theatre ventilation issues were reported to the IPCP, minutes available.
	All High Impact interventions inc hand hygiene scoring less than 95% with formulate an action plan with evidence of actions taken and returned to IP&C Team, this which will be discussed at the Divisional Governance meetings	Ward/Dept Manager/ Hon/HoM	Monthly	Divisions continue to send action plans though; there are still some delays in sending action plans and evidence to the IPCT.

	Any member of staff persistently not complying to hand hygiene policy or high impact intervention will be named on audits for review and escalation as required	Ward/Dept Manager/ HoN/HoM	Monthly	Captured in the IPC exception reports by Divisions, tabled at the IPCP.
	Isolate patient with an infection e.g diarrhoea within two hours (DH) to reduce the risk of cross infection	Matron/ward manager	Ongoing /monthly	Failure to isolate continues to be monitored daily, Datix, and monthly report sent to the HoN
	For all new equipment to be purchased cleaning instruction for the equipment should be obtained from the manufacturer and these submitted to IPCT for approval before a purchase is agreed.	Hon/HoM Matron	As required	IPCNs assess the cleaning instructions prior to new equipment being bought, to ensure the equipment can be adequately decontaminated, this has continued.
	Patient equipment e.g Commodes, BP cuffs must be cleaned in between each patient use	Ward/Dept Manager/ Matron	As required	Weekly commode audits by IPCNs, bi monthly CoP (previously HII8) audits by IPCNs
	Patient isolated in side room for infection control reasons should have dedicated equipment for use e.g disposable BP cuffs, hoist slings.	Ward/Dept Manager/ Matron	As required	Monitored via the bi monthly HII8/CoP audits by IPCNs
	Equipment decontamination /cleaning schedules that specifies cleaning standards for equipment such as commodes, BP cuffs are in place	Ward/Dept Manager/ Matron	Monthly /Ongoing	Monitored via Test your Care audits
	Refurbishment program to be developed by each ward and in conjunction with estates	HoN/Head of estates	As required	The IPCT have been involved in the refurbishments of the Cardiac centre and Endoscopy expansion.
Duty 1 and 2	**Estates and Facilities; Operational**			
	Assure quality of environmental cleanliness/ audit of the clinical areas All areas should have a schedule of cleaning responsibilities, and frequency include an SLA	Head of Facilities	Monthly On going	Joint cleaning audits undertaken by monitoring officers, Scores discussed at the Bi monthly IPCP. A new Trust Cleaning group that reports to the IPCP has been formed.
	Annual PLACE inspection	Head of Facilities	Yearly	This was undertaken.

	Involve Infection Prevention and Control in all building works (from planning to finish of the building works)	Director of Environment	As required	The IPCT has been involved in the refurbishments of the Cardiac centre and Endoscopy expansion.
	Minutes and papers from the Water Safety Group meetings to be tabled at the IPCP Water safety issues escalated to the Board via IPCP	Water Safety Manager	Monthly	All minutes from the monthly meeting has been tabled at the Bi Monthly IPCP, issues escalated to the QSG.
	Review Trust water safety plan	Water safety Group	March 2017	Water Safety Policy is under review. The revised Water safety plan is in place.

INFECTION PREVENTION & CONTROL TEAM PLAN

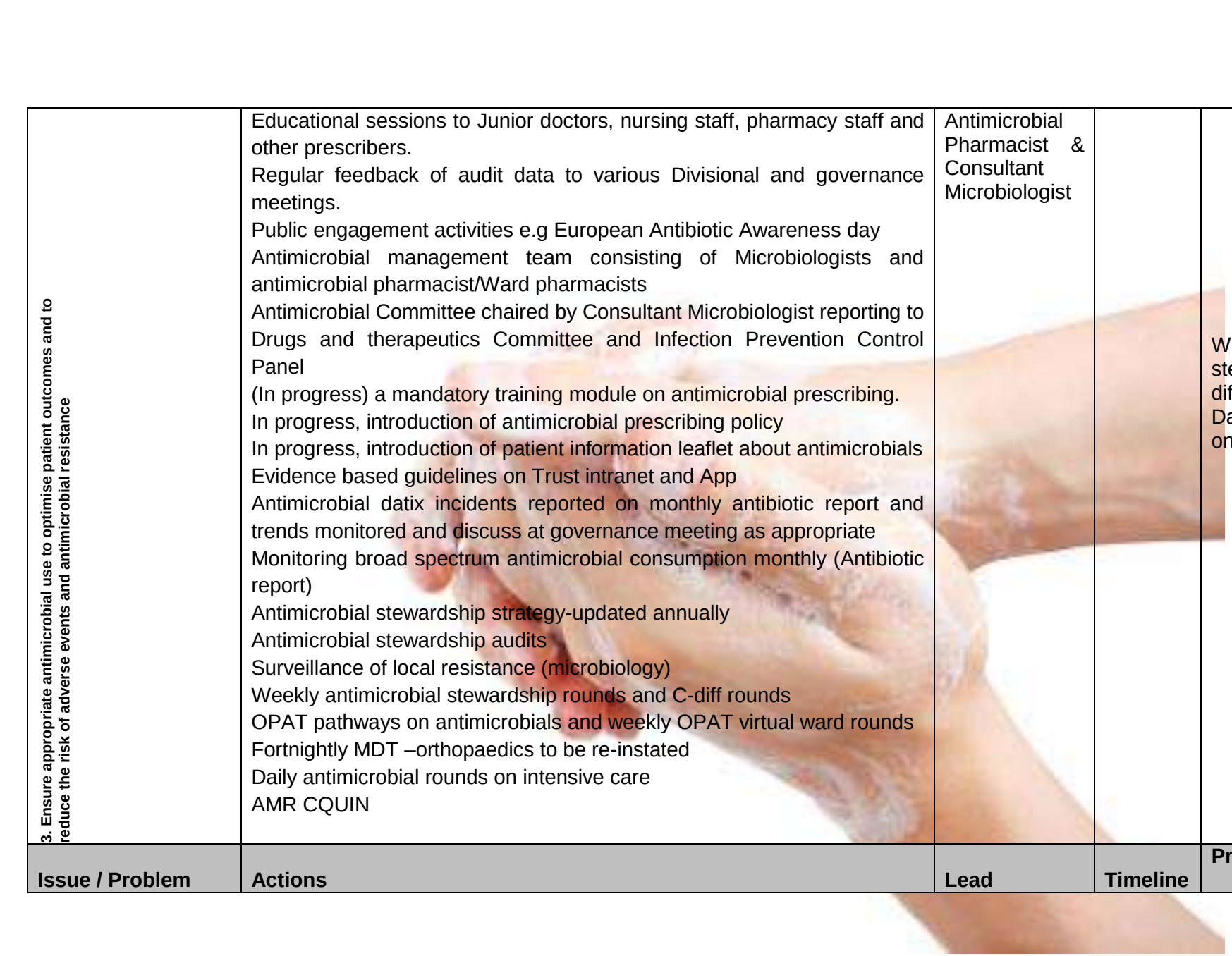
Issue / Problem	Actions	Lead	Timeline	Progress/Assurance
1.Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptibility of service users and any risks that their environment and other users may pose to them.	The IPCP will receive monthly information on: Mandatory surveillance (MSSAb, MRSAb & E colib and CDI) Audits IPC Training compliance Progress on action plans(inc CQUIN targets) Outbreaks & Incidents Surveillance of other HCAIs New publication relating to IPC/Microbiology	ADIPC ICD	Monthly/ on going	IPC dashboard has information on all key IPC issues Mandatory surveillance figures discussed at all IPCP meetings 90-94% an improvement compared to this time last year. Stroke – CDI increased incidents , Sarratt - Norovirus Outbreak and SCBU Pseudomonas, all discussed at IPCP.
	Provide reactive service to meet needs of incidents/enquiries/outbreaks	ADIPC	As required	Clinical Teams continue to be supported in all PII and Outbreaks. IPCT cover is 24 hours. Support audits undertaken in areas where there has been outbreak or PII

	Work proactively with multi-disciplinary staff and departments to reduce risk of HCAI attend Divisional Governance meetings	ADIPC/ Lead Nurse/I CD	Monthly	IPCT attends Divisional Governance meetings where IPC is a standing item on their agenda.
	Work collaboratively with Clinical Commission Group, NHS Improvement & the Hertfordshire HCAI reduction group	ADIPC/I CD	Monthly /as required	ICD and ADIPC have continued to attend the whole systems meetings/Herts Infection Control Group meetings to share best practice.
	Infection Surveillance software	ADIPC/ CGI	2017	The IPCNs are currently using iReporter to capture any patients that are previously known to have an infection that are re admitted.
	Collate and submit alert organisms as directed by the Public Health England onto the data capture system.	ADIPC	Monthly	Monthly submission in the PHE DCS, completed
	Work collaboratively with Operations teams, matrons and ward managers: review of side rooms Appropriate placement of patients with a known or a possible infection	Lead Nurse IPC	As required	IPCNs continue to review side rooms to ensure appropriate placement of patients by the operations team. Failure to isolate patients with 2 hours is datixed Monthly isolation report is produced by the IPCT for the clinical areas.
Issue / Problem	**Actions**	**Lead**	**Timeline**	**Progress/Assurance: Q1 and Q2**

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	**Audits by the Infection Prevention and Control nurses:** Decontamination of patient equipment (HII8)/Code of Practice audit (CoP) Personal Protective Equipment Management of Linen Isolation Precautions Management of sharps Test your care audits	Lead Nurse	As per audit schedule	Mini IPC audits include practice, PPE, isolation equipment cleanliness have been undertaken in areas by IPCNs. Bi monthly HII8/CoP; Sharps audits have been undertaken,
	Audit availability of hand hygiene facilities in the trust	ADIPC	December 2016	Partial completed.
	Also refer to the estates & divisional actions			

Issue / Problem	Actions	Lead	Timeline	Progress/Assurance

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Educational sessions to Junior doctors, nursing staff, pharmacy staff and other prescribers. Regular feedback of audit data to various Divisional and governance meetings. Public engagement activities e.g European Antibiotic Awareness day Antimicrobial management team consisting of Microbiologists and antimicrobial pharmacist/Ward pharmacists Antimicrobial Committee chaired by Consultant Microbiologist reporting to Drugs and therapeutics Committee and Infection Prevention Control Panel (In progress) a mandatory training module on antimicrobial prescribing. In progress, introduction of antimicrobial prescribing policy In progress, introduction of patient information leaflet about antimicrobials Evidence based guidelines on Trust intranet and App Antimicrobial datix incidents reported on monthly antibiotic report and trends monitored and discuss at governance meeting as appropriate Monitoring broad spectrum antimicrobial consumption monthly (Antibiotic report) Antimicrobial stewardship strategy-updated annually Antimicrobial stewardship audits Surveillance of local resistance (microbiology) Weekly antimicrobial stewardship rounds and C-diff rounds OPAT pathways on antimicrobials and weekly OPAT virtual ward rounds Fortnightly MDT –orthopaedics to be re-instated Daily antimicrobial rounds on intensive care AMR CQUIN	Antimicrobial Pharmacist & Consultant Microbiologist		Weekly antimicrobial stewardship rounds and C-diff rounds Daily antimicrobial rounds on intensive care
Issue / Problem	**Actions**	**Lead**	**Timeline**	**Progress/Assurance**



4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	**Maintain information leaflets for patients and visitors** Ensure all patient and public information leaflets are current and available on the Trust website	Lead Nurse IPC	As required	Leaflets are in date.
	Maintain information leaflets for contractors/volunteers/bank & locum staff	ADIPC	Decemb er 2016	Deferred to September 2017
	Participate in international Hand Hygiene Awareness Day. Activities that include patients, visitors and staff – display stands	IPC Team	May 2016	Completed Activities that include patients, visitors and staff – Display stands in the staff canteen, visits to clinical areas, talks with patients , staff and members of the public. Various competitions play stands, competitions
	Participate in international Infection Prevention and Control Week Activities that include patients, visitors and staff – display stands	IPC Team	October 2016	Completed, with various activities.
	Maintain up to date polices and guidelines for Infection Prevention on the Trust intranet.	ADIPC	As required	All policies and guidelines are in date.
	Staff information leaflets to be available	ADIPC/ Lead IP&C Nurse	As required	Leaflets are in date.
	Inform G.P. if patients are discharged before MRSA results are known and new MRSA	Lead IP&C Nurse	As required /daily	This has continued in 2016/17
	Inform G.P of admitted patients identified to have *Clostridium difficile* including those with *antigen positive toxin negative clostridium difficile*	Lead IP&C Nurse	As required /daily	IPCNS have continued to send *Clostridium difficile* GP letters

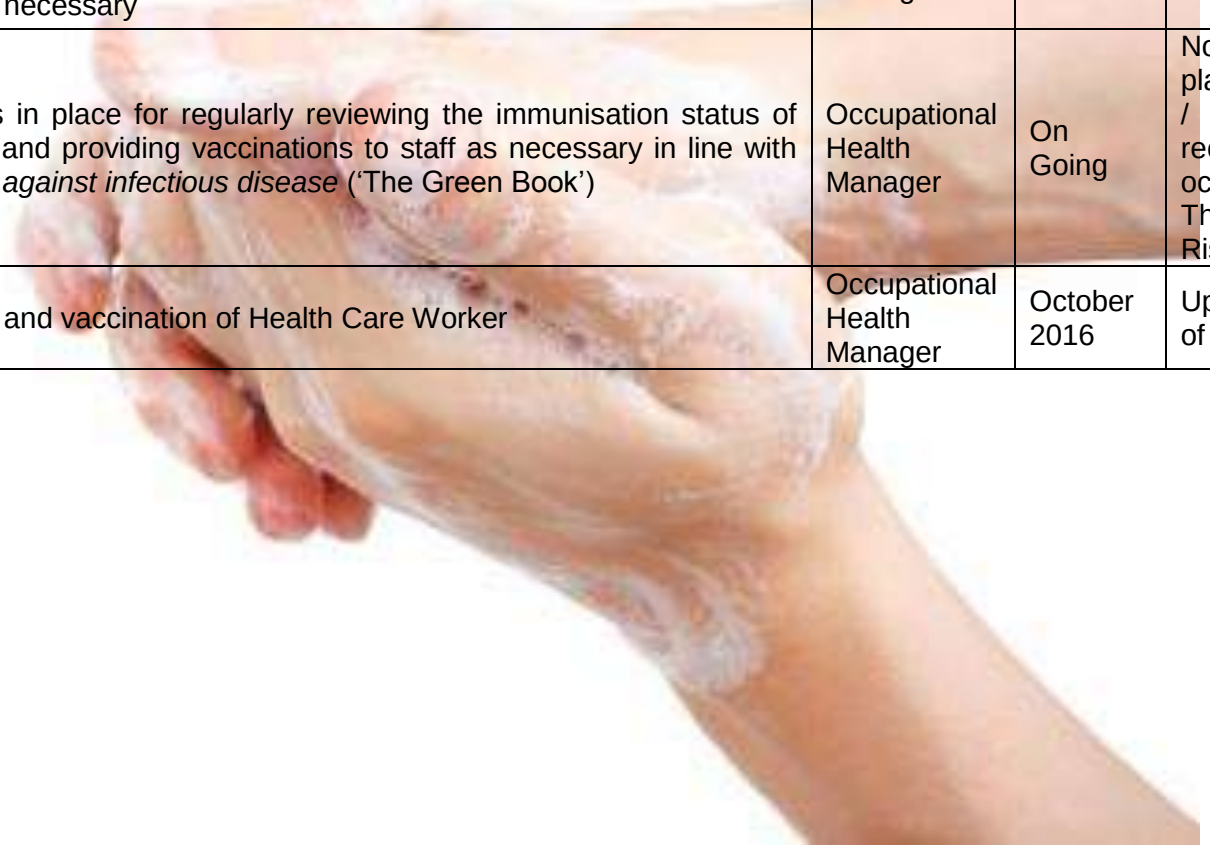
	Flagging on Patient Administration System/ICE information system for appropriate management. Continue inserting information stickers for alert organisms in the health records of patients.	IPCT	As required/ daily	,Alerts put in place for CPE contacts following identification of a CPE patient on various wards.
		IPCT	As required/ daily	IPCNs have continued to visit wards were patients have an alert organism to ensure appropriate management and placement, this is also documented in the patient's notes/Kardex
	Raise awareness on current IPC issues within the Trust; "Top Tips" IPCN news letter	IPCT	Bi Monthly	2 published
Issue / Problem	**Actions**	**Lead**	**Timeline**	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	All patient `s microbiological results are managed as a priority within the IP&C team. Regular audit to monitor compliance with statement 4 of NICE quality standards of antimicrobial stewardship (all patients prescribed antibiotics have a microbiological samples taken and treatment reviewed when results are available)	Lead Nurse IPC/Antimicrobial Pharmacist	As required/ daily	IPCNs have continued to visit wards and patients with alerts.
	Ensure timescales for RCA/PIRs reporting are met and corrective actions/learning shared across Divisions through Clinical governance meetings	IPCT/HoN	As required/ monthly	RCA actions followed up in the Divisional Governance meetings, timescale for completing are not being achieved.
	Appropriate use of detection, management and isolation of diarrhoea flow chart for timely isolation of affected patients.	IPCT/HoN	As required /daily	

	Audit MRSA and *Clostridium difficile* care pathways and feedback results to clinical areas, HoN/HoM and IPCP	Lead Nurse/ ADIPC	Monthly	Done monthly through Test your care
	Mandatory update to includes outbreak management and isolation	Lead Nurse	As required /daily	Mandatory update to includes outbreak management and isolation included in the IPC Mandatory update
	Inform bed management /ED staff of any outbreaks (e.g of Norovirus or any other infection) in local care home and NHS Trusts; Circulate report from SMH PHE	ADIPC/ Lead Nurse	As required /daily	Alerts from PHE were sent out to key staff, Bed managers/ operation team, HoN, ED and on call managers
Issue / Problem	**Actions**	**Lead**	**Timeline**	**Progress/Assurance**
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Review and update IPC Training schedule for all Trust employees including contractors and volunteers : Mandatory, Induction; Ad hoc related to DH & local initiatives	Lead Nurse	April 2016 Annually and as required	This was reviewed.
	Review formal training on peripheral line insertion, CV/aseptic technique, ongoing management to be included in Education /training review; (Peripheral IV study day, Central IV study day, Venepuncture and Cannulation)	PDN/Vascular Access Nurse	As required when new updates are publishe	CVC study day was reviewed now include a mandatory successful completion of e learning module including a test. 3 sessions had been undertaken with positive

			d	feedback from participants.
	Link Practitioner Educational meetings – maintaining records of attendance	Lead Nurse	Bi-monthly	Various topics discussed at the meetings: CDI; MRSA,, CPE, Documentation, E. colib hand hygiene
	Infection Prevention is included in all Job descriptions (JD) and all new staff should attend Trust Induction (IPC is included in trust Induction for new staff.	Human Resources	As required	IPC is included in all new staff JD.
Issue / Problem	**Actions**	**Lead**	**Timeline**	**Progress/Assurance**
7. Provide or secure adequate isolation facilities	**Ensure adequate isolation precautions and facilities as appropriate to prevent or minimise the spread of infections** Ongoing review of capacity within isolation ward to meet clinical need.	IPCNs	As required /daily	IPCNs review side room as required to ensure appropriate placement of patients.
	Isolation Policy is audited by the IPCT annually	ADIPC/ Lead Nurse IP&C	January 2017	Compliance with Isolation policy audited as part of the IPC audit. Isolation policy was reviewed this year.
	Audit side room availability including rooms with both negative & positive ventilation	ADIPC/ Lead Nurse IP&C	As required	
	The IPCT will provide advice and support on the management of infectious patients during an increased incidence of infection or outbreak to contribute in the management of appropriate usage of the side rooms.	ADIPC/Lead Nurse	As required/ daily	*Clostridium difficile*; PII/ outbreak Pseudomonas in SCBU. Norovirus outbreak.
Issue / Problem	**Actions**	**Lead**	**Timeline**	

8. Secure adequate access to laboratory support as appropriate	Ensure the microbiology laboratory has appropriate protocols and standard operating procedures as required for UKAS accreditation in compliance with ISO15189	ICD/ Consultant Microbiologist/HoD	As required	Compliant: Assessed against a comprehensive set of standards (ISO15189) on both the clinical and laboratory components.
Issue / Problem	**Actions**	**Lead**	**Timeline**	**Progress/Assurance**
9.Have and adhere to policies, designed for The individual's care and provider organisations, that will help to prevent and control infections. ***Compliance with key policies is ensured through the implementation of high impact interventions and monitored through audit.***	Policies are updated with review dates and clearly marked up where they link to other policies both on the actual policy.	ADIPC/Infection Control Doctor		All current IPC policies and guidelines are in date.
	Building and Renovation in hospital (NEW)	ADIPC	Nov 2016	Deferred to 2017
	Immunisation of service Users	ICD	Nov 2016	Deferred to 2017
Issue / Problem	**Actions**	**Lead**	**Timeline**	**Progress/Assurance**
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Annual Gap analysis of training needs for staff	Lead Nurse IPC	May 2016 Annually	Completed

	Review Annual training programme for all staff including contractors, locums, volunteers, bank & agency.	ADIPC/ Lead Nurse IPC	May 2016	Completed
	Related Occupational Health policies/procedures are in date: management of occupational exposure to infection a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary	Occupational Health Manager/ Health and Safety Manager	As required	Needle sticks injury reports taken to the Health and safety committee.
	Arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with *Immunisation against infectious disease* ('The Green Book')	Occupational Health Manager	On Going	Not compliant: Mitigation in place , Immunisation status / vaccination history is recorded in staff member occupational health records. The risk number is 3046 Risk score is 12
	Flu campaign and vaccination of Health Care Worker	Occupational Health Manager	October 2016	Uptake is 49.61% as of end of December 2016



APPENDIX 4: REDUCTION OF CLOSTRIDIUM DIFFICILE ACTION PLAN

This action plan is intended to: Assist all clinical areas to focus on patients with diarrhoea and to assess their risk of Clostridium *difficile.*

PRIORITY ISSUE TO BE ADDRESED	ACTION REQUIRED TO ENABLE	DELIVERY DATE	RESPONSIBLE OWNER	PROGRESS UPDATE	RAG
Update to all staff and Board on our CDI cases and plans for improvement	Share themes identified from 2015/16 and Q1 & Q2 CDI cases	October 2016	Tracey Carter	Completed	**Green**
	Share themes from 2015/16 and April to date CDI cases at Clinical Advisory Group	September 2016	Prema Singh	Completed 14.09.16	**Green**
	Update the Board on actions being undertaken following the increased cases and outbreak in August 2016	September 2016	Tracey Carter	Completed, shared the actions undertaken and brief summary of themes at Safety and Quality.	**Green**
Inappropriate samples sent to the laboratory	Reminder letter sent to Clinical directors, Jnr Doctors, and Consultants	August 2016	Tracey Carter	Completed. Email sent to Jnr Doctors, Heads of Nursing and Consultants	**Green**
	Revise the flow chart for sending specimen	November 2016	Vishal Sookhoo/Jiovanna Foley	The policy and flow chart is under review. This will go to the November IPCP.	**Green**
	Flagging up specimen sent from previous CDT and CDA positive for BMS to discuss with microbiologist	October 2016	Microbiologist	In the interim memo has been produced while awaiting electronic flagging on Winpath	**Green**
	Review Specimen request form	October 2016	Microbiology		**Amber**
	Include the flow chart for sending a stool specimen to the laboratory in the Induction for Temporal workers	November 2016	IPCNs		**Green**
Improve compliance to Trust guideline for antimicrobial prescribing	**Continue with antimicrobial stewardship rounds**	August 2016	Hala Kandil and Tejal Vaghela	This is in place	**Green**
	Implement weekly review of CDI & **antigen positive patients** in patients	September 2016	IPCT	These have been re convened.	**Green**
	Implement Bi weekly Clostridium *difficile* ward rounds with Gastroenterologists	October 2016	IPCT and Gastro Team	Implemented on 5th October 2016. Dr Landy will join the rounds biweekly	**Green**
	Implement stickers for the Clostridium *difficile*	September 2016	Hala Kandil & Tejal Vaghela	C-diff round stickers have been developed and in use. Draft version attached.	**Green**

	Introduce new antimicrobial guidelines for care of elderly (Re-submit the request to MUSP for the use of (Temocillin) in elderly care)	December 2016	Hala Kandil	Approved at antibiotic committee meeting in August 16. Will be submitted to next MUSP in November 16	**Green**
Monitor of actions from the Root Cause Analysis (RCA)	**Each division to** share key learning points at their clinical governance from all the RCAs	End October 2016	HoN/Clinical Directors	Q 4 cases to be shared and thematic review of all cases.	**Amber**
Training and Education to raise more awareness of CDI and its management	Grand round to discuss CDT testing and guideline	November 2016	IPCT	Completed	**Green**
	Education on antimicrobial stewardship and CDI to FY2	October 2016	Hala Kandil and Tejal Vaghela	Completed. Grand round organised for the 21st October 2016 and European antibiotic awareness day grand round on 18th November 2016	**Green**
	Targeted training (Power training) focusing on Isolation, hand hygiene, decontamination of medical equipment, PPE, specimen collection and labelling and Quiz to test staff knowledge on these.	Review October 2016	Nyarayi Mukombe	Quiz has now been implemented with good feedback from the staff	**Green**
	Support Hand hygiene audits on wards with a new WHHT apportioned C.diff	until a target of >95% compliance is reached for 3 consecutive weeks	Nyarayi Mukombe	These are in progress on Cassio ward. No further CDI cases	**Green**
	Support weekly audits for the decontamination of medical equipment (high impact intervention no.8)	until a target of >95% compliance is reached for 3 consecutive weeks	Nyarayi Mukombe	These are in progress on Cassio ward; No further CDI cases	**Green**
	The September IPC newsletter issue of the monthly 'Top Tips to focus on *Clostridium difficile*.	September 2016	Nyarayi Mukombe	This was completed the next `Top Tips` will be on the new Flow Chart for stool specimen collection.	**Green**

Cleanliness of medical equipment	Dedicated patient equipment in side rooms (to limit the potential risk of transmission of infection).	Review October 2016	HoN/HoM	Completed, CoP audits undertaken by the IPCNs	**Green**
Environmental Cleanliness	Nurse in charge to check at the beginning of the early shift if this has taken place (daily quality ward checks)	Review October 2016	HoN/HoM	Ward daily checks, verified by the CoP audits	**Green**
	Monthly ward quality checks by matrons	Review October 2016	HoN/HoM	Done via Test your Care	**Green**

APPENDIX 5: INFECTION PREVENTION AND CONTROL POLICIES

Guide:

	Due for review within the next 30 days or are past their review date
	Due for review within the next 30-90 days from now
	Due for review more than 90 days from now

Description	Link	Department	Author	Job title	Ratified Date	Review Date	Document Type	Days until review	Weeks until review
Viral Haemorrhagic Fever Policy - Ebola, Lassa, Marburg, Crimean Congo Haemorrhagic Fever	view	Infection Prevention and Control	Prema Singh, Eleni Mavrogiorgou	Microbiology, Infection Prevention and Control Doctor and Microbiology Specialist Registrar	15/05/2016	15/07/2017	policy	58	8.3
Prevention of infections associated with venous access devices - Central venous catheters, peripheral catheters, blood stream infections	view	Infection Prevention and Control	Nyarayi Mukombe		15/11/2014	15/11/2017	policy	181	25.9
Carbapenemase-Producing Enterobacteriaceas - Early Detection, Management and Control	view	Infection Prevention and Control	Prima Singh, Eleni Mavrogiorgou	Microbiology, Infection Prevention and Control Doctor, Microbiology Specialist Registrar	15/06/2016	15/06/2018	policy	393	56.1
Hand Hygiene Policy - Infection control, soap, alcohol gel	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director Infection Prevention and Control	15/02/2016	15/11/2018	policy	546	78
Outbreak Policy - Infection control, outbreak, disease, isolation	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director Infection Prevention and Control	15/03/2016	15/01/2019	policy	607	86.7
Isolation Policy - For Patients with Communicable Diseases / Infections and Immuno-compromised patients	view	Infection Prevention and Control	Vishal Sookhoo	Senior Infection prevention and control nurse	15/06/2016	15/01/2019	policy	607	86.7
Standard Infection Control Precautions policy - gloves, clothing, aprons, gowns, hand hygiene, washing, sterile	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	15/06/2016	15/05/2019	policy	727	103.9
Management of Infection Prevention and Control - infection control, hand hygiene, washing, sterile	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	15/06/2016	15/05/2019	policy	727	103.9

Description	Link	Department	Author	Job title	Ratified Date	Review Date	Document Type	Days until review	Weeks until review
Norovirus policy, diarrhoea, vomiting, outbreak, disease, gastrointestinal infections	view	Infection Prevention and Control	Jiovanna Foley	Lead Infection Prevention and Control Nurse	15/06/2016	15/06/2019	policy	758	108.3
Central Venous Catheter Insertion and Management in Adults and Paediatrics - CVC, PICC, Subclavian, Intravenous, vascular access device	view	Infection prevention and control	Julia Awad	Vascular Access Nurse	15/07/2016	15/06/2019	policy	758	108.3
Ward Based Equipment Decontamination Policy Including the Management of Blood and other Body Fluid Spillage	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	15/07/2016	15/06/2019	policy	758	108.3
Aseptic / Aseptic Non-Touch Technique Policy - Aseptic, Infection control, gloves, clothing, aprons	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	15/07/2016	15/06/2019	policy	758	108.3
Operational Policy for the Management of Patients on the Isolation Ward AAU-3 Blue - Isolation, Healthcare associated Infections, Clostridium difficile	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	15/06/2016	15/06/2019	policy	758	108.3
TUBERCULOSIS Prevention and control of in hospital - TB, MDRTB, Isolation, Tuberculosis	view	Infection Prevention and Control	Dr Prema Singh	TB Lead/Respiratory Team	06/09/2016	15/08/2019	policy	819	117
Peripheral Intravenous Cannulation policy	view	Infection Prevention and Control	Julia Awad	CNS Vascular Access	15/02/2017	01/11/2019	policy	897	128.1
Clostridium Difficile Infection, CDI - CDiff, C-Diff - Policy for Management of Patients	view	Infection Prevention and Control	Infection Prevention, Control Team	Infection Prevention and Control	15/12/2016	15/11/2019	policy	911	130.1
Blood Culture Collection Policy	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	13/03/2017	15/02/2020	policy	1003	143.3
MRSA policy - Trust Policy for Methicillin Resistant Staphylococcus Aureus - Mupirocin, Isolation, Hand washing, Protocol, Screening, Emergency, Elective, POA, Infection	view	Infection Prevention and Control	Nyarayi Mukombe	Assistant Director of Infection Prevention and Control	13/03/2017	15/02/2020	policy	1003	143.3
Vancomycin / Glycopeptide Resistant Enterococci (VRE/ GRE) Policy	view	Infection Prevention and Control	Hala Kandil, Infection Prevention and Control Team	Infection Prevention and Control Team	15/02/2017	20/02/2020	policy	1008	144

Trust Board
07 September 2017

Title of the paper	**Biannual Establishment Review – Adult Inpatient Wards**
Agenda item	**14/51**
Lead Executive	**Tracey Carter, Chief Nurse**
Author	**Jo Prytherch Lead Nurse Workforce and Education** **Maxine Mc Vey Deputy Chief Nurse**
Executive summary **(including resource implications)**	Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2014) which make explicit the Board's corporate accountability for quality. The Safe Nursing Care Tool which is used as part of this process was in line with the current establishments; this review was completed in February 2017 and has demonstrated there is coverage of nurse to patient ratio of 1:6 to 1:8 for adult in patient wards. Where these ratios are lower this is due to the small size of wards or level 2 units within the wards. In addition all other triangulated data would suggest the inpatient wards are suitably established for the activity, dependency and occupancy of patients. The data does not suggest at this time that there are wards that would benefit from an increase in staffing establishments. It was agreed as part of the internal review with the relevant Head of Nursing and Chief Nurse that a number of wards would benefit from a detailed review of the skill mix and shift patterns– these are Tudor/Castle, Croxley, Sarratt, Blue and Yellow level 3 AAU and the St Albans site – De La Mare and Beckett. Two wards which are Flaunden and Red Suite due to changing acuity of patients over the past two years may need to be considered for further investment at the next establishment review. Post this review there is to be a reconfiguration of the surgical floor at Watford General Hospital with a creation of a 13 bedded elective orthopaedic ward and changes to the two wards at the St Albans site to accommodate segregation of elective orthopaedics. The staffing configurations for these areas are being reviewed and will be outlined in the September adult inpatient establishment review. Maintaining safe staffing levels to ensure high quality and safe patient care requires the use of bank/agency due to vacancies at band 5 and has financial implications. In areas with increased vacancy the use of direct booking has been agreed until the end of September – 4 adult wards. In areas with an increased junior staff actions plans are in place to support the development and transition of these staff. The Corporate Educational team are giving direct support to the transitional nurses. Each Division has a trajectory saving on agency spend that is monitored monthly at the agency steering group meeting. The Trust has set up a task and finish group to address the high turnover factor which is at 29% in the band 5 nursing posts.

	The next adult establishment review is September 2017 and will incorporate a scoping exercise re developing band 3 and 4 support roles and associate nursing roles. External benchmarking with other NHS Trusts and a costing exercise re the CHPPD. The Chief Nurse has agreed an outline for an external review which is planned in September 2017 with the safe staffing team from NHSI for the adult establishments.
Where the report has been previously discussed, i.e. Committee/Group	Review Meetings with the Heads of Nursing and The Chief Nurse. Review meeting with the clinical leaders/ward managers. Safety and Compliance Committee August 2017 Trust Executive Committee August 2017

Action required:

- The Trust Board is asked to receive this report 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) ☐ **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

Ensuring we have adequate numbers of nurses across our adult clinical areas is a fundamental standard set out by Care Quality Commission. There are established and evidenced links between having the right people with the right skills in the right place at the right time and patient safety and outcomes (NQB 2016)

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

There is a risk that due to the number of newly appointed nurses from overseas in the clinical area that they will not receive adequate support on induction and the ability to ensure adequate skill mix and retention of these staff **(3704)**. This has been mitigated through additional capacity in the corporate nursing team to work alongside the nurses from Overseas

Agenda Item: 14/51

Trust Board meeting – 07 September 2017

Biannual Establishment Review - Adult Inpatient Wards

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

1. Introduction

1.1 Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2014) which make explicit the Board's corporate accountability for quality.

1.2 The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). The NHS England guidance 'A Guide to Care Contact Hours' (2014) recommends inclusion of contact time by nursing staff in the establishment reviews. This is referred to as 'care hours per patient day' (CHPPD)

1.3 Care Hours Per Patient Day (CPPD) was introduced in May 2016 and provides a single consistent way of reporting deployment of staff working in inpatient wards/units. It is calculated by adding the hours of registered nurses to hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions. It forms part of the national safer staffing programme and form part of an integrated ward/unit level quality framework and dashboard encompassing patient outcomes, people productivity and financial sustainability and is reported on monthly as part of UNIFY and Trusts performance Integrated Performance Review (IPR) slide.

1.4 There is evidence to suggest that the lower the ratio of RN to patient the greater the outcomes are for patients. NICE (2014) and the RCN (2010) suggest that this ratio should be no higher than 1:8 during the day with a recommendation that this is no lower than 1:7 in older people's areas. The recommended optimum level of RNs to patient ratio has been found to be 1:6 (Aiken 2002, RCN). This has a mortality risk for patients of 4%, rising to 31% with a ratio of 1:8. The Chief Nurse agreed that the review would benchmark against a 1:7 nurse to patient ratio and also the recommended staffing levels for older people(RCN), stroke (Clinical Standards Committee for Stroke Service Standards) trained to untrained skill mix ratios (RCN 2010). The Royal College of Nursing (RCN) Guidance on Safe Staffing levels (2010) reported an average ration of 60:40 registered to unregistered staff.

1.5 The Report from the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) recommendation 195 states that to enable nurse leadership, ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. Currently all the bands 7s across adult inpatient operate in a supervisory capacity. However due to staff vacancies and patient acuity this can fluctuate and acts as a safety measure for the Trust.

1.6 The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, all of which align to the Trusts Quality priorities for 2016/2017:

- Our Quality Improvement Plan
  Theme 1- Our people – ensuring that we sufficient skilled well-supported and happy staff is absolutely essential to the delivery of safe high quality patient care.
  Theme 2- Getting the basics right
- Improved mortality
- Improving harm free care - Reducing pressure ulcer incidence. Reducing adverse incidents, particularly related to medication errors and patient falls.
  Theme 3 Patient focus
- Patient focused pathways for example reducing the length of stay for specific identified conditions such as stroke.
- Dementia and end of life quality improvements.
- Improving patient experience.

1.7 Although not directly referenced within this report, other quality indicators have been taken into consideration, i.e. red flags, red ward triggers and the Ward score card. These indicators are considered and reported within the monthly Trust Integrated Performance Reports (IPR). In March 2017 there was a detailed paper discussed at the Trust Executive committee and Part 2 Trust board relating to the ward sister supervisory role and the measureable impacts of this role.

2. Purpose

2.1 This establishment review was under taken for the following reasons:-

2.2 The need to provide assurance both internally and externally that ward establishments are safe, that staff are able to provide appropriate levels of care to patients and levels of care that reflect the Trust values and the 6 C's contained within the national nursing strategy (2012). This is particularly important in light of key recommendations made in the Francis Report (2013), the Berwick Report (2013) and the National Quality Board publication (2016) 'How to ensure the right people, with the right skills are in the right place at the right time- A guide to nursing, midwifery and care staffing capacity and capability' in terms of safe ward staffing levels.

2.3 To comply with Care Quality Commission requirements under the Fundamental Standards including regulations 18 (Staffing) and 12 (Safe care and Treatment).

2.4 To support the implementation of the Trust's quality priorities and strategic objectives.

2.5 Emergency Department; Outpatients; Maternity and Paediatric establishment's reviews do not form part of this paper and will be reported on separately.

3. Establishment Review Methodology and Background

3.1 The Safer Nursing Care Tool methodology recommends that key patient, staffing and flow information is collected over a 20 day period. Details of the methodology data collected and process are in appendix 1.

3.2 There is also a requirement to ensure that the skill mix of RN: HCA is monitored and considered when evaluating the establishments.

3.3 The data collected and reviewed was used to inform the following recommendations in this paper

4. Analysis and Discussion

4.1 Data Triangulation

4.1.1 Skill mix and Nurse to bed ratio

West Hertfordshire NHS Hospital Trust (WHHT) target ratios are 60% registered vs 40% unregistered and both Medicine Unscheduled Care and Surgery meets the RCN criteria, however in 3 areas Aldenham, a respiratory ward which has non-ventilation patients. Cardiac Care where there are level 2 patients monitored and cardiac procedures and the Stroke unit which has hyper acute stroke unit (HASU). These three ward areas due to patient acuity the ratio is 70:30.

All wards have a planned registered nurse to patient ratio of no more than 8 patients to one registered nurse during the day and night in line with national recommendations and dependant on speciality. The target and actual skills mix available can be seen in Appendix 2 – Table 1. The number of registered and unregistered nurses along with registered nurse to bed ratio for each inpatient ward can be seen in Appendix 2 -Table 2. The staff to bed ratio indicates the total number of registered nurses required caring for a specific number of patients; this will vary according to the type of ward, acuity and patient, location/ward layout, activity and patient flow. The impact of having small wards of bed numbers ranging from 11 beds to 18 beds can be seen in these tables.

At the time the review was undertaken the Trusts % nursing fill rate versus planned was 96.2% above National Threshold of 95%.

Recruitment and retention continues to be a focus in The Trust. Since this review there has been an increase in the turnover in band 5 staff nurse which is currently at 29% in June 2017. A number of Health Care Assistants (HCAs) have been appointed this should reduce reliance on the use of temporary HCAs.

The vacancy rate for the period the establishment review was 133.48 WTE. The vacancies were backfilled with bank and temporary workers. The work to reduce the reliance on temporary workers, particularly agency nurses and midwives continues and is monitored and reviewed monthly at the agency steering group meeting and at the nursing and midwifery monthly workforce.

The Agency and Bank fill rates during that period were as follows:

Outcome	All Shifts
Bank Filled	2,983
Agency Filled	2,733
Agency Unfilled	792
Unfilled	245
Total	**6,753**

4.2 Care Hours Per Patient Day (CHPPD)

The review of NHS productivity, chaired by Lord Carter, is part of an overall NHS plan to regain £5 billion in efficiencies. To provide a single consistent way of recording and reporting deployment of staff working on inpatient wards, Lord Carter's team developed and adopted Care Hours per Patient Day (CHPPD). CHPPD can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by the number of inpatients at 23:59 hours. CHPPD should not be used in isolation and should be used alongside triangulated data which includes skill mix, nurse to bed ratio, Safer Nursing Care tool and the professional judgement model. At WHHT CHPPD is reported monthly and part of the Key Performance indicators for workforce.

Care Hours per Patient Day includes:
Direct patient care

- all hands-on care (for example assistance with eating and drinking, patient hygiene, administering medication, taking clinical observations)
- providing one-to-one observation or support to patients (for example, taking them too or from theatre)
- all direct communication with patients Indirect patient care time :
- patient documentation
- professional discussions to plan patient care
- discharge planning
- communication with patients relatives and friends
- ordering investigations
- shift handovers

Care Hours Per Patient Day is reported on as part of monthly UNIFY but was not used as the preferred metric to inform the review. Using CPPH looks at all patient activity over a 24 hour period thus allowing a more accurate measure of patient acuity the midnight inpatient count.

In the September 2017 adult establishment review it will be used in costing to be part of the triangulation with other methods to set the establishment. The Trust is reviewing the tasks and competences within different posts for example observations.

At the time of the review in February the CPPH for the Trust was 7.2. The Range in the adults wards are 5.1 to 11.4.

4.3 Safer Nursing Care Tool and Safecare

The Safer Nursing Care tool is evidence based tool developed to help NHS hospitals measure patient acuity and dependency to inform evidence-based decision making on staffing and workforce. In the future acuity/dependency is measured on all inpatient wards three times a day and recorded on Safecare.

SafeCare implementation is planned from September 2017 starting with 4 inpatients wards. This live information informs the senior nurses that wards are staffed safely throughout the day and night shifts, and highlights any red flag events that require escalation.

When using this tool other variables should also be taken into consideration:

- Clinical model
- Labour market
- Staff capacity, capability, seniority and onfidence
- Organisational support and support roles
- Ward manager supervisory time

Currently in the Trust uses a planned against actual and professional judgement model to Rag rate the shifts.

4.4 Safer Nursing Care Tool (SNCT)

The detailed results of the establishment review from February 2017 are shown in Appendix 4. SNCT is used to inform evidence based decision making on staffing and workforce and has an expected 10% variation The columns are broken down into the recommendation from SNCT Whole Time Equivalent (WTE) excluding ward clerk and house keeper, the actual worked and the budgeted establishment. In addition the band 7 supervisory was also excluded to 100%. Triangulation of this information along with nationally recognised recommendations by the Heads of Nursing are used to provide assurance that in their professional judgement that they agree with staffing levels currently worked in each department across the Trust.

In reviewing the data the shift patterns worked were looked at in relation to the actual budget. This is shown in Appendix 3.

4.4.1 Variance between shift pattern and actual budget

Shift Pattern	Actual Budget	Variance
890.55	972.3	81.75

In completing this analysis there are additions to the budgets on the ledger that accounts for this variance. AAU Purple budget contains the transfer team, twilight team and MAU staff in the actual Budget.

In addition the need to support patients with enhanced care needs is not included in the current ward establishments this has been addressed in the Trust by developing a business case for an enhanced care team that commenced in May 2017.

4.4.2 Variance between Total SNCT recommendation and actual Total WTE worked

Below is a table indicating the breakdown of SNCT and the budget establishment minus ward clerks house keepers and band 7 (Appendix 3).

SNCT excludes ward clerks and house keepers and band 7s supervisory	Numbers worked excludes ward clerks and house keepers and band 7s	Variance
850.83	897.5	46.67

However these figures do not take in to account the limitations of SNCT which measures actual and not predictive acuity and this is not suitable for smaller wards. The Trust has 9 wards that are 18 beds or less in size .A number of wards in the Trust have complex layouts these include Sarratt ; Blue and Yellow Level 3 AAU which contains the isolation suite and Gade and Heronsgate.

The ward establishments across the adult inpatient areas have been set and agreed to enable the Senior Sisters to function in a supervisory capacity at least 90% of the time. This is monitored monthly through the ward score card. The number of supervisory hours lost for February was 25.1%.

The Senior Sisters will fulfil the following:

- Being visible and accessible in the clinical area and to the clinical team, patients and service users. They participate in ward rounds alongside the medical team, working on complex discharges with the multidisciplinary team and are fundamental in leading the daily safety huddles. Their role is crucial to sustaining the length of stay and the development of the SAFER initiative and Red to Green days.
- Working alongside the team in different ways, e.g. supporting junior staff, facilitating learning in practice and care plan reviews. This is particularly crucial in reducing and sustaining vacancy rates and their role in supporting the Transitional Nurses and Student nurses should not be underestimated.
- Managing and coordinating root cause analysis when an incident or complaint has occurred.
- Monitoring and evaluating standards of care, ensuring effective handovers, monitoring ward score cards and audits and participating in ward based and peer audit
- Support the evaluation of care during each shift, e.g. leading clinical supervision and reflective practice and ensuring that there are suitable processes in place to gain feedback from patients and their relatives on their experience of their care
- Creating a culture for learning and development, supporting new and existing staff in their personal and professional development.

4.5 Clinical Areas – detailed review of variance in specialist areas:

In completing this analysis contained in Appendix 3 which shows the variance of the actual budgets against the SNCT February 2017 figures. It needs to be noted that the actual budget contains ward clerks, housekeepers and the band 7 (ward sister/charge nurse).

4.5.1 Unscheduled Care

- *AAU Level 1* - this is 4 areas of 15 beds the SNCT higher multiplier was used because the ward descriptors are not sensitive enough to recognise the patient case

mix and the layout of the AAU. Benchmarking has been undertaken across two hospitals with similar sized AAUs and the overall establishments are similar; there is an opportunity to review the skill mix as part of the work underway to review the urgent and emergency care pathway.

- *In AAU* – there is band 7 cover 7 days a week (days only)

	Funded Establishment	**Actual Worked**	**SNCT**	**Variance**
Purple	47.8. this includes band 7s	52.1	22.4	25.4 Band 7 included here 2.61 WTE The MAU establishment Transfer Team 9 WTE
Yellow	27.5	29.8	21.6	5.6
Blue	31.3	27.3	22.5	13.5
Green	27.7	24.6	23.7	4

The SNCT does not highlight the movement of patients with in the unit/transfers. This unit has 7 day a week cover by a band 7 and other budget for the Medical Assessment unit (MAU) and the transfer team which accounts for the variance ion budget. The CHPPD is 8.5.which appears high. However this is taken at one point in the day at 23.59hrs and does not reflect the movement of patients in and out of the assessment unit.

- *Bluebell Ward* - 16 beds there is no guidance or robust benchmarking for staffing ratios or skill mix for patients being cared for in an elderly care/frailty unit. Although the acuity reported was significantly lower than the recommended budgeted establishment and the professional judgement of the Head of Nursing is for this establishment to remain as it is as it is acknowledged that the unit cares for patients with complex needs. In addition it questions the validity of using the SNCT in an area with such complex needs. CHPPD is 11.4 which is high however out of this 6.6 are unregistered Care Staff. The Staffing Ratio is 40% Registered. These indicators are reflective of the care needs of the patients on Bluebell.

Funded minus ward clerk, house keeper and band 7	**SNCT**	**Variance**
41.2	24.7	+16.5

- *Tudor/Castle Ward* - 36 beds this area is used as surge area for elderly care. The acuity of the patients is low but high on basic nursing care needs and there is no designated budget for Castle. Castle (12 beds) was closed in June 2017. CHPPD 10.6.which is high and the SNCT indicates a higher acuity then the funded establishment, see below.

- The Head of Nursing is going to undertake a review of the establishment and the skill mix for the types of patients allocated to this ward.

Funded minus ward clerk, house keeper and band 7	**SNCT**	**Variance**
47.9	60	- 12.1

- *Croxley Ward - 28 bedded* ward for the elderly care. SNCT indicated higher acuity then the funded establishment, see below. In January 2016 SNCT was 34.24 and in September 2016 39.5 and therefore this clinical area will be kept under review as the first time its appearing over the SNCT. CHPPD is 6 which is within a normal range.

Funded minus ward clerk, house keeper and band 7	**SNCT**	**Variance**
39.5	45.2	-5.7

- *Sarratt Ward* - 36 bedded care of the elderly. SNCT indicated slightly higher acuity then are establishment, see below. In January 2016 SNCT was 51.39 and in September 2016 54.4 and therefore this clinical area will be kept under review. The CHPPD 6.5 is within normal range. The Ratio of Registered against unregistered is 50% vs 50%. The Head of Nursing is going to undertake a review the skill mix for the types of patients allocated to the ward.

Funded minus ward clerk, house keeper and band 7	**SNCT**	**Variance**
60.3	63.9	- 3.3

- *Red Suite* – 18 bedded care of the elderly ward. SNCT indicated higher acuity then establishment see below .In January 2016 the SNCT was 25.4 and in September 2016 it was 35.79 and therefore this clinical area will be kept under review. CHPPD is 8.3 which is on the upper range of normal so would indicate we should review. The types of patients being allocate this ward have changed over the two years. The Head of Nursing is going to undertake a review of the establishment and the skill mix for the types of patients allocated to this ward.

Funded minus ward clerk, house keeper and band 7	**SNCT**	**Variance**
22.7	27.9	-5.2

- *Blue and Yellow Level 3 AAU* – 36 bedded care of the elderly which contains a 6 bedded isolation ward within these bed numbers. SNCT indicated lower acuity then are establishment see below. The Head of Nursing is going to undertake a review of the establishment and the skill mix for the types of patients allocated to this ward.

Funded minus ward clerk, house keeper and band 7	**SNCT**	**Variance**
58.3	54.2	+ 4.1

4.5.2 Surgery

De La Mare and Beckett is an isolated ward on the St Albans Elective site with 36 beds which is an inpatient and partial day surgery ward. The establishment has been set for weekend working and extra surgical lists. The Head of Nursing is going to undertake a review of the establishment with relevant activity analysis The CHPPD 9.1.which is above the normal range. However this indication is taken at one point in the day at 23.59hrs.and equals does not reflect the movement of patients in and out of ward.

Funded minus ward clerk, house keeper and band 7	SNCT	Variance
57.1	24.9	+32.2

- *Ridge* is a 29 bedded orthopaedic ward with elective bays. In January 2016 SNCT was 29.7 and in September 2016 28.6 and therefore this clinical area will be kept under review. CHPPD 5.4. This is below the range and ratio is 45% registered vs 55% unregistered.

Funded minus ward clerk, house keeper and band 7	SNCT	Variance
33	38.9	- 5.9

- *Flaunden* is a 28 bedded acute surgical ward in January 2016 SNCT was 39.56 and in September 2016 33.9 and therefore this clinical area will be kept under review. CHPPD 5.4. This is below the range and this is the ward that might need investment at the next adult review.

Funded minus ward clerk, house keeper and band 7	SNCT	Variance
32.2	38.9	- 6.7

In August 2017 it has been agreed that the surgical floor at Watford General will be reconfigured in light of the findings from an external review and a separate elective orthopaedic ward will be created. This will be reported on in regard to the staffing levels in the next Adult Establishment review in September 2017.

4.5.3 Ward Score Card

The Trust uses readily available information and statistical tools to examine indicators of care. Including process and observational indicators –Test your Care and outcome indicators such as; pressure ulcers, complaints, patient falls, drug administration errors, C-difficile rates, MRSA rates. This is available on I-Reporter and used at Performance Reviews. The ward scorecard monitors two of the NICE red flags around staffing and the quality metrics associated with nurse sensitive indicators.

On the Ward scorecard the table below the safety alerts/measures against the supervisory hours are shown. These two indicators have a number of variations that impact on the delivery of safe and effective compassion care such as the maturity and experience of the nursing team. This needs to be considered when analysing the data.

Table 3 in appendix 2 shows the safety alerts on the ward scorecard against the supervisory hours of the ward sisters over the past 6 months.

Our top performing wards in February 2017 for safety alerts are Cardiac/purple and green level 3 AAU, AAU level 1 Yellow and Cleves.

The supervisory hours on AAU level 1 Yellow have a higher percentage of red for supervisory hours. This area is part of 4 areas that make up the Acute Assessment Unit on level 1 and in addition these clinical areas function with a band 7 during the day time 7 days a week to co-ordinate due to the nature of the patient pathway, assessment function and turnover of patients in this area.

The 3 lowest performing wards are Tudor, Sarratt and AAUBY3 (all have 36 beds) – All 3 wards have a higher bed capacity and complex layouts.

All 3 wards are care of the elderly and have had leadership changes over the last year. There has been a high vacancy factor and turnover in these ward areas.

Tudor was a surge area up until April 2016 when a substantive workforce for 24 beds was approved in budget setting. Castle (12 beds) which is part of Tudor remains as a surge area.

Table 4 in appendix 2 shows the Process alerts on the ward scorecard against the supervisory hours of the ward sisters over the past 6 months

The top performing wards in the process measures are ICU, Cleves and Simpson. In the last two months all 3 areas have had 100% supervisory hours. ICU has a different staffing profile due to the nature of Critical Care.

The three lowest performing wards are AAU Blue and Yellow level 3, AAU Yellow level1 and Sarratt.

If the process measures are not in place an increase in safety alerts are seen as demonstrated by Blue and Yellow level 3 and Sarratt wards. Both these wards have improvement support and focus in place from the Heads of Nursing and Chief Nurse.

4.5.4 Red Triggered Shifts

The Trust reports red triggered shifts on a daily and monthly basis via the IPR on safe staffing. Mitigating action is taken by the senior nurses for the division and out of hours by the senior clinical rota and on call manager each day. Factors affecting red triggering shifts:

- Temporary Staffing Fill
- Vacancy Rate
- Sickness
- Enhanced care requirements
- Opening of surge capacity areas
- National strategy for agency reduction restricted the use of cap non-compliant agencies

In the professional review this has been considered by the Heads of Nursing.

4.5.5 Summary of Recommendations.

The SNCT requirements were in line with current establishments; this review has demonstrated there is a reasonable coverage of nurse to patient ratio of 1:6 to 1:8 for adult in patient wards. Where the ratio is lower than 1:6 this is either due to the low number of beds in the ward which makes it's impossible to lower the qualified number or the high dependency/speciality areas in the ward. In addition all other triangulated data would suggest most inpatient wards are suitably established for the activity, dependency and occupancy of patients.

The data does not suggest at this time that there are wards that would benefit from an increase in staffing. The data has suggested that a number of wards would benefit from the scoping exercise below.

5. Next Steps

5.1 A Scoping Exercise Developing Band 3 and 4 Support/Associate Nursing Roles

Since the publication of the Francis Inquiry many Trusts have increased their nursing establishment, and this coupled with national reductions in pre-registration nursing intakes, has led nationally to a general shortage in the number of nurses available to recruit. As a Trust we need to look at new ways of working and 'growing our own' to ensure we can continue to give quality value care to our patients. Commitment 8 of 'Leading Change Adding Value' states "We will seek to widen access and develop new roles and more flexible routes to graduate education". Developing a successful workforce depends on providing the necessary motivation, skills, behaviours and opportunities, as set out in the 2015 review by Lord Willis, 'Raising the bar - Shape of caring; a review of the future education and training of registered nurses and care support workers'. The Trust recognises the importance of building up the future workforce, through talent spotting, making the education, learning and training of staff a priority to drive new ways of working across organisational and professional boundaries. The Trust supports the differing needs of older and younger staff and ensure all caring roles are fulfilling and ones in which staff are supported, have a positive experience and want to stay in our organisation.

The Trust is part of the Nursing Associates Pilot and has 17 individuals in training. Work has begun to explore the appropriate skill mix of the inpatient wards.

5.2 Changes to e-rostering practice

Version 10 e-Roster was implemented in November 2016, the NHSP interface was completed in May 2017, while ultimately the plan is to have all area utilising the interface due to high vacancies in some areas direct booking has been allowed to continue for patient safety under the control of the Chief Nurse. The e-roster team are working with clinical areas and super users to create demand templates aligned to budgets. Once this has been completed those responsible for roster development need to do good rostering as this leads to high quality and productivity. Safer Staffing is to be implemented starting in September 2017.

5.3 Internal Reviews

Following the check and challenge process led by the Chief Nurse with the Heads of Nursing (HoN) a number of actions are to be undertaken. The HoNs with their clinical leads will follow the governance process of the next adult establishment review in September.

5.4 External Review

The Trust has agreed an outline review with the safe staffing team from NHSI to review of the adult establishments.

The next establishment review for adult inpatient areas is scheduled for September 2017.

Planned for the September 2017 Review

- An exercise benchmarking key metrics with other Trusts namely:

- East & North Hertfordshire, Luton, Milton Keynes, Bedford and Royal Free.
- Costing of the scoping exercise re band 4 roles
- Costing and benchmarking of the CHPPD

6. Risks

6.1 There is a risk that due to the number of newly appointed nurses due to the number of newly appointed nurses in the clinical area that they will not receive adequate support on induction and the ability to ensure adequate skill mix and retention of these staff may be affected ***(3704)***. This has been mitigated through additional capacity in the corporate nursing team to work alongside the nurses from Overseas:

7. Recommendations

7.1 The Trust Board is asked to receive the report for information and assurance.

Tracey Carter

Chief Nurse, Director Infection Prevention & Control

August 2017

Appendix 1 Establishment Review Methodology

The Safer Nursing Care Tool methodology recommends that key patient, staffing and flow information is collected over a 20 day period. Details of the methodology are listed below.

The following information was also collected and reviewed; a review of all relevant literature and guidelines was undertaken prior to commencement of this review, these included:

- NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2012)
- Compassion in Practice, NHS England (2012)
- Safer Nursing Care Tool • Nurse sensitive indicators
- Safer Staffing Guidance, Trust Development Authority (2015)
- Leading Change Adding Value (2016)
- Lord Carter Report (2016)
- Lord Willis Report (2015)

As part of this review the information was collected and reviewed. This data was then used to inform the recommendations.

The Heads of Nursing were fundamental to this review process working closely with the ward sisters and matrons. The Deputy Chief Nurse with the workforce team had check and challenge on the process. Finance leads worked closely in this process. This was achieved via a number of check and challenge meetings. The Chief Nurse was involved in the final agreements.

The final data included

- Comparison of current establishment review data with previous two Safer Staffing reviews to identify changes or trends
- Service or speciality provided, this includes identify any geographical or layout changes undertaken during the last six months. This includes the challenges of smaller wards of below 18 bed
- Patient number and acuity for each ward for a continuous 20 day period. This data was Monday to Fridays excluding weekends.
- Professional judgement of the ward leaders was part of the triangulation.
- The registered to unregistered nursing skill mix was assessed against national guidelines. The registered nurse to bed ratio for each shift was assessed against national guidelines.
- Target care hours per patient day (CHPPD) were used to calculate appropriate staffing required.
- The Safer Nursing Care tool (SNCT) was used to calculate the appropriate staffing required.
- Incidents of red triggering shifts, indicating when wards fall below acceptable staffing levels for the patients on the ward
- Current staffing shortfalls for each ward
- Analysis of the current applied headroom compared to actual staff unavailability
- Analysis of the current shift patterns and relevant WTE budgets required for these shift patterns.

- A review of nursing and midwifery quality indicators, this includes reviewing falls, hospital acquired pressure ulcers and 'harm events' as per national guidelines.
- Other clinical factors including a review of serious incidents, Datix incidents and complaints for which staffing could have an impact.

Planned for the September 2017 Review

- An exercise benchmarking key metrics with other Trusts namely:
- North &East Hertfordshire, Luton, Milton Keynes, Bedford and Royal Free.
- Costing of the scoping exercise re band 4 roles
- Costing and benchmarking of the CHPPD

SNCT methodology, patient classifications, multipliers and definitions

- Ward managers allocated each patient a score between zero and three based on Critical Care patient definitions.
- Scores were reviewed, validated and challenged daily by a senior nurse.
- Scores were multiplied by the factors outlined in SNCT guidelines the sum of the factors provided a recommended daily staffing establishment, reflecting qualified and unqualified nursing staff. An average score was calculated based on the three week period.
- Specific recommended multipliers were used for AAU to reflect patient turnover.
- All Multipliers were adjusted to reflect the 21.6 % uplift applied at WHHT.
- Surge areas were excluded from the review
- Supernumerary Band 7s were excluded from the SNCT recommendation and funded baseline.

	Adult inpatient		AAU			
Score	**SNCT multiplier**	**WHHT multiplier***	**SNCT multiplier**	**WHHT multiplier***	**Definition**	**Example care requirements**
Level 0	0.99	0.99	1.27	1.27	Patient requires hospitalisation. Needs met by provision of normal ward cares	Elective admission; Underlying medical condition requiring on-going treatment; Regular observations (2 - 4 hourly); ECG monitoring; Fluid management; Oxygen therapy < 35%; Single chest drain, Confused patient not at risk; Requires assistance of one person to mobilise
Level 1a	1.39	1.39	1.66	1.65	Acutely ill patients requiring intervention of those who are unstable with a greater potential to deteriorate	Increased level of observations and therapeutic intervention; Oxygen therapy > 35%; Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains
Level 1b	1.72	1.71	2.08	2.07	Patients who are in a stable condition but are dependent on nursing care to meet most or all activities of daily living	Complex wound management requiring more than one nurse or taking more than one hour; Mobility or repositioning difficulties requiring more than two people; Complex Intravenous Drug Regimes; Patients on EoL pathway; Confused patients at risk or requiring constant supervision
Level 2	1.97	1.96	2.26	2.25	May be managed within clearly identified designated beds, resources with required expertise and staffing level, or dedicated L2 facility	Deteriorating/ compromised single organ system; Patients requiring non-invasive ventilation/ respiratory support; CPAP/ BiPAP; Greater than 50% oxygen; Drug infusions requiring monitoring; CNS depression of airway and protective reflexes
Level 3	5.96	5.94	5.96	5.94	Patients needing advanced respiratory support and/ or therapeutic support of multiple organs	Monitoring and supportive therapy for compromised/ collapse of two or more organ/ systems; Respiratory or CNS depression/ compromise requires mechanical/ invasive ventilation; Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection

Appendix 2

TABLE 1

STAFFING NUMBERS PER SHIFT

The Table below shows the available staff on a shift to bed ratio

	WARD	DAY Registered Nurse	DAY Unregistered staff	NIGHT Registered Nurse	NIGHT Unregistered Staff	RN to bed ratio DAY	RN to bed ratio NIGHT
USC HON PD	AAU L3 BY	7	6	7	3	1:5	1:5
	Red	3	2	3	1	1:6	1:6
	Bluebell	3	5	3	5	1:6	1:6
	Winyard	3	2	3	1	1:6	1:6
	Tudor Castle	5	6	5	6	1:7	1:7
	Oxhey	2	2	2	1	1:5	1:5
	Stroke	6	4	6	4	1:5	1:5
	Simpson	3	3	3	2	1:7	1:7
	Croxley	4	4	4	3	1:7	1:7
	Heronsgate and Gade	7	4	6	2	1:5	1:6
	Sarratt	6	6	5	4	1:6	1:7
USC HON AW	CCU	6	2	5	1	1:4	1:5
	Cassio	3	2	3	1	1:7	1:7
	Aldenham	6	3	5	1	1:5	1:6
	AAU L1 B/G/Y	3	2	3	2	1:5	1:5
	AAU L1 P	6	2	3	2	1:3	1:5
SURGERY HON PK	Ridge	4	3	3	2	1:7	1:9
	Langley	3	2	2	1	1:5	1:8
	Cleves	3	3	3	2	1:7	1:7
	Flaunden	4	3	4/3	½	1:7	1:7
	Letchmore	3	2/3	3	1/2	1:7	1:7
	Elizabeth	4/5	¾	¾	2	1:7	1:8
	De La Mare	4	2	3	1	1:6	1:7
	Beckett	2	1	2	1		

The Wards in Blue are all small bedded wards ranging from 11 beds to 18 beds

The Wards in Green have high dependency areas within the wards. The band 6 cover in these areas are 24hrs 7 days a week.

AAU L3 B/Y contains an isolation unit in the ward which is a separate 6 beds.

AAU l1 P is the triage area and is 15 beds.

TABLE 2

STAFFING NUMBERS PER SHIFT

The Table below shows the registered and unregistered %

	WARD	RCN Registered recommended ratio %	RCN Unregistered staff Recommended %	Actual RN 5	Actual unregistered staff %
USC HON PD	AAU L3 BY	60%	40%	60%	40%
	Red	60%	40%	70%	30%
	Bluebell	60%	40%	40%	60%
	Winyard	60%	40%	65%	35%
	Tudor Castle	60%	40%	40%	60%
	Oxhey	60%	40%	65%	£5%
	Stroke	65%	35%	60%	40%
	Simpson	60%	40%	50%	50%
	Croxley	60%	40%	60%	40%
	Heronsgate and Gade	60%	40%	70%	30%
	Sarratt	60%	40%	50%	50%
USC HON AW	CCU	75%	25%	80%	20%
	Cassio	60%	40%	70%	30%
	Aldenham	60%	40%	70%	30%
	AAU L1 G	60%	40%	70%	30%
	AAU L! Y	60%	40%	70%	30%
	AAL1 B	60%	40%	65%	35%
	AAU L1 P	60%	40%	70%	30%
SURGERY HON PK	Ridge	60%	40%	55%	45%
	Langley	60%	40%	60%	40%
	Cleves	60%	40%	50%	50%
	Flaunden	60%	40%	60%	40%
	Letchmore	60%	40%	60%	40%
	Elizabeth	60%	40%	60%	40%
	De La Mare	60%	40%	TBC	
	Beckett				

The Wards in Blue are all small bedded wards ranging from 11 beds to 18 beds

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AAU L3 B/Y contains an isolation unit in the ward which is a separate 6 beds.

AAU L1 P is the triage area and is 15 beds.

Table 3 shows the safety alerts on the ward scorecard against the supervisory hours of the ward sisters over the past 6 months up to February 2017

Table 3

Top and bottom 3 Safety Alerts

	Ward	Measure	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Safety total alerts last six months	Rank
Top 3 fewer alerts	CCU/ P/G 3	Safety Alerts	1	2	0	0	0	0	3	1
		% of Supervisory filled Hours	84%	76%	100%	84%	88%	85%		
	AAU Y1	Safety Alerts	1	0	0	1	1	2	5	2
		% of Supervisory filled Hours	52%	52%	72%	53%	100%	33%		
	Cleves	Safety Alerts	0	2	1	1	0	1	5	2
		% of Supervisory filled Hours	86%	84%	91%	86%	95%	100%		
Bottom 3 more alerts	Tudor	Safety Alerts	4	1	2	4	3	4	18	23
		% of Supervisory filled Hours	107%	144%	116%	91%	82%	116%		
	Sarratt	Safety Alerts	4	4	3	3	2	3	19	24
		% of Supervisory filled Hours	87%	50%	36%	165%	58%	54%		
	AAU B/Y 3	Safety Alerts	3	6	3	3	3	3	21	25
		% of Supervisory filled Hours	89%	103%	100%	73%	45%	50%		

Table 4 shows the Process alerts on the ward scorecard against the supervisory hours of the ward sisters over the past 6 months up to February 2017

Table 4

Top and bottom 3 Process Alerts

	Ward	Measure	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Process total alerts last six months	Rank
Top 3 fewer alerts	ICU	Process Alerts	2	3	1	2	2	3	13	1
		% of Supervisory filled Hours	100%	100%	NA	98%	100%	100%		
	Cleves	Process Alerts	1	5	0	3	3	2	14	2
		% of Supervisory filled Hours	86%	84%	91%	86%	95%	100%		
	Simpson	Process Alerts	4	3	3	2	1	2	15	3
		% of Supervisory filled Hours	50%	29%	72%	85%	102%	104%		
Bottom 3 more alerts	AAU B/Y 3	Process Alerts	5	6	4	5	5	6	31	23
		% of Supervisory filled Hours	89%	103%	100%	73%	45%	50%		
	AAU Y1	Process Alerts	4	6	4	9	7	4	34	24
		% of Supervisory filled Hours	52%	52%	72%	53%	100%	33%		
	Sarratt	Process Alerts	6	9	7	5	5	4	36	25
		% of Supervisory filled Hours	87%	50%	36%	165%	58%	54%		

APPENDIX 3

Ward	No. of beds	SNCT Level					Jan-16	Sep-16	SNCT WTE	Professional Judgement	Agreed with WM and Matron Yes/No	shift pattern budget	Actual worked in M11	Minus Band 7 HKs and WCs	Budgeted establishment	CHPPD		
		Level 0	Level 1a	Level 1b	Level 2	Level 3										Registered midwives/ nurses	Care Staff	Overall
		Total	Total	Total	Total	Total												
AAU L1 Blue	15	10.4	8.71	3.22	0.22	0	18.9	38.81	22.5	31.3	yes	27.31	27.3	30.3	31.3	5.2	3.3	8.5
AAU L1 Green	15	12	4.98	6.76	0	0	16.11	20.2	23.7	27.7	yes	27.31	24.6	26.7	27.7	5.0	3.3	8.3
AAU L1 purple	15	12.6	4.81	4.16	0.89	0	17.09	20.5	22.4	47.8	yes	32.91	52.1	39.2	+47.8	6.2	2.8	9.0
AAU L1 Yellow	15	10.92	5.47	5.2	0.11	0	18.45	20.6	21.6	27.5	yes	27.31	29.8	26.5	27.5	5.1	3.3	8.4
AAU L3 blue and yellow	36	6.48	10.77	37.06	0	0	44.47	52.5	54.2	63.85	Yes	61.00	70.1	60.3	61.3	4.3	3.0	7.3
Aldenham	27	12	2.5	13.5	8.1	0	34.8	33	36.1	42.3	Yes	40.36	39.9	39.3	42.3	4.6	1.9	6.5
Bluebell	16	3.4	0.06	21.32	0	0	23.57	29.2	24.7	44.2	Yes	42.97	41.5	41.2	44.2	4.8	6.6	11.4
Cardiac Care	24	2.22	25.29	4.98	0.59	0	33.68	31.8	32.9	38	yes	37.75	36.8	35.0	38.0	5.4	1.6	7.0
Cassio Ward	20	6.23	0	23.56	0	0	25.8	24.3	29.7	26.8	yes	24.70	28.1	23.8	26.8	3.8	2.1	5.9
Cleves	22	4.95	0.13	28.38	0	0	33.39	33.3	33.4	32	yes	29.92	33.1	29.0	32.0	3.5	2.8	6.3
Croxley Ward	28	0.99	1.46	42.2	0.59	0	34.24	39.9	45.2	45.2	Yes	40.36	44.3	39.5	42.5	3.5	3.6	6.0
DLM	36	23.3	1.62	0	0	0			24.9	58.1	yes	27.31	45.0	57.1	58.1	5.4	3.7	9.1
Elizabeth	33	33.4	0	0	0	0	28.28	27.2	33.4	36.8	yes	40.36	42.2	33.8	36.8	2.9	2.4	5.1
Flauden	28	12.77	2.22	24	0	0	39.56	33.9	38.9	38.9	yes	32.53	38.9	32.2	35.2	3.6	1.8	5.4
Heronsgate/Gade	37	14.5	2.53	35.1	0	0	48.33	48.9	52.1	53.6	Yes	50.80	58.3	51.6	53.6	3.9	1.9	5.8
Langley	16	7.17	6.8	5.3	0	0	18.17	19.7	19.2	23.1	yes	22.09	21.3	21.1	23.1	3.8	2.4	6.2

Letchmore	22	13.46	1.5	11.4	0.09	0	22	24.33	26.4	26.1	yes	24.70	33.0	23.1	26.1	3.4	2.4	5.8
Oxhey	11	2.67	2.78	9.54	1.4	0	12.1	10.89	16.2	18.2	Yes	19.48	22.2	16.2	18.2	4.6	4.0	8.6
Red Suite	18	2.17	1.9	23.9	0	0	25.4	35.79	27.9	27.9	Yes	24.95	27.6	22.7	25.7	4.0	4.3	8.3
Ridge	29	16.73	3.47	10.06	0	0	29.7	28.6	30.23	35	yes	32.53	34.7	33.0	35.0	3.1	2.3	5.4
Sarratt	36	5.29	12.92	41.66	4.1	0	51.39	54.4	63.9	63.3	Yes	56.02	54.4	60.3	63.3	3.4	3.1	6.5
Simpson	21	10	0	16.7	0	0	29.19	27.8	26.7	31	Yes	29.92	27.1	29.0	31.0	3.6	2.6	6.2
Stroke (Dick Edmonds)	33	0	4.3	30.9	21.8	0.2	55.07	42.3	57.2	57.6	Yes	54.63	41.5	54.6	57.6	4.7	3.1	7.8
Tudor and Castle	36	0.49	5.76	52.6	1.18	0	41.7	37	60	53.1	Yes	58.63	54.4	47.9	50.9	4.9	5.7	10.6
Winyard	18	6.68	0.97	18.6	1.2	0	25.12	25.9	27.4	27.4	Yes	24.70	34.7	24.1	26.1	4.0	2.3	6.3
	607	230.82	110.95	470.1	40.27	0.2	759.22	743.31	850.83	976.75		890.55	963.0		961.7			
Housekeeper AAU													10.6	10.6	10.6			
Total													973.0	908.1	972.3			

Budgeted and actual WTE worked based on ledger figures at M11 16/17.
1 WTE per ward excluded from WTE on budget and actuals for supernumerary ward manager.
Figures for safer nursing care tool are for registered nurses and HCAS only. **They do not include housekeepers or ward clerks.**
Actual worked will include housekeepers and ward clerks
Budgeted Establishment includes ward clerk and housekeepers
3rd January to 24 February Monday to Friday Only
13 HK Shared across AAU L1,L3 A&E Red
Head Room 21.6

Trust Board meeting
07 September 2017

Title of the paper	**Safeguarding Annual Report 2016/17**
Agenda item	**15/51**
Lead Executive	**Tracey Carter, Chief Nurse**
Author	**Dawn Bailey - Lead Nurse, Safeguarding Adults** **Michelle Mulvaney - Named Nurse, Safeguarding Children** **Denise Mallan- Named Safeguarding Midwife** **Gloria Rowland – Associate Director for Midwifery & Gynaecology Nursing** **Maxine McVey – Deputy Chief Nurse**
Executive summary	This annual report gives an account of the safeguarding activity across the Trust covering the period May 2016 – April 2017. The report demonstrates the organisations commitment to protecting children, young people and vulnerable adults at risk of harm across all service areas. The key indicators of activity are showing that the Trust is protecting children, young people and at risk adults and the referral rates are appropriate for an Acute Trust. Safeguarding activity across the Trust remains a high priority. During the reporting period the Herts Valleys Clinical Commissioning Group undertook a Section 11 of the Children Act audit and an adult assurance visit, both of which highlighted good safeguarding practice across all areas of the Trust. Safeguarding cases are often very complex and challenging for all staff involved. The reporting period has seen staff dealing with emerging national safeguarding issues such as trafficking, female genital mutilation, child sexual exploitation and domestic abuse. 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. The recommendations from these external reviews are part of the focus of the safeguarding team and are included in the 2017/18 work plan. The training rates continue to meet the Trust's target and in August adult level 2 was at 96% and children level 3- 97%, children level 2 - 95%. All relevant policies are in date and updated in regard to national learning from safeguarding cases or recommendations. Additional targeted training for the surgical division staff caring for patients of 16-17 years old has been completed.

	A tracking process for Deprivation of Liberty has been in place since October 2016 with improvements demonstrated with this process and a good partnership working with the supervisory body. The Quality improvement plan in the Trust has focused on mental capacity assessments with improvements in both the training rates and understanding in the Trust. The audit strategy consists of regular dip dives on practice and to demonstrate that practice and processes of safeguarding are in place. Key achievements to note in 2016/17: • The regional recognition of the children passports which is embedded across paediatrics/neonates. This passport records supervision and training for safeguarding. • The Lavender Team within Maternity that supports women with complex needs. • The high profile of the domestic violence adviser (IDAV) with good numbers of referrals being made from key frontline areas. • Two clinical areas have been recognised for outstanding service and reasonable adjustments for people with learning disabilities. • The establishment of the FGM clinic and this now forms part of the maternity monthly mandatory training.
Where the report has been previously discussed, i.e. Committee/Group	• Safeguarding Panel - June 2017 • The Maternity elements at the WaCs Divisional Governance.- June 2017 • Quality and Safety Group - July 2017 • Safety and Compliance Committee – August 2017
Action required: • The Trust Board is asked to note the report for information and assurance.	
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	☒ To deliver the best quality care for our patients ☒ To be a great place to work and learn

Benefits to patients/staff from this project/initiatives

Safe and effective processes and procedures are in place to ensure patients accessing services across the Trust are effectively safeguarded

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

Failure to comply with Section 11 of the Children Act; Adult assurance framework :Social Care Act

Increased awareness of adult safeguarding resulting in increased workload

Quality requirement to reach a training target of 95% for MCA and DoLS - August 2017 87%

There is a current vacancy in the safeguarding adults team of 0.8 WTE

Agenda Item: 15/51

Trust Board meeting – 07 September 2017

Safeguarding Annual Report 2016/17

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

Executive Summary

This Annual Report gives an account of the safeguarding activity across West Hertfordshire NHS Hospitals Trust (WHHT), covering the period May 2016 – April 2017. The report demonstrates the organisations commitment to protecting children, young people and vulnerable adults at risk of harm across all service areas.

Safeguarding activity across the Trust remains a high priority, often involving very complex and challenging cases. The reporting period has seen staff dealing with emerging national safeguarding issues such as trafficking, female genital mutilation and child sexual exploitation. The safeguarding team endeavour to keep safeguarding issues high on the Trust agenda to ensure that safeguarding is seen as everyone's responsibility.

Key indicators of activity

- Increased number of referrals for adult safeguarding issues predominantly relating to allegations of neglect against care homes and care agencies.
- Increasing number of referrals to the Independent Domestic Violence Advisor (IDVA)
- 833 referrals were completed to Children's Services where there have been concerns about a child's welfare.
- 227 referrals sent to Children's Services to share information about vulnerable children
- 48 child protection medicals were carried out by Consultant Paediatrician/ Registrars – all due to concerns about physical abuse
- 125 Safeguarding referrals have been completed to adult social care with concerns of neglect, financial abuse, and self-neglect.
- 201 referrals were made to social care for patients that were at risk but did not meet the safeguarding criteria in accordance with the Care Act, 2014. These mainly related to patients who were no longer coping at home and required new / increased packages of care or required assessment for residential care
- 1 Safeguarding Adults Review. The Trust contributed to this review by completing an Internal Management Review.
- The Trust is contributing to 1 Domestic Homicide Review. A completed chronology and Internal Management Review has been submitted to the DHR panel.
- In Maternity 981 safeguarding referrals were received
- 737 mental health referrals for maternity cases.
- 90 Unborn babies on Child Protection Plans
-

Key Achievements within the reporting period

- Section 11 audit visit completed by Designated Safeguarding Team in CCG, was positive with areas of good practice highlighted
- Majority of work completed on safeguarding annual work plan 2016
- No serious incidents or involvement in serious case reviews for safeguarding children during reporting period
- Significant increase in compliance with MCA and DoLS training rates.
- Development of MCA and DoLS booklet designed and distributed across the Trust.
- Completion of Trust Lampard action plan with evidence to ensure compliance with key recommendations.
- Continued high compliance with safeguarding children training - Level 3 safeguarding children training has remained at 95% or above for 10 months of the reporting year
- Health Wrap (Prevent) training is being rolled out in key clinical areas with high rates of compliance in paediatrics/neonates, maternity and unscheduled care
- Safeguarding training delivered on Trust Board development day
- Safeguarding Children Supervision and Peer Review Policy was ratified in June 2016 and rolled out across key areas.
- Several key policies have been updated and ratified i.e. Safeguarding Children, young people and unborn babies policy, Chaperone Policy, suicide prevention and anti-ligature policy and Domestic abuse policy.
- Use of Safeguarding Children Passports embedded across paediatrics/neonates. Named Nurse presented Safeguarding passports at a regional NHS England conference.
- CP-IS introduced within paediatric out patients to identify vulnerable children
- Information Sharing form developed to help Trust staff share information with Children's Services about vulnerable children
- Development of the Lavender Team – specialist midwives to support pregnant women with complex needs launched in July 2016. Lavender team recognition at regional and national level
- Safeguarding newsletter– distributed to all Trust staff in June and December 2016
- Trust Safeguarding Training Strategy 2017-19 – fully updated in line with all national guidance.
- Audits around safeguarding activity carried out, showing overall good safeguarding practice
- High profile across the Trust of the Independent Domestic Violence Advisor (IDVA) with good numbers of referrals made from key clinical areas.
- Safeguarding team have completed modus training for MARAC
- An additional 2 clinical areas awarded with the purple star award in recognition for outstanding service and reasonable adjustments for people with learning disabilities
- Introduction of clinical competencies in key areas for Mental Capacity Act and Deprivation of Liberty Safeguards.
- Development of e-learning package for safeguarding adults level 2, MCA, DoLS and PREVENT awareness to meet core skills framework.
- Development of a process to track patients under a DoLS and the expiry dates of the authorisations.
- In maternity the creation of Psycho/Social File on the IT system
- Introduction of risk assessment tool to improve early detection/deterioration of mental health in pregnancy.
- Collaboration with the community mental health team to provide care throughout pregnancy pathway till 1 year of childbirth
- Introduction of maternity safeguarding dashboard
- Establishment of FGM clinic
- Introduction of FGM training in maternity monthly mandatory training
- Presentation of maternity safeguarding activities to the Trust board with a service user.
- Strong collaborative working with local mother & baby unit

- Involvement in teaching safeguarding at the local university.
- 6 monthly rotation of clinical midwives into the Lavender team
- Presentation of safeguarding activities at all women services governance forum such as Clinical governance and case presentation at prenatal mortality meetings.
- Better support for pregnant asylum seekers such as fund raising/baby care project

Future priorities for the period May 2017 – April 2018

- Achieve and maintain 95% compliance for all levels of Safeguarding training
- Achieve compliance with CCG target for Prevent training (awareness and Healthwrap).
- Ensure Lampard recommendations are part of the Trusts core business.
- Continue to raise awareness of child sexual exploitation (CSE).
- Evaluate the impact of safeguarding adult training.
- Continue work with Trust Informatics to secure information sharing systems to support transfer of patient identifiable information with partner agencies.
- Ensure Trust participation in the LeDeR project.
- Continue work around 'Think Family' to improve outcomes for children.
- Embed 'making safeguarding personal' in adult services.
- Develop safeguarding adult supervision for key clinicians across the Trust.
- Raise awareness of safeguarding issues for 16 and 17yr olds who are seen in adult areas across the Trust.
- Continue to ensure that Level 3 safeguarding training is delivered to key staff groups across the Trust.
- Development of safeguarding adults' dashboard in conjunction with datix to enable identification of themes of referrals.
- Carry out scoping exercise to identify the training needs in the Trust relating to domestic abuse
- In maternity case loading of socially complex women in line with the recommendations in the better births document
- Introduction of time-alone with midwife for private disclosure of abuse
- Introduction of black dots for disclosure of abuse
- Strengthened communication with local GPs
- Involvement in the phase 2 perinatal mental health bids

CONTENTS

1. Introduction

Safeguarding is a fundamental component of all care provided within the Trust. West Herts Hospitals NHS Trust understands and acknowledges that safeguarding children and adults is everyone's responsibility and we all have a duty to protect our patients from abuse and harm. The purpose of this report is to provide an overview of safeguarding activity across the Trust for the year (May 2016 – April 2017). The report aims to provide evidence and assurance that the Trust is effectively safeguarding children and adults who are at risk and meeting its statutory responsibilities in relation to safeguarding. Safeguarding work across the Trust is led by the named safeguarding teams. The teams are supported by the divisions within the Trust through membership of the Safeguarding Panel, which is chaired by the Chief Nurse who is Executive Lead for safeguarding.

2. Background

At a time of ongoing change and financial constraint in the NHS, the need to safeguard those who are most vulnerable in our society has never been so visible and tangible. Throughout 2016/17 there have been high profile media cases of celebrities who have abused vulnerable children and adults, the radicalisation of young people in our society leading to extremist views and acts, evidence of slavery within our communities and a significant increase in allegations and prosecutions of abuse and neglect against those working in public and professional bodies. This has led to greater scrutiny of organisations safeguarding responsibilities.

All health providers are required to have effective arrangements in place to safeguard vulnerable individuals and to assure themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse a Named Midwife and a Named lead for MCA/DoLS.

The requirement of Acute Trusts to safeguard and promote the welfare of children as set out in section 11 of the Children Act 2004 and Working Together (2015) are monitored by the Care Quality Commission (CQC) NHS England and the Clinical Commissioning Groups (CCG).

Ultimately the Trust Board requires assurance that the organisation is fulfilling its obligations to make arrangements to safeguard and promote the welfare of children and vulnerable adults. The Trust remains compliant with Section 11 of the Children Act. The Trust is committed to developing a joined up approach to safeguarding all our patients whatever their age. The Adult safeguarding assurance visit took place in May 2017.

All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported.

In April 2015 the Care Quality Commission changed their regulation framework. Two regulations are now specific to safeguarding within the Trust:

Regulation 12: Safe Care and Treatment.
Regulation 13: Safeguarding service users from abuse and improper treatment

3. Safeguarding work plan

The Safeguarding work plan underpins and leads the safeguarding activity across the Trust. The plan was developed at the beginning of 2016. The format allows for a monthly review of all objectives. The review process is RAG rated so progress across the year is clearly visible. Actions from audits and external reviews and inspections are added to the plan and progress against these actions is reviewed monthly. The work plan is overseen, monitored and reviewed by the Safeguarding Panel. Appendix 1 is a copy of the completed work plan for 2016 / 2017.

Key Achievement - Annual work plan completed with high percentage of actions achieved.

4. Overview of progress made relating to national Safeguarding Policy/Legislation 2016 – 2017

4.1 Independent Inquiry into Child Sexual Abuse

The Inquiry initially chaired by Justice Goddard and latterly Professor Jay, commenced in April 2015. The Inquiry aims to examine child sexual abuse across all institutions and organisations, exposing past failures, systemic failures, confront those responsible, and provide support to victims and survivors and to make recommendations that will help to prevent the sexual exploitation of children in the future.

A letter was sent by Justice Goddard in the summer of 2015 to all Trust CEO's via NHS England specifically stating that no lines of investigation should be curtailed by the premature destruction of files or records. She requested CEO's take a proactive stance toward the Inquiry and to review safeguarding policies to ensure they are consistent with best practice. Since the commencement of the Inquiry we have:

- Presented a report and gap analysis to Safeguarding panel specifically around files and records that may be of relevance to the Inquiry. At this time a decision was made by the Panel to cease the destruction of records in the Trust awaiting further advice from NHS England.
- Completed a check list provided by the Designated Office in the CCG to ensure that as a Trust we are prepared should the Inquiry contact the Trust. This completed checklist was presented to Safeguarding Panel in June 2016.
- At the Safeguarding Panel in June 2016, a further review of the decision to cease destruction of records was made. NHS England will be sending out further guidance based on risk assessment once approved by the Inquiry. Trust to await further guidance.
- Taken a briefing to the Trust Executive Committee (TEC) in November 2016 looking at the implications to the Trust of non-destruction of records – financial costs and legal implications

- Presented a further update to Safeguarding Panel in February 2017 looking at progress of the Inquiry. During the reporting period, there have been no requests for information by the Inquiry to the Trust.

4.2 Trust Action Plan for the Recommendations made in the Lampard Report

The Lampard Report (2015) looked at themes and made recommendations for NHS providers following the offences carried out within the NHS by Jimmy Saville. The Named Safeguarding Nurses developed a Trust action plan including all the recommendations made by Lampard. Work to complete the action plan has been monitored by the Safeguarding Panel. This has included;

- ensuring all volunteers within the Trust have safeguarding awareness training
- all volunteers have DBS check prior to commencement
- a Volunteer Manager is in place who is a member of the National Association of Volunteer Managers
- the Trust has a VIP policy in place with awareness of this policy among relevant staff
- consideration given at Trust board regarding frequency of DBS checks
- Policy for staff internet usage in place and safety issues around guest Wi-Fi reviewed
- An audit to ensure that agency/contracted staff (Medirest and NHSP) have safe recruitment practices in place in line with Trust policy

During the reporting period, the completed action plan was reviewed at Safeguarding Panel, completed and closed. The Lampard recommendations need to be part of core Trust business. Work and actions have been included in the safeguarding work plan for 2017 – 2018 to provide assurance that this is the case.

Key achievement Trusts Lampard action plan fully completed and closed
Monitoring will continue via safeguarding work plan

4.3 LeDeR Mortality Review

The confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) reported that for every 1 person in the general population that dies three people with learning disabilities will do so. One of the CIPOLD recommendations was that there would be greater scrutiny of deaths of people with learning disabilities.

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. Work on the LeDeR programme commenced in June 2015 for an initial three-year period. The remit of the programme is to support local areas to review the deaths of people with learning disabilities from the age of 4 years. The programme will collate information, review documents so that common themes, learning points and recommendations can be made and taken forward into policy and practice improvements.

Local reviewers will be looking at the deaths, regardless of whether the death was expected or not, the cause of death or the place of death. This will enable them to identify good practice and what has worked well, as well as where improvements to the provision of care could be made. There is currently no fixed date arranged for when this will commence. The programme is in the process of establishing review teams, implementation and strategic oversight groups.

NHS Trusts will be expected to demonstrate their participation by:-

- Having internal systems in place that flags the need for a review when a patient with learning disabilities dies. This has been completed. All patient that are known to have a learning disability have been identified on the Trust PAS system
- Notifying deaths of people with learning disabilities to the LeDeR programme.
- Contributing to the reviews of deaths of people with learning disabilities. The Trust has identified two key individual to attend training as part of this programme to become reviewers. The Named nurse for safeguarding adults is a member of the oversight group which will review themes and recommendations from reviews.
- Having a process in place through which to implement and monitor progress against local action plans. This will be completed via the learning disability sub group, which is chaired by the named nurse and the safeguarding panel.

Progress in WHHT during reporting period

- The special register has been updated to allow all patient with LD to be "flagged" on hospital systems
- 2 members of staff have been nominated to become reviewers for the programme and they have attended initial training programmes
- Participation and general awareness raising has been undertaken via e-update and LD sub group
- Named nurse safeguarding adults has joined in the LeDeR steering group

4.4 Law commission review of Deprivation of Liberty Safeguards - DoLS

The DoLS have been under heavy criticism since they were introduced for being overly complex. The House of Lords select committee made a recommendation in March 2014, that the current Deprivation of Liberty Safeguards were "not fit for purpose" and that stated that a review was required. The Law Commission was asked to review this recommendation. Following a consultation, a report was published on 13th March 2017 detailing its findings, along with draft legislation to replace the entire Deprivation of Liberties framework. This is currently awaiting parliamentary approval.

The Law commissions' replacement scheme is called the Liberty Protection Safeguard (LPS). The new scheme will ensue that the safeguards are not limited to specific forms of accommodation or residence; they could be used for any setting including shared living. Under LPS authorisations would be given to authorise the arrangements for the persons care rather than just the Deprivation of Liberty.

Currently DoLS only applies to those over the age of 18 and so for those younger applications are made to the Court of Protection. It has been established that this is costly and so the age limit will be reduced to 16 years
The Supervisory body will be replaced with a "responsible body" that will create stronger links between the commissioning of the arrangements and the consideration of whether deprivation of liberty is justified.

5. Safeguarding Leadership and Accountability

The Chief Nurse is the Trust Executive Lead with responsibility for safeguarding within the Trust. She takes responsibility for governance, systems and maintaining organisational focus

on safeguarding. Appendix 2 shows the current reporting structure and accountability for the safeguarding team.

The Safeguarding Panel is chaired by the Chief Nurse and meets bi monthly. The panel oversees all safeguarding work across the Trust. The panel is attended by the safeguarding team, Divisional Head Nurses/Midwifery and members of the designated teams within the CCG. The panel reports safeguarding activity and provides assurance to the Quality and Safety Group within the Trust.

During the reporting year, there has been continuity within the Named Nurse posts for both children and adults. The Trust has an experienced Named Doctor for children. During the reporting period, a new Named Doctor for adults was appointed; he is also the Medical lead for learning disabilities. The post holder works collaboratively with the Lead Nurse and provides medical advice when required for adult safeguarding cases.

The Named Professionals have a key role in promoting good professional practice within the Trust providing advice and expertise for fellow professionals and undertake duties to safeguard children and adults in line with guidance and legislation (Working Together 2015 and the Care Act 2014).

The job descriptions and personal specifications for the Named professionals for children are complete and are aligned to the Intercollegiate Document (2014).

The Named professionals have a key role in ensuring a safeguarding training strategy is in place and is delivered across the organisation. They also lead on the safeguarding audit strategy, carrying out regular audits looking at process and outcomes. These audits are presented and action plans monitored at safeguarding panel.

6. Inspections and reviews

6.1 CQC inspection in Sept 2016

The CQC report published in March 2017 highlighted the following for safeguarding

- Overall, staff felt confident reporting safeguarding concerns.
- Policies and procedures for safeguarding were in place and were updated to reflect changes in national guidance and legislation
- Staff were able to tell the CQC how they would report concerns through Trust procedures and who they should contact. There were effective safeguarding procedures in place for both adults and children
- There was evidence of strong links with the adult and children safeguarding boards and this was reflected in the Trust annual report
- The bi annual safeguarding newsletter distributed to all staff was noted

Children

- There was a clear structure in place for safeguarding children responsibilities within the Trust.
- The positive use of the safeguarding children's alert process (CP-IS) by the children's emergency department was noted. The staff had raised concerns for a child with an injury of unknown origin and took appropriate steps to escalate this. Staff kept the child safe in the department until children's social services arrived to review the patient.

- It was noted that staff in the children's department were knowledgeable about female genital mutilation (FGM) and information was displayed in the staff areas on the identification of this, and how to report it.
- It was noted that the safeguarding team were able to access the computerised community records of children in their care via a community based electronic records system. The record detailed some GP visits and interactions with health visitors, occupational therapists, children's community nursing, speech and language therapists and physiotherapists (System One).
- It was noted that the Trust's safeguarding children handbook (3rd Edition) had been fully updated with new information – child sexual exploitation (CSE), mandatory duty to report FGM and prevent. The handbook provided information and support to staff to use in the assessment and decision making process when they had safeguarding concerns about a child.
- It was noted that the Trust had a sexual health pro forma which was used to assist in assessing young people attending with concerns about risky sexual behaviours and to assist in identifying potential CSE.
- It was noted that staff working in both the paediatric and neonatal departments were issued with a safeguarding passport booklet that was completed with all safeguarding training and supervision sessions that they had attended. The passport also contained relevant information about female genital mutilation and child sexual exploitation. It also explained how to make referrals. This was a valuable record and supported staff with their personal revalidation.
- It was noted that several safeguarding ward rounds took place. These included a psychosocial ward round every Friday. This was a multi-agency meeting attended by hospital staff, child and adolescent mental health services and the crisis assessment and treatment team.
- There was evidence of an appropriate safeguarding supervision programme in maternity and paediatrics

However

- The Trust must ensure that all staff caring for patients less than 18 years of age have completed safeguarding Level 3 training. It was noted that there were areas within the Trust that saw patients aged 16 – 18 years that did not have training to Level 3 – this was particularly highlighted in surgical areas.
- It was noted that there was a discrepancy in the compliance figure for Level 3 for the doctors in the emergency department and what was reported by staff – 2 senior clinicians who were in charge of a shift reporting that they had not had training.

Adults

- Overall, staff stated that they felt confident reporting safeguarding concerns and were given support with this.
- Policies and procedures were in place and were updated to reflect changes in national guidance
- Staff were able to inform the CQC of how to report a safeguarding concern and knew who to contact
- It was noted that the safeguarding team has strong links with Safeguarding boards
- Overall compliance with safeguarding training met the Trust threshold of 90%
- It was noted that the Trust had a named lead nurse to support patients and offer advice to staff with regards to Learning disabilities
- The "This is me" document was in use across all areas
- Two wards have commenced working towards the purple star award.

However

- It was noted that not all patients had their mental capacity assessed in accordance with the requirements of the Mental Capacity Act, 2005.
- It was noted that there were not appropriate systems in place to track the patients and the expiry of those being treated under a Deprivation of Liberty Safeguards.
- Staff completing "do not attempt cardio-pulmonary resuscitation forms where a person lacks capacity to make an informed decision or give consent, act in accordance with the requirements of the Mental Capacity Act, 2005.
- The Trust did not have a system to capture information on the number of patients with Learning Disabilities, so were unable to comment on how many patients with Learning Disabilities were inpatients at any one time.

Progress

- All identified issues in both adults and children have been included in the Safeguarding Quality Improvement Plan which has been completed.
- Additional training has been provided by the named consultant for adult Safeguarding for medical staff across all divisions. These sessions have included "Grand Round", clinical Governance session and individual session. Additional training has been provided to clinical "hot spots" by the named nurse for safeguarding adults. Hertfordshire wide MCA & DoLS competencies have been introduced into key clinical area and progress has been monitored via the Quality Improvement Plan
- A process to track patients under a DoLS and the expiry dates of the authorisations has been created. A spreadsheet is shared via e mail on a weekly basis with the matrons and heads of nursing. The supervisory body are informed of when a patient is transferred, discharged or no longer required a DoLS
- The Resuscitation Panel have reviewed and decided to change the DNACPR form. The replacement will have the MCA section printed on it. The Trust plans to introduce these as a priority.
- Information regarding registered LD patients has been provided by the strategic lead nurse for Learning Disabilities. This information has been updated onto the Trust PAS system to enable this information to be obtained via the special register on I-Reporter.
- An update on the review of safeguarding children Level 3 training is included in the training section 7.9.
- 4 clinical areas are working towards the purple star award for people with Learning disabilities
- Additional training for level 2 safeguarding children covering issues relevant to 16-17 year olds (Mental health issues, child sexual exploitation) has been delivered to senior nurses within the Trust
- Training delivered at level 3 covering practical management of safeguarding children issues in an emergency department delivered to A&E consultants and registrars.

6.2 Arrangements to Safeguard Children under Section 11 of the Children Act 2004

A Section 11 audit visit was carried out in February 2017 to the Trust to ensure compliance with our responsibilities under the Children's Act to safeguard children. The visit was carried out by the Chief Nurse in the CCG, and the Designated and Deputy Designated Nurses for Safeguarding Children. An audit tool was used that looked at 8 key standards for safeguarding. The tool looked at evidence as to how the trust had met elements of the standard and evidence to show improved outcomes. The tool was completed by the Named Nurse and covered all safeguarding children activity within the Trust.

The letter following the visit received from the CCG highlighted that overall safeguarding children practices were good. It was highlighted that some additional input is required from maternity services in particular availability and visibility of the safeguarding midwife at external meetings and maternity safeguarding audits.

A number of notable practices were highlighted

- Divisional managers responsibility for safeguarding within their divisions evidenced through attendance at Safeguarding Panel
- Good supervision practices with high compliance
- Monthly Quality and Safety meetings held in maternity department
- High compliance with Level 3 training and specific safeguarding teaching to the Trust Board delivered
- Safeguarding training passport presented at a regional conference
- Safeguarding Children Handbook
- Implementation of CP-IS within out patients
- Think Family Audit led to changes to documentation in Emergency Department, to provide prompts that alert staff to potential caring issues for children
- Schwartz rounds – safeguarding round
- Safety Huddles include sharing relevant safeguarding information throughout the shift

Recommendations from the audit were:

- To ensure that safeguarding children is understood by all staff caring for adults, evidenced through referrals made to Children's Services / contact with safeguarding children team / information sharing about vulnerability of care givers
  Progress Following a Think Family Audit carried out by the CCG on adult attendances into unscheduled care, the ED documentation was updated to include more specific questions about risks to dependent children. The safeguarding children nurses review records of concerning adult presentations the next working day to ensure any risks to dependent children have been recognised by the staff and to ensure relevant referrals are made. The Trust continues to make high numbers of referrals for adult attendances particularly from unscheduled care.
- Audit Plan for 17/18 to be shared with HVCCG
  Progress Audit plan has been for 2017 – 2019 has been written and will be presented to Safeguarding Panel in June 2017 for review and agreement
- Revised and updated Safeguarding Children Policy to be shared with HVCCG
  Progress Safeguarding Children Policy has been updated, ratified and shared with the Designated Team in the CCG
- Ensure LADO process is disseminated throughout Trust
  Progress Information regarding the LADO process will be included in the Safeguarding Newsletter June 2017. The Named Nurses meet monthly with a member of the HR team to discuss any relevant cases and share appropriate information.
- Trust to work with HCT to find a way to facilitate the sharing of information about vulnerable families
  Progress- following the withdrawal of the paediatric liaison service there has been regular meetings with HCT staff to look at all available options for sharing information about paediatric attendances between the two Trusts. IT options have been developed to share paediatric attendances to unscheduled care by way of a weekly

data upload. The Trust has developed an electronic Health Visitor referral system and also an electronic system to notify Health Visitors about admissions to SCBU. Plans have been shared with the Designated Team in the CCG.

- Trust to ensure maternity safeguarding activity is included in self – assessment
  Progress Maternity safeguarding activity has now been included in the self-assessment tool.
- Maternity staff to increase system wide involvement in safeguarding, particularly in relation to FGM.
  Progress Maternity safeguarding team (Lavender Team) have now increased their involvement maternity systems.

A 'Think Family' audit was carried by the Designated Safeguarding team during the reporting year. Seventeen records were randomly selected for adults who had attended the emergency department at Watford. Overall, staff had recognised concerning attendances that impact on dependent children with Children's Services referrals made where appropriate. Staff had not recognised as well, concerns at an early help stage which could have warranted a referral to the paediatric liaison service. Following the audit, the emergency department record has been update to include more specific questions about risks to dependent children and updating the safeguarding box. Completion of the new records will be audited as part of the Trust safeguarding record keeping audit. Following the cessation of the paediatric liaison service, information regarding attendances that might require early help services will be forwarded to the GP via the discharge summary.

Key Achievement Positive Section 11 Audit visit – overall safeguarding children practices were good and several areas of good practice recognised

6.3 Safeguarding Adult Assurance Visit

The adult assurance visit was postponed and has been rescheduled to take place in May 17. Following a written response from this visit, any action or recommendations will be added to the safeguarding work plan and presented to the safeguarding panel

7. Safeguarding Children

7.1 Safeguarding children activity

Safeguarding children work can be divided into 3 areas within the Trust

- Acute paediatrics including emergency care, inpatient care, day patients and paediatric out patients. This would also include children seen in Urgent Care and Minor Injuries and in other departments within the Trust
- Maternity services including inpatient services and community midwives
- Adult services - where concerns are raised about an adult's attendance and the impact of that presentation on a dependent child. The majority of this activity takes place within the Trusts unscheduled care settings but is applicable to all adult areas of the hospital.

7.2 Service developments within safeguarding children

Developments to improve safeguarding children practices across the Trust over the reporting period include the following

Information Sharing Form

- An information sharing form has been developed in agreement with Children's Services to assist staff to share information on children who attend the Trust but do not meet threshold for a safeguarding referral. These include children who have a child protection plan in place (CPPIP), children who are looked after (LAC), children who are known to Children's services and children who are home educated.

CP – IS introduced in paediatric out patients

- The child protection information system that has previously been used in unscheduled care has been introduced in paediatric out patients. CP- IS is checked for all children on the clinic lists – this enables staff to identify vulnerable children who are attending appointments. The information is available to the practitioner who is seeing the child to consider as part of their assessments. It also allows the clinic staff to share information with Children's Services and identifies vulnerable children who are not brought to appointments. The Named Nurse is also

Safeguarding on infoflex medical discharge summary

- An infoflex discharge summary for the GP is completed for all children admitted to the unit. Work with the infoflex team has allowed a safeguarding box to be included on the summary that must be completed to allow completion on the summary. If safeguarding concerns have been identified on admission, they are recorded on the summary and contact details of the safeguarding team are included. The safeguarding box has been included on all discharge summaries for children and young people under 18. If the safeguarding box is completed then a copy of the summary is sent electronically to the safeguarding team for review.

Interim medical report

- An interim medical report has been developed to use by the paediatric consultants and registrars following a child protection medical. The report allows immediate medical opinion (pending any results) to be shared with Children's Services and the police to allow them to make timely decisions about protecting the child or associated siblings. The full medical report is then completed and submitted 72 hours following the medical.

Emergency Department records update to include 'think family'

- The emergency department record has been updated to include more specific questions about risks to dependent children – on triage notes 'are there any risks to dependent children?' The safeguarding box has been updated to include information about dependent children and 16 and 17yr olds who are seen in adult ED.

Safeguarding Newsletter

- The newsletter has been produced bi annually and is distributed to all Trust staff electronically, with some hard copies available in clinical areas. The newsletter contains information about the safeguarding team with photographs and contact numbers as well as articles about safeguarding issues and current concerns.

Key Achievements

- Information Sharing form introduced to improve communication with Children's Services about vulnerable children
- CP-IS introduced in paediatric out patients

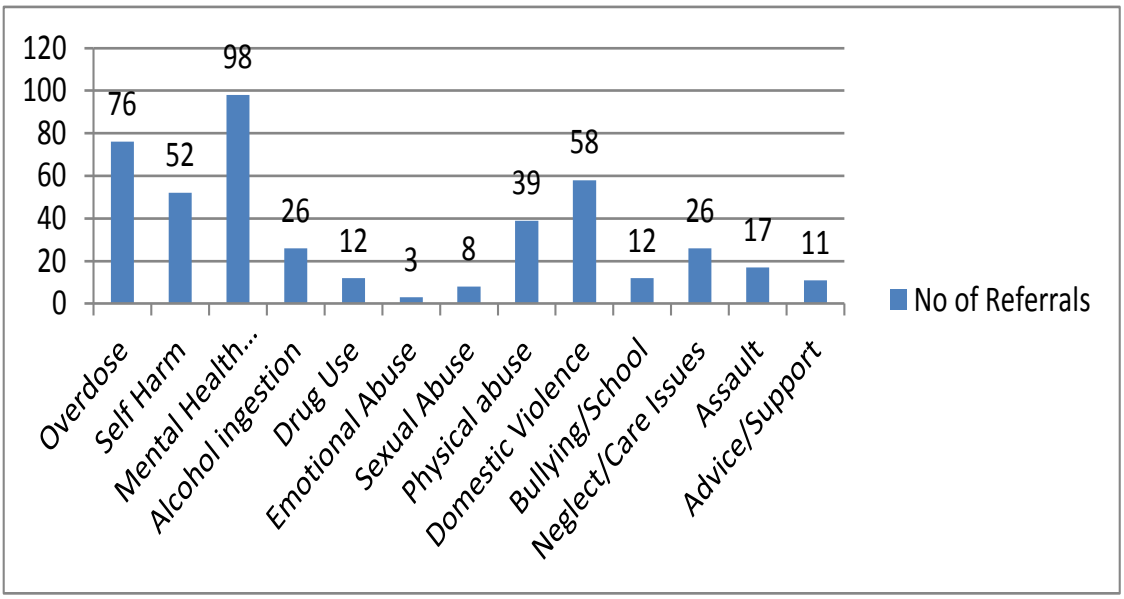
- Infoflex discharge summaries improved to include better safeguarding information and emergency department records improved to encourage staff to 'think family'
- Interim medical report developed to give more timely medical opinion following child protection medicals

7.3 Referrals to Children's Services

Referrals to Children's Services from across the Trust for children under 18 and include;

- Child protection concerns – these include children attending with for example, possible non accidental injury, mental health issues or neglect issues. It also includes referrals done regarding attendance of adults who are parents. These referrals are done predominantly by unscheduled care staff and include attendances for domestic abuse, drug and alcohol issues and mental ill health.
- Information sharing referrals – these are done for children who attend our services who are known to Children's Services e.g. child protection plan in place, looked after children.

Identifying and referring vulnerable children and families is a key role of all Trust staff in all areas of the hospital. There continues to be high numbers of referrals for parental attendances to the Trust due to concerns about the impact of the parental behaviour on the child. The majority of these referrals are made from unscheduled care although referrals are also received from other areas of the hospital such as ITU, AAU and the wards.



Graph 1 Total Number of Child Protection Referrals made for children less than 18yrs made by WHHT staff from May 2016 – April 2107

The number of referrals for children under 18 where there are child protection concerns is down from the previous reporting year

- 2015 / 2016 - 486 referrals
- 2016 / 2017 – 438 referrals
-

Although a fall, this does not indicate referrals that have been missed. The safety net in unscheduled care involves checking records for every paediatric attendance by the

safeguarding children nurses. This enables safeguarding decisions made by clinical staff to be reviewed and any appropriate referrals made. The lower number of referrals could be due to the demographic of attendances over the reporting period and could also indicate that staff are making more appropriate referrals in line with Hertfordshire Safeguarding Children Board's meeting the needs document.

The table below looks at trends of referrals and there has been a further fall in referrals made for young people attending with overdoses and self-harm. The number of referrals made for children attending with mental health issue has increased. Often young people attend with a combination of presentations such as mental health issues and self-harm – depending on how the referral is recorded will reflect in the final statistics. An audit carried out in the reporting year of 25 young people attending unscheduled care with mental health issues, showed that an appropriate referral to Children's Services had been completed in 100% of cases.

There has been an upward trend in referrals made for children living in a house where there is domestic violence. This has increased steadily over the previous 5 years. This is likely to be due to the increased awareness and teaching done across the Trust around domestic abuse and also the current high visibility of the Trust Independent Domestic Violence Advisor (IDVA).

There has also been a significant rise in referrals made for suspected physical abuse and a small rise in children attending where sexual abuse is suspected. Two of these referrals were for young people where there were concerns about possible child sexual exploitation. Both of these children lived outside of Hertfordshire.

During the reporting period – 48 child protection medicals were carried out by Consultant Paediatrician/ Registrars. The medicals were all done due to concerns about physical abuse.

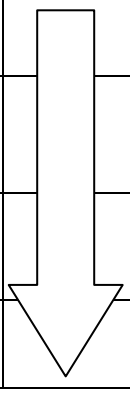
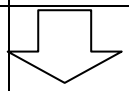
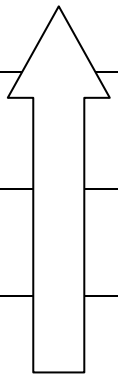
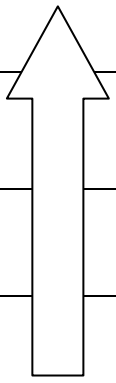
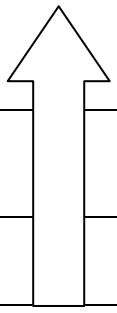
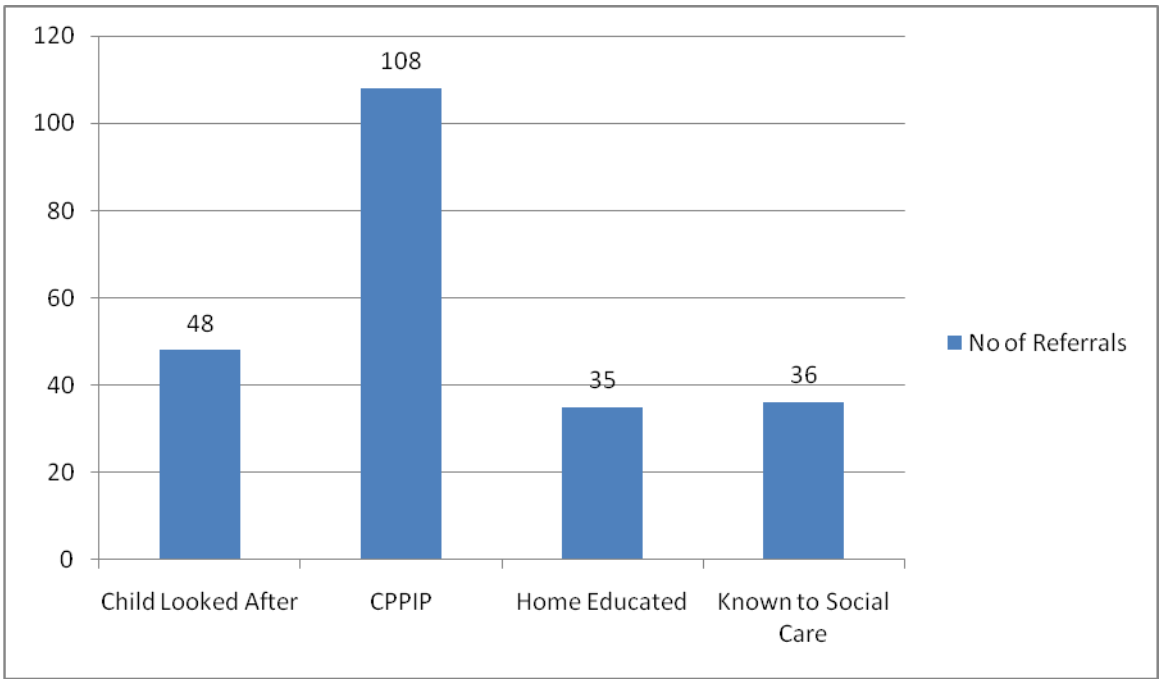
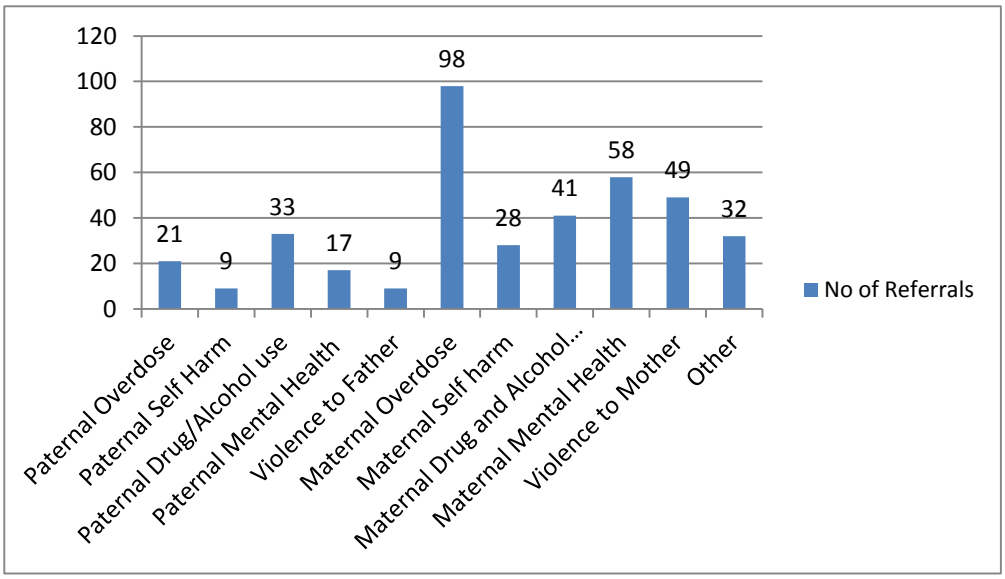
Period	Self-Harm	Trend	OD	Trend	Physical abuse	Trend	Domestic violence	Trend
2016 - 17	52		78		39		58	
2015 – 16	75		115		21		56	
2014 - 15	121		107		21		42	
2013 - 14	130		47		18		35	

Table 1 Trends of referrals of vulnerable children to Children's Services over preceding reporting years



Graph 2 Total Number of Information Sharing referrals made for children less than 18yrs made by WHHT staff from May 2016 – April 2017

Information sharing referrals on children under 18 remain high but are significantly lower than in previous years. This is particularly the case for children who have been seen who have a child protection plan in place and also for children who are looked after. This is despite the Trust introducing new information sharing forms and introducing CP-IS into paediatric out patients to identify children who would fall into these categories. Again though, the figures do not indicate vulnerable children are being missed but reflect the current situation in Hertfordshire, with very low numbers of children having plans in place. In March 2014, 1140 children in Hertfordshire had a child protection plan in place. In March 2017, this figure had reduced to 520, the lowest it has been for a long period of time.



Graph 3 Total Number of Child Protection Referrals made for adult attendances by WHHT staff from May 2016 – April 2017

Referrals made about adult concerns (when the parent/guardian is the patient) are predominantly done by unscheduled care. The table below looks at trends of referrals over

the last 4 years. Numbers of referrals made are fairly similar year on year. The number of referrals done for paternal attendances remains the same – 89 this reporting period compared to 92 in 2015/2016. There has been a fall in referrals for violence to fathers this period but there has been a rise in violence to mothers and an overall rise in referrals for children living in houses where there is domestic abuse. The number of referrals for maternal attendances remains high especially for all mental health presentations. There have been small increases in referrals for maternal overdoses and self-harm.

Period	Father overdose	Trend	Father self harm	Trend	Violence to father	Trend	Father mental health	Trend
2016 - 17	21		9		9		17	
2015 -16	25		9		16		16	
2014 – 15	31		7		7		15	
2013 - 14	32		1		10		15	
	Mother overdose	Trend	Mother self harm	Trend	Violence to mother	Trend	Mother mental health	Trend
2016 - 17	98		28		49		58	
2015 -16	96		27		39		86	
2014 - 15	120		31		56		84	
2013 - 14	122		58		74		88	

Table 2 Trends of referrals to Children's Services over preceding years for adult attendances

Work needs to continue across the Trust about 'Think Family' and that safeguarding children is everyone's responsibility. This will ensure that all areas of the Trust are able to recognise concerns about vulnerable children from adult attendances and make referrals appropriately.

The majority of referrals made by staff to Children's Services continue to be faxed due to the issues of sending e mails with patient details via WHHT accounts. Staff who have access to NHS.net accounts are able to send referrals safely due to the safe link with Children' Services e-mail accounts. During the reporting period, work has been ongoing to develop software to enable Trust staff to send referrals safely from the intranet site. This work is ongoing with initial attempts not being successful.

7.4 Multi agency working

The Trust ensures that inter-agency working is encouraged and supported. There are currently three ward rounds that run across the Trust weekly that look specifically at vulnerable children and safeguarding issues.

- Starfish psychosocial ward round every Friday is a multi-agency meeting attended by hospital staff and occasionally CCATT (CAMHS Crisis Assessment and Treatment Team). During the reporting year, there has been regular attendance by a social worker from the Watford assessment team, Children's Services. This has been valuable for staff for advice and updates on cases and allows staff to discuss if cases reach thresholds for Children's Services involvement. The meeting reviews all children who have been admitted to the ward over the preceding week. Staff are also able to bring cases of concern to be discussed. The meeting is chaired by the safeguarding team and remains well attended.

- SCBU psychosocial ward round every Tuesday is a multi-disciplinary meeting attended by SCBU staff and the safeguarding team. Cases on the unit are discussed, with plans and actions clearly defined.

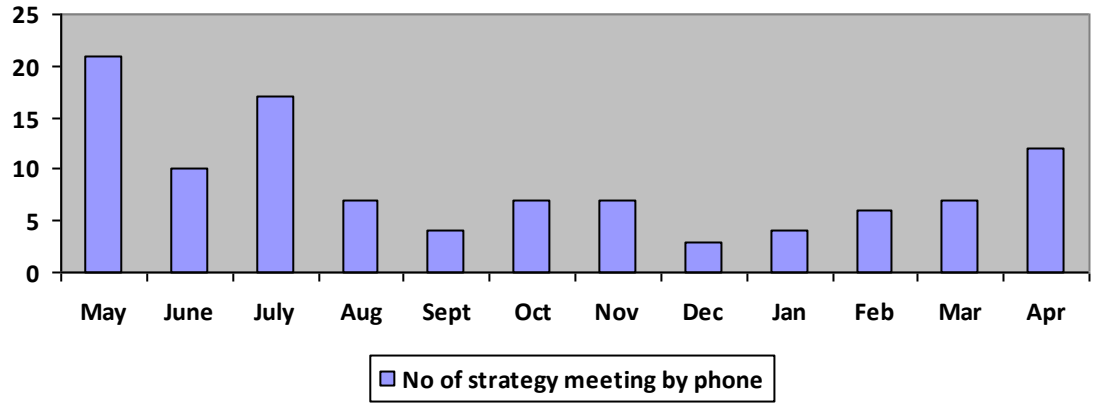
- CED/ED child protection meeting every Wednesday is a multi-disciplinary meeting that reviews all referrals made to Children Services the proceeding week. The review process ensures that all referrals are dealt with appropriately, with information shared effectively to protect children.

Other areas of multi-agency working include;

- The CED manager has been a key member of the multi-agency Rapid Response operational group.
- The Named Doctor attends a 'Not at school/chronic fatigue' meeting held once a term with CAMHS and education.
- Regular attendance at MARAC (multi agency risk assessment committee) for high risk domestic abuse cases (see section 8.16.1)

Inter-agency involvement in ward rounds leads to better information sharing, reflection, learning and understanding of others roles and helps staff make decisions about thresholds for referral.

The safeguarding team continue to contribute regularly to section 47 strategy telephone conference calls. These calls involve police, Children's Services and health and are for information sharing and to assess a current risk to a child. Further action is then decided. The majority of the telephone strategy's that the Trust contributes to involve unborn babies as part of the HSCB pre-birth protocol.



Graph 4 – Number of Section 47 strategy conference calls contributed to by Trust Safeguarding Team

7.5 Safeguarding work within unscheduled care

The safeguarding nurses continue to support staff working within unscheduled care. A safeguarding nurse reviews the records of all children attending CED on the next working day to ensure all safeguarding policies were followed and staff acted appropriately. All referrals made to Children's Services are also reviewed daily in case of any urgent action or further information sharing needed. There is also a review system in place of notes of adults who have attended with concerning presentations who may have dependent children. Consideration is then made about the risks to any children and a referral made if appropriate.

A review process also exists weekly within the Hemel Urgent Care Centre.

CP-IS (child protection information sharing system) has been in place in unscheduled care for some time. It is checked for every child who attends and ensures that we are aware of children who are vulnerable (with protection plans in place or who are looked after) to assist in the assessment process. Although, the national roll out of CP-IS has been slower than expected, many of our local authorities are now live, which helps us recognise vulnerable children who attend who are out of area.

The safeguarding nurses are also able to access System One (read only) – this record system contains health visitor, school nurse, community nurses and some GP records. It is invaluable for gathering information when a child with a concern is in CED. This access is only currently available, when a safeguarding nurse is on duty. Discussions have taken place with the System One team in Herts Community Trust at potentially allowing access to senior staff in CED e.g. shift leaders

Over the reporting year, a decision has been made by to decommission the paediatric liaison service. Currently HCT are continuing to provide a service until IT options have been developed and tested. Work is ongoing with HCT to look at alternative ways to share information about paediatric attendances into unscheduled care. IT options have been developed to share paediatric attendances to unscheduled care by way of a weekly data upload. The Trust has developed an electronic Health Visitor referral system and also an electronic system to notify Health Visitors about admissions to SCBU.

7.6 Safeguarding Children Audits

During the reporting period, the Safeguarding Audit Strategy 2015 – 2017 has been in place and has given a robust framework for safeguarding audits to be carried out to provide evidence and assurance of procedures and practice around safeguarding children.

The following audits have been carried out during the reporting period:

7.61 Dip sample audit carried out for each Safeguarding Panel.

Outcome A dip sample audit is carried out on a set of records selected from across paediatrics/neonates/unscheduled care that involved a safeguarding children case. These were presented and reviewed at Safeguarding Panel and any issues or areas of good practice are fed back to the clinical area. Overall, the findings of the audits demonstrate a good standard of safeguarding practice and documentation in key areas of the Trust.

7.62 Audit to examine referrals made and documentation of under 18's attending A & E with mental health issues.

Outcome The audit was carried out in April 2016 on 25 records of young people attending CED and A & E with mental health issues including overdose and self harm. The results of the audit showed good practice in key areas. All the cases audited had appropriate referrals to the mental health team and Children's services. They all had a mental health assessment before they left hospital with a clear plan documented in the notes.

7.63 Audit to show evidence of leaning around Female Genital Mutilation (FGM) within the paediatric division.

Outcome The audit was carried out in July 2016 to examine paediatric staff knowledge around FGM specifically the mandatory reporting duty introduced in October 2015, following training and awareness raising by the Safeguarding Team. A brief questionnaire was given to 20 paediatric staff (nurses and doctors) followed by a discussion with the Named Nurse. Overall there was evidence of good knowledge about dealing with cases of FGM within paediatrics, safeguarding issues and the legal requirements that staff need to follow. Ongoing work will continue around training and education.

7.64 Audit of the Trusts Celebrities/VIP Visitors Access Policy.

Outcome An audit was carried out on staff awareness and adherence to the Trust VIP policy during September 2016. A celebrity visit to Starfish ward was audited against key requirements in the policy. Overall, staff on Starfish ward followed the policy well, adhering to all the requirements to ensure that children were kept safe during the visit. The Trust Communications team lead on the Policy and awareness raining has taken place for all new members of this team. Awareness raising of the policy for all staff will take place in the coming weeks via e update.

7.65 Audit of safeguarding children record keeping

Outcome An audit was carried out looking at 80 clinical records across key clinical areas (inpatient and unscheduled care). Overall, it demonstrated a very good standard of record keeping within safeguarding. CPPIP status was recorded in 78 records. There were good improvements in recording of key information e.g. parental responsibility and whether safeguarding has been considered in HUCC. There were clinical areas highlighted in the audit that require some improvement. Safari Day Unit needs to improve specific areas and signing the safeguarding box and full completion of the head injury proforma needs to improve in CED records.

7.66 Audit of the procedure for children not brought to appointments with safeguarding concerns

Outcome An audit was carried out to provide evidence and assurance that children who are not brought to appointments where there are safeguarding concerns are recognised and followed up appropriately. A selection of 30 records of children who had an appointment in paediatric outpatients were audited. Records were audited to ensure that they had all been checked against the CPPIP list and that this had been recorded in the records. The results showed 100% compliance with checking and for those children with CPPIP, an information sharing referral was completed in 100% of

cases. 20 discharge letters were reviewed for children who had not attended appointments, with all safeguarding issues raised appropriately. The results showed that the process for missed appointments appears to be adhered to and safeguarding concerns are recognised and followed up for children not brought to an appointment. Recommendations to further improve practice was to introduce the checking of CP-IS by nurses and HCAs for all clinic lists and to introduce an Information Sharing form to improve communication with Children's Services.

7.67 Audit /Survey to review the quality and impact of safeguarding supervision within paediatrics

Outcome An audit and survey were carried out to assess the impact and quality of safeguarding supervision. 30 paediatric and neonatal nurses completed a survey regarding supervision and the safeguarding passport. The results of the survey were very positive. All nursing staff surveyed felt that they benefitted from safeguarding supervision and that it helped them to improve their practice and better protect vulnerable children. Some staff found attending supervision difficult to manage when working busy clinical shifts. Discussions with ward managers have led to flexibility around delivering sessions. The Safeguarding passports were viewed very positively by nursing staff and helped ensure that they achieve what is expected in terms of training and supervision. Team leaders and managers have been reminded to use the passport as part of the appraisal process.

Key Achievements – Audits for safeguarding children procedures and activity carried out show good overall safeguarding practices

7.7 Serious Case reviews

During the reporting period the trust has had no involvement in any new Serious Case Reviews

7.8 Serious Incidents

During the reporting period there have been no serious incidents within safeguarding children reported within the Trust.

Key Achievement – No Serious Incidents declared for safeguarding children during the reporting period or involvement in any new Serious Case Reviews

7.9 Training

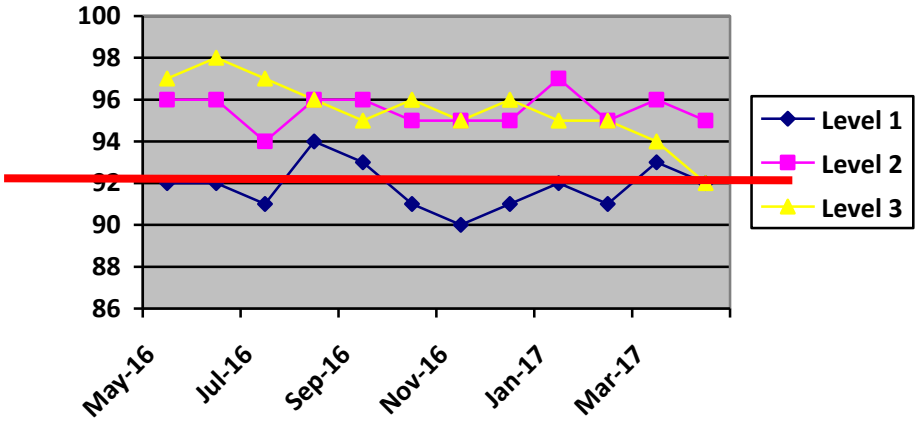
Safeguarding children training is a fundamental part of the Trusts duty to safeguard and promote the welfare of children under Section 11 of the Children's Act (2004) and Working Together 2015. Staff need to be trained and competent to recognise potential indicators of abuse, know what to do about concerns and fulfil their responsibilities in accordance with the Hertfordshire Safeguarding Children Board procedures.

During the reporting period, Level 1 and 2 safeguarding training has been delivered as part of the 3 yearly mandatory clinical and non-clinical days. Level 2 training has also been delivered to all new staff as part of the Trusts mandatory corporate induction programme.

In January 2017, the Trust has moved to delivering the majority of mandatory training by e learning. National e learning packages for Levels 1 and Levels 2 have been adapted to include local information and are now available for Trust staff to complete. Staff must complete a short test following the package to be compliant. The safeguarding team have also offered ad hoc sessions of Level 1 and 2 to clinical areas where compliance with training is low.

Level 3 training sessions are held up to twice a month. They are organised by the safeguarding team and a programme of sessions is advertised in key clinical areas for staff to book places. Core Level 3 sessions are for 3 hours and Level 3 updates run for 1 ½ to 2 hours. Staff that require Level 3 are aware of the expected hours required for training as defined in the Intercollegiate Guidelines (RCPH 2014). Staff requiring core Level 3 require 6 hours of training within 3 years and staff that require Level 3 with additional skills require 12 – 16 hours every 3 years. Hours of training for this group are monitored via the staff's individual safeguarding passport.

Training compliance rates are reported monthly by the Trust Training Department and these figures are reported to the Safeguarding panel.



Graph 5 showing compliance rates for safeguarding children training for the reporting period. The red line indicates the expected compliance rate for 95% set by the CCG.
During the reporting period:

- Level 3 training has remained at or above 95% for 10 months of the reporting period - compliance fallen slightly to 92% in April 2017 – this is partly due to an increase in new band 5 nurses in ED and also a change in how maternity safeguarding training is delivered. Work is taking place to target both areas to ensure that 95% compliance is achieved.
- Tailored Level 3 session held for Paediatric and Obstetric Consultants / Registrars led by Named Doctor with presentations from Designated Doctor for Hertfordshire.
- A Level 3 update session was run by an ISVA (Independent Sexual Violence Advisor) for young people attended by paediatric and A & E staff.
- Non-compliance list for Level 3 produced monthly and individuals contacted to book sessions.
- Paediatric and Neonatal Nurses record attendance at training within their Safeguarding Passport – this is reviewed at their yearly appraisal to ensure compliance.
- Level 2 has been above 95% compliance (except for 1 month when dropped to 94%).
- Level 2 training has been delivered by the Named Doctor on Trust Grand Round.

- All Safeguarding training packages have been fully updated to ensure they are in line with national guidance and best practice including the Intercollegiate Role Framework for Looked After Children.
- All volunteers receive safeguarding training at Level 1
- Health Wrap (Prevent training) has been rolled out during the reporting period in paediatrics and neonates. The training can be recorded as a Level 3 update and currently over 90 staff have completed the workshop
- Awareness of FGM is included within all Levels of training. Specific FGM sessions regarding the new reporting duty have been carried out within paediatric and A & E clinical governance sessions.
- Paediatric staff have attended training organised by the CCG on FGM/Forced Marriage/ Honour Based Abuse.

A Safeguarding Children session was also delivered to the Trust Board - Executives and Non Executives as part of a Board development day in July. This session included core competencies set out in the Intercollegiate Document 2014 specific to Trust Board members.

7.9.1 Level 3 training review

A review of Level 3 training took place in October 2016 following the CQC inspection. This was presented and agreed at the Trust Safeguarding Panel. The Designated Nurse for Safeguarding Children for the Hertfordshire CCG's supported the review. The outcome of the review was that the Trusts current strategy for Level 3 training is in line with the Intercollegiate Document 2014. The groups of staff in the Trust currently identified as requiring Level 3 are appropriate. Staff who predominantly work in adult areas but may occasionally see 16 and 17yr olds receive Level 2 training which allows them to recognise safeguarding concerns and refer on appropriately. The review recognised that these staff would not require the competencies as set out in the Intercollegiate Document for Level 3.

The review did recognise that there were some areas in the Trust were adult orientated staff did see children, such as dermatology and ENT, and that relevant staff working in these areas should have Level 3.

Recommendations from the review were;

- To make improvements by increasing staff awareness around safeguarding for 16 and 17yr olds in the next safeguarding newsletter (Dec 16)
  Progress – completed – information about safeguarding issues relevant to young people were included in the newsletter
- To undertake additional training for matrons (surgical and medical) around specific safeguarding issues for 16 and 17yrs olds – CSE (child sexual exploitation), drug and alcohol, mental health, domestic abuse.
  Progress – additional training at Level 2 has been provided for senior nurses within surgical areas. Several areas have requested that this training be delivered to ward staff which has taken place.
- To ensure at least one Consultant in key areas noted has Core Level 3 training
  Progress – areas were identified that treated children regularly and relevant staff were offered training. Consultants in dermatology, urology, orthopaedics, anaesthetics, ophthalmology and general surgery are now compliant. Consultants in ophthalmology and ENT have booked places. Specialist nurses in dermatology, ENT and ophthalmology have been trained. Senior nurses in

general out patients that have paediatric clinics have been trained and staff in fracture clinic are compliant.

Additional training has also been provided to the Consultants and Registrars in ED. This was a Level 3 update looking specifically at the practical aspects of safeguarding children in an emergency department. This training was delivered in groups or one to one and was delivered to all the relevant staff.

A further review of Level 3 training, fully updated with the above progress will be presented to the Safeguarding Panel in June 2017.

7.9.2 Multi agency training

Multiagency training provided by the Hertfordshire Safeguarding Children Board (HSCB) enhances the single agency training provided by the Trust. The Board provides a programme of day courses and "Lite Bites" on a variety of subjects e.g. neglect, children with disability, bruise protocols, parental mental health. Staff are encouraged to attend the HSCB training with courses advertised via clinical facilitators. During the reporting year, paediatric nurses on the rotation programme have attended several HSCB courses. The benefits of multi-agency training within safeguarding children are significant and benefit Trust staff greatly. It is important that the safeguarding team continue to highlight the training and encourage staff attendance.

The Safeguarding Children Nurse within the Trust continues to be a member of the HSCB training pool and delivers courses on the multi-agency training programme several times a year. During the reporting year, she has led on the delivery of training about the 'toxic trio' highlighting the risks to children living in homes where there is substance misuse, domestic abuse and mental ill health.

Key Achievement –

- Compliance rates for all levels of training has remained above 90%
- Health Wrap (Prevent) delivered to high numbers of paediatric and neonatal staff
- Safeguarding training delivered to Trust Board
- Comprehensive review of Level 3 training carried out identifying areas to improve practice

7.10 Supervision

Safeguarding children supervision is a formal process of professional support and learning which enables practitioners to develop knowledge and competencies and assume responsibility for their own practice in a safe and supportive environment.

The new Safeguarding Children Supervision and Peer Review Policy was ratified by the Trust Quality and Safety Group in June 2016. The policy was written to replace the Safeguarding Supervision Strategy that had previously been in place.

During the reporting period:

- Paediatric and neonatal nurses and doctors have received regular supervision (they must have 3 – 4 sessions per year).
- Supervision has been delivered in a variety of way – group sessions, ad hoc supervision with a member of the safeguarding team, attendance at one of the three psychosocial/supervision ward rounds.
- Paediatric and Neonatal Nurses record attendance at supervision within their Safeguarding Passport – this is reviewed at their yearly appraisal to ensure compliance with Policy.
- Quarterly figures show that compliance with supervision remains over 95% for paediatric / neonatal nurses and paediatric Consultants and Registrars
- Named Nurse has provided group supervision sessions for the Safeguarding Children Nurses and the safeguarding midwives
- Named Nurse has had supervision from the Designated Nurse in the CCG.
- The Named Doctor runs a peer review group for medical staff

A staff survey of safeguarding supervision (30 paediatric and neonatal staff) carried out in the reporting period found that;

- 100% of staff surveyed said that supervision helped them to improve and reflect on practice
- 100% felt supervision helped them to protect children in their role
- 100% felt supervision supported them in their role.
- 83% found supervision easy to access.

Staff were asked about how useful they found the safeguarding passports that were issued in 2016

- 100% said that they found the passport was good for recording all their supervision/training.
- 93% said that it helped them to be clear about what was expected of them and
- 90% felt it helped them to improve their safeguarding practice.

The Named Nurse for safeguarding children presented the Safeguarding passport at a regional NHS England conference on Leading Change and Adding Value in Dec 2016.

The Named Nurse participated in a Schwartz Round that focussed on a safeguarding story of a baby who presented to the trust with significant inflicted injury. The Round allowed members of staff to tell the story and discuss the emotional impact the case had on them as individuals. Over 100 Trust staff attended with a Panel comprising of the Named Nurse, Paediatric Consultant, Chaplain and Play Leader. The Trust Schwartz team went on to present the Round at a national conference and it won first place in the category of the most powerful Round.

Key achievements

- New Safeguarding Supervision and Peer Review Policy in place
- High compliance with safeguarding supervision from paediatric/neonatal staff
- Survey of supervision found that
- Named Nurse presented Safeguarding Passports at a regional NHS England conference

7.11 Policies and procedures

Safeguarding policies are in place and are accessible to staff via the Trust intranet. Hertfordshire Safeguarding Children's Board policy and procedures are also available via links on the staff intranet site.

During the reporting period, the following policies have been written / updated, agreed at Panel and ratified.

- Safeguarding supervision and peer review policy
- Safeguarding Children, Young people and Unborn babies Policy
- Chaperone Policy (paediatric section updated in line with best practice policy from Cambridge University Hospitals NHS Trust).

7.12 Partnership work

The Trust has a responsibility to cooperate with the Local Authority in the operation of the Hertfordshire Safeguarding Children Board (HSCB) as a statutory partner. It needs to share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children by ensuring there is appropriate representation at the HSCB Board meetings and sub groups.

Currently, the Trust Safeguarding Team are involved in the following groups –

- Chief Nurse / Deputy Chief Nurse attends HSCB Board meetings
- Improving Outcomes Group (sub group of HSCB) – attended by Named Nurse Safeguarding Children
- Policy and Procedures Group (sub group of HSCB) – attended by Named Doctor Safeguarding Children
- Strategic Safeguarding Adolescent Group (sub group HSCB) – attended by Named Nurse Safeguarding Children
- Training Group (sub group HSCB) – attended by Safeguarding Children Nurse

The Trust Safeguarding Team have also been involved within the following areas of work

- Named Nurse has contributed to a group looking at developing a policy for the Admission and Discharge of Children in Care and Care Leavers to Accident and Emergency Departments with mental health issues
- Safeguarding Children Nurse is a trainer with the HSCB training pool and delivers multi agency training about the 'toxic trio'

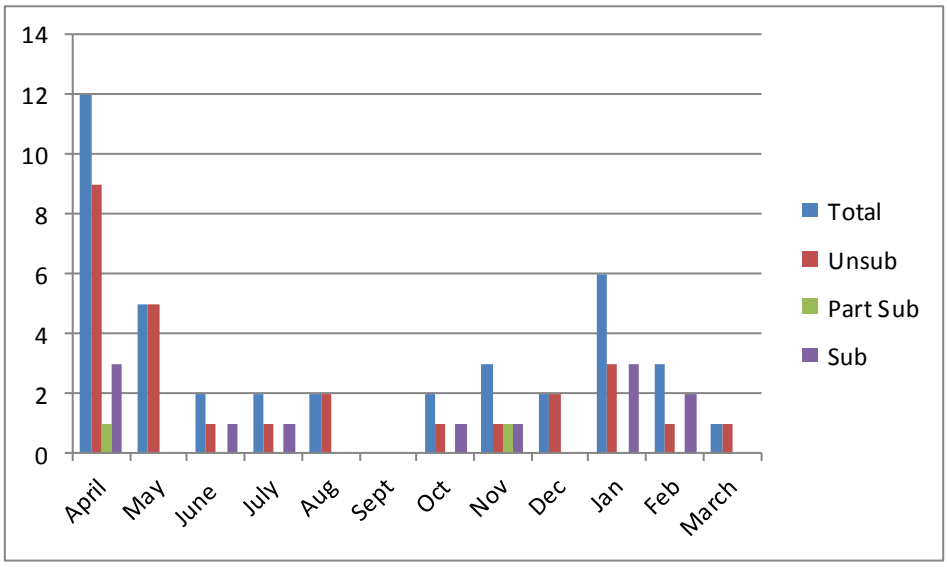
Key Achievement – Continued good representation of Trust safeguarding team on Board sub groups and participation in specific work streams

8. Safeguarding Adults

8.1 Safeguarding Adults Activity

Although safeguarding adults spans across the entire Trust, the Safeguarding adults work can be divided into 3 areas:-

- These are concerns raised against the Trust. These may include a variety of allegations but mainly fall into the neglect category
- Concerns that Trust staff raise against individual care providers
- Sharing information where social care are investigation a care provider and require information from the acute Trust about the patients' condition.



Graph 5 Demonstrates the total numbers and outcomes of safeguarding concerns raised against the Trust

The concerns raised against the Trust consist mainly of neglect, however there was 1 for sexual abuse which was unsubstantiated and 1 for organisational which was substantiated. This related to a patient with LD that was moved multiple times due to bed pressures. As a result of the multiple moves her medication was missed, however this patient did not come to any harm as a result of this incident.

8.2 Service developments within safeguarding adults include:

Developments to improve safeguarding adult practice across the Trust over the reporting period include the following:-

Staff Development

Band 6 and above staff, have been supported by the named nurse for safeguarding adults to attend strategy meetings and case conferences. This has enable staff to participate in the safeguarding enquiry and gain an understanding of the safeguarding process. Valuable lessons have been learnt following investigation and then shared at divisional clinical governance

Special Register update

- The special register "flags" patients who have a learning disability. It was identified that this had not been updated for a significant amount of time. In partnership with the acute health Liaison team for learning disability; all known patients with learning disabilities were uploaded on to the Trust Patient Administration System (PAS) by the safeguarding administrator**.** This allows for early identification of patients that may require additional support and reasonable adjustments to be made to ensure they are cared for appropriately.

Safeguarding on infoflex medical discharge summary

- An infoflex discharge summary for the GP is completed for all adults admitted to the Trust. Following a safeguarding investigation, the process was amended to ensure that any drugs or dietary supplements now come from pharmacy to ensure everything required on discharge is supplied to the patient.

Emergency Department records update to include Mental Capacity

- The emergency department record has been updated to include a question relating to prompt staff to consider a Mental Capacity Assessment.

Key Achievements

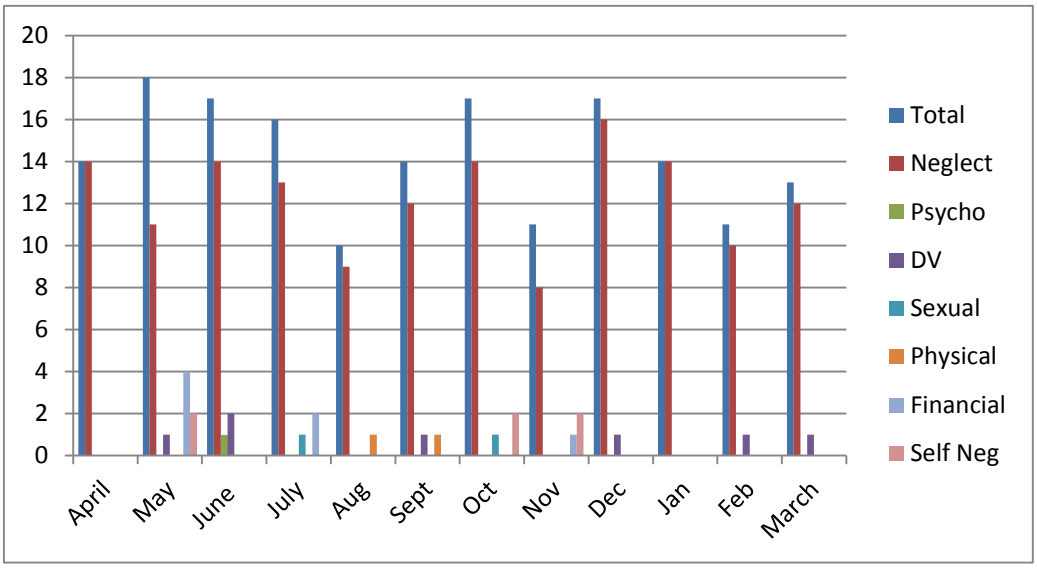
- Special register updated to include all known learning disability patient who may be vulnerable and require adjustments
- Infoflex discharge summaries improved to include prescribed fluid thickener to prevent further discharge concerns

8.3 Referrals to Adult Care Services

The number of referrals to social from across the Trust has remained high during the reporting period. This provides assurance that staff remain vigilant. These include

- Adult protection concerns – these include adults attending with unexplained injuries from care homes, mental health issues or neglect issues.
- They also include referrals for patients who are do not meet the safeguarding criteria according to the Care Act, 2014 but remain at risk as they are no longer coping at home due to a decline in their health or failure in their support mechanisms..

The majority of these referrals are made from A&E and AAU, although care although referrals are also received from other areas of the hospital.



Graph 6 Demonstrate numbers and categories of referrals made to adult social care

Making Safeguarding personal

Making Safeguarding Personal (MSP) requires a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. Safeguarding must respect the autonomy and independence of individuals.

Making safeguarding personal has been written into the updated safeguarding adults at risk policy, however further work is required to embed MSP across the Trust.

8.4 Multi agency working

The Named Nurse and Named Doctor ensure that inter-agency working is encouraged and supported.

- There are weekly meetings with social care team to follow up on safeguarding concerns that have been raised both with the Trust and with other care providers. This data is added to the Trust vulnerable adults register.
- The Named Nurse, Named Consultant and Deputy Chief Nurse attends the Hertfordshire Safeguarding Adults board sub groups.
- The Named Nurse is a regular attender at Improving Health Outcomes for learning disabilities. Actions and information from this group is shared with the Trust Learning disabilities sub group
- Regular attendance at MARAC (multi agency risk assessment committee) for high risk domestic abuse cases (see relevant section)

- The Named Nurse and Named Consultant have bi monthly supervision with the Lead nurse for safeguarding at the Clinical Commissioning Group.

The safeguarding team continue to contribute regularly strategy meetings and case conferences. These meetings may involve police, adult care services, heath provider and individuals and their family. Information is shared to ensure the individual is safe, identify and discuss concerns. Further action is then decided. Once the enquiry is complete an action plan is generated and monitored by the safeguarding panel.

8.5 Audits

During the reporting period, the Safeguarding Audit Strategy 2015 – 2017 has been in place and has given a robust framework for safeguarding audits to be carried out to provide evidence and assurance of procedures and practice around safeguarding adults.

The following audits have been carried out during the reporting period:

8.5.1 Dip sample audits are carried out on sets of records selected from across the Trust. These are presented and reviewed at Safeguarding Panel and any issues or areas of good practice are fed back to the clinical area The dip samples are carried out re:

- MCA and DoLS compliance
- Learning disability – Reasonable adjustments
- Safeguarding documentation

Overall, the findings of the audits demonstrate a good standard of safeguarding practice and good adjustments in key areas of the Trust for Learning Disability patients.

8.5.2 A Trust wide Mental Capacity and DoLS audit was undertaken in June 2016 and presented to the safeguarding panel. The aim was to provide evidence and assurance that WHHT staff are completing good quality Mental Capacity Assessments and applying for DoLS appropriately and recording in the medical notes to compliance with relevant Trust policies.

Overall, the findings of the audit demonstrated a good standard of Mental Capacity Assessments and appropriate application of the Deprivation of Liberty Safeguards. There is a significant improvement on the previous 2015 audit. Continued training and education is needed to ensure the focus on the importance on Mental Capacity and DoLS. Additional training is required to increase knowledge and focus on the importance of re-assessment and including family/carers in any decisions made.

8.5.3. A Trust wide Missing person's audit was undertaken for the first time in January 2017. The aim of the audit was to provide evidence and assurance that WHHT staff are compliant with the Trusts Missing Patient Policy, Procedures & Check Lists policy. From the audit it was highlighted that staff were not fully compliant with Trust policy when patients go missing.

The reason for this was established following a dip dive on staff knowledge. The outcome of this identified that staff were lacking awareness of the missing persons policy and were not aware of where to find the policy. The policy was promoted by the safeguarding team and the audit is due to be repeated in July as part of the Safeguarding audit strategy.

Key Achievements – Audits for safeguarding adult procedures and activity carried out demonstrate an improvement in safeguarding practices

8.6 Safeguarding Adult review

During the reporting period the Trust has involvement in one Safeguarding Adult Review. The Safeguarding Named Nurse provided an Internal Management Review for the Hertfordshire Safeguarding Adults Board SAR sub group. This case involved the death of a young lady. The Trusts input into this case was minimal, due to medical complications in her care she was transferred to a specialist hospital. The case is now closed and recommendations have been made and actions from this review have been added to the safeguarding work plan.

8.7 Serious Incidents

During the reporting period there have been 2 serious incidents raised regarding safeguarding adults. Both of these allegations were unsubstantiated.

Datix number	Allegation
DW71834	Allegation of malpractice
DW69401	Allegation of neglect

8.8 Safeguarding Adult Training

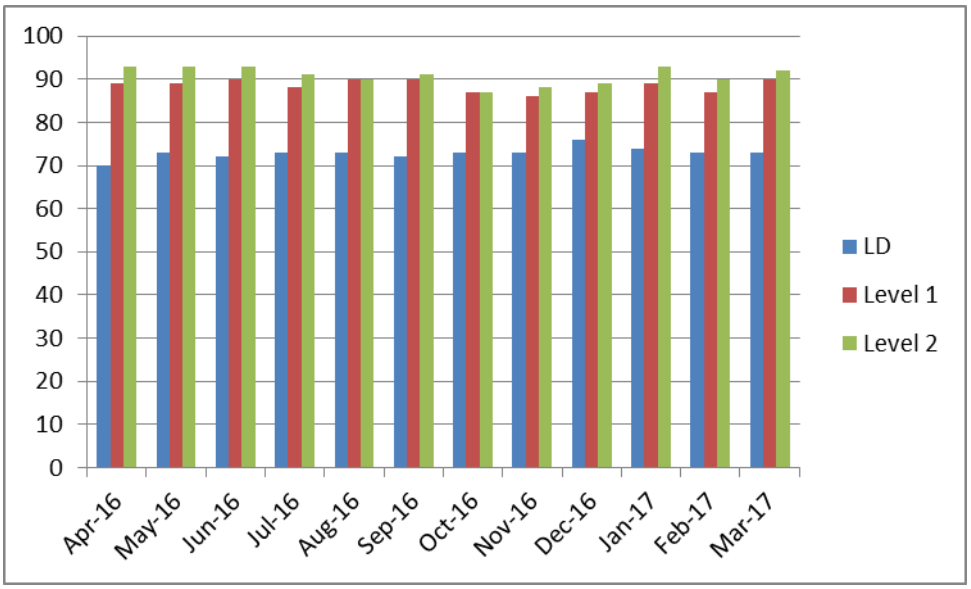
Safeguarding adults training is a fundamental part of the Trusts duty to safeguard and promote the welfare of adults according The Care Act., 2014. Staff need to be trained and competent to recognise potential indicators of abuse, know what to do about concerns and fulfil their responsibilities in accordance with the Hertfordshire Safeguarding Adults Board procedures. The Trust Safeguarding Training Strategy was reviewed and fully updated during the reporting period. It was presented and agreed at Safeguarding Panel in July 2016.

During the reporting period, Level 1 and 2 adult safeguarding training has been delivered as part of the 3 yearly mandatory clinical and non-clinical days. Level 2 training has also been delivered to all new staff as part of the Trusts mandatory corporate induction programme.

In January 2017, the Trust moved to delivering the majority of mandatory training by e learning. National e learning packages for Levels 1 and Levels 2 have been adapted to include local information and ensure compliance with the Core Skills framework. These have now been uploaded and are now available for all Trust staff to complete. Staff must complete a short test following the package to be compliant. The safeguarding team have also offered ad hoc sessions of Level 1 and 2 to clinical areas where compliance with training is low.

Training compliance rates are reported monthly and these figures are reported to the Safeguarding panel.

Compliance training with Mental Capacity (MCA, Deprivation of Liberties (DoLS) and Learning disability awareness (LD) is monitored monthly and shared at Safeguarding panel. The Safeguarding adults' team have arranged additional training sessions to ensure compliance figures are in an upward trajectory. Up until July figures for DoLS were collected by the number of people that had attended training, however it was recognised that this information was meaningless. From July data has been collected on the percentage of staff to ensure it is more meaningful.



Graph 7 Compliance rates for training for Mental Capacity (MCA) deprivation of Liberties (DoLS) and Learning Disabilities (LD).

During the reporting period:

- Additional training sessions regarding MCA and DoLS have been provided by the Named consultant at surgical clinical governance
- Additional training sessions regarding MCA and DoLS have been provided by the Named consultant at medicine and unscheduled care clinical governance
- Training for MCA has been delivered at Grand Round for medical staff
- Training for medical staff has been undertaken by the Named consultant for reasonable adjustments and having difficult conversations with people with Learning Disabilities
- Additional training has been carried out by the Named nurse and clinical nurse for theatres and St Albans in patient areas regarding safeguarding , MCA and DoLS
- Additional training by the clinical nurse for safeguarding has taken place on the Hemel site and MCA/DoLS competencies have been introduced
- All Safeguarding training packages have been fully updated to ensure they are in line with national guidance and HSAB policies.
- All volunteers receive safeguarding training at Level 1
- Health Wrap (Prevent training) has been rolled out during the reporting period in AAU and A&E. Currently over 90 staff have completed the training.

A Safeguarding Adult session was also delivered to the Trust Board development - Executives and Non Executives as part of a Board development day in July. This session included core competencies set out in the Intercollegiate Document 2014 specific to Trust Board members.

8.8.1 Multi agency training

Multi-agency training provided by the Hertfordshire Safeguarding Adults Board (HSAB) enhances the single agency training provided by the Trust. The Board provides a programme of day courses on a number of different subjects' e.g. self-neglect, people trafficking, safeguarding conference and IMR writing. The benefit of multi-agency training within adult safeguarding is of benefit to staff. It is important that the safeguarding team continue to advertise the training and encourage staff attendance.

Key Achievement –

- Health Wrap (Prevent) delivered to high numbers of staff in A&E and AAU
- Safeguarding training delivered to Trust Board
- Increased training compliance amongst medical staff

The Named Nurse and the clinical nurse for safeguarding participated in a Schwartz Round that focussed on the emotions around adult safeguarding. The stories included a domestic abuse victim and a patient with mental health and Learning disabilities. The Round allowed members of staff to tell their story and discuss the emotional impact the case had on them as individuals. Over 50 Trust staff attended and the cases generated a good discussion.

8.9 Policies and procedures

Safeguarding policies are in place and are accessible to staff via the Trust intranet. Hertfordshire Safeguarding Adults Board policy and procedures are also available via links on the staff intranet site.

During the reporting period, the following policies have been written / updated, agreed at Panel and ratified.

- Domestic Abuse policy
- Suicide prevention and anti-ligature policy
- Chaperone Policy (paediatric section updated in line with best practice policy from Cambridge University Hospitals NHS Trust).
- Missing person policy
- Care of adult patient with Learning disabilities and autism
- Mental Capacity Policy

8.10 Partnership work

The Trust has a responsibility to cooperate with the Local Authority in the operation of the Hertfordshire Safeguarding Adults Board (HSAB) as a statutory partner. It needs to share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of adults at risk by ensuring there is appropriate representation at the HSCB Board meetings and sub groups.

Currently, the Trust Safeguarding Team are involved in the following groups –

- Chief Nurse / Deputy Chief Nurse attends HSCB Board meetings
- Policy and Procedure sub Group Review (HSAB sub group) - attended by the Named Consultant Safeguarding Adults
- Public engagement (HSAB sub group)- attended by the Deputy Chief Nurse
- Safeguarding Adult Review (HSAB sub group)- attended by the Named Nurse Safeguarding Adults
- Performance sub group (HSAB sub group)- attended by the Named Nurse Safeguarding Adults

The Trust Safeguarding Team have also been involved within the following areas of work

- Named nurse has contributed to the Improving Health Outcomes for Learning disabilities group. This is a multiagency group that looks at developing and improving services for patients with Learning Disabilities across health providers. Actions from this group are added to the LD sub group action plan and monitored via the safeguarding panel.
- The Named nurse attends a Mental Capacity forum. This is a multi agency group chaired by the Lead nurse for safeguarding in the CCG. The group explores ways of promoting the Mental capacity Act and shares good practice with other care providers
- The Named nurse attends the Care Crisis partnership sub Group. This group oversees the actions of the sub groups to ensure Hertfordshire partner organisations adhere to the collective commitments made in the Mental Health Crisis Care Development plan to improve the outcomes for people experiencing mental health crisis through delivery of the local Action Plan.

- The Dementia lead nurse attends the date share sub group of the care Crisis Group. The aim of the group is that the partner agencies to develop and operate a robust information sharing and a joined up approach to supporting people in crisis because of a mental health condition, so that they are kept safe and receive the most effective interventions swiftly.

Key Achievement – Continued representation of Trust safeguarding team on Board sub groups and participation in specific work streams

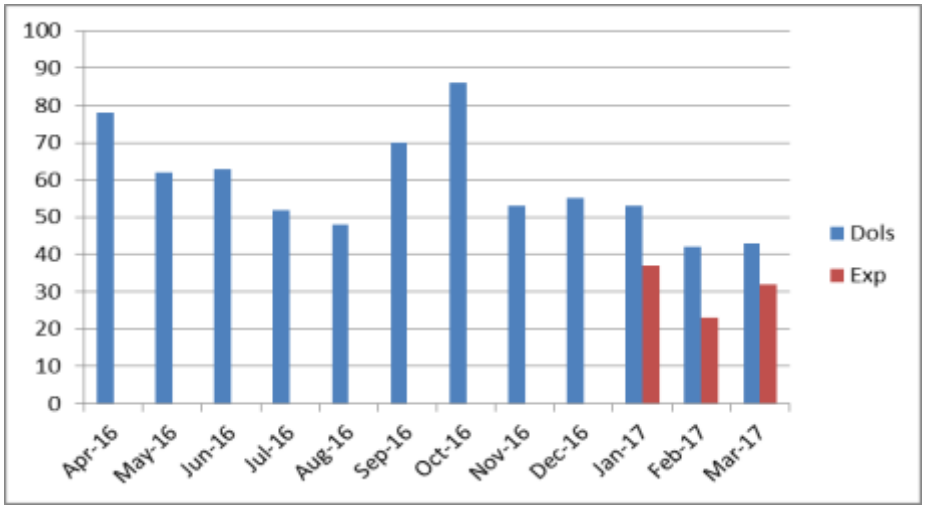
8.11 Deprivation of Liberty Safeguards (DoLS) and Mental Capacity

Mental capacity and DoLS training is core training for clinical facing staff. Staffs need to be compliant with the Mental Capacity Act and deprivation of Liberty Safeguards to ensure the Trust meets statutory Guidance.

During the reporting period MCA and DoLS training has been uploaded as an e learning package. This is available to all Trust staff via the Trust intranet site. Training compliance has fluctuated throughout the reporting year. Hot spots of clinical areas within the Trust have been identified and additional training has been provided in a variety of ways. This has included sessions at Grand Round, individual clinical areas, clinical governance and one to one sessions to ensure staff are educated and compliant.

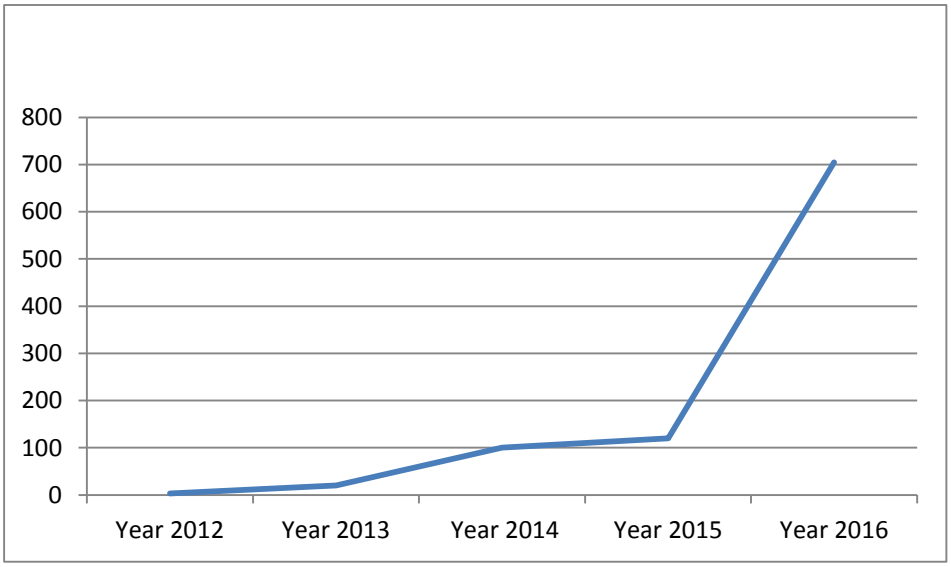
Training rates are monitored on a monthly basis by the Named Nurse for Safeguarding Adults and are shared at the Safeguarding panel on a bi-monthly basis.

Graph 8 Training compliance for MCA and DoLS



Graph 9 Number of DoLS the Trust has applied for in the last year and urgent authorisations expired

Following the Cheshire West ruling there has been an increase number in the number of DoLS applied. The graph below demonstrates the increase in the number of DoLS applications by the Trust over the last 5 years which shows our compliance with this change in the law.



Graph 10 Number of DoLS applications by the Trust

8.12 Learning Disabilities (LD)

The Acute Liaison Learning Disability Nurses (Hertfordshire Health and Community Services) are involved with supporting patients with LD and their carers when using hospital services. They will assist Trust staff in making reasonable adjustments for patients, advising staff about what reasonable adjustments might be required, using appropriate communication tools for people with LD, enabling appropriate discharge packages of care, end of life care and will provide training for staff around the needs of patients with a learning disability.

The Trust uses PAS alerts (Patient Administration System) to attach an alert to the PAS record of a patient with a Learning Disability where that information has been shared from the Hertfordshire GP disability register or when a patient is identified to have a learning

disability and consents to the alert being used. The use of the alert helps to identify when a patient with LD is admitted attends the Emergency Department or is due to attend for an outpatient clinic or for an elective admission and may need additional support or reasonable adjustments. During the reporting period the administrator for the safeguarding team has updating the PAS system. Some of the reasonable adjustments made have included:

- Multi-disciplinary team and carers care planning and best interests decisions for complex clinical case involving Independent Mental Capacity Advocate , social care, residential care, Council legal team, medical team
- Arranging for patient to monitored via GP liaising with the specialist consultant to prevent patient coming into hospital for screening (patient becomes distressed when attending appointments)
- Home visit by radiology staff to carry out ultrasound in patients in own home undertake scan to prevent distressing hospital visit
- Learning Disability Nurses attending hospital appointments with patients with LD
- Adjustments made to appointment times and theatre schedules to accommodate the needs of an adult with LD
- Carer support to enable carers to remain with patients in hospital where needed
- Pre-operative arrangements made with a person's care home and carers to enable pre-operative medication and preparation to be given at home to minimise the amount of time the person needed to stay in hospital
- Using the patient's 'Purple Folder' or health passport to understand the needs of an individual
- Discharge planning meetings to involve patient and carers organise discharges to include complex care requirements

Every quarter the Acute Liaison team provide a report detailing the patients and carers feedback. These are shared at the LD sub group, safeguarding panel and to individual ward areas. These reports are used to highlight areas that require further training and areas of good practice that may be shared.

In the reporting period, three clinical areas have been presented with the Purple Star Award. This is an award that is recognised by Herts County Council for providing an outstanding service to people with learning difficulties.

The purple star award was presented to the West Herts Hospital Trust's Abdominal Aortic Aneurysm (AAA) team, St Albans Day Surgery team and Vascular Lab in recognition of providing good health equality for people with learning disabilities. In addition another four clinical areas are working towards achieving this award.

The policy for the care of adult patient with learning disabilities and Autism was reviewed and updated in September 2016, in Partnership with the Acute Health Liaison team (AHLT) strategic nurse.

The safeguarding team work closely with the Acute Health Liaison Team (AHLT). The Acute Health Liaison Team are informed by clinical staff when patients with Learning Disabilities are admitted to hospital. The team provide expert advice and support to staff, patients and carers. This may relate to reasonable adjustments, the purple folder or communication. The numbers of referrals received by the AHLT is demonstrated below.

Month & Year	April '16	May '16	June '16	July '16	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17
No's of Referrals	19	27	20	28	24	20	35	20	23	27	14

Table 3 Referrals to the Acute Health Liaison Team

Key Achievement – Three Trust departments have achieved the purple star award.

8.13 World Elder Abuse Awareness Day

The United Nations (UN) has designated June 15 as World Elder Abuse Awareness Day (WEAAD*).* The day aims to focus global attention on the problem of physical, emotional, and financial abuse of elders.It is recognized that any older person can potentially become a victim of elder abuse and people can be abused in many different ways. Elder abuse has been defined as 'A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person' (World Health Organization, 1993).

On the 15th June the Safeguarding team prepared a presentation stand in the hospital restaurant for staff and visitors to access information regarding elder abuse and where to access assistance. In addition the team raised money for WEAAD by selling a selection of cakes. Photographs were taken and published in the WEAAD newsletter.

8.14 Prevent

The Counter Terrorism and Security Act passed legislation in early 2015. Prevent is part of the governments counter terrorism strategy CONTEST and aims to stop people becoming terrorists or supporting terrorism. Radicalisation is comparable to other forms of exploitation and is therefore a safeguarding issue that staff working in the health care sector must be aware of.

Raising awareness of the prevent strategy amongst health care workers is crucial. As an acute Trust, we are one of the best placed sectors to identify individuals who may be groomed into terrorist activity. Staff must be able to recognise signs of vulnerability to radicalisation and be confident in referring individuals who can then receive support.
Seven members of the safeguarding team have been trained as Healthwrap facilitators. WRAP is a DVD-facilitated product produced by the Home Office. It is designed for front-line staff. The quality contract agreed with the CCG expects 95% compliance by end of 2018. Clinical areas have been identified as being "high risk". These areas are maternity, paediatrics and accident and Emergency and will be targeted with training first.

8.15 Dementia

Key Achievements in Dementia care include

- Updated the Dementia Training Strategy for Trust. Dementia awareness is part of essential training. Dementia training days for staff with direct patient contact.

- Updated guidelines for the management of Acute Agitation/ Delirium and BPSD (Behavioural and Psychological Symptoms of Dementia) in partnership with Herts Parts NHS Trust.
- National Dementia Audit, WHHT took part in this national audit.
- DOLS care plan, magnet and leaflet for patients and carers has been developed.
- Delirium leaflet has been developed
- Dementia champions programme has been established
- Trust Carers lead has been appointed to support all relatives who care for patients, she can visit them on the ward to support and signpost if appropriate

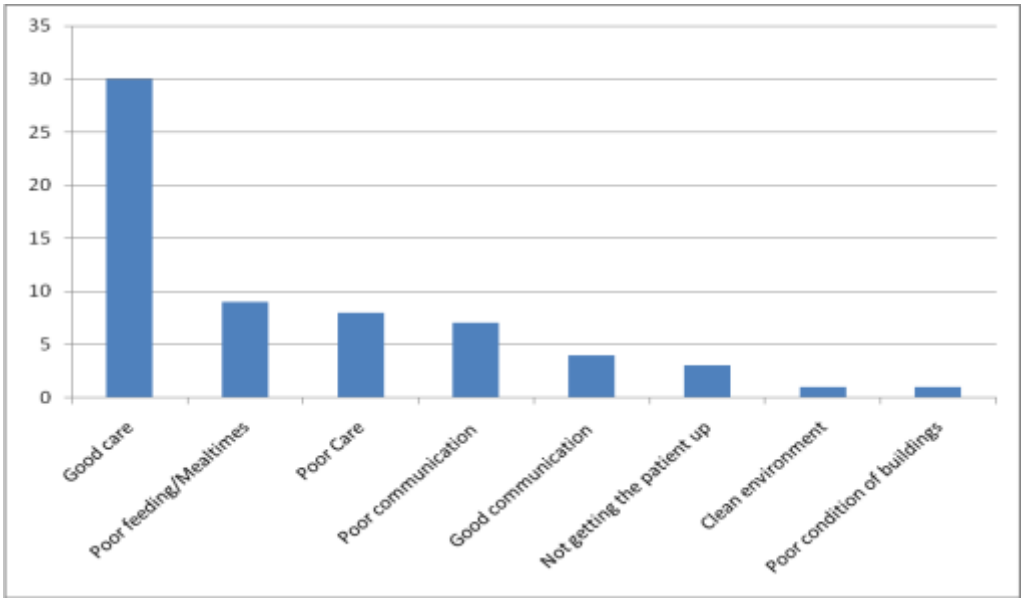
Further information regarding the above achievements is documented in the Dementia annual report.

Public Health England and the Alzheimer's Society joined together to inspire the Dementia Friends Campaign. The dementia friend's campaign helps increase the understanding of dementia and instigates a change of attitude towards people living with dementia in our society. The trust has supported the Dementia Friend's Campaign by holding three dementia days, one at St Albans and two at WGH. Over 350 staff attended this event including 70 members of staff from Medirest.

A unique product named "twiddle muffs" has been designed to provide a stimulation activity for restless hands. This is primarily for patients suffering from dementia but can also be used for patients with learning disabilities.

The National Audit of Dementia in General Hospitals was established in 2008, with funding from the Healthcare Quality Improvement Partnership to examine the quality of care received by people with dementia in hospitals. For the first time (2016) the audit was open to carers to allow them to provide feedback.

Many of the carers who completed the questionnaire returned free text comments with valuable information on aspects of care. All comments were made anonymous. All comments are of value to the Trust to enable improvement in the care given to patients with dementia



Graph 11 Areas of care registered in the feedback comments.

An audit was undertaken of protected mealtimes in WHHT. The impact of malnutrition results in negative clinical and patient centred outcomes. Inadequate oral intake impacts greatly on a patient's nutritional state. Within the Trust, protected mealtimes are practiced. The rationale behind protected mealtimes is by providing interruption-free time to eat during a hospital admission could encourage an increased nutritional intake, particularly for patients who are at risk of becoming malnourished or are malnourished.

In west Hertfordshire hospitals, there are 5 gold standards for mealtime:

1. Seven drinks per day
2. Patients are to make their meal choice using the glossy menu only. Staff will then complete the menu cards
3. All members of ward staff to be available to deliver/assist meals
4. Patients to eat meal uninterrupted
5. Red/beaker/jugs to highlight assistance with feeding if required.

West Hertfordshire hospitals have also developed a standard operating procedure for mealtimes, outlining what should be done before, during and after mealtimes. This incorporates all aspects of protected mealtimes but also include additional tasks that would facilitate patients comfort and enhance enjoyment at mealtimes.

In conclusion the audit demonstrated that on all wards patient who needed help were identified. This was done by a red tray indicator. Puree meals, Halal meals and vegetarian meals were provided to patients who required them. From doing this audit it is apparent that staff may not fully comprehend the significance of the red tray system. Although on most wards patients were assisted eventually, this was done some time after patients had received their meal.

Recommendations from this audit are listed below

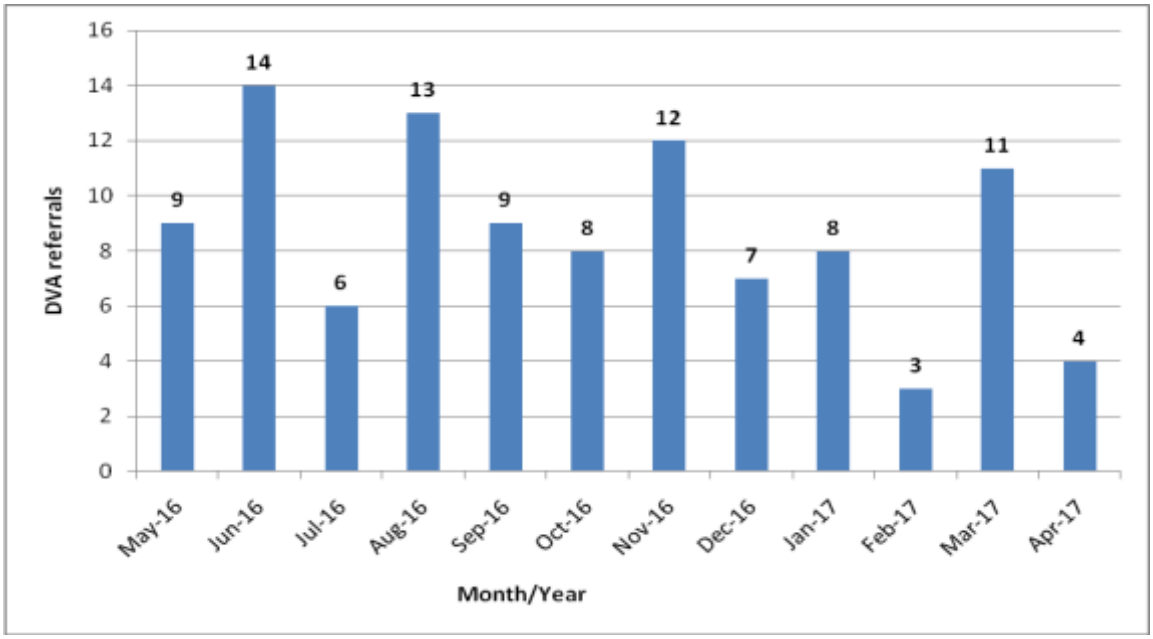
- Red tray practices should be continued. Staff should delegate job roles during mealtimes so that there is an adequate number of staff delivering meals and sufficient staff to provide assistance to patients.
- Staff need to ensure all patients are in the correct position for feeding and patients who are sleeping should be woken so as to not miss their meal.
- The presentation of food has an impact on people's willingness to eat their meals, therefore it is important to ensure plates are clean and food in packets is opened and placed on a plate.
- It would be beneficial if all staff were provided with education and training on protected mealtime policy. Protected mealtime signs would be useful to highlight mealtimes.

These recommendations have been added to the Dementia Implementation Group work plan and will be monitored via the safeguarding panel. This impacts on the patient experience across the whole of the Trust and is an important basic to get correct

.

8.16 Domestic Abuse / IDVA

The Trust continues to have an IDVA (Independent Domestic Violence Advisor) in post that is based on the Watford site. The Trust IDVA (employed and managed by Victim Support until 30th September 2016, and Refuge from 1st October 2016 to present) continues to support patients who disclose domestic abuse within the Trust.



Graph 12 Number of referrals that the Trust IDVA has received from staff for patients or their families, who have disclosed domestic abuse.

Referral Source	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	Total
A & E/CED	1	5	1	2	3	6	4	5	6		5	1	39
UCC HHH			1		1								2
SACH Minor Injuries													0
Maternity	3	1	2	2	1	1	2	2		1	1		16
Safeguarding Midwife		1		1	1				1		1		5
Adult's Safeguarding Nurse	2				1							1	4
Children's Safeguarding Nurse	2			1			2			2			7
General Wards		1		1					1				3
Drug and Alcohol Service		1									1		2
Out Patient's		2											2
Other	1	3	2	6	2	1	4				3	2	24
Total per month	**9**	**14**	**6**	**13**	**9**	**8**	**12**	**7**	**8**	**3**	**11**	**4**	**104**

Table 4 Source of referrals to the IDVA service

During the reporting period, the IDVA has increased her profile in key clinical areas across the Trust, especially within A & E, Urgent Care and Maternity.

The IDVA has also continued to support staff to gain an understanding of recognising and responding to domestic abuse. Regular 'Introduction to Domestic Violence' training sessions have been conducted for WHHT staff, details below. Groups who have undertaken this training between May 2016 and April 2017 include:

- A and E nurses (on A and E 'nurse development days')
- Band 5 CED nurses
- Transitional Nurses (Regular training arranged)
- Level 3 safeguarding
- FY2, A and E doctors (Regular training arranged)
- Band 5 nurses
- Midwives (Regular training arranged)
- St Albans Day Surgery staff
- De La Mare Ward staff

The WHHT IDVA has continued to raise awareness of domestic abuse and the support available within the trust. This has included contributed to the 'Safeguarding Newsletter. On the 15th June (WEAAD), information was available regarding Domestic Abuse in the older population.

8.16.1 MARAC

Over the last year the Safeguarding team has been consistently attending the Watford and Three Rivers MARAC meetings. From January 2017, the team have also started attending the St Albans and Dacorum MARAC. This involves sharing relevant information about victims, perpetrators and any associated children in a multi-agency forum to identify risks and share actions to reduce the risks to a victim and any children. Currently WHHT is the only health provider who attends local MARACS.

The Named nurses and the safeguarding administrator have all received modus training. This will be MARACs new information system. It will allow agencies to share information about vulnerable individuals and ensure that any actions are competed in a timely manner.

9. Named Midwife Report

Safeguarding activity in maternity remains high, often involving very complex and challenging cases with co-morbidities. Some of the women seen can have both socially and medically complex pregnancy/childbirth needs. The reporting period has seen staff dealing with emerging national safeguarding issues such as trafficking, female genital mutilation and domestic abuse.

9.1 Lavender Team

The lavender team was established in April 2016 caring for women with social complex needs. More work was done this year 2017 to raise the profile of the team by restructuring and relaunching the team. The referral rate has also increased.

There are now 7 midwives in the team 3 band 7's and 4 band 6's each has an area of speciality i.e. safeguarding, social issues, domestic violence, asylum seekers, teenage pregnancy and mental health.

The midwives are allocated to locality area linking in with the local health visiting service and local children's centre. Working in a defined area promotes continuity of carer and good communication between other health professionals and multiagency working at a local level. West Hertfordshire Hospital Trust has a team of midwives who care for women with complex

social needs. Each of the midwives hold individual caseloads of about 30–40 women per year. The Lavender midwives provide full antenatal, and postnatal care for all women referred to them.

Women are allocated a named midwife to provide continuity, emotional and social support, flexible, individualised care and robust multi-agency liaison. The overall aim is that women are offered a more intensive, individualised programme of care that is as accessible as possible and provided by someone they know.

The Lavender midwives have a buddy system where a 2/3 midwives work in a post coded area together. Women can choose to receive their care in community settings or at home when appropriate. Where hospital care is indicated, the Lavender midwives continue support for women, acting as their advocates and ensuring their care is coordinated. With a dedicated midwife working autonomously and organising her own diary, care can be tailored to meet women's needs, while any missed appointments are followed up promptly and efficiently.

9.2 Access to care

Where complex social risk factors are identified, by GP referral or by the midwife booking appointment a referral is made to Lavender Team). The referrals are discussed at the weekly Triage meeting, the form is returned to the referrer with details of triage assessment with date and time of appointment.

The lavender team have daily safeguarding ward round Monday to Friday covering all ward area in maternity. The ward round ensures continuity for the women, this is also a service to support and advice hospital midwives with any safeguarding issues. All advice and support is documented in the Lavender file along with the woman details and plan of care.

Our model of care is risk assessment based where women referred to the team are allocated risk status based on their care needs (Low, moderate, high risk). When a pregnant woman is referred to the Lavender team she is assessed for complex social factors using the criteria for risk. The case is RAGED in red, amber or green.

This also gives the women within each category the opportunity to have focused multi-disciplinary integrated care plan (See appendix 1 & 2 for the referral form and risk assessment template).

9.3 Maternity Safeguarding Activity

981 safeguarding and mental health referrals were received by the Lavender Team in 2016/17. As part of the pre-birth protocol the Lavender team midwives continue to attend the pre-birth information meetings and taken part in the telephone strategies discussions.
This year we have had several high risk cases that have necessitated involvement with security and mental health team to plan and put a risk assessment in place prior to delivery.

Demographics of vulnerable cases

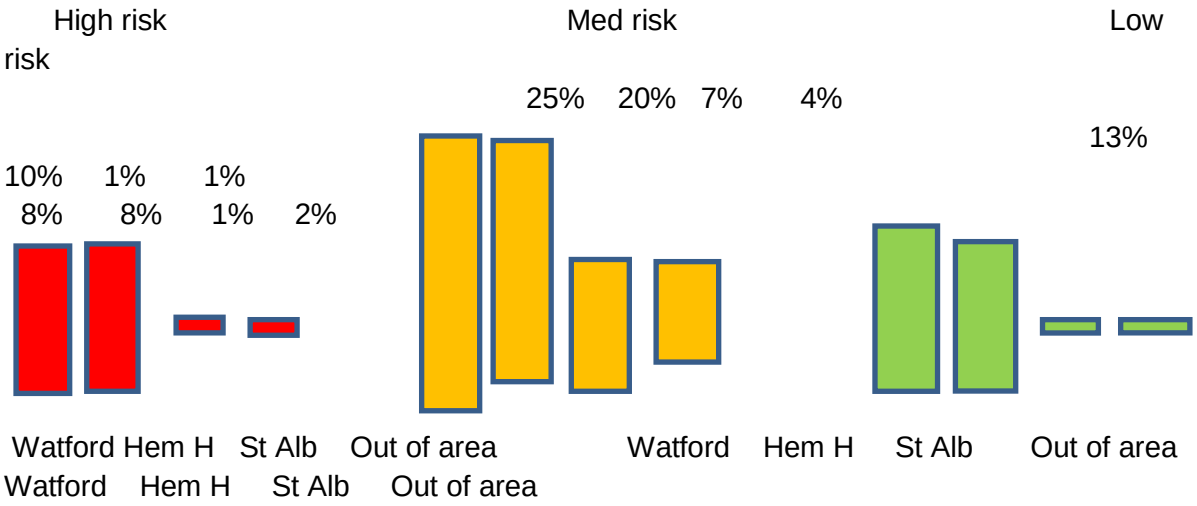


Table 5 Referrals from April 2016 to March 2017

	Activities
Mental Health	852
Domestic Abuse	105
Substance of Misuse	6
FGM	18
Total	981

Table 5 above highlights the annual maternity safeguarding activities. Mental health been the highest referral received of 852 (87%) women. Hemel Hampstead has the highest mental health referrals proportionate to birth rate.

Table 6 Lavender Team Case Mix after Triage

	Child Protection/In Need	**Perinatal Mental Health**
Watford	68	65
Hemel Hampstead	94	68
St Albans	18	24
Total	182	157

Table 6 above highlights the case mix of the women cared for by the lavender team in 2016/17. This equate to a total of 339 women.

Table 7 Unborns on Child Protection Plan for April 2016 to March 2017 = 90

April	May	June	July	August	September	Oct	Nov	Dec	Jan	Feb	March	Total
8	7	9	5	6	5	7	8	10	7	8	6	**90**

90 unborn babies were placed on child protection plan. Table 4 below gives the percentages of case mix of the unborn child protection plan.

Table 8 Indicators for U/B's on CP plan

44%	17%	5%	30%	5%
Domestic abuse	Substance abuse	Teenage Preg	Mental Health	Learning Disabilities

9.4 Domestic Abuse

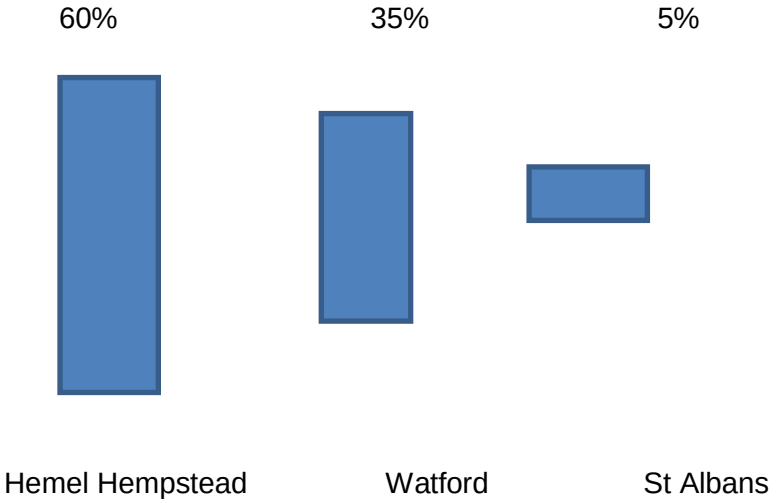
DA appears to be the one of the main indicators for unborn babies on a child protection plan. Recent studies have shown that over a third of domestic abuse begins or becomes more intense when a woman is pregnant .All women booking at West Herts Hospital Trust are asked sensifity as part of routine antenatal care, whether or not they are experiencing domestic abuse. Women are asked on two occasions during pregnancy, as evidence has shown that women do not disclose abuse the first time they are asked. The team are introducing new initiatives in helping women to disclose domestic abuse such as "the black dot" system where women apply a small stick to the urine test pot if they wish to identify they require help, the sicker is identified by the midwife who will offer help discreetly. There is also a poster in development a "Time alone with the midwife" this is to remind women to request a woman only appointment to allow then to discuss only fears they may have.

9.5 Mental Health

The majority of the referrals to the Lavender team are issues around mental health, this is appears to be an indicator in unborn babies on a child protection plan. Therefore early Identification of mental issues is paramount in assessing risk to mother and child.

The team holds a weekly triage meeting with the two specialist obstetricians, Mental Health Social Worker 2 Lavender Team Midwives and a CPN or Psychiatrist. At the weekly meeting the weeks referral are discussed and each woman is given a plan to meet her individual needs.

Demographics of Perinatal Mental Health Referrals



The team work closely with the new Community Perinatal Team who supports mother and their babies up to a year after birth. The team support the wider family at an important time by intervening early; the programme facilitates recovery to promote well-being and attachment between mothers and their babies to raise awareness and to reduce the impact of mental health conditions on the next generation.

9.6 Teenage pregnancy

Teenage pregnancy has been in decline nationally (Under 18 conceptions rates have declined by 55% since 1998) the number of teenagers booked at West Herts Maternity is also low. The lavender team have a named midwife for teenage pregnancy. The midwife coordinates the care for young women minimising the number of hospital visits and provides care in the young woman's home where possible. The midwife has developed links with community groups & charities that give support specific to teenagers.

However with the small case load the Lavender team have been involved in the new programme within Hertfordshire, that has replaced the Family Nurse Partnership, A Lavender Team midwife has been involved in the setup meetings of the "Young Parents Work Stream" programme.

9.7 Mothers with Learning Disabilities

The 2001 white paper on Learning disabilities (LD) services that the incidence of LD is around 5% of the general population, changes in the political and social climate mean that further young people with LD growing up with similar aspirations as their non-disabled peer in areas such as family life. Therefore it is likely that the numbers of people with LD who have children is growing.

The number of mothers with learning disabilities is equal or has been higher than the number of teenage mothers. The Lavender team have supported number mothers in the last year; a small of the babies went into foster care a few days after birth. The majority were well supported by the Lavender team working with the multidisciplinary team who provided parenting sessions all the parents have adapted well to parenthood.

9.8 Training

During the reporting period safeguarding training is now delivered with in a 3 day annual midwifery mandatory training in a 5.5 hrs session. The training now has stand-alone sessions on adult safeguarding, domestic violence, FGM, safeguarding children and mental health. Prevent training is now also included on the day.

Safeguarding for Children level 3 has remained above 95% and Safeguarding for adults level 2 has remained at 90% or above.

9.9 Maternity New Starter Safeguarding Tour

The education team in maternity now ensure that midwives are given guidance on safeguarding in maternity. This includes the user guidelines for the Psycho/Social File on the IT system.

9.10 Maternity Psycho/Social File

The maternity social file is a communication system for the maternity team to gain information on women with complex social issues. This information is available for midwives to view on the G drive of the trusts IT system this gives an overview of all cases referred to the Lavender Team.

The file is Key in the units safeguarding communication system the system has been updated in the last reporting year to include risk factors (High Med or Low).
This communication system was highlighted in the CQC report as an example of good practice.

As has been stated in the report all new staff are given an information sheet on the P/S file in regard to safeguarding.

9.11 Audits

The Lavender team are involved in regular audits that focus on 5 key areas

1. Audit of outcomes (Quarterly)
2. Audit of compliance of the routine enquiry for domestic abuse (Quarterly).
3. Audit of emotional well-being assessment at booking and mid trimester (Quarterly).
4. Audit of screening for complex social needs (Quarterly)
5. Audit of compliance to training (Monthly).

9.11.1 Audit of outcomes

Six (2%) set of case notes of women who were classified as moderate to high risk at the point of referral to the Lavender team and had received antenatal and postnatal care from the Lavender team.

Women were assessed at booking using the risk assessment criteria.
Then assessed 28 days postnatally again using the risk criteria. All women had moved to either med risk or to low risk resulting in improved outcomes for them and their infants.

9.11.2 Audit of routine enquiry for domestic abuse at booking & mid trimester

	Booking	Mid trimester
November	100%	96%
December	100%	98%
January	100%	98%
February	100%	100%
March	100%	96%

9.11.3 Audit of assessment for mental well-being at booking and mid trimester

	Booking	Mid trimester
November	100%	100%
December	100%	98%
January	100%	98%
February	100%	100%
March	100%	100%

9.11.4 Audit of compliance to screening for complex social needs

11 sets of case notes were audited. The main theme in the audit was the communication between agencies; this lack of communication was highlighted with GP's and the maternity unit. The audit has been presented at the divisional quality and safety meeting with and action plan in place.

The recommendation from the audit:

9.11.5 Dip Dive audits

Dip sample audits were carried out bi monthly and presented at the safeguarding panel meeting. The audits highlighted many safeguarding issues where learning outcomes have benefited women's care.

Issues raised

- One audit highlighted the importance of reviewing patient case notes before an initial appointment. The community midwives who complete the antenatal booking assessment had minimal information on the woman's medical and social history. Therefore the trust needed to explore how midwives could have access to a woman's medical records for the routine antenatal booking assessment. From a safeguarding point of view the information held in a woman's medical record is key when completing the social assessment.

Actions taken:

- The safeguarding team liaised with admin team to explore how midwives have case notes available and how booking midwives assess for any safeguarding issues.
- Women with complex needs to have booking assessment completed by Lavender Team midwife ASAP**.**

Issues raised

- Another audit identified the importance of a multiagency meeting early in pregnancy as this can improve a more holistic approach early in pregnancy allowing time for a plan of early intervention to be in place. Also identified was the benefits of the Lavender team midwives using the Common Assessment Framework this would ensure a more holistic approach to a woman's care.

Actions Taken

- Ensure multiagency approach early in pregnancy.
- Midwives to be trained in using the CAF (Common Assessment Framework)

9.11.6 Audit of compliance to training

Monthly audit are collated to identify any gaps in compliance to training.

9.12 Support /Training for Lavender Team

The complexities and emotional demands of case loading vulnerable women are widely acknowledged, Lavender Team midwives are fully supported by manager who is the lead for safeguarding. Safeguarding supervision support is provided by the named safeguarding nurse and for adult safeguarding, supervision is provided by a member of the Perinatal Mental Health Team.

As the majority of women in the caseload have mental health issues, the aim is for all team midwives to have completed a perinatal mental health course at Herts University. Also to have attended Hertfordshire Safeguarding Children Board training for professionals and the Hertfordshire CC CAF training (Common Assessment Framework).

10. Employment Practice

The Trust has safe recruitment practices with policies in place. The Trust has a DBS policy, which was fully updated and ratified in June 2016. The policy includes mechanisms to ensure that the required DBS have been received for staff and an audit process in place within the recruitment team.
All volunteers within the Trust also have DBS checks following recommendations from the Lampard report. A dip sample audit carried out in July and August 2016 of volunteers on the Trust volunteer database showed that 100% had a DBS check completed.
The Trust has an Allegations of abuse against staff policy was fully updated. This was fully updated in 2015 following changes to Working Together 2015 and policies issued by NHS England about managing allegations against staff.
During the reporting period, the Trust made no referrals to DBS. It did make two referrals to the Designated Officer (LADO) in the Local Authority. Neither of these referrals were about Trust staff but were about patients where a concerning allegation had been made and both had significant contact with children in their professional roles. Both were appropriate and resulted in full investigations by the Designated Officer and in one case, the police child abuse investigation unit.

11. Risks

- Risk regarding compliance with the Mental Capacity Act. There is a lack of evidence of MCA application and compliance across the Trust. There could be legal implications for the Trust. This is on the risk register number 2899 and currently scores 4.Inital risk grading was 16 but with improvement to MCA documentation that has been implemented into the clinical areas. MCA becoming part of the mandatory training from January 2016, the development of an e learning package to increase staff knowledge the risk has now been significantly reduced. Training Compliance rates are monitored via the safeguarding panel and at divisional performance reviews.

- In the Trust there is a defined process for the application of DoLS reporting to the supervisory body. An urgent DoLS lasts for 7 days and this is automatically extended for a further 7 days by the Supervisory body. Within those 14 days a Best Interest Assessor (BIA) should come out and review the patient. However this does not occur due to a shortage of BIAs and an increase in the number of DoLS following the Cheshire West ruling. As a result after 14 days there is no statutory framework for detaining these individuals. This is on the risk register 3713 and scores 8. This will be reviewed following the Law Commissions proposals.

- There is a clinical risk due to the reduction/changes to the commissioning arrangements for the current Health Visitor Liaison service. Historically the service has been provided by HCT and involves the liaison of all children attending WHHT with community staff e.g. all attendances at CED, UCC and MIU, all admissions to Starfish Ward, children where there are safeguarding concerns and a referral has been made to Children's Services. Due to changes in commissioning the current service has been funded until March 2017. The service is currently continuing to be provided by HCT until safe and tested IT systems are in place to ensure that there is transfer of information regarding paediatric attendances. Reducing or losing the service could lead to a gap in assurance on information about vulnerable children being shared with community staff which would impact on safeguarding such children. This is on the risk register 3762 and currently scores 12.

12. Recommendations

Safeguarding children and adults at risk continues to have a high profile within the Trust. A robust safeguarding structure and processes ensure that the Trust meets its statutory requirements and safeguards its most vulnerable patients.

The Trust Board are therefore requested to:

- The Trust Board is asked to note the report for information and assurance.
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Appendix A – Work Plan Completed 2016/2017

	Objective	Actions required	Operational lead/ involved individuals	Date of delivery/ review timescales	Evidence of Impact	Progress and escalation	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
General Safeguarding																		
	Provide Safeguarding Reports to provide assurance to the Board around safeguarding activity across the Trust	Annual report to be produced for Trust board by June 2016. To present at Safeguarding panel July 2016	Safeguarding leads	Jul-16	Trust Board will be provided with assurance re quality of safeguarding activity carried out across the Trust	Annual Report presented to QSG in June and will be on July Safeguarding panel	A	A	A	A	G	G	G	G	G	G	G	G
		Mid-year report to be submitted to QSG with update on safeguarding activity -Trust Board April 2016	Named Nurse and named midwife	Feb 16 and Nov 16	As above	Completed - to be presented at Q S group in March and then Board. Next 6mthly report written and submitted to Q&S and safeguarding Panel November	G	G	G	G	G	G	G	A	A	G	G	G
		Reports to be supplied to Trust panels as requested- Yearly assurance visits by the CCG for both adults and children.	Safeguarding leads		As above	Mid-year report completed. Annual report completed July 16. 6 month report completed - to SG Panel Nov 16	A	A	A	A	G	G	G	G	A	G	G	G
	Safeguarding Newsletter to be produced bi-annually	Newsletter due June and Dec with contributions needed by wider safeguarding team	Safeguarding team	Jun-16	Newsletter available to all staff in the Trust with relevant and up to date safeguarding information	2nd edition of newsletter produced and distributed June 2016. 2nd newsletter produced and distributed Dec 2016	A	A	A	A	G	G	G	G	G	G	G	G

Ensure Trust policies and procedures relevant to safeguarding are updated in line with national guidance and are relevant and in date	Review and update of Missing Person Policy	Safeguarding Leads	Feb-16	Updated policy available to all staff	Policy now ratified by QSG,	A	G	G	G	G	G	G	G	G	G	G	G
	Review and update Volunteers Policy	PPI Lead	Jun-16	Updated policy available to all staff	Ratified July 16	A	A	A	A	A	G	G	G	G	G	G	G
	Implement of suicide prevention policy	Named nurse safeguarding adults	Nov-15	Updated policy available to all staff		G	G	G	G	G	G	G	G	G	G	G	G
	Review medically challenging behaviours policy and restrictive practices	Named nurse safeguarding adults	Jan-16	Updated policy available to all staff		G	G	G	G	G	G	G	G	G	G	G	G
	Review and update VIP policy (following Jimmy Saville)	Safeguarding Leads	Jan-16	Updated policy available to all staff		G	G	G	G	G	G	G	G	G	G	G	G
	Review and update Chaperone Policy (following Bradbury report)	Safeguarding Leads	Jan-17	Updated policy available to all staff	Policy has been updated and sent to key staff for review - on agenda for Safeguarding Panel Feb 2017 for agreement to PRG	A	A	A	A	A	A	A	A	A	A	A	A
Ensure trust has framework in place for PREVENT agenda	Review 'Safeguarding our patients' Day on Induction to include Prevent awareness	Safeguarding Leads/ Training Dept.	Apr-16		Safeguarding day reviewed - awaiting confirmation from training re implementation date.Prevent. Awareness e-learning now available	A	G	G	G	G	G	G	G	G	G	G	G
	Develop programme of Healthwrap 3 training for relevant staff	Safeguarding leads	Jan-17	No of Trust staff trained in Healthwrap 3	Programme now in place to deliver Healthwrap in key clinical areas	A	A	A	A	A	A	A	A	A	A	G	G
	Compliance levels for Healthwrap training for identified staff in A and E, Paeds and maternity will meet target agreed by CCG in Quality Schedule	Safeguarding leads	Jul-17	Compliance level for WRAP meeting CCG target	Quality schedule for Healthwrap is 40% by Qtr 1 2017. Training has commenced for high priority areas in Paeds and A&E, Maternity and AAU level 1	A	A	A	A	A	A	A	A	A	A	A	A

	Training needs analysis to be carried out to identify key staff in line with national framework	Safeguarding leads	Feb-16	Staff are given appropriate training in line with their roles and national framework	TNA completed and submitted to training	G	G	G	G	G	G	G	G	G	G	G	G
Ensure completion of Trust action plan in relation to the Lampard report (Jimmy Saville).	Assurance required re safe employment practices of contracted staff	HR - recruitment manager	Jun-16	Trust to be compliant with Lampard recommendations	Evidence obtained re NHSP (monthly audits sent to Trust) and Medirest. HR auditing a selection of contractors used by Trust regarding their recruitment procedures - HR presenting to Panel Jun 16	A	A	A	A	G	G	G	G	G	G	G	G
	Peer support and learning opportunities will be arranged for voluntary staff	PPI lead	Jul-16	Trust to be compliant with Lampard recommendations	Trust recently joined National Volunteer Group. All volunteers receive training on induction	A	A	A	A	A	A	A	G	G	G	G	G
	Evidence that Workforce/HR have considered frequency of DBS checks carried out by Trust	HR/Estates	Feb-16	Trust to be compliant with Lampard recommendations	Completed - Evidence received - minutes of discussion held at Trust board	G	G	G	G	G	G	G	G	G	G	G	G
	Completed action plan reviewed with assurance / dip audits to ensure Trusts continued compliance	Safeguarding Team	Oct-16	Trust to be compliant with Lampard recommendations	Completed action plan with dip audits to be presented to Panel October 16	A	A	A	A	A	A	A	A	G	G	G	G
	Trust action plan completed and closed Oct 16 - Ensure that Lampard recommendations are core trust business	Safeguarding Team	Dec-16	Lampard recommendations are core Trust business	Ensure audits included within Safeguarding Audit strategy (due for review 2017). Ensure SG teaching continues to include awareness raising								A	A	G	G	G
Ensure that the Trust has a suitably	Safeguarding Training Strategy to be updated in line with current guidance	Safeguarding leads	Jul-16	Staff are given appropriate training in line with their roles and	Safeguarding Training Strategy presented to panel July 16 and agreed.	A	A	A	A	A	G	G	G	G	G	G	G

trained workforce who recognise and respond appropriately to safeguarding concerns				national framework													
	Continue work towards 95% compliance target for all levels of training set by CCG	Safeguarding leads	Mar-17	95% compliance rates achieved and maintained for all levels of safeguarding training	See separate adult/children sections for progress	A	A	A	A	A	A	A	A	A	A	A	A
	Divisions to ensure that all relevant staff attend mandatory training and divisions report training rates at Safeguarding panel	Divisions / Lead Nurses	Mar-17	95% Compliance rates achieved and maintained for midwives for safeguarding children. 93% of midwives compliance for safeguarding adults	Work continues with divisions to standardise exception reports presented to panel and to improve training rates	A	A	A	A	A	A	A	A	A	A	A	A
Ensure Trust meets its mandatory duties around FGM and staff are educated and responsive	Awareness raising around the mandatory reporting duty for all under 18s who present with FGM	Safeguarding team	Feb-16	Clinical staff refer all cases of reported or visualised FGM to police as per duty.	Information in e update and paediatric newsletter. Presentations given at clinical governance sessions. Policy updated and ratified. Posters distributed and displayed in key areas. All levels of training updated	G	G	G	G	G	G	G	G	G	G	G	G
	Awareness raising and education about FGM for staff across the Trust. Ensure appropriate safeguarding referrals are made and women have access to specialist	Safeguarding Team / maternity team	Sep-16	Staff identify cases of FGM, respond in a sensitive manner and carry out appropriate risk assessments and referrals.	16 staff have attended specialist FGM training provided by CCG. Paper on evidence of learning around FGM in paediatrics presented to Panel in July - showing good knowledge across Paed staff	A	A	A	A	A	G	G	G	G	G	G	G

		services			Reported via CCG dashboard and via Quality schedule																			
	Ensure the Trust follows the Multi Agency Practice Guidelines on Forced Marriage and has systems in place to recognise honour based abuse	Ensure trust representation on the FM/HBA/FGM sub group of Domestic Abuse Board and complete and submit self-assessment audit tool	Named Nurse Safeguarding Children / Lead Midwife for Complex Needs	Feb-16	Assessment audit tool completed and submitted, next sub group meeting in Sept 16	Completed - Assessment tool submitted. Lead Midwife complex needs to lead on sub group	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
		Review progress from self- assessment tool - FM/HBA to be included in safeguarding training. Domestic Abuse policy to be updated in line with practice guidance.	Lead midwife Vulnerable women? Trust IDVA	Feb-17	Staff have an awareness and understanding of FM/HBA/trafficking , can recognise signs and refer appropriately	Safeguarding adult training now include FM/HBA/Trafficking. Domestic Abuse policy needs updating. Information included in Lavender team operational policy	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
	Maintain Safeguarding Intranet site	Regular review by safeguarding leads and Trust Intranet lead	Safeguarding Leads Trust Intranet Lead	Dec-16	Trust staff are able to access relevant, up to date information to help them protect children and adults at risk	Recent additions made re Trust IDVA service. Intranet updated as necessary - ongoing	A	A	A	A	A	A	A	A	G	G	G	G	G	G	G	G	G

	Ensure Trust compliance with annual Section 11 visit and Annual assurance visits for Safeguarding Adults	Trust to participate in all Inspection visits and ensure completion of any recommendations	Safeguarding Leads	Feb-16	Trust able to demonstrate compliance with Section 11 of Children's Act and adult assurance visits - action plans developed re recommendations made from each visit	Section 11 visit took place 08/01/16. Adult assurance visit took place 17/02/2016	G	G	G	G	G	G	G	G	G	G	G	G	
	Ensure the Trust is responsive to Serious Case Reviews, Domestic Homicide reviews and Serious Adult reviews	Trust has current involvement in 1 SCR, 1 SAR and 1 DHRs	Safeguarding leads	Mar-17	Recommendations and action plan in place.	DHR ongoing - draft overall report was presented for review by panel 4/07/2016. Currently no reccs for health. SAR ongoing - recommendations reviewed in maternity. Trust internal SI to be completed by end of September with action plan	A	A	A	A	A	A	A	A	A	A	A	A	
Safeguarding Children and Unborns																									
	Ensure Trust has a robust safeguarding children supervision strategy in place for all relevant	Review and update current Supervision Strategy to a Supervision policy - particularly strengthening supervision within maternity	Named Nurse Safeguarding Children Named Midwife Safeguarding	Mar-16	Lavender midwife to facilitate group supervision for community leads and 1 to 1 for complex needs midwifery team.	New Policy presented and agreed at Panel Apr 16 - sent for next policy review group	A	G	G	G	G	G	G	G	G	G	G	G	

	staff	Supervision Policy to be implemented across key areas	Named Nurse Safeguarding Children, Safeguarding Nurses, Matron Paediatrics	Jul-16	Supervision process in place with 90% compliance Agen	Policy now ratified by QSG and available to staff	A	A	A	G	G	G	G	G	G	G	G	G
		Dip sample audits to be carried out on supervision records to review quality. Questionnaires to staff to review opinions on effectiveness and support	Safeguarding leads	Feb-17	Evidence from dip sample audits reported to SG panel	Audits to be presented at February panel	A	A	A	A	A	A	A	A	A	A	A	A
	Ensure Trust achieves and maintains 95% compliance with Levels 2 and 3 training and increases Level 1. Ensure staff train staff according to roles in	Maintain current high compliance with Level 3 by monitoring monthly compliance lists identifying new staff or staff who are about to expire	Named Nurse	Ongoing	Evidence from training compliance rates issued monthly and submitted to CCG via dashboard and Quality indicators	Current compliance figure Nov 16 - 96%	G	G	G	G	G	G	G	G	G	G	G	G

	line with Intercollegiate Guidelines																							
		Continue with additional level 2 sessions and continue to identify hotspots with divisions	Named Nurse, Training Department, Divisional Leads	Ongoing	As above	Current compliance figure Nov 2016 Level 2 - 96%. Level 2 e learning package now available	A	G	G	G	G	G	G	G	G	G	G	G
		Provide level 1 session with specific competencies for Trust Board members as part of Board development programme	Named Nurse, Named Doctor, Named Midwife	Jun-16	Board members understand roles and responsibilities for safeguarding.	Safeguarding Children and Adult session presented to Trust Board.	A	A	A	A	G	G	G	G	G	G	G	G
		Carry out training needs analysis on staff groups requiring Level 3 training	Named Nurse	Oct-16	Staff have training commensurate with their roles	Paper presented to Panel Oct 16 - agreed with Panel and Designated Team CCG								A	G	G	G	G
		Produce Safeguarding Passport for staff to record training hours and supervision sessions	Safeguarding Nurses	Mar-16	All paediatric and neonatal nurses and doctors will have a personal document containing evidence of training hours attended and supervision sessions attended to show compliance with	Completed - all paediatric nurses and doctors (registrar and above) have individual copy of passport	A	G	G	G	G	G	G	G	G	G	G	G

					mandatory requirements																		
		Provide additional training for matrons and senior nurses in adult areas re safeguarding issues for 16 and 17 year olds	Named Nurse	Jan-17	Staff working in adult areas are able to recognise and act on safeguarding concerns for young people in their clinical areas	Sessions carried out with Matrons/Senior Nurses within surgery division. Information on safeguarding for 16 and 17yr olds included in December safeguarding newsletter								A	A	A	A	G
		Ensure that Consultants and Registrars working in A and E are able to put Level 3 training into practice	Named Doctor Named Nurse	Jan-17	Consultants /Registrars in A and E are able to safeguard children in line with Trust and HSCB policies	Sessions delivered to A and E Consultants and Registrars - Clinical governance, small groups, Registrar training, One to one. Sessions focussed on practical aspects of safeguarding in A and E with case studies								A	A	A	A	G
		Update e learning packages for Level 1 and Level 2 to ensure that packages in line with core competencies	Named Nurse	Feb-16	Packages available on Trust system for staff to access as an alternative to classroom teaching	Completed - Updated e learning packages are now available for Trust staff to access	G	G	G	G	G	G	G	G	G	G	G	G
	Ensure Audits are completed in line with Trust Safeguardi	Audit of the standard of referrals sent to CS from unscheduled care, paediatric inpatients and maternity	Safeguarding Nurse, Named Midwife	Jan-16	Referrals sent to CS by Trust staff are appropriate, identify risks and are completed to a high standard to	Audit completed and presented to SG Panel Jan 16 - rec to provide info in level 3 training - training updated	G	G	G	G	G	G	G	G	G	G	G	G

	ng Audit strategy				ensure protection of vulnerable children																			
		Audit of the standard of case conference reports completed by maternity staff	Named Midwife, Maternity Department	Jan-16	Case conference reports submitted by maternity staff are of a good standard, clearly identify risks, strengths and progress and contribute to the decision making process around vulnerable children	Audit completed and presented to SG Panel Jan 16 - rec to update midwives training re report writing - completed	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
		Audit of the DNA process in paediatric out patients	Named Nurse and Named Doctor	Nov-16	Children who DNA appointments in paediatric out patients who may be vulnerable are identified promptly and referred to appropriate agencies	Audit to be presented to Panel Nov 16	A	A	A	A	A	A	A	A	A	G	G	G	G	G	G	G	G	G
		Audit of the pathway and referrals done for young people presenting with mental health concerns	Safeguarding Team / CED	Jun-16	Young people who attend with mental health concerns follow clear care pathways and have appropriate referrals made to agencies for support	Audit presented to Panel Jun2016	A	A	A	A	G	G	G	G	G	G	G	G	G	G	G	G	G	G

		Audit of the compliance with high risk birth plans within maternity services	Named midwife	Jun-16	Women and babies who are deemed high risk are given appropriate care and safeguarded within a multi-agency plan	Audit presented to Panel Jun2016	A	A	A	A	G	G	G	G	G	G	G	G
		Audit of the standard of safeguarding record keeping across key areas in the Trust	Safeguarding Team	Nov-16	Safeguarding record keeping across the Trust is of a high standard that contributes to the protection of vulnerable children.	Audit to be presented to Panel in Nov 16	A	A	A	A	A	A	A	A	A	G	G	G
	Maintain and strengthen Trust representation and work with the HSCB	Trust to be responsive to the HSCB Business Plan ensuring shared objectives where possible	Named Nurse, Named Doctor, Named Midwife	Nov-16	Safeguarding work within Trust is in line with priority areas identified by the HSCB	Business plan reviewed regularly. Safeguarding team involvement in HSCB subgroups that review action and progress around plan. Named Nurse attended launch of HSCB Neglect strategy Oct 16 and will present to Panel Nov 16. Work continues within Trust around CSE. Trust SG Nurse contributes to HSCB training pool delivering Toxic trio training.	A	A	A	A	A	A	A	A	A	G	G	G
		Trust staff to attend nominated sub groups whenever possible and to contribute to the work of the HSCB	Safeguarding Leads	Feb-16	Evidence from sub group membership and attendance records. Raised profile of Trust in HSCB work	WHHT Safeguarding team represented on all relevant HSCB panels with regular attendance at sub groups. Contributions made by WHHT team to HSCB activity e.g. training pool, procedure updates	G	G	G	G	G	G	G	G	G	G	G	G

						(concealed pregnancy).																		
	Ensure Trust carries out recommendations from Section 11 inspections	Trust to have safe IT systems in place to enable secure sending of electronic referrals by all staff	Trust IT leads	Mar-17	All staff are able to send electronic referrals from the Trust e mail system that are timely, legible and sent safely to Children's Services. Evidence from dip sample audits presented to Panel	External firm developing software to enable safe transmission of referrals	A	A	A	A	A	A	A	A	A	A	A	A
		Trust to ensure that temporary staff have access to Trust policies and procedures so that they are able to safeguard unborns and children at risk effectively	Named Nurse and Midwife Lead Nurse Workforce	Sep-16	Evidence from induction to ward checklists	Guideline produced for non - substantive staff re managing safeguarding cases. Available in each clinical area. Non - substantive staff information sheet which they sign on each shift contains info re safeguarding contacts and information.	A	A	A	G	G	G	G	G	G	G	G	G
	Ensure the Trust is responsive to Serious	Ensure completion of Action plan from Bradford SCR	Named Midwife, Maternity Dept	Jun-16	Recommendations and action plan in place.	Action plan completed - to be presented at Panel Sept16	A	A	A	A	A	A	G	G	G	G	G	G

	Case Reviews, Domestic Homicide reviews etc.	Ensure Trust has a postnatal policy that includes risk assessments of mental health and domestic abuse	Postnatal Manager, Community Matron	Mar-16	Audit to ensure compliance	Postnatal policy ratified within maternity to include relevant risk assessments. Dip sample audit completed.	A	A	A	A	A	A	G	G	G	G	G	G
		All staff (midwives and Obstetricians) carry out relevant risk assessments at key time and document	Lead Obstetrician, Antenatal manager, Safeguarding Midwife	May-16	Audit to ensure compliance	Safeguarding midwife presented SCR at clinical governance May 16. A copy of the presentation of the SI laminated and included in the learning folder in all maternity area to remind midwives of routine questioning.	A	A	A	A	A	A	G	G	G	G	G	G
		Ensure that the maternity notes includes information about who accompanies women to appointments	Consultant Midwife	Apr-16	Audits to ensure compliance	New records are now in use across maternity that have specific areas for recording who accompanies women to appointments - dip sample audit carried out showing 100% compliance	A	A	A	A	A	A	G	G	G	G	G	G
	Trust to be responsive to the Inquiry into offending by Bradbury	Review and update Chaperone Policy and add statement to all paediatric out-patient letters	Safeguarding Leads	Feb-17	Updated policy available to all staff	Policy has been updated and sent to key staff for review - on agenda for Safeguarding Panel Feb 2017 for agreement to PRG	A	A	A	A	A	A	A	A	A	A	A	A
		The Trust should consider how best to inform doctors and medical students of the help available to them if they have inappropriate sexual thoughts about patients.	Named Nurse Named Doctor	Mar-16		Information available via occupational health and will be included in safeguarding newsletter	A	G	G	G	G	G	G	G	G	G	G	G

	Trust to ensure it is compliant with requests from the Goddard Inquiry	Trust needs to ensure that any records relating to historical sexual abuse cases are available if requested by Inquiry	Named Nurse, Head of Medical Records	Jun-16		Goddard checklist presented to Panel in June - decision made to stop all destruction of records awaiting further guidance from NHS England. All other areas on checklist were met. Paper presented to TEC Nov 16 re costs/risks of stopping destruction of records	A	A	A	A	G	G	G	G	G	G	G	G
	Trust to ensure it is recognising children and young people who are at risk of or are being sexually exploited	Re launch sexual health proforma in key clinical areas and provide guidelines for use	Named Nurse	Feb-16	Children at risk of CSE are identified and referred appropriately. Evidence reported via CCG dashboard and quality indicators	Completed	G	G	G	G	G	G	G	G	G	G	G	G
		Named Nurse to be an active member of the HSCB Strategic Safeguarding Adolescents Group	Named Nurse	Ongoing	As above	Completed	G	G	G	G	G	G	G	G	G	G	G	G
		Continued awareness raising of CSE across the Trust and being responsive to local information or national guidelines	Safeguarding Team	Nov-16	As above	Lavender Team to use sexual health proforma in relevant cases. Review will take place of referrals and use of sexual health proforma to ensure consistency and use is appropriate	A	A	A	A	A	A	A	A	G		G		G
Safeguarding Adults																							
	Ensure Audits are completed in line with Trust	Dip and dive individual case reviews	Named Nurse	ongoing	To provide Trust Board with assurance re	Completed monthly	G	G	G	G	G	G	G	G	G	G	G	G
		Audit of Mental Capacity Act compliance	matrons / safeguardi	Jul-16		Audit presented to safeguarding panel in Jun 2016	A	A	A	A	G	G	G	G	G	G	G	G

Safeguarding Audit strategy		ng team		quality of safeguarding activity carried out across the Trust																			
	Audit of the Deprivation of Liberty applications	matrons / safeguarding team	Jul-16		Audit presented to safeguarding panel in Jun 2016	A	A	A	A	G	G	G	G	G	G	G	G
	Audit of consent for procedures using consent form 4	Head of nursing	Jan-16		Completed and presented to safeguarding panel in January 2016	G	G	G	G	G	G	G	G	G	G	G	G
	audit of compliance with the missing persons policy	safeguarding team	Feb-17		Audit to be presented to February Panel	A	A	A	A	A	A	A	A	A	A	A	A
	Dementia carers survey (CQUINN target)	Dementia team	monthly	Audit to ensure that contact is made with as many dementia carers as possible and signpost them to appropriate service/support		G	G	G	G	G	G	G	G	G	G	G	G
	Audit of compliance with the dementia care pathway including "blue clasps" and "this is me"	Dementia team	monthly	Audit to ensure compliance		G	G	G	G	G	G	G	G	G	G	G	G
	Audit of the dementia screening tool (CQUINN)	Dementia team	monthly	Audit to ensure compliance	Awaiting new CQINN targets currently 95%	A	G	G	G	G	G	G	G	G	G	G	G
	National dementia audit for 2016	Dementia team	Sep-16		Will be commenced in April 2016	A	A	A	A	A	A	A	A	G	G	G	G
	Dip and dive sampling of compliance with temporary nurse induction into clinical areas	safeguarding team	bi-monthly	Audit to ensure all temporary staff are inducted to the clinical areas	This audit will commence in July 2016	A	A	A	A	A	A	A	A	A	G	G	G

		Dementia teaching strategy, target 80%	Dementia team	annual	Audit to ensure compliance	Meeting arranged for 14th April with training dept. to discuss future needs	G	G	G	G	G	G	G	G	G	G	G	G
	Ensure Trust achieves and maintains 95% compliance with Levels 1 and 2 training rates	Update e learning packages for Level 1 and Level 2 to ensure that packages in line with core competencies	Named nurse safeguarding adults	Dec-15			G	G	G	G	G	G	G	G	G	G	G	G
		Continue with additional level 2 sessions and continue to identify hotspots with divisions	Safeguarding adults team	Jan-16			G	G	G	G	G	G	G	G	G	G	G	G
	Ensure Trust achieves and maintains 95% compliance with mental Capacity and Deprivation of Liberty Safeguards	Update teaching PowerPoint presentation with RAID	Named nurse safeguarding adults	Dec-15	Updated to ensure compliant with the Care Act 2014		G	G	G	G	G	G	G	G	G	G	G	G

	Medical staff to be compliant with the mandatory framework relating to MCA and DoLS target 95%	Named consultant for safeguarding	Mar-17	All medical staff will have a good awareness of MCA and DoLS and will be able to demonstrate compliance with mandatory requirements	External expert presented at Grand Round. Sessions completed for surgery and anaesthetics Named consultant has provided additional sessions for medical staff - ongoing	A	A	A	A	A	A	A	A	A	A	A	A
	The impact of training will be monitored by using a quiz at the end of training sessions	Safeguarding adults team	ongoing	Provide assurance that staff have an understood safeguarding and know how to make a referral		A	A	A	A	A	A	A	A	A	G	G	G
	Provide additional training sessions for clinical staff to increase compliance to 95%	named nurse /safeguarding adults/ RAID Team	Jul-17		additional training sessions being arranged with training department	A	A	A	A	A	A	A	A	A	A	A	A
There will be robust monitoring systems in place to support the safeguarding agenda	The safeguarding adult data base will be maintained and cross referenced hospital social workers and tissue viability	Named nurse safeguarding adults	ongoing	Trust is able to demonstrate effective safeguarding of adults	Referrals and patients being admitted from care homes are monitored for themes and trends	G	G	G	G	G	G	G	G	G	G	G	G
	A thematic review will be undertaken on all safeguarding incidents reported on Datix	Named nurse safeguarding adults	Mar-17	To identify themes in serious incidents/ RCA to inform the adult safeguarding		A	A	A	A	A	A	A	A	A	A	A	A

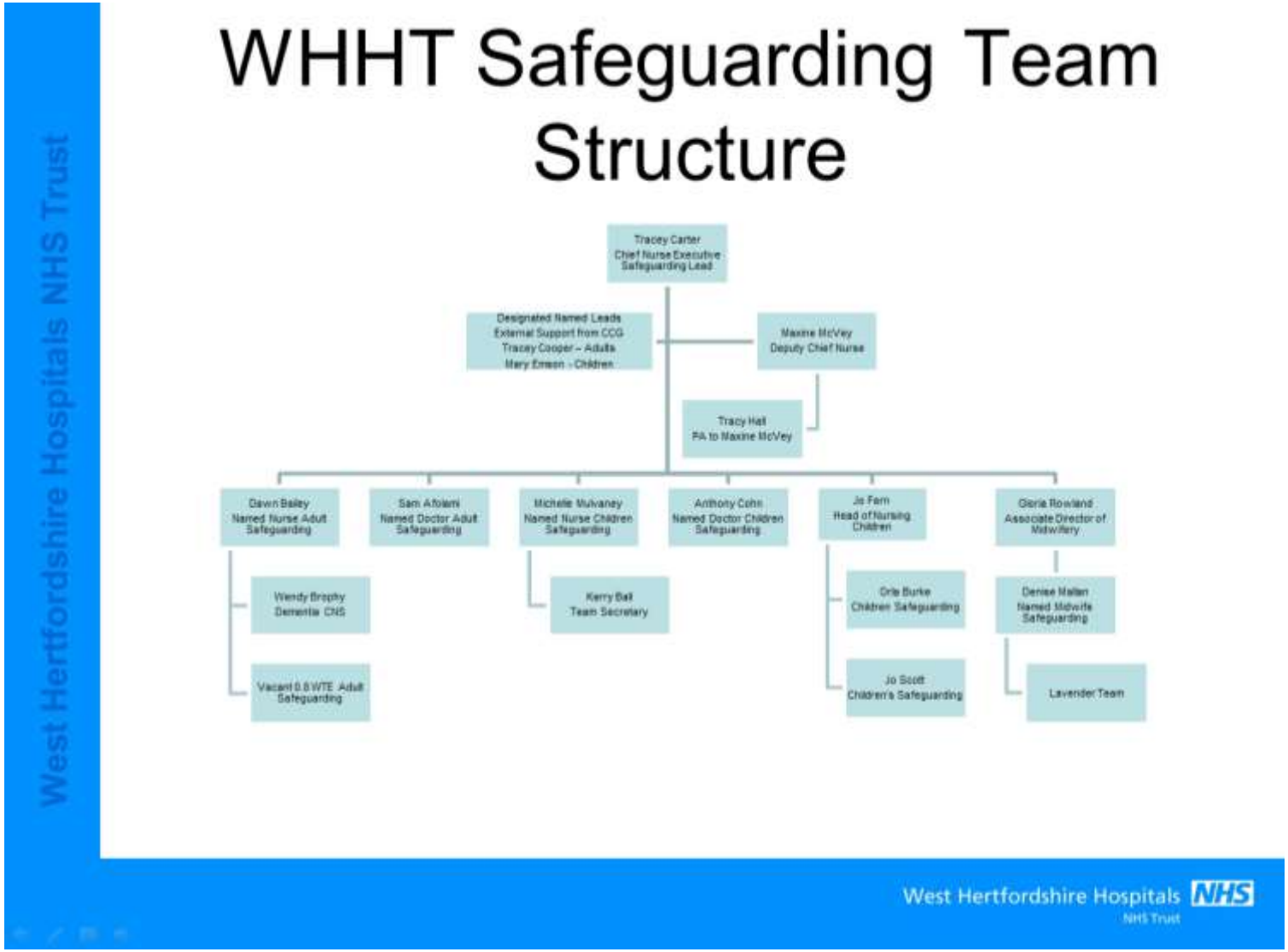
				strategy work plan and to review the root causes.													
	A DoLS care plan will be developed for staff and will incorporate restraint/restriction	Dementia lead nurse	Mar-17	Staff will be able to identify individual care needs and be able to identify when the DoLS is due to expire	A Dols care plan has been trialled on 4 wards. Amendments to be made following suggestions by nursing staff						A	A	A	A	A	A	A
	A data base for recording Deprivation of Liberty safeguard applications will be maintained	Named nurse safeguarding adults	ongoing	The Trust is able to reference the number of DoLS applications applied for and track them to ensure compliance		G	G	G	G	G	G	G	G	G	G	G	G
The Trust will work in partnership	The sub groups of HSAB will be atteneded by safeguarding adults team	Named nurse safeguarding adults	Feb-16	The Trust is able to demonstrate working in partnership with HSAB	All sub groups of the HSAB have a Trust representative	G	G	G	G	G	G	G	G	G	G	G	G
	The trust will be responsive to Serious adult reviews (SARS)	Named nurse safeguarding adults	ongoing		Trust has contributed to one SAR and one DHR	G	G	G	G	G	G	G	G	G	G	G	G
	There will close working partnership with the Acute Health liaison team and community learning disability team	Safeguarding adults team	Ongoing		evidence of partnership working and making reasonable adjustments documented in minutes of sub group and strategy meetings	G	G	G	G	G	G	G	G	G	G	G	G

		There will be a learning disability sub group that will be effective and responsive	Safeguarding adults team	bi-monthly	The needs of patients with LD will be met and reasonable adjustments made.	Service user feedback shared at safeguarding panel and with matrons &HON, minutes of LD sub group and LD action plan	G	G	G	G	G	G	G	G	G	G	G	G
		The "purple star" strategy will be implemented on all wards and departments	Safeguarding adults team	ongoing		Vascular Lab,AAA Screening and day surgery have completed	A	A	A	A	A	A	A	A	A	A	A	G
		Accessible information standards for identifying, recording, flagging to meet the communication support needs of patients and carers requires implementation	Comms Team / PPI Manger	Mar-17			A	A	A	A	A	A	A	A	A	A	A	A
		Further easy read information leaflets are required	Safeguarding adults team	Sep-16			A	A	A	A	A	A	A	G	G	G	G	G
	The trust has consistent high standards for responding to reporting and learning from safeguarding incidents	Safeguarding incidents will be escalated appropriately	Divisional leads and risk leads	ongoing	Evidence can be found in safeguarding panel minutes and review of vulnerable adults register		G	G	G	G	G	G	G	G	G	G	G	G
	The Trust will have a clear focus on safeguarding all adults at risk who access our	all safeguarding referrals will be input onto infoflex to provide data for reports and monitoring	Safeguarding administrator	ongoing			G	G	G	G	G	G	G	G	G	G	G	G

services																							
	The trust intranet home page for safeguarding is up to date	safeguarding team	ongoing			G	G	G	G	G	G	G	G	G	G	G	G						
There will be continue and improved intervention and practice in safeguarding adults at risk	Introduction of MCA/DoLS knowledge and competency framework will be incorporated into ward accreditation	Named nurse safeguarding adults	Sep-16		Competencies introduced on Sarratt, Croxley, Winyard, Bluebell Wards and Red Suite AAU.	A	A	A	A	A	A	A	A	A	A	G	G						
	A MCA/DoLS app will be developed and launched	named nurse with CCG	Apr-17			A	A	A	A	A	A	A	A	A	A	A	A						
	The Trust will support 5 staff to undertake the Best Interest Assessors course	Heads of nursing	Sep-16		3 staff commenced course in April and 3 fully trained	A	A	A	A	A	A	A	G	G	G	G	G						
Ensure Trust has a safeguarding adults supervision strategy in place for all relevant staff	Review and update current Supervision guidance	Named nurse safeguarding adults/ education team	Apr-17		Supervision policy is being written by the Lead Nurse for Learning and Development	A	A	A	A	A	A	A	A	A	A	A	A						

Ensure the Trust has a high standard of care for people living with dementia	The development of a dementia bundle will be developed to include "this is me" and the Abbey pain scale	Dementia lead nurse	Mar-17												A	A	A	A	A
	A policy will be developed for dementia and frailty	Dementia lead nurse	Aug-17		The dementia has been approved via safeguarding panel and also ratified										A	G	G	G	G
	A family/carer information leaflet will be developed	Dementia lead nurse	Apr-17												A	A	A	A	A

Appendix B Accountability structure



Trust Board meeting
07 September 2017

Title of the paper	**Medical Revalidation Annual Organisational Audit 2016/17**
Agenda item	**16/51**
Lead Executive	**Dr Mike van der Watt, Medical Director**
Author	**Deborah Wadsworth, Senior Business Manager**
Executive summary **(including resource implications)**	The aim of this paper is to demonstrate the effectiveness of the Trust's medical revalidation programme and to provide assurance that the Trust's Responsible Officer is discharging his respective statutory responsibilities
Where the report has been previously discussed, i.e. Committee/Group	

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

- The Board is asked to receive the report for information and assurance that the statutory responsibilities are being managed appropriately.

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 This audit provides assurance to patients that doctors at the Trust meet the standards of Good Medical Practice as defined by the General Medical Council (2013) and that the systems underpinning medical revalidation recommendations made by the Responsible Officer to the General Medical Council (GMC) are effective, consistent and fully compliant with NHS England requirements.	

Agenda Item: 16/51

Trust Board Meeting – 07 September 2017

Medical Revalidation Annual Organisational Audit 2016-17

Presented by: Dr Mike van der Watt, Medical Director

1. Purpose

The Trust is required to submit an Annual Organisational Audit to NHS England (Appendix 1), sharing medical revalidation performance data and providing assurance around systems for appraisal and responding to concerns. Once this information is presented to the Board, the Trust must submit a Statement of Compliance.

The purpose of this paper is to demonstrate the effectiveness of the Trust's medical revalidation programme and to evidence compliance with the Trust's obligation to revalidate all doctors at the Trust every 5 years.

The Trust also provides the Responsible Officer function for the Peace Hospice and the Hospice of St Francis. For completeness the hospice Annual Organisational Audits have been added as Appendix 2 and 3 for information. Both hospices achieved 100% compliance across a total of 10 doctors.

2. Background

2.1 The appraisal and revalidation process was introduced in 2012. To maintain their registration with the General Medical Council (GMC) and their licence to practise, doctors are now required to undertake an annual appraisal and to be revalidated once every 5 years. The revalidation process requires a doctor to satisfy and evidence the 4 domains of Good Medical Practice:

Knowledge, skills and performance
Safety and quality
Communication, partnership and teamwork
Maintaining trust

Effective appraisal allows for proper evaluation of a doctor's progress against these domains and supports the establishment of a valuable Personal Development Plan.

To evidence the effectiveness of its revalidation programme, the Trust is required to submit an Annual Organisation Audit (AOA) (Appendix 1), as part of the 'Framework for Quality Assurance for Responsible Officers and Revalidation' to NHS England. For 2016/17, this submission was made on 23 May 2017.

2.2 At 31 March 2017, there were 358 doctors with a prescribed connection to the Trust. The AOA examined how many of these doctors received an appraisal for 2016/17 and required the Responsible Officer to provide assurance on 20 quality checks.

2.3 Assurance was possible on all of the 20 checks

3. Analysis/Discussion

3.1 Of the 358 doctors with a prescribed connection to the Trust, for 2016/17, 341 (95.2%) doctors received an appraisal. 6 (1.6%) doctors had appraisals which at the time of counting were incomplete, or had been missed with approval (e.g. maternity leave, long term sickness) and 11 (3.0%) missed their appraisal without approval.

3.2 Of the 11 doctors with a prescribed connection to the Trust who missed their appraisal during 2016/17 without approval, 9 have now completed. 6 of these doctors fell out of time close to the cut-off date for counting. Of the remaining 2, 1 has had their appraisal postponed to June (this was agreed after the submission was made) and 1 booked and then cancelled an appraisal. This case is being pursued. A further consultant had previously not been engaging with the process, this was discussed with the GMC and that individual subsequently engaged and received an appraisal before being referred. Overall compliance at 31 March for 2016/17 was 96.9%

3.3 The 20 positive quality checks assured are set out below. These equate to 100% of the framework standards

a) A responsible Officer has been appointed in compliance with the regulations
b) No cases of conflict of interest or appearance of bias have been identified
c) Sufficient funds, capacity and other resources have been provided by the Trust to enable the Responsible Officer to carry out the responsibilities of the role
d) The Responsible Officer is appropriately trained and remains up to date and fit to practice in the role
e) Accurate records are kept of all relevant information, actions and decisions relating to the Responsible Officer role
f) The Trust's medical revalidation policies and procedures and in accordance with equality and diversity legislation
g) The Responsible Officer makes timely recommendations to the General Medical Council (GMC) about the fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer protocol
h) The governance systems are subject to external or independent review
i) The Trust has commissioned or undertaken and independent review of its processes relating to appraisal and revalidation
j) Every doctor with a prescribed connection to the Trust with a missed or incomplete appraisal has an explanation recorded
k) There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the Board (or an equivalent governance group)
l) There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance and the outcomes are recorded in the annual report template
m) There is a process in place for the Responsible Officer to ensure that key items of information are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified

n) The Trust has sufficient numbers of trained appraisers to carry out medical appraisals for all doctors with whom it has a prescribed connection
o) Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice
p) There is a system for monitoring the fitness to practice of doctors with whom the designated body has a prescribed connection
q) A responding to concerns policy is in place which is ratified by the Trust Board (or an equivalent governance group)
r) The Board receives an annual report detailing the number and type of concerns and their outcome.
s) The Trust has arrangements in place to access sufficient trained case investigators and case managers
t) There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors

4. Risks

Through the Annual Organisational Audit, the Trust is able to evidence an effectively embedded appraisal and revalidation system. This system was subject to a desktop review by NHS England at the start of 2016 and was found to be exemplar.

The Trust is able to offer a high level of assurance that its doctors meet the standards of good medical practice as defined by the General Medical Council.

5. Recommendation

5.1 The AOA for 2016/17 demonstrates that the Responsible Officer is discharging the respective statutory responsibilities of the role. It also offers firm assurance that the revalidation programme is being managed and is operating effectively.

5.2 The Board is therefore asked to receive this paper for information and assurance.

Dr Mike van der Watt
Medical Director
September 2017

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	06491
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2017
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2015/16 AOA cleared with Publications Gateway Reference 04543
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Please do not use this version of the form to submit your response.

Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2017** for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

Please do not use this version of the form to submit your response.

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** West Hertfordshire Hospitals NHS Trust	
	Head Office or Registered Office Address if applicable line 1 Trust Offices	
	Address line 2 Watford General Hospital	
	Address line 3	
	Address line 4	
	City Watford	
	County Hertfordshire	Postcode WD18 0HB
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☑
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☑
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

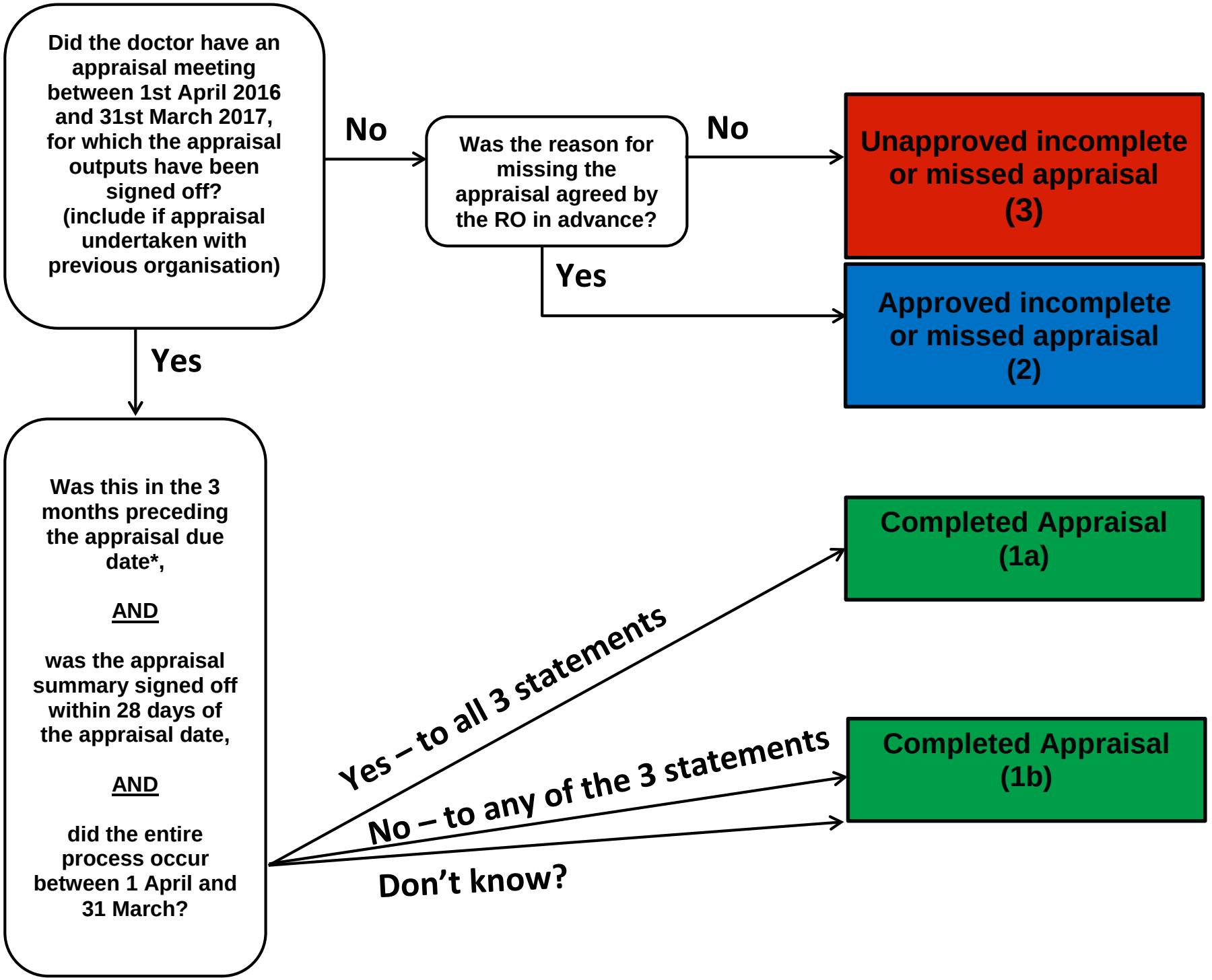
1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	226	205	9	4	8	226
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	61	53	5	1	2	61
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	71	66	3	1	1	71
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	358	324	17	6	11	358

Please do not use this version of the form to submit your response.


Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

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2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

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2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

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	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1		

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012, updated 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	06491
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2017
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2015/16 AOA cleared with Publications Gateway Reference 04543
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2017** for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

Please do not use this version of the form to submit your response.

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Peace Hospice Care	
	Head Office or Registered Office Address if applicable line 1 Peace Drive	
	Address line 2	
	Address line 3	
	Address line 4	
	City Watford	
	County	Postcode WD17 3PH
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	 GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	 Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☑
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☑
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

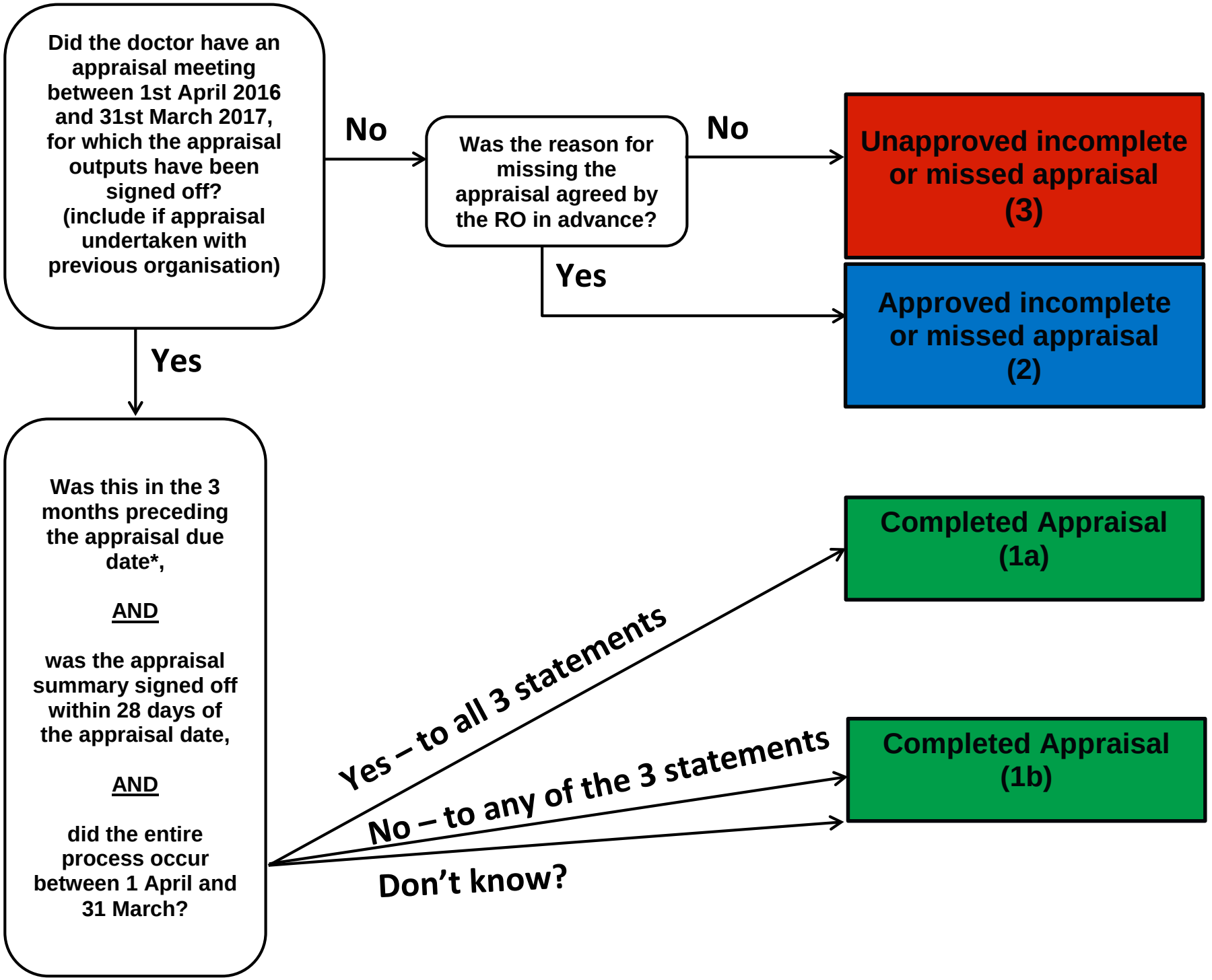
1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	2	2	0	0	0	2
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	1	1	0	0	0	1
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	1	1	0	0	0	1
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	4	4	0	0	0	4

Please do not use this version of the form to submit your response.


Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

Please do not use this version of the form to submit your response.

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☐ Yes ☐ No ☑ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1		

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012, updated 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	06491
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2017
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2015/16 AOA cleared with Publications Gateway Reference 04543
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2017** for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

Please do not use this version of the form to submit your response.

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Hospice of St Francis	
	Head Office or Registered Office Address if applicable line 1 Spring Garden Lane	
	Address line 2	
	Address line 3	
	Address line 4	
	City Berkhamsted	
	County Hertfordshire	Postcode HP4 3GW
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☑
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☑
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	2	2	0	0	0	2
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	4	3	1	0	0	4
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	0	0	0	0	0	0
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	6	5	1	0	0	6

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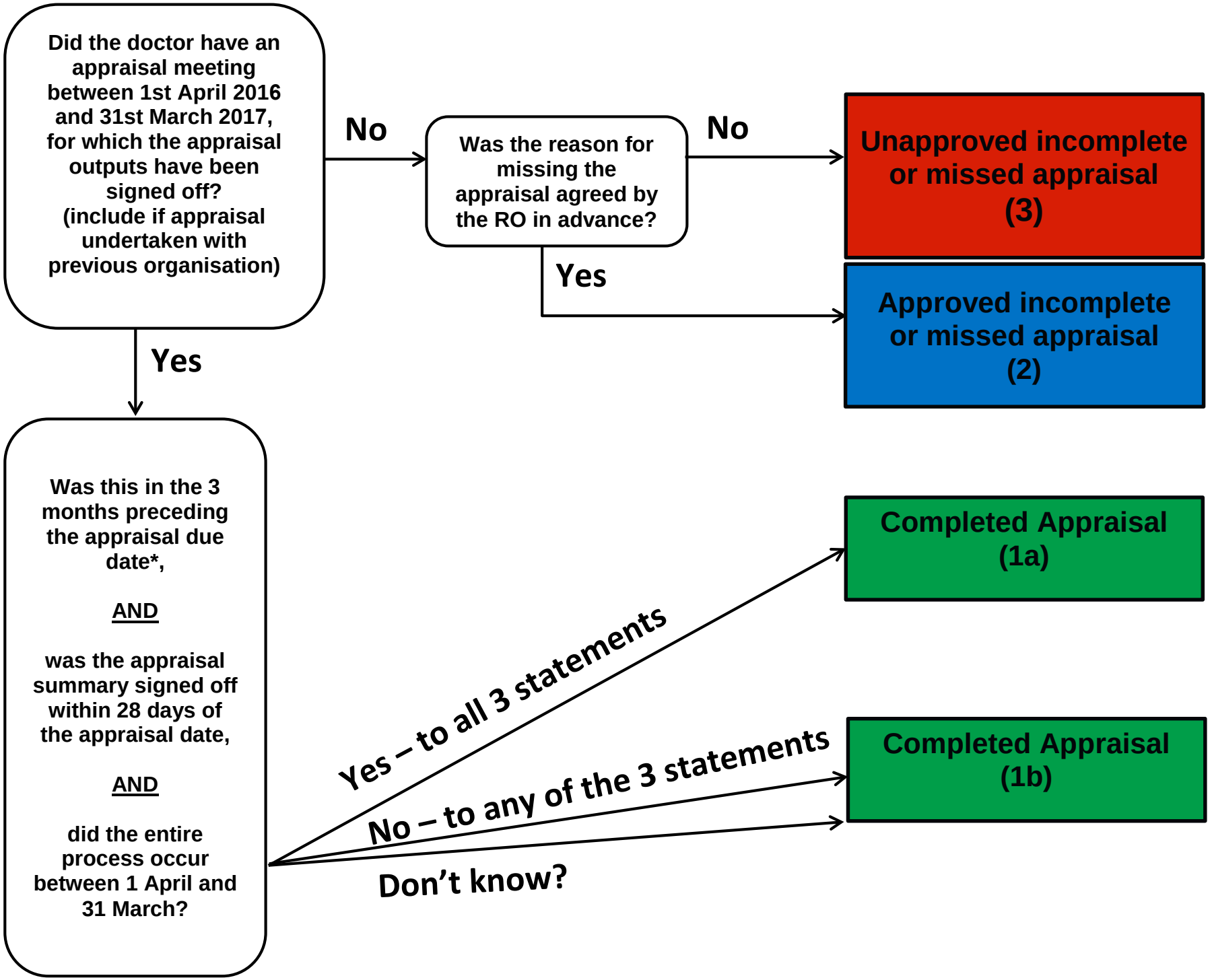

Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

Please do not use this version of the form to submit your response.

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☐ Yes ☐ No ☑ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1		

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012, updated 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

Trust Board meeting
07 September 2017

Title of the paper	**Annual Public Sector Equality Duty Report 2016/17**
Agenda item	**17/51**
Lead Executive	**Paul Da Gama, Director of Human Resources**
Author	**Monika Kalyan, Equality and Diversity Manager**
Executive summary **(including resource implications)**	The purpose of this report is to outline the key findings of the Trust's 2016/17 Public Sector Equality Duty Report (PSED), along with priority areas for 2017/19, to ensure that WHHT is compliant with the Equality Act 2010. Publication of the PSED report will fulfill our legal requirement to report on ED. Publication of the PSED report on the public website would be evidence of compliance with the specific duty of the Equality Act 2010.
Where the report has been previously discussed, i.e. Committee/Group	• Patient and Staff Experience Committee • Trust Executive Committee
Action required: • The Board/ is asked to approve the full PSED report and WRES data.	
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 workfor ☐ **PR3** Current estate and infrastructure compromises the ability to delive 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 Emergen 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 i 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 Promoting an inclusive culture is key to ensuring patient safety and excellent patient and staff experience.	
Risks attached to this project/initiatives and how these will be managed The current published PSED report requires updating; the risk of legal challenge is low.	

Agenda Item: 17/51

Trust Board meeting – 07 September 2017

Annual Public Sector Equality Duty Report 2016/17

Presented by: Paul Da Gama, Director of Human Resources

1. Background and context:

From the 6th April 2011 the **general and specific duties** of the Equality Act 2010 come into force. The duties introduced the concept of protected characteristics, which are the nine groups that are covered by the law (age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex and sexual orientation).

In brief the **general duty** means that WHHT must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

Having due regard for advancing equality involves WHHT:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the duty may involve treating some people more favorably than others.

The **specific duties** are designed to help public bodies meet the general duty. WHHT must comply with the specific duties of the Act and this means that it must:

- Publish employment monitoring statistics and information on performance against equality and diversity (ED) to demonstrate its compliance with the general equality duty at least annually.

This is WHHT's fifth annual PSED report and fulfills part of our public sector equality duty to report on ED. It signals the Trust's commitment to equality and diversity and the ethos of the duties placed upon us. The report includes data analysis as well as areas for further investigation. We also outline our priority areas and highlight progress made over the past year.

A copy of the fully comprehensive PSED report is included in Appendix 1. The PSED Report covers a 12-month reporting period from April 2016 – March 2017.

2. Equality achievements & progress in 2016/17

Our vision is that equality and diversity is firmly embedded in the full breadth of the Trust's work. We aspire to understand, reflect and meet the needs of the diverse communities we serve by providing services that are accessible, inclusive and non-discriminatory.

The Trust's approach goes beyond fulfilling statutory and regulatory obligations. It aims to support the development of a workplace where individuals feel empowered and equally valued in their diversity.

In 2016/17, our objectives and outcomes were focused around ensuring strong foundations for progress on ED. Over the life of the previous PSED report, our key successes include:

- Creation of the Trust's Workforce Equality Forum, with membership drawn from across the Trust including chair of our Staff Side enabling a more innovative and creative approach to solving ED issues

- Continued focus on training and guidance incorporating unconscious bias awareness for recruiting managers. Initial feedback has been positive, with managers indicating that they have been provided with new insights

- Focus on complying with requirement to complete Equality Impact Assessments

- Staff-led disability network Let Me See / Hear You Panel launched in 2015 successfully broadened to include patient representatives

- We signed up to the 'Disability Confident' employer scheme and have made a number of commitments

- Monitoring ED aspects of our workforce through the national Workforce Race Equality Standard (WRES)

- Maintained multi-cultural staff network *Connect* to champion the Black and Minority Ethnic (BME) agenda on progression

- Holding a drop in session for staff with disabilities

- To ensure that our workforce is aware of their responsibilities under the Equality Act, we introduced mandatory online ED training. The training is focused around PSED obligations, behaviors and equality impact assessments

- Organising health & well-being workshops

- Preparing for implementation of the Accessible Information Standard to ensure the communications and information needs of all patients are met

- New apprenticeship levy which will widen access to work and training opportunities, for young people and those looking to return and retrain

3. Key results of our 2016/17 PSED report

Over the last 3 years the Trust has focused on improving our diversity monitoring for staff this has enabled us to develop a clearer picture of who our staff are and where inequalities exist, and to measure progress in reducing discrimination.

The key findings of the 2016/17 PSED report are shown in table below. A copy of the full PSED report is included in Appendix 1.

Table 1: Summary of key results

Key results	Analysis of results
A). Black and Minority Ethnic (BME) staff make up 32.1% of the Trust's workforce. 62.3% of our workforce is White. The data show a steady increase in diversity over the last 3 years: In 2015/16, 31.2% BME; 63.5% White The figure for 2014 was 29.9% for BMEs and 64.4% for the White group.	Our workforce is more ethnically diverse than the local and patient population. BME representation has increased over the last 3 years but there remains significantly less BME people in senior roles in the non-medical workforce. This pattern is apparent across the NHS as described in a recent NHS report *Snowy White Peaks of the NHS*. In contrast, there is an overrepresentation of BME staff in the higher bands in the medical workforce (Consultant and Other Medical) compared to their overall representation in the Trust.
B). The male / female gender split at WHHT is 78.7% female and 21.3% male These figures are similar with those of previous years: last year 79.3% of our workforce was female and 20.7% male. Overall NHS workforce of 77% female and 23% male.	Our gender profile is comparable to other NHS organisations. We continue to monitor return to work following maternity leave. Full comparative data is shown in the attached PSED report. Regulations on mandatory gender pay gap reporting in place. The Trust is preparing to report its gender pay gap by 31 March 2018. .
C). The largest cohort of staff are found in age band 25 – 29 this group accounts for 15% (694 staff) of the workforce followed by the 40 – 44, 45 – 49 and 50 - 54 age groups. The age split of the workforce remains	The 50-54 age group is the largest age band for similar acute Trusts nationally, followed by the 45 to 49 age group and then the 40 – 44 group (source: Health & Social Care Information Centre). The planned work for Apprentices and

Key results	Analysis of results
consistent with the previous year.	Bands 1-4 is vital to refresh the workforce and enable new roles and career pathways.
D). Staff in the 26 – 30 age band show the highest proportion of staff leaving (accounting for 24.3% (229 staff) of all leavers) followed by the 21 - 25 and 31 – 35 age bands. These figures are similar with those of last year.	High turnover of younger workforce has implications for recruitment, retention and development. Our plan is to refresh the 'See, Start, Support & Sustain' approach for a joined-up approach to recruitment, retention & development. This is a key part of the overall workforce strategy.
E). Declaration levels for disability are low. 41 staff (0.9% of the workforce) have declared a disability. The figure for last year was 28 staff. 2.1% of staff in similar acute Trusts have declared themselves disabled. When comparing against all Trusts in Bedfordshire and Hertfordshire, 1.9% of staff have declared a disability.	We believe that 41 staff declaring themselves to be disabled seems very low. In the 2016 national staff survey, 239 of staff declared a disability. We will continue to work with the staff-led Let Me Hear / See You Panel to encourage staff to declare their disability status to update our records.
F). As at 31st March 2017, 67.9% of staff employed by the trust were working full time and 32.1% were employed on a part time basis. This is broadly similar to last year's figures: 66.4% full time and 33.6% part time.	There are more staff working part time in lower bands. Bands 2, 5 and 6 have the highest number of staff working on a part time basis. We analysed data on part time working patterns for 18 EOE Acute Trusts. We ranked 15 out of 18. The Trust recognises that to achieve equality in the workplace, we must address the part time gap across the organisation. Our aim is to complete a gap analysis of our current practice around flexible and part-time working looking at what higher performing EOE trusts are doing differently on this agenda.

4. A focus on Race: NHS Workforce Race Equality Standard 2016/17

The national NHS Workforce Race Equality Standard (WRES) came into effect in 2015. It is designed to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. There are a total of nine indicators that make up the WRES split across workforce data, the national NHS Staff Survey and Trust Board composition.

Going forward from 2017/18 the Trust will replace the existing PSED reporting template with one single template incorporating both the WRES and PSED metrics. Outcomes of the WRES data support findings of the PSED report. The WRES data has been published on the Trust's external website as stipulated in the Standard Contract.

The Trust's performance data for 2016/17 is presented in the table below and demonstrates areas of good practice and highlights areas where the Trust should undertake further inquiry and action. 2015/16 data included for comparison.

Table 2: WRES data 2016/17 areas of improvement

WRES Indicators	2016/17 performance	Better ▲ or worse ▼compared to 2015/16 data
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce (Organisations should undertake this calculation separately for non-clinical and for clinical staff).	• Similar to the previous year, there continues to be more BME staff in the lower AfC bands than higher bands in both clinical and non-clinical roles. Key successes 2016/17: • Training for recruiting managers to raise awareness of unconscious bias • All our HR people processes are aligned with our Trust values. • Support multi-cultural staff network	No change
Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts	• The relative likelihood of White staff being appointed from short listing compared to BME staff is 1.31. • 2015/16: 1.64. Key successes 2016/17: • Extended recruitment & selection training • HR core skills training delivered to staff & managers to influence people management practices	▲
Indicator 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	• BME staff are 1.31 times more likely to be disciplined than White staff. • 2015/16: 2.3 times more likely. Key successes 2016/17: • Portal and suite of tools developed to support staff and managers on a range of employee relations issues • New resolution guide which provides clearer support for staff	▲
Indicator 4 Relative likelihood of staff accessing non-mandatory training and	• White staff are 1.17 more likely than BME staff to access non-mandatory training & CPD. • The figure for 2015/16 was 0.9.	▼

WRES Indicators	2016/17 performance	Better ▲ or worse ▼compared to 2015/16 data
CPD	<u>Key successes 2016/17:</u> • Continued to deliver HR core skills training delivered to staff & managers to influence people management practices	
Indicator 5, 6, 7 & 8 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months Percentage believing that trust provides equal opportunities for career progression or promotion In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	• Decrease in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public. Results to closer to that of White staff • Marked difference in percentage of BME staff experiencing harassment, bullying or abuse from staff. 30% in 2015 dropped to 24% in 2016 staff survey. 1% less than the figure for White staff • Increase in the percentage of BME staff believing that trust provides equal opportunities for career progression or promotion • Drop in the percentage on BME staff stating that they have personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues but still twice as high as White staff <u>Key successes 2016/17:</u> • Bullying & Harassment advisers made available to all staff • Bullying & Harassment advisers have been allocated to specific divisions & hotspot areas • Bullying & Harassment intranet site with a wealth of information to support staff including external support	▲
Indicator 9 Percentage difference between the organisations' Board voting membership and its overall workforce	• There is a bigger percentage difference between the Trust's Board voting membership and its overall workforce. The percentage difference between BMEs in the overall workforce compared to the Board Voting Membership is -28.5%. Trust workforce BME 32.2% White 62.3% Non-voting execs BME 0% White 100%	▼

WRES Indicators	2016/17 performance	Better ▲ or worse ▼compared to 2015/16 data
	Voting execs BME 20% White 80% The figure for 2015/16 was -24.2% percentage difference <u>Key successes 2016/17:</u> • Board session on ED • Equality impact assessment completed as part of the development of policies and procedures	

5. ED priorities for 2017/19

We have complied with our legal duties and regulatory expectations. However, closer analysis of our PSED and WRES data indicate that there are opportunities to further strengthen our approach.

Our aim is to ensure ED is integral to all decision making and to representative as possible of the communtites we serve. Together with the Workforce Equality Forum and Let Me See/Hear You Panel, we have identified key priority areas for 2017/19 to maximize impact and achieve the priority outcomes.

Our main areas of focus for this year are set out in the table below. Four out of five of our objectives are staff focused and the remaining one looks at the experience of disabled patients.

We will build upon the earlier successes (section 2) to work towards our vision of 'effortless inclusion'.

<u>Table 3: Key ED priority areas for 2017/19</u>

Priority area	Outcome measure of success	Responsible owner	Timescale
1. BME groups, people with disabilities and males less successful in recruitment and selection process	At least 1 member of 90% of interview panels trained in recruitment & selection	Associate Director of HR	12/18
2. BME staff more likely to be disciplined than white staff)	By the end of 2017 we will have scoped options for a panel of in-house mediators	Head of Employee Relations	11/16

	We deliver all actions in the 2017/18 WRES plan with input from *Connect* multicultural staff network and Workforce Equality Forum		06/18
3. NHS Staff Survey show fewer BME staff believe that trust provides equal opportunities; higher percentage of BME staff believe that they have personally experienced discrimination	Reduction in gap in results between White and BME staff who believe the trust provides equal opportunities for career progression or promotion from 13% to 8% difference Reduction in the no of BME staff reporting that they have at work from a manager / team leader or other colleagues in the next survey from 12% to 8%	Head of Employee Relations & HRBPs	09/18
4. NHS Staff Survey results show disabled staff feel less positive about their experience at work	By the end of 2018 achieve Level 2 Disability Confident employer status	Head of Employee Relations & ED Manager	06/18
5. Access to and experience of service needs improving for disabled patients	Implement national Equality Delivery System2 in 2018 in consultation with Disability Watford and PPI panel	ED Manager with PPI lead	12/18

Monitoring

Overall monitoring of ED takes place with both internal and external stakeholders using the national NHS Equality Delivery System2 (EDS2) performance framework. As part of the EDS2 grading process, the Trust's performance is reviewed every three years and policy and practice modified as necessary. The next EDS2 grading assessment is scheduled for July 2018.

The Trust Board has overall responsibility of equality and diversity and is responsible for reviewing progress and performance annually. Reports on progress will be made biannually to the Patient & Staff Experience Committee, and annually to the Board. Our priorities and plans will be assessed and updated annually. A PSED annual report will be produced for staff, patients and other stakeholders.

6. Recommendation

The board is approve publication of the full PSED report and WRES data.

Paul da Gama,
Director of Workforce & Organisational Development
August 2017

NHS
West Hertfordshire Hospitals
NHS Trust

Public Sector Equality Duty Report 2016/17

A report detailing West Hertfordshire Hospitals NHS Trust's equality information as required by the Equality Act 2010

Foreword

West Hertfordshire Hospitals NHS Trust is proud to be a significant employer in Hertfordshire; our sites across the county bring diversity to our workforce representing a broad spectrum of cultures, nationalities, and backgrounds. Our catchment areas present us with unique challenges and opportunities.

West Hertfordshire Hospitals NHS Trust wholeheartedly supports the principles of equal opportunities and we seek to ensure that the Trust includes everyone and that no one is treated less favorably on the grounds of sex, gender reassignment, sexual orientation, marital/civil partnership status, pregnancy/maternity, religion or belief, age, disability or race (which includes colour, nationality, ethnic or national origins).

The Trust also recognises the benefits of a diverse workforce and is committed to providing a working environment that is free from any form of discrimination and victimisation on any grounds. We aim to achieve equality for all, encouraging mutual respect, and promoting an inclusive culture.

The annual Public Sector Equality Duty Report 2016/17 demonstrates our commitment to advancing equality at the West Hertfordshire Hospitals NHS Trust. This report explains how we are addressing the requirements of the Equality Act 2010, in particular:

- the progress we are making on equality matters
- the findings from our staff by protected characteristic, and
- where issues are identified, what the Trust intends to do about them

We believe that publishing relevant equality information will make us transparent about the progress we are making on equality, and more accountable to our patients and local communities.

Contents

Chapter 1

Introduction

Introduction

West Hertfordshire Hospitals NHS Trust's aim is to develop a culture which values each person uniquely and equally as an individual and to become an effortlessly inclusive organisation.

As outlined in the Public Sector Equality Duty (PSED) of the Equality Act 2010, the Trust is required to publish a comprehensive report each year, setting out key equality data and summarising the Trust's main equality-related activity during the preceding year.

This report sets out key information covering the period 1st April 2016 to 31st March 2017. This report provides an overview of the West Hertfordshire Hospitals NHS Trust's activities in support of equality and diversity during the financial year 2016/17, including a summary of key staff and patient data.

Chapter 2

Equality legislation

Equality legislation

The Equality Act 2010 places all public bodies under a duty to promote equality, which includes:

- Having due regard to the aims of the General Equality Duty 'in the exercise of their functions';
- Carrying out equality analysis;
- Setting at least one equality objective; and
- Publishing information and data to demonstrate their compliance with the Equality Duty.

As a public body, the Trust must give due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010;
- Advance equality of opportunity between people who share a protected characteristic and those who do not, by
    a. Removing or minimising disadvantages suffered by people due to their protected characteristics;
    b. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
    c. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low; and
- Foster good relations between people who share a protected characteristic and those who do not, by
    a. Tackling prejudice, and
    b. Promoting understanding between people from different groups.

Chapter 3

Progress towards achieving equality in 2016/17

Progress towards achieving equality in 2016/17

The Trust is committed to promoting a productive, harmonious environment that values diversity. We aim to be an inclusive provider of healthcare and to create an environment in which the services we provide and our workplace are free from unfair or unlawful discrimination, harassment or bullying.

3.1 Equality & diversity training

All new staff are required to complete online Equality and Diversity training as part of the mandatory training programme. All permanent, fixed term, bank and agency are required to complete equality and diversity training every three years.

Our aim is to encourage self-awareness to facilitate change in individuals, in teams and departments, focusing on engaging 'hearts and minds' and to equip staff with key the principles of inclusive practice and provide them with practical actions that will assist them in contributing towards a more inclusive culture at the trust.

3.2 Equality impact assessments

The Trust continues to analyse the effect of any policy, service, function, on staff or patients from the nine protected characteristics. An equality analysis is a review of a policy, service or function and aims to establish whether there is an impact on particular groups of staff or patients. In turn this enables the organisation to demonstrate it does not discriminate and, where possible, promotes equality. Our Equality Impact Analysis form incorporates all 9 protected characteristics to ensure compliance with the Equality Act 2010. Our Equality Impact Analysis process allows us to establish whether there is a negative or positive effect or impact on particular protected group.

3.3 Communication support for patients

We are committed to ensuring that all our patients are able to access services regardless of any special needs their background they may have. For example:

- We provide support for non-English speakers, for those people for whom English is a second language and for those patients with a sensory impairment. Information on our interpreting services is available on our public website: www.westhertshospitals.nhs.uk/visitors/translating_interpreting_visitors.asp.
- The Trust has in place systems to improve our communication with patients and their carers and families. An example of this is an exciting feature of our website which provides enhancements to allow those with sight, learning difficulties and those who speak English as a second language access to the range of information available on our website. By pressing 'buttons' users can select options to highlight, magnify and translate text to allow easier reading. There is also a facility whereby text can be spoken in an increasing number of languages. The service provided by BrowseAloud, is proving popular with patients of the hospital.
- Patient information is available in different languages, larger formats and in Braille on request. Following a very strict Trust format, all patient information leaflets/booklets/posters must clarify that

patient information can be made available in Braille, large print or audio version (as per below)
"If you need this leaflet in another language, large print, Braille or audio version, please call 01923 217 187 or email pals@whht.nhs.uk"

- We have created a page on our website so that our new patient information leaflets are now available online and accessible to the public and staff: www.westhertshospitals.nhs.uk/patientinformation. To date there are 210 leaflets available online for staff, patients and carers use. An email account has also been set up for the monitoring of new and updated patient information requests: patientinformation@whht.nhs.uk.

Staff who have patient contact are required to make every effort to understand the communication needs of the patients.

3.4 Improving the care of people with learning disabilities

The Acute Liaison Nurses, employed by Hertfordshire County Council, work closely with the Trust Safeguarding Lead Nurse and clinical staff. The Trust is working to a clear and comprehensive action plan aligned with the national Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) recommendations. The plan is part of an overarching programme to improve health outcomes for people with learning disabilities (LD).

Our service provision is designed around the needs of patients with learning disabilities and their families and carers:

- There is a "special register" which details patients with LD who are admitted or discharged from the Trust. This is monitored by the Safeguarding Adults Named Nurse.
- The Health Liaison Team responds within 24hrs of receiving a referral within the working week to provide support to the patient and carers and to provide expert advice to clinical teams
- Easy read leaflets are available relating to: Hospital Discharge, PALS leaflets and Taking Your Baby Home
- For patients that are admitted via the elective route for planned procedures under general anaesthetic, the specific clinical area are notified via an electronic pre operative assessment clinic communication sheet
- Hospital passports are available and used, currently in place on every patient's bedside cabinet
- Learning Disabilities Champions available across the Trust including in Day Surgery, Accident & Emergency and Outpatient Departments
- Patients with learning disabilities are prioritised on theatre lists where possible

3.5 Dementia care

Our service improvements in respect of dementia are being driven by the Trust's Dementia Implementation Group. A number of initiatives have been implemented to improve the care of patients with dementia:

- Memory boards in ward areas to provide information and support to people with dementia
- Implementing finger food initiative to ensure nutrition is available throughout the day for people with dementia

- The Alzheimer's Society visit on the last Monday of every month to support carers and provide information regarding help in the community
- A blue clasp is attached to wrist bands in order that all staff can recognise and identify people with dementia
- Carers charter in place
- There is a dementia specialist nurse as part of the corporate team
- Champions on all wards and Champions day arranged Day arranged for 7th September
- We have held 3 Dementia Friends Days in the Trust together with the CCG to promote dementia awareness. 1 in SACH and 2 in Watford all have been well attended with over 100 staff at each session.
- Medirest have also held Dementia Friends for their staff
- We celebrated Dementia Week by having two nurses dressed in 1950's nursing uniforms to promote awareness of dementia to the general public
- Clinical Leaders day Dementia and Carers Conference with key speaker Tommy Whitelaw (carer) to promote caring for people with dementia
- Ongoing training in dementia with new Training Strategy for 2017-2020
- Deprivation of Liberty Care Plans developed
- New Dementia Bundle being developed
- Dementia Outreach Service being developed
- Twiddle Muffs being knitted by League of Friends/staff for patients with dementia who may be finding it difficult to settle in our environment.

Carer participation

We recognise the vital role that carers play in the care of our patients. We perceive carers as part of the holistic view of the patient. We believe supporting and working more closely with carers can assist us deliver smoother transitions from one service to another and help improve the whole experience of being a patient with us – from the first appointment contact through to discharge.

A Carers Policy and carers contract has been developed and a Carers Lead Nurse has been appointed on a 12 month secondment from Hertforshre County Council to support the role of carers whilst they or their cared for are hospitalised.

An electronic special register has been developed that allows for patients who are cared for or are a carer to be identified on the patient registration system. This information can be used to provide support for the carer and the cared for.

3.6 Spiritual, pastoral and religious needs

The Trust's Spiritual and Pastoral Care Team provides pastoral, spiritual and religious care for patients of any faith and no faith as well as their relatives and carers. If a patient would like a member of the spiritual and pastoral care team to visit them, ward staff can arrange this. Should a patient wish to make contact with their own religious or spiritual leader, a member of staff can assist with this also. The Spiritual and Pastoral Care Team is able to provide support in the following areas of patient and staff care:

- Personal support to all people, regardless of belief
- Religious support
- Facing distressing news
- End of life issues and support for palliative patients

- Pastoral/spiritual care of patients and of their relatives
- Bereavement care
- Ethical issues in patient care
- Staff support
- Memorial and funeral Services

The Trust-wide Compassionate End of Life Care Panel, which includes care in bereavement, was attended by the manager of the spiritual and pastoral care team.

Improvements made in 2016-17:

- Watching (Vatching). The Trust continues to support Jewish relatives to 'watch' their deceased out of hours.
- Refurbished multifaith room opened. Our multifaith room provides space for prayer, reflection and religious services. The multifaith room is open to patients and staff 24 hours a day. We meet specific requirements such as flexibility of furnishing and use of religious symbolism for different faiths. The spiritual and pastoral care team has links with many faith leaders in the local community.
- Newly refurbished multi faith room opened at St Alban's Community Hospital.
- Resources have been placed on the Trust intranet page for Spiritual and Pastoral Care outlining things that may be important to discuss with the patient or their family, if the patient is Jewish, Sikh, Hindu or Muslim and towards the end of life.
- Celebration of Eid by sharing sweets with Muslim patients, staff and visitors and promoting this as a contribution to fostering good relationships between people of different protected characteristics.
- One chaplain is involved in the Trust multicultural staff network, giving opportunity to share cultural insights and support.
- One chaplain (recruited on a bank contract) is skilled in using and developing spiritual assessment tools to ascertain sources of resilience and strength in patients' lives (from any tradition or none) and how these might best be supported during hospital admission.
- Leaflets of comforting quotations from a variety of faiths and humanist perspectives available in the multi faith rooms, again as a way of promoting understanding and good relations between people of different protected characteristics.

3.7 Assessments and documentation

Assessment is a key component of nursing practice, required for planning and provision of patient centered care. The Trust has a clear guidelines and protocols to ensure all patients receive consistent and timely nursing assessments. Confidential Patient Information assessment covering patient history, general appearance and physical examination is completed for all patients at the time of admission. The assessment is a useful tool to help support staff in meeting patients' individual preferences. The. assessment covers all 9 protected characteristics. In the assessment we also ask the following questions:

- Has a safeguarding incident been raised
- Is Deprivation of Liberty Safeguards (DOLS) required
- Carers details
- If the patient lacks capacity, refer to Trust policy on Mental Capacity

- Blue Clasp for diagnosis of dementia
- First language
- Interpreter required

Key referrals are made as required to the following:

- Psychiatric Liaison / Raid
- Spiritual Advisor Chaplin
- Dementia
- Learning Disabilities
- Alcohol / Drugs

The Confidential Patient Information assessment, our new Risk Assessment booklet and Nursing Assessment Profoma were widely consulted. A diverse range of stakeholders were given the opportunity to provide comments including Healthwatch Hertfordshire, Acute Liaison Nurses, Trust Safeguarding Lead Nurse, Equality & Diversity manager.

Aspects of the above assessments and documents are be picked up in our monthly audits - Test Your Care and the Matrons monthly checks with ad hoc documentation audits carried out throughout the year by clinical divisions and specialist nurses. Pre-operative assessment (POA) and planning, carried out prior to treatment, ensures that the patient is fully informed about the procedure and the post-operative recovery, is in optimum health and has made arrangements for admission, discharge and post-operative care at home. The POA Proforma is completed on arrival at the pre-operative assessment. The assessment includes questions around communication requirements. We then act on what is contained in the completed proforma. Interpreters are organised via PALS as required.

3.8 Menu options offered to meet cultural and religious diversity

The Trust responds to individual patient requests for meals to meet cultural and religious needs including vegetarian, egg free, halal and kosher options.

3.9 Patient involvement and community engagement

The Rose Project:

The Trust continues to ensure that the Rose Project initiative is being used on all wards in relation to end of life and care of the dying and the deceased that gives a quiet time to patients, carers, relatives and provides staff with an acknowledgement that a patient on their ward has reached or reaching their end of life.

This project continues to be generously supported by the League of Friends who approves business cases from the Trust to purchase all those items required to make this a success.

Watching (Vatching):

This is a service that continues to be supported within the Trust for our deceased Jewish patients.

Patient Affairs and the mortuary staff continue to support all religions and cultures in respect of viewings in the Chapel of Rest.

Bereavement Focus Groups:

The Trust held their first Bereavement Focus Group in June and September 2016 that enabled relatives, carers and friends of our deceased patient's to meet off site with Trust staff supporting, to understand what service improvements could be made around bereavement and end of life care.

These participants had previously completed a bereavement questionnaire and requested attendance to give further feedback. The Trust has also managed to gain feedback on the Rose Project and the content of the bereavement questionnaires themselves.

More Bereavement focus groups are planned for June and September 2017.

Pre-Apprentices:

The Patient & Public Involvement team has been working with Firstrung a charity that supports young students, who may be disadvantaged to work within the Trust for 12 weeks prior to a possible apprentice placement.

The team also work with Youthconnexions.

Trans Implementation Group:

The Lead for Patient & Public Involvement continues to be a member of the Trans Implementation Group, chaired by a lay-person and supported by Viewpoint.

The Trust also supported the re-launch of the Transgender Joint Strategic Needs Assessment (JSNA) at County Hall, Hertford in October 2016.

Volunteer recruitment:

Large Volunteer recruitment campaigns through our religious leaders, various community groups, libraries, GP surgeries to support such roles as volunteer drivers; end of life volunteers; dining room companions; ward and department volunteers; League of Friends and many more roles to bring a variety of volunteers into the Trust.

Let Me See You, Let Me Hear You Panel:

This Panel continues to support both staff and patients/carers who are blind/partially sighted and deaf/hard of hearing. Chaired by a member of staff who herself has a disability, this Panel also dovetails into the Healthwatch Sensory & Physically Disability Service Watch Group.

Patient & Public Involvement Panel:

The Patient & Public Involvement Panel continues to meet on a quarterly basis with many new external stakeholders attendance from Hertshelp; The Pulse Hospital Radio, updates from the Transgender community and the Kissing It Better Charity; Community Navigators and various other communities.

This is another opportunity to ensure that the agendas, minutes and action plans are linked to the Trust's Patient Experience & Carer Strategy with ultimately approval by the Patient Experience Group (PEG), chaired by the Chief Nurse.

Patients' Panel:

The Patients' Panel has continued to maintain its numbers. New members have joined with various expertise, whilst we have seen two members leave the Panel, Eddie Lucas regularly supported our Jehovah Witness patients and those with a disability and John Howley supported the Trust in giving advice on all our patient information to ensure it is 'user friendly'. Frances Kipping has come onto the Panel, who has great knowledge around estates and PLACE audits and Leigh Hutchings bring another dimension to support patients who are visually impaired. It is hoped that during the new financial year the Panel will take on two more members.

Chapter 4

Workforce information 2016/17

Workforce information

As outlined in the Public Sector Equality Duty (PSED), the Trust is required to publish specific information about staff with protected characteristics. This chapter sets out key statistical information covering the period 1st April 2016 to 31st March 2017.

The data not only allow us to report on the protected characteristics, buts also help inform the development of workforce equality objectives.

Reporting on the workforce does not always include medical staff. This is because many staff are included on rotational training schemes and the Trust does not directly recruit them. It therefore helps in many areas of analysis to exclude this staff group – where all staff are included this is stated.

4.1 Composition of the workforce

Staffing by Staff Group

The Trust's largest staff group is registered qualified Nurses and Midwives who make up 30.8% of the total employees followed by Administrative and Clerical who make up 24.3% of the workforce.

Figure 1:

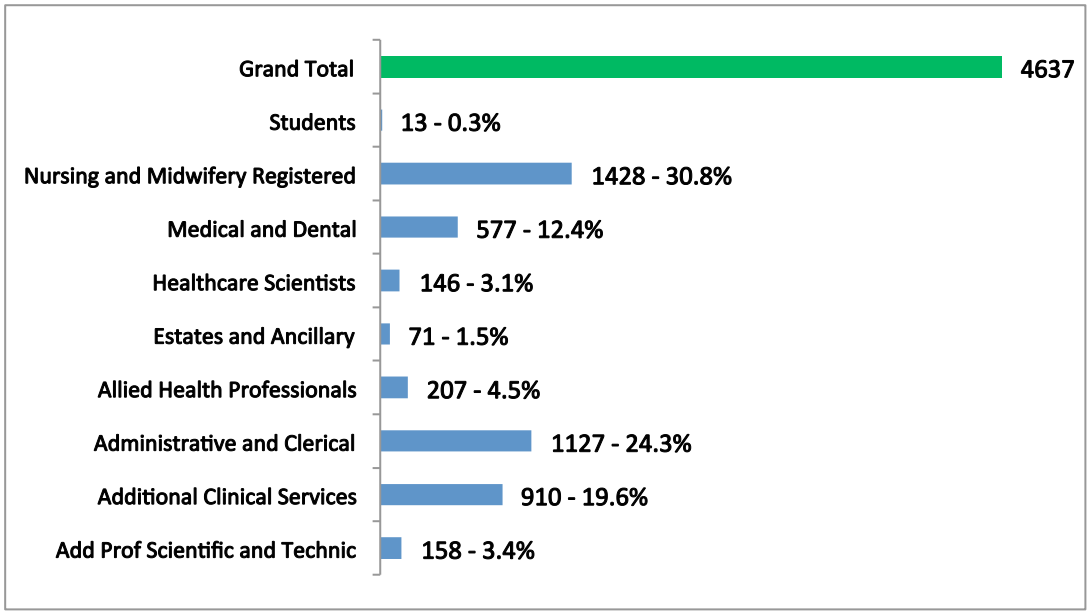
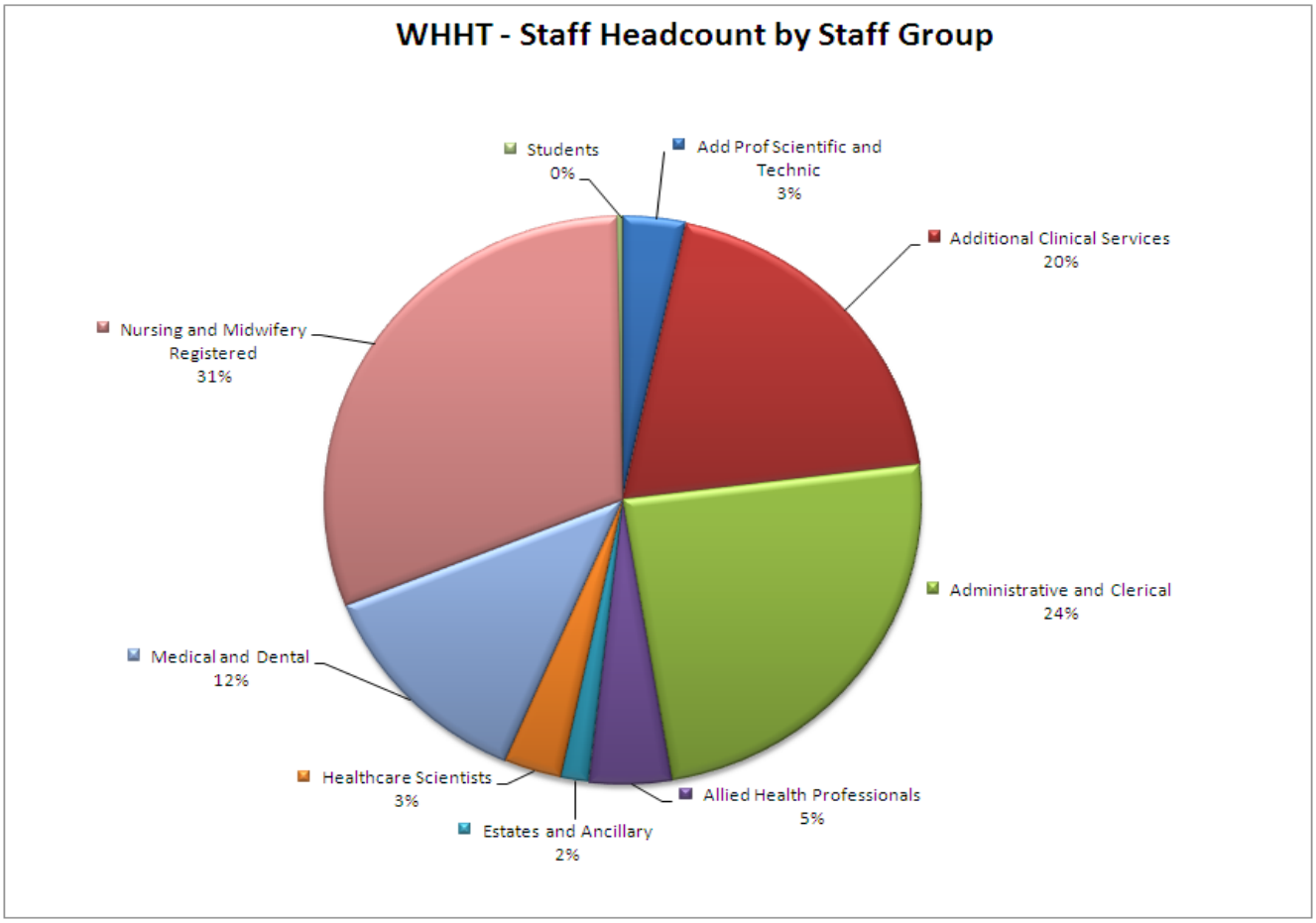


Figure 2:


WHHT - Staff Headcount by Staff Group
Students 0%
Add Prof Scientific and Technic 3%
Additional Clinical Services 20%
Nursing and Midwifery Registered 31%
Administrative and Clerical 24%
Medical and Dental 12%
Healthcare Scientists 3%
Allied Health Professionals 5%
Estates and Ancillary 2%

Age

The data show that 25 - 29 is the largest age band followed by the 40 – 44, 45 – 49 and 50 – 54 age groups. The 50-54 age group is also the largest age band for similar acute Trusts nationally, followed by the 45 to 49 age group (source: Health & Social Care Information Centre).

Figure 3:

Age	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students	Grand Total
Under 18	0(0%)	1(0.1%)	3(0.3%)	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)	4(0.1%)
18 - 19	0(0%)	7(0.8%)	5(0.4%)	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)	12(0.3%)
20 - 24	10(6.3%)	53(5.8%)	37(3.3%)	26(12.6%)	2(2.8%)	4(2.7%)	11(1.9%)	137(9.6%)	3(23.1%)	283(6.1%)
25 - 29	25(15.8%)	119(13.1%)	108(9.6%)	45(21.7%)	2(2.8%)	13(8.9%)	127(22%)	250(17.5%)	5(38.5%)	694(15%)
30 - 34	27(17.1%)	123(13.5%)	79(7%)	33(15.9%)	5(7%)	22(15.1%)	74(12.8%)	148(10.4%)	2(15.4%)	513(11.1%)
35 - 39	26(16.5%)	125(13.7%)	101(9%)	30(14.5%)	9(12.7%)	24(16.4%)	69(12%)	140(9.8%)	0(0%)	524(11.3%)
40 - 44	14(8.9%)	115(12.6%)	91(8.1%)	20(9.7%)	4(5.6%)	21(14.4%)	94(16.3%)	232(16.2%)	0(0%)	591(12.7%)
45 - 49	21(13.3%)	120(13.2%)	153(13.6%)	9(4.3%)	9(12.7%)	14(9.6%)	63(10.9%)	188(13.2%)	2(15.4%)	579(12.5%)
50 - 54	11(7%)	95(10.4%)	195(17.3%)	20(9.7%)	15(21.1%)	19(13.0%)	56(9.7%)	160(11.2%)	1(7.7%)	572(12.3%)
55 - 59	14(8.9%)	85(9.3%)	188(16.7%)	14(6.8%)	10(14.1%)	16(11.0%)	47(8.1%)	111(7.8%)	0(0%)	485(10.4%)
60 - 64	9(5.7%)	46(5.1%)	123(10.9%)	10 (4.8%)	8(11.3%)	7(4.8%)	26(4.5%)	51(3.6%)	0(0%)	280(6.0%)
65 - 69	1(0.6%)	10(1.1%)	32(2.8%)	0(0%)	5(7%)	5(3.4%)	8(1.4%)	9(0.6%)	0(0%)	70(1.5%)
70 and over	0(0%)	11(1.2%)	12(1.1%)	0(0%)	2(2.8%)	1(0.7%)	2(0.3%)	2(0.1%)	0(0%)	30(0.6%)
Grand Total	**158**	**910**	**1127**	**207**	**71**	**146**	**577**	**1428**	**13**	**4637**

Disability

The Trust is a 'Disability Confident' employer meaning we encourage applications from disabled people and make commitments towards our disabled staff. Where applicants have a disability, as defined under the Equality Act 2010, they will be guaranteed an interview subject to meeting the essential criteria for the job, in accordance with the ‚Disability Confident' 'scheme. As at 31st March 2017 the Trust employed 41 staff (or 0.9%) who have declared themselves disabled.

24.4% of records relate to staff who have not declared their status. These records are usually due to staff employed over 10 years ago who have not declared their status upon employment. Nationally, similar acute Trusts have an average of 27% of records of staff who have not declared their disability status. Regarding staff who have stated that they have a disability, 2.1% of staff in similar acute Trusts have declared themselves disabled, compared to the 0.9% at West Hertfordshire Hospitals NHS Trust. When comparing against all Trusts in Bedfordshire and Hertfordshire, 1.9% of staff have declared a disability. Disability status is a mandatory field on the application forms and starter forms for Trust staff, although an option exists that staff can state that they do not wish to disclose if they have a disability.

Figure 4:

Disability	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students	Grand Total
No	108(68.4%)	637(70%)	763(67.7%)	144(69.6%)	46(64.8%)	89(61.0%)	408(70.7%)	1009(70.7%)	13(100%)	3217(0.4%)
Not Declared	15(9.5%)	95(10.4%)	40(3.5%)	15(7.2%)	6(8.5%)	11(7.5%)	4(0.4%)	61(4.3%)	0(0%)	247(69.4%)
Undefined	35(22.2%)	168(18.5%)	311(27.6%)	44(21.3%)	19(26.8%)	44(30.1%)	163(28.2%)	348(24.4%)	0(0%)	1132(24.4%
Yes	0(0%)	10(1.1%)	13(1.2%)	4(1.9%)	0(0%)	2(1.4%)	2(0.3%)	10(0.7%)	0(0%)	41(0.9%)
Grand Total	**158**	**910**	**1127**	**207**	**71**	**146**	**577**	**1428**	**13**	**4637**

Figure 5:

Staff Group	No	Not Declared	Undefined	Yes	Grand Total
Add Prof Scientific and Technic	108	15	35	0	158
Additional Clinical Services	637	95	168	10	910
Administrative and Clerical	763	40	311	13	1127
Allied Health Professionals	144	15	44	4	207
Estates and Ancillary	46	6	19	0	71
Healthcare Scientists	89	11	44	2	146
Medical and Dental	408	4	163	2	577
Nursing and Midwifery Registered	1009	61	348	10	1428
Students	13	0	0	0	13
Grand Total	**3217**	**247**	**1132**	**41**	**4637**

Ethnicity

Figure 12 below shows the Trust's staff by ethnicity groups. 32.1% of staff are from a Black and Minority Ethnic (BME) background. 62.3% of our workforce is White. The Trust is slightly more diverse than it was last year: 31.2% BME; 63.5% White.

Figure 6:

PSED Ethnic Origin	Staff Headcount	Current %	Last Year (2016)%
A White - British	2266	48.9%	51.9%
B White - Irish	115	2.5%	2.4%
C White - Any other White background	507	10.9%	8.7%
D Mixed - White & Black Caribbean	14	0.3%	0.3%
E Mixed - White & Black African	14	0.3%	0.2%
F Mixed - White & Asian	14	0.3%	0.4%
G Mixed - Any other mixed background	33	0.7%	0.8%
H Asian or Asian British - Indian	435	9.4%	9.5%
J Asian or Asian British - Pakistani	122	2.6%	2.3%

K Asian or Asian British - Bangladeshi	23	0.5%	0.3%
L Asian or Asian British - Any other Asian background	323	7.0%	7.4%
M Black or Black British - Caribbean	78	1.7%	1.6%
N Black or Black British - African	237	5.1%	4.9%
P Black or Black British - Any other Black background	43	0.9%	0.5%
R Chinese	46	1.0%	1.3%
S Any Other Ethnic Group	111	2.4%	2.3%
Undefined	133	2.9%	2.3%
Z Not Stated	123	2.7%	2.8%
Grand Total	**4637**	**100.0%**	**100.0%**

Figure 7 shows Trust ethnicity by site.

Figure 7:

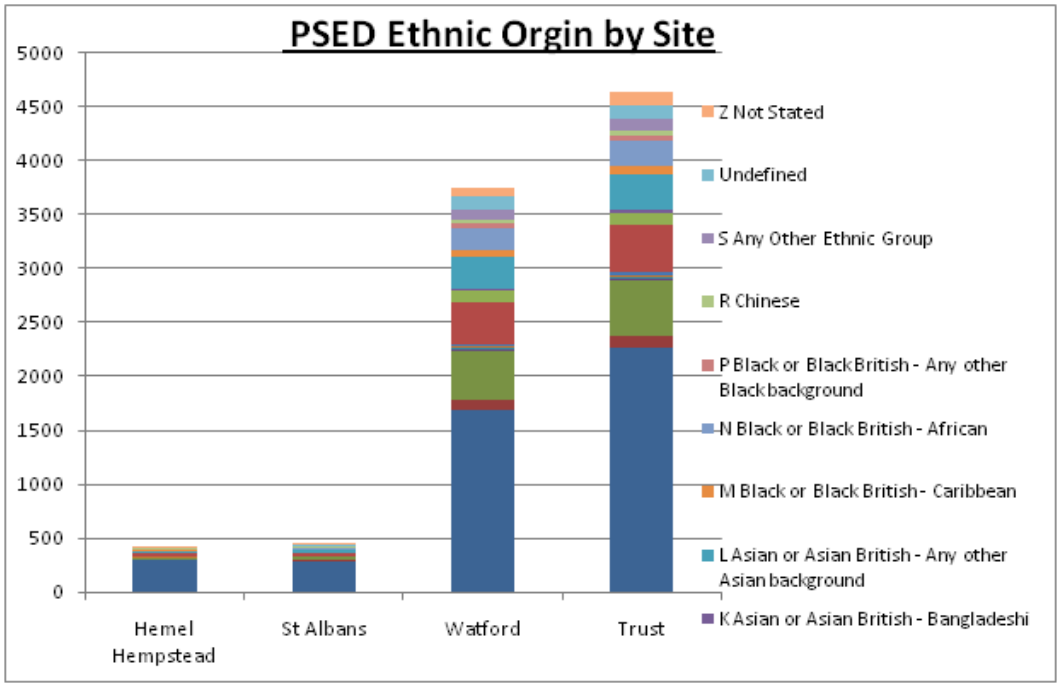
PSED Ethnic Origin	Hemel Hempstead	St Albans	Watford	Trust
A White - British	292	288	1686	2266
B White - Irish	7	9	99	115
C White - Any other White background	23	30	454	507
D Mixed - White & Black Caribbean	0	0	14	14
E Mixed - White & Black African	0	3	11	14
F Mixed - White & Asian	2	2	10	14
G Mixed - Any other mixed background	2	2	29	33
H Asian or Asian British - Indian	33	24	378	435
J Asian or Asian British - Pakistani	8	6	108	122
K Asian or Asian British - Bangladeshi	2	0	21	23
L Asian or Asian British - Any other Asian background	11	22	290	323
M Black or Black British - Caribbean	7	5	66	78
N Black or Black British - African	10	19	208	237
P Black or Black British - Any other Black background	1	1	41	43
R Chinese	6	6	34	46
S Any Other Ethnic Group	3	14	94	111
Undefined	4	10	119	133
Z Not Stated	19	13	91	123
Grand Total	**430**	**454**	**3753**	**4637**

A comparison of Trust employees to other trusts has been made.

Figure 8:

Trusts	White	BME	Unknown	Total	White%	BME%	Unknown%
East of England	38195	9455	3565	51215	74.6%	18.5%	7.0%
North West London	10580	12435	1790	24805	42.7%	50.1%	7.2%
South London	26070	20930	3510	50510	51.6%	41.4%	6.9%
North Central and East London	24095	24965	2860	51920	46.4%	48.1%	5.5%
WHHT	2888	1494	255	4637	62.3%	32.2%	5.5%

Figure 9:



Staff by ethnicity (broken down to BME and White group) and band are shown in the table below.

There is an overrepresentation of BME staff in the higher bands in the medical workforce (Consultant and Other Medical) compared to their overall representation in the Trust. 50.8% of the Consultant group and 50.9% of the Other Medical group is made up of BME staff. 32.1% of the Trust's workforce is from a BME background. However there is underrepresentation of BME staff within the senior bands in the non medical workforce: 20.6% of band 8 and 8.3% of Directors made up of BME staff.

Figure 10:

PSED Band	BME	Unknown	White
Band 1	47.6%	0.0%	52.4%
Band 2	37.9%	5.6%	56.5%
Band 3	24.9%	7.3%	67.8%
Band 4	19.8%	3.9%	76.3%
Band 5	34.1%	4.2%	61.7%
Band 6	30.4%	5.2%	64.3%
Band 7	23.1%	2.8%	74.1%
Band 8	20.6%	3.6%	75.9%
Band 9	0.0%	0.0%	100.0%
Consultant	50.8%	6.3%	42.9%
Director	8.3%	0.0%	91.7%
Non-Exec	0.0%	0.0%	100.0%
Other Medic	50.9%	14.2%	34.9%
Grand Total	**32.2%**	**5.5%**	**62.3%**

The Trust's profile in terms of ethnicity and band is broadly similar to other acute Trusts in Bedfordshire & Hertfordshire.

Figure 11:

Beds and Herts acute Trusts by Ethnicity	White - Beds and Hert Acute Trusts	White - West Herts	BME - Beds and Hert Acute Trusts	BME - West Herts	Unknown - Beds and Hert Acute Trusts	Unknown - West Herts	Total - Beds and Hert Acute Trusts	Total - West Herts
Band 1	3.1%	0.2%	4.8%	0.4%	4.1%	0.0%	3.5%	0.2%
Band 2	18.9%	17.6%	21.0%	26.8%	19.2%	23.7%	19.4%	20.5%
Band 3	11.7%	11.2%	7.0%	8.7%	12.3%	18.4%	10.5%	10.8%
Band 4	11.3%	12.7%	6.4%	6.9%	6.8%	10.5%	9.9%	11.0%
Band 5	18.5%	21.0%	30.5%	26.4%	28.8%	21.1%	21.9%	22.5%
Band 6	18.2%	16.3%	20.0%	18.2%	17.8%	18.4%	18.6%	16.9%
Band 7	12.3%	13.3%	7.6%	9.1%	8.2%	5.3%	11.0%	11.7%
Band 8	5.9%	7.5%	2.8%	3.5%	2.7%	2.6%	5.0%	6.1%
Band 9	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Religion or belief

This section of the report details the religion or belief of our staff see figure 17. Christianity represents the largest number of staff with 24.2% of the workforce. 'Undefined' results represent 42.5% of the total data and so it is difficult to form firm conclusion.

Figure 12:

Religious Belief	Total	Religious Belief as % of total staff
Undefined	1972	42.5%
Christianity	1122	24.2%
I do not wish to disclose my religion/belief	851	18.4%
Atheism	180	3.9%
Islam	158	3.4%
Hinduism	153	3.3%
Other	138	3.0%
Judaism	26	0.6%
Sikhism	14	0.3%
Jainism	13	0.3%
Buddhism	10	0.2%
Grand Total	**4637**	**100.0%**

The following table highlights religion or belief and by Band.

Figure 13:

PSED Band	Atheism	Buddhism	Christianity	Hinduism	I do not wish to disclose my religion/belief	Islam	Jainism	Judaism	Other	Sikhism	Undefined	Grand Total
Band 1	0	0	2	0	6	3	0	0	2	0	8	21
Band 2	33	2	273	22	211	37	0	1	24	1	275	879
Band 3	24	2	109	14	72	10	2	0	15	0	206	454
Band 4	18	0	99	6	72	10	1	2	12	0	215	435
Band 5	28	1	233	22	190	20	0	4	21	0	339	858
Band 6	16	0	177	12	112	14	3	3	19	1	313	670
Band 7	18	1	113	11	60	5	3	1	8	0	248	468
Band 8	7	0	39	4	33	4	1	1	3	1	160	253
Band 9												4
Consultant	6	1	24	26	20	12	2	1	6	1	141	240
Director	0	0	0	0	4	0	0	1	0	0	6	11
Non-Exec												6
Other Medic	30	3	52	36	69	43	1	12	28	10	54	338
Grand Total	**180**	**10**	**1122**	**153**	**851**	**158**	**13**	**26**	**138**	**14**	**1972**	**4637**

Gender

This section details the split of Trust employees by gender and Banding in 2016/17. The male / female gender split at WHHT is 78.7% female and 21.3% male. Last year 78.8% of our workforce was female and 21.2% was male.

The ratio is almost identical when compared to all Other NHS Acute Trusts in the country where the ratio is approximately 78% female staff and 22% male staff (source: Health & Social Care Information Centre, November 2014).

Figure 14:

Gender	Trust Staff	Trust Staff %
Female	3648	78.7%
Male	989	21.3%
Grand Total	**4637**	**100.0%**

The following tables highlight gender and Pay Band.

Figure 15:

PSED Band	Female	Male	Grand Total
Band 1	0.4%	0.6%	0.5%
Band 2	19.8%	15.9%	19.0%
Band 3	10.2%	8.4%	9.8%
Band 4	10.2%	6.5%	9.4%
Band 5	19.7%	14.0%	18.5%
Band 6	16.0%	8.7%	14.4%
Band 7	10.9%	7.1%	10.1%
Band 8	5.1%	6.7%	5.5%
Band 9	0.1%	0.2%	0.1%
Consultant	2.4%	15.3%	5.2%
Director	0.2%	0.4%	0.3%
Non-Exec	0.0%	0.5%	0.1%
Other Medic	5.0%	15.9%	7.3%
Grand Total	**100.0%**	**100.0%**	**100.0%**

Figure 16:

PSED Band	Female	Male	Grand Total
Band 1	15	6	21
Band 2	722	157	879
Band 3	371	83	454
Band 4	371	64	435
Band 5	720	138	858
Band 6	584	86	670
Band 7	398	70	468
Band 8	187	66	253
Band 9	1	2	3
Consultant	89	151	240
Director	8	4	12
Non-Exec	1	5	6
Other Medic	181	157	338
Grand Total	**3648**	**989**	**4637**

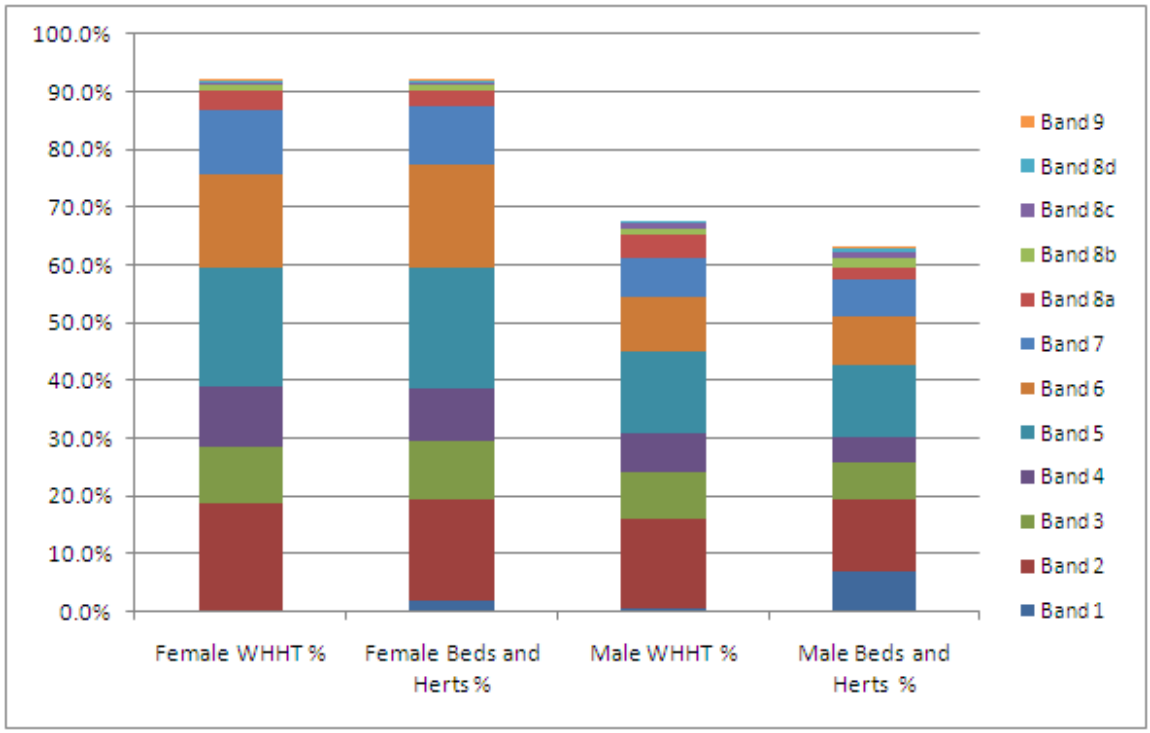
The following table compares gender by pay band for acute Trusts in Bedfordshire and Hertfordshire and West Hertfordshire Hospitals NHS Trust. The Trust's distribution of the female workforce across Pay Bands is similar to that of Bedfordshire and Hertfordshire.

Figure 17:

Job Band	Female WHHT %	Female Beds and Herts %	Male WHHT %	Male Beds and Herts %
Band 1	0.1%	2.0%	0.5%	6.7%
Band 2	18.6%	17.6%	15.4%	12.7%
Band 3	9.7%	9.9%	8.2%	6.2%
Band 4	10.4%	9.2%	6.7%	4.5%
Band 5	20.8%	21.0%	14.4%	12.5%
Band 6	16.0%	17.7%	9.2%	8.6%
Band 7	11.1%	10.2%	6.7%	6.2%
Band 8a	3.3%	2.8%	4.1%	2.2%
Band 8b	1.1%	0.9%	1.0%	1.5%

Band 8c	0.4%	0.3%	1.0%	1.1%
Band 8d	0.4%	0.4%	0.5%	0.6%
Band 9	0.1%	0.1%	0.0%	0.4%
Consultants	2.5%	2.4%	15.4%	17.0%
Registrars	2.5%	2.9%	7.7%	10.5%
Other Doctors in Training	1.9%	1.7%	4.6%	4.3%
Hospital Practitioners & Clinical Assistants	0.0%	0.0%	0.0%	0.2%
Other Medical and Dental Staff	0.5%	0.6%	3.6%	3.4%
Unknown	0.5%	0.4%	1.0%	1.5%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Figure 18:



Gender reassignment

There is currently no data available within the Trust's workforce information system (ESR) for this protected characteristic as there is no field in ESR to record the data. It is not within the remit of the Trust to change the fields in ESR as it is a national system. This lack of field on ESR is being looked into by McKesson (the system owners).

Sexual orientation

The table below shows the sexual orientation disclosed by Trust employees. The total number of declared Gay, Lesbian and Bisexual (GLB) employees in the Trust is 29 which represents 0.7% of our total workforce. 'Undefined' results represent 42.1% of the total data therefore it is difficult to form any definitive conclusion.

Figure 19:

Sexual Orientation	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students	Grand Total
Bisexual	2	7	2	0	0	0	0	1	0	12
Gay	0	3	4	0	0	0	2	5	0	14
Heterosexual	64	435	421	89	33	50	342	623	1	2058
I do not wish to disclose my sexual orientation	29	154	121	39	8	24	41	170	12	598
Lesbian	0	0	2	0	0	0	0	1	0	3
Undefined	63	311	577	79	30	72	192	628	0	1952
Grand Total	**158**	**910**	**1127**	**207**	**71**	**146**	**577**	**1428**	**13**	**4637**

Figure 20:

Sexual Orientation	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students	Grand Total
Bisexual	1.3%	0.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.3%
Gay	0.0%	0.3%	0.4%	0.0%	0.0%	0.0%	0.3%	0.4%	0.0%	0.3%
Heterosexual	40.5%	47.8%	37.4%	43.0%	46.5%	34.2%	59.3%	43.6%	7.7%	44.4%
I do not wish to disclose my sexual orientation	18.4%	16.9%	10.7%	18.8%	11.3%	16.4%	7.1%	11.9%	92.3%	12.9%
Lesbian	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
Undefined	39.9%	34.2%	51.2%	38.2%	42.3%	49.3%	33.3%	44.0%	0.0%	42.1%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Marriage and civil partnerships

The marital and civil partnership status of the Trust's employees is shown in the tables below, over half of our workforce is married.

Figure 21:

Marital Status	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students	Grand Total
Civil Partnership	0(0%)	1(0.1%)	6(0.5%)	1(0.5%)	2(2.8%)	1(0.7%)	3(0.5%)	3(0.2%)	0(0%)	17(0.4%)
Divorced	3(1.9%)	40(4.4%)	82(7.3%)	6(2.9%)	3(4.2%)	3(2.1%)	7(1.2%)	38(2.7%)	0(0%)	182(3.9%)
Legally Separated	0(0%)	17(1.9%)	15(1.3%)	1(0.5%)	1(1.4%)	0(0%)	2(0.3%)	10(0.7%)	0(0%)	46(1%)
Married	78 (49.4%)	451 (49.4%)	615 (49.4%)	86 (41.5%)	40 (56.3%)	90 (61.6%)	306 (53%)	699 (48.9%)	4 (30.8%)	2369 (51.1%)
Single	66 (41.8%)	345 (37.9%)	351 (31.1%)	106 (51.2%)	19 (26.8%)	46 (31.5%)	173 (30%)	586 (41%)	9 (69.2%)	1701 (36.7%)
Unknown	10(6.3%)	46(5.1%)	47(4.2%)	7(3.4%)	5(7%)	6(4.1%)	83(14.4%)	81(5.7%)	0(0%)	285(6.1%)
Widowed	1(0.6%)	10(1.1%)	11(1%)	0(0%)	1(1.4%)	0(0%)	3(0.5%)	11(0.8%)	0(0%)	37(0.8%)
Grand Total	**158**	**910**	**1127**	**207**	**71**	**146**	**577**	**1428**	**13**	**4637**

Full-time and part-time staff

As at 31st March 2017, 67.9% of staff employed by the trust were working full time and 32.1% were employed on a part time basis. This is broadly similar to last year's figures: 66.4% full time and 33.6% part time. There are more staff working part time in lower bands. Bands 2, 6 and 5 have the highest number of staff working on a part time basis. 797 of our 1416 part time staff can be found in these bands. In contrast only 137 staff working on a part time basis at senior levels.

Figure 22:

Employee Category	Total	% of Total
Full Time	3147	67.9%
Part Time	1490	32.1%
Grand Total	**4637**	**100.0%**

The following chart illustrates Full and Part Time working by Band. Staff working Part time tend to be in lower pay bands.

Figure 23:

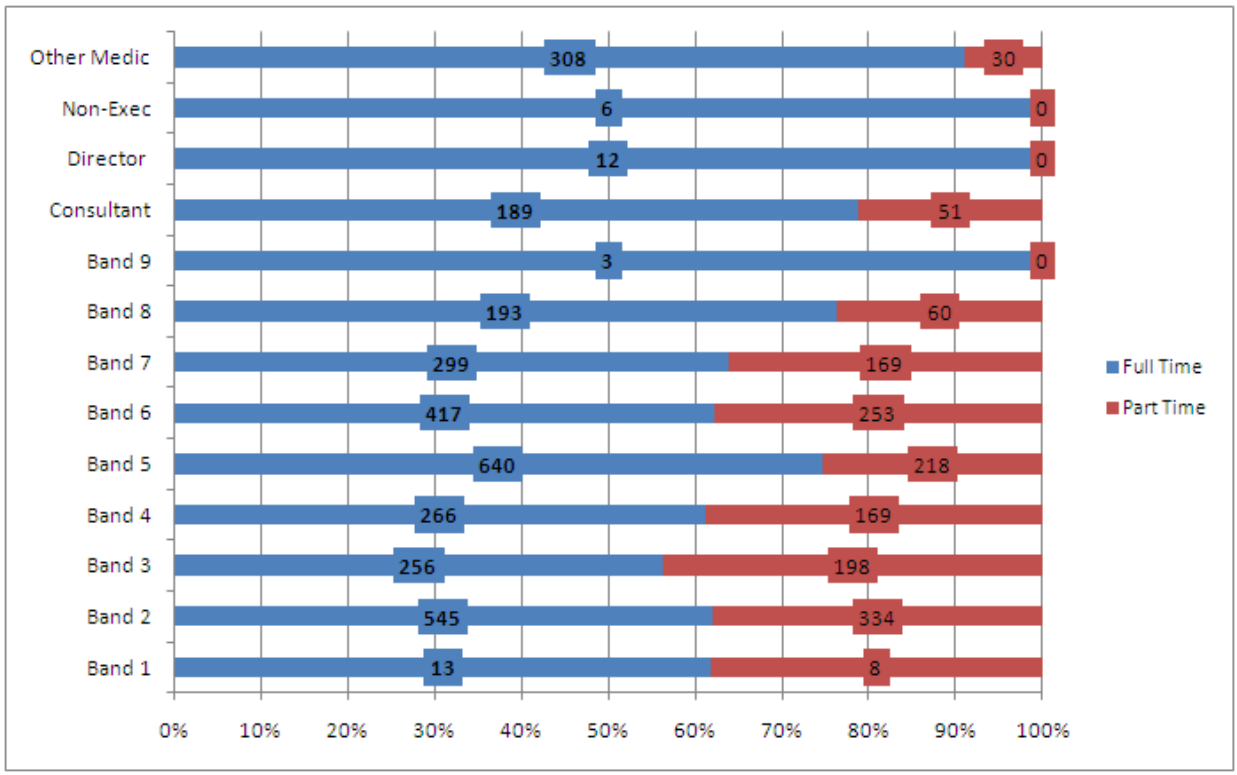
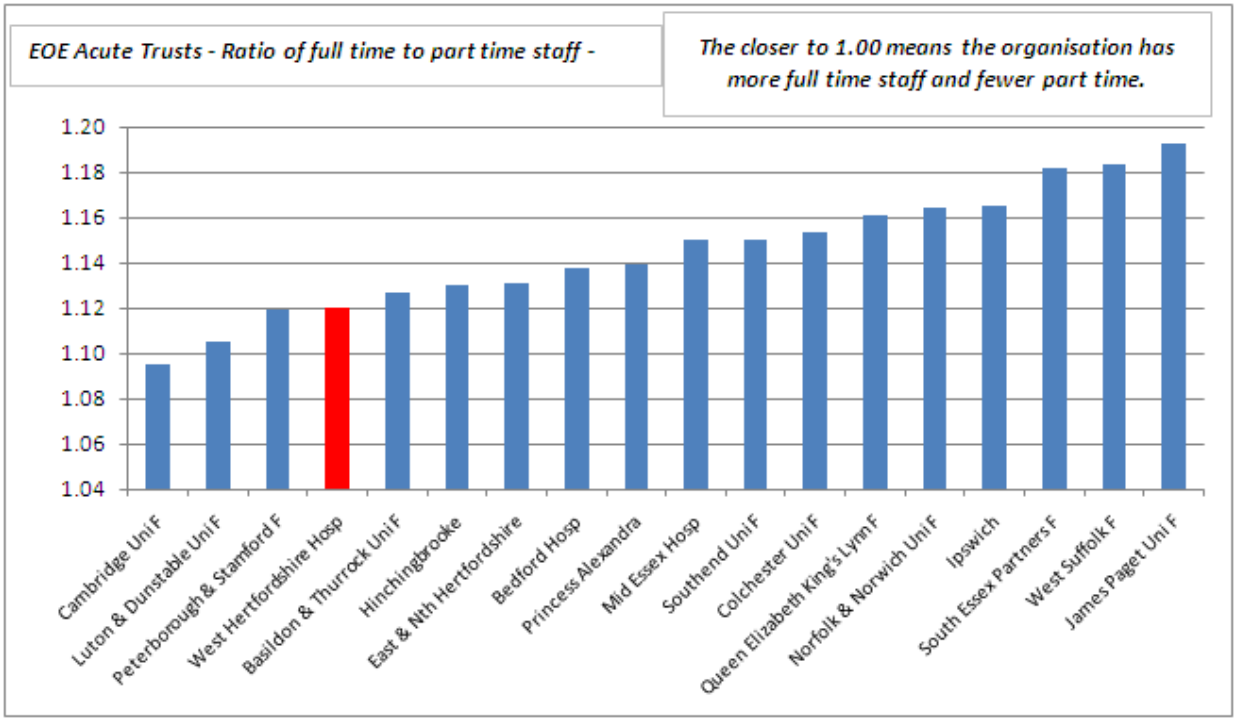


Figure 24:

EOE Acute Trusts - Ratio of full time to part time staff



The closer to 1.00 means the organisation has more full time staff and fewer part time.

Pregnancy and maternity / adoption

The table below shows details of staff whose maternity leave

Figure 25:

Staff Group	Return Full time	Return Part time	Left	All on Maternity	Returned Full time %	Returned Part time %	Left %	Returned %
Add Prof Scientific and Technic	4	1	1	6	66.67%	16.67%	16.67%	83.33%
Additional Clinical Services	8	12	5	25	32.00%	48.00%	20.00%	80.00%
Administrative and Clerical	8	8	1	17	47.06%	47.06%	5.88%	94.12%
Allied Health Professionals	1	2	4	7	14.29%	28.57%	57.14%	42.86%
Healthcare Scientists	3	0	0	3	100.00%	0.00%	0.00%	100.00%
Medical and Dental	6	1	4	11	54.55%	9.09%	36.36%	63.64%
Nursing and Midwifery Registered	26	14	5	45	57.78%	31.11%	11.11%	88.89%
Grand Total	**56**	**38**	**20**	**114**	**49.12%**	**33.33%**	**17.54%**	**82.46%**

The Trust retains the majority of staff who take maternity leave and appears able to accommodate requests for flexible working in order to support their return. Our return to work rate following maternity leave in 82.46%. Data was made available for East & North Hertfordshire NHS Trust and show that they continue to have a slightly higher return to work rate than WHHT (85.27%).

4.2 Recruitment

The tables below contain information for staff who applied for posts, were shortlisted and appointed (staff who started at the Trust) between 1st April 2016 and 31st March 2017.

Category	Description	Applications	Shortlisted	Offered	Applications %	Shortlisted %	Offered %
Gender	Male	4,874	1,195	259	28.5%	22.5%	16.8%
	Female	12,214	4,101	1280	71.3%	77.3%	83.0%
	Undisclosed	40	7	3	0.2%	0.1%	0.2%

There appears to be a drop-off in percentages between short-listing to appointment for the some groups including males, people with disabilities, BME people.

Figure 26:

Category	Description	Applications	Shortlisted	Offered	Applications %	Shortlisted %	Offered %
Disability	Yes	657	193	50	3.8%	3.6%	3.2%
	No	16,108	4,898	1357	94.0%	92.4%	88.0%
	Undisclosed	363	212	135	2.1%	4.0%	8.8%

Figure 27:

Category	Description	Applications	Shortlisted	Offered	Applications %	Shortlisted %	Offered %
Ethnicity	WHITE - British	6,004	2,052	651	35.1%	38.7%	42.2%
	WHITE - Irish	222	106	45	1.3%	2.0%	2.9%
	WHITE - Any other white background	2,188	540	116	12.8%	10.2%	7.5%
	WHITE - COMBINED	8,414	2,698	812	49.1%	50.9%	52.7%
	ASIAN or ASIAN BRITISH - Indian	2,093	554	106	12.2%	10.4%	6.9%
	ASIAN or ASIAN BRITISH - Pakistani	979	202	48	5.7%	3.8%	3.1%
	ASIAN or ASIAN BRITISH - Bangladeshi	229	59	11	1.3%	1.1%	0.7%
	ASIAN or ASIAN BRITISH - Any other Asian background	1,275	379	103	7.4%	7.1%	6.7%
	ASIAN or ASIAN BRITISH - COMBINED	4,576	1,194	268	26.7%	22.5%	17.4%
	MIXED - White & Black Caribbean	97	26	5	0.6%	0.5%	0.3%
	MIXED - White & Black African	101	28	6	0.6%	0.5%	0.4%
	MIXED - White & Asian	109	17	9	0.6%	0.3%	0.6%
	MIXED - any other mixed background	180	57	14	1.1%	1.1%	0.9%
	MIXED - COMBINED	487	128	34	2.8%	2.4%	2.2%
	BLACK or BLACK BRITISH - Caribbean	452	157	35	2.6%	3.0%	2.3%
	BLACK or BLACK BRITISH - African	1,794	532	109	10.5%	10.0%	7.1%
	BLACK or BLACK BRITISH - Any other black background	352	112	28	2.1%	2.1%	1.8%
	BLACK or BLACK BRITISH COMBINED	2,598	801	172	15.2%	15.1%	11.2%
	OTHER ETHNIC GROUP - Chinese	80	33	10	0.5%	0.6%	0.6%
	OTHER ETHNIC GROUP - Any other ethnic group	501	151	39	2.9%	2.8%	2.5%
	OTHER ETHNIC GROUP - COMBINED	581	184	49	3.4%	3.5%	3.2%
	Undisclosed	472	235	144	2.8%	4.4%	9.3%

Figure 28:

Category	Description	Applications	Shortlisted	Offered	Applications %	Shortlisted %	Offered %
Religion	Atheism	1,676	489	184	9.8%	9.2%	11.9%
	Buddhism	184	52	11	1.1%	1.0%	0.7%
	Christianity	8,316	2,739	760	48.6%	51.7%	49.3%
	Hinduism	1,679	440	100	9.8%	8.3%	6.5%
	Islam	1,969	448	100	11.5%	8.4%	6.5%
	Jainism	44	14	5	0.3%	0.3%	0.3%
	Judaism	116	51	11	0.7%	1.0%	0.7%
	Sikhism	180	58	10	1.1%	1.1%	0.6%
	Other	1,176	384	101	6.9%	7.2%	6.5%
	Undisclosed	1,788	628	260	10.4%	11.8%	16.9%

Figure 29:

Category	Description	Applications	Shortlisted	Offered	Applications %	Shortlisted %	Offered %
Sexual Orientation	Lesbian	24	9	3	0.1%	0.2%	0.2%
	Gay	96	42	6	0.6%	0.8%	0.4%
	Persons of the same sex (Homosexual)	65	18	7	0.4%	0.3%	0.5%
	Bisexual	157	40	14	0.9%	0.8%	0.9%
	Heterosexual	15,280	4,644	1279	89.2%	87.6%	82.9%
	Undisclosed	1,506	550	233	8.8%	10.4%	15.1%

Figure 30:

Category	Description	Applications	Shortlisted	Offered	Applications %	Shortlisted %	Offered %
Marital Status	Married	6,838	2,264	611	39.9%	42.7%	39.6%
	Single	8,198	2,264	655	47.9%	42.7%	42.5%
	Civil partnership	348	96	25	2.0%	1.8%	1.6%
	Legally separated	179	56	11	1.0%	1.1%	0.7%
	Divorced	773	265	55	4.5%	5.0%	3.6%
	Widowed	139	53	11	0.8%	1.0%	0.7%
	Other	191	60	27	1.1%	1.1%	1.8%
	Undisclosed	462	245	147	2.7%	4.6%	9.5%

4.3 Internal appointments to a higher band (promotions)

During financial year April 2016 and March 2017 there were a total of 301 non medical internal appointments within the Trust meaning 9.4% (297 staff) of the workforce were appointed to a higher grade.

Further analysis of these employees shows a slightly higher proportion of female employees were appointed than male employees.

Figure 31:

Gender	Band Decreased	Band Increased	No Change	Overall	Band Decreased	Band Increased
Female	32	239	2392	2663	1.2%	9.0%
Male	5	58	444	507	1.0%	11.4%
Grand Total	**37**	**297**	**2836**	**3170**	**1.2%**	**9.4%**

Breakdown by ethnicity indicates that the largest numbers of promotions were made for the White group.

Figure 32:

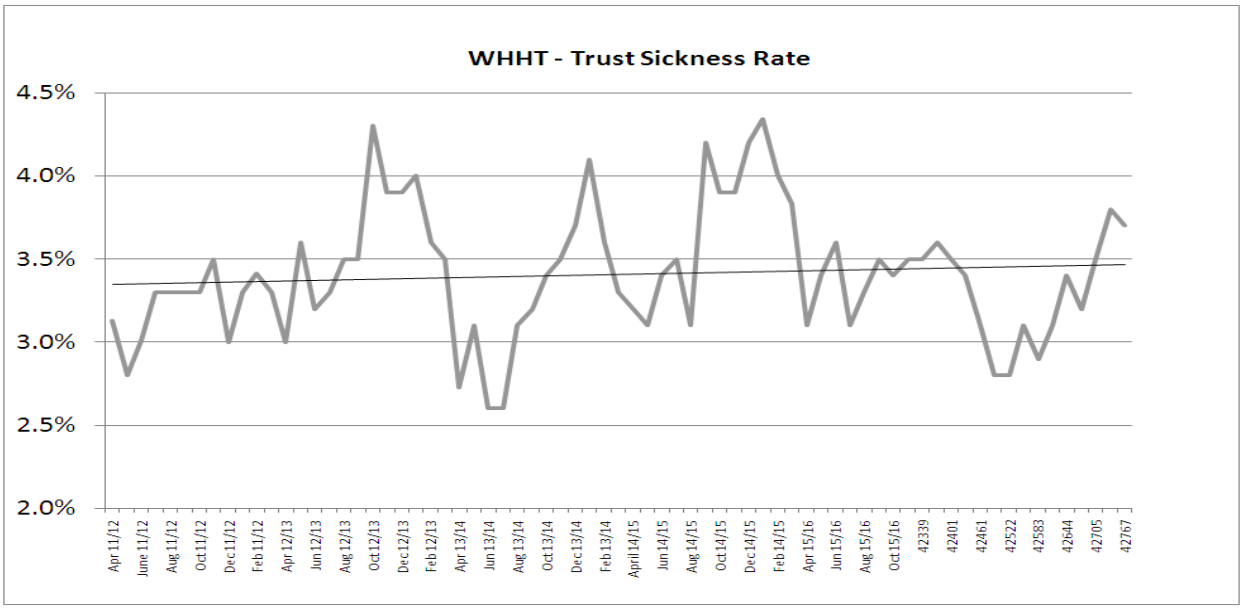
PSED Ethnic Origin	Band Decreased	Band Increased	No Change	Grand Total	Band Decreased %	Band Increased %	No Change
A White - British	23	149	1593	1765	1.3%	8.4%	90.3%
B White - Irish	1	12	76	89	1.1%	13.5%	85.4%
C White - Any other White background	2	47	210	259	0.8%	18.1%	81.1%
D Mixed - White & Black Caribbean	0	2	8	10	0.0%	20.0%	80.0%
E Mixed - White & Black African	0	0	8	8	0.0%	0.0%	100.0%
F Mixed - White & Asian	0	0	8	8	0.0%	0.0%	100.0%
G Mixed - Any other mixed background	0	1	15	16	0.0%	6.3%	93.8%
H Asian or Asian British - Indian	1	24	223	248	0.4%	9.7%	89.9%
J Asian or Asian British - Pakistani	2	5	49	56	3.6%	8.9%	87.5%
K Asian or Asian British - Bangladeshi	0	1	6	7	0.0%	14.3%	85.7%
L Asian or Asian British - Any other Asian background	1	17	212	230	0.4%	7.4%	92.2%
M Black or Black British - Caribbean	0	5	52	57	0.0%	8.8%	91.2%
N Black or Black British - African	0	12	139	151	0.0%	7.9%	92.1%
P Black or Black British - Any other Black background	1	0	15	16	6.3%	0.0%	93.8%
R Chinese	1	4	27	32	3.1%	12.5%	84.4%
S Any Other Ethnic Group	2	6	58	66	3.0%	9.1%	87.9%
Undefined	0	9	45	54	0.0%	16.7%	83.3%
Z Not Stated	3	3	92	98	3.1%	3.1%	93.9%
Grand Total	**37**	**297**	**2836**	**3170**	**1.2%**	**9.4%**	**89.5%**

Notes - (Data compared April 2016 to April 2017 Data, so excludes medical staff group and new starters over the year.)
(Also data does not include band 8a's who might be promoted to band 8b,8c,8d.)

4.4 Sickness Absence

The table below shows the Trust's sickness absence by month for the last 4 years.

Figure 33:



We are not able to report on disability related sickness through ESR as there is no mechanism for collecting this data through the regular sickness absence returns.

4.5 Disciplinary and grievances

This employee relations section relates to the number of staff involved in disciplinary or grievance procedures in the period 1st April 2016 2014 to 31st March 2017.

Disciplinary cases by gender

The table shows that males are disproportionately likely to be involved in a disciplinary

Figure 34:

Gender	Trust Staff	Disciplinary Total	Trust Staff %	Disciplinary %
Female	3648	28	78.7%	65.1%
Male	989	15	21.3%	34.9%
Grand Total	**4637**	**43**	**100.0%**	**100.0%**

Disciplinary cases by ethnicity

White staff account for 39.5% of disciplinary cases. 62.3% of Trust staff are from a White background. The Asian or Asian British - Indian group accounts for the second largest number of disciplinary cases - 18.6% but make up only 9.4% of the workforce.

Figure 35:

Ethnic Origin - PSED	Staff Headcount	Ethnicty as a %	Disciplinary Totals	Disciplinary as a %
A White - British	2266	48.9%	12	27.9%
B White - Irish	115	2.5%	0	0.0%
C White - Any other White background	507	10.9%	5	11.6%
D Mixed - White & Black Caribbean	14	0.3%	0	0.0%
E Mixed - White & Black African	14	0.3%	0	0.0%
F Mixed - White & Asian	14	0.3%	1	2.3%
G Mixed - Any other mixed background	33	0.7%	0	0.0%
H Asian or Asian British - Indian	435	9.4%	8	18.6%
J Asian or Asian British - Pakistani	122	2.6%	4	9.3%
K Asian or Asian British - Bangladeshi	23	0.5%	0	0.0%
L Asian or Asian British - Any other Asian background	323	7.0%	6	14.0%
M Black or Black British - Caribbean	78	1.7%	0	0.0%
N Black or Black British - African	237	5.1%	6	14.0%
P Black or Black British - Any other Black background	43	0.9%	0	0.0%
R Chinese	46	1.0%	0	0.0%
S Any Other Ethnic Group	111	2.4%	0	0.0%
Undefined	133	2.9%	0	0.0%
Z Not Stated	123	2.7%	1	2.3%
Grand Total	**4637**	**100.0%**	**43**	**100.0%**

The following table shows disciplinary cases by age band and numbers as a percentage of staff in post. The 25-29 age group has the highest number of disciplinary cases.

Figure 36:

Age Bands	Staff Headcount	Staff Headcount %	Number of Disciplinary Cases	Disciplinary Cases as a %	Disciplinary cases as a % of age band
Under 18	4	0.1%	0	0.0%	0.00%
18 - 19	12	0.3%	0	0.0%	0.00%
20 - 24	283	6.1%	0	0.0%	0.00%
25 - 29	694	15.0%	9	20.9%	1.30%
30 - 34	513	11.1%	6	14.0%	1.17%
35 - 39	524	11.3%	7	16.3%	1.34%
40 - 44	591	12.7%	5	11.6%	0.85%
45 - 49	579	12.5%	7	16.3%	1.21%
50 - 54	572	12.3%	3	7.0%	0.52%
55 - 59	485	10.5%	3	7.0%	0.62%
60 - 64	280	6.0%	3	7.0%	1.07%
65 - 69	70	1.5%	0	0.0%	0.00%
70 and Over	30	0.6%	0	0.0%	0.00%
Grand Total	**4637**	**100.0%**	**43**	**100.0%**	**0.93%**

Grievances

There were 11 grievances in 2016/17 – these are shown by gender and ethnicity in the following tables. The largest number of grievances were in the White group (7 in total). 8 of the 7 grievances were raised by female staff.

Figure 37:

Gender	Grievance not upheld	Grievance upheld in part	Resolved informally	Grand Total
Female	1	4	3	8
Male	0	1	2	3
Grand Total	**1**	**5**	**5**	**11**

Figure 38:

Ethnicity	Grievance not upheld	Grievance upheld in part	Resolved informally	Grand Total
A White - British	1	3	3	7
H Asian or Asian British - Indian	0	0	1	1
M Black or Black British - Caribbean	0	1	0	1
N Black or Black British - African	0	1	1	2
Ethnicity Total	**1**	**5**	**5**	**11**

4.6 Leavers

During the period 1st April 2016 to March 31st 2017 a total of 944 non-medical staff left the Trust. Leavers from a rolling 12 month period have been used as this form the basis of labour turnover calculations and provides greater information.

The following table shows the ethnicity of leavers from the Trust against the proportion of staff employed. The single largest category of leaver is the White - British group (576 leavers). The percentage of White leavers is 60.9% of the leavers, in line with the Trust's ethnic composition. The White group accounts for 62.3% of the workforce.

Figure 39:

PSED Ethnic Origin	Total Staff	Total Staff %	Leavers	Leavers %
A White - British	2266	48.9%	412	43.6%
B White - Irish	115	2.5%	21	2.2%
C White - Any other White background	507	10.9%	143	15.1%
D Mixed - White & Black Caribbean	14	0.3%	7	0.7%
E Mixed - White & Black African	14	0.3%	5	0.5%
F Mixed - White & Asian	14	0.3%	3	0.3%
G Mixed - Any other mixed background	33	0.7%	11	1.2%
H Asian or Asian British - Indian	435	9.4%	89	9.4%
J Asian or Asian British - Pakistani	122	2.6%	19	2.0%
K Asian or Asian British - Bangladeshi	23	0.5%	7	0.7%
L Asian or Asian British - Any other Asian background	323	7.0%	51	5.4%
M Black or Black British - Caribbean	78	1.7%	17	1.8%
N Black or Black British - African	237	5.1%	58	6.1%
P Black or Black British - Any other Black background	43	0.9%	4	0.4%
R Chinese	46	1.0%	17	1.8%
S Any Other Ethnic Group	111	2.4%	21	2.2%
Undefined	133	2.9%	49	5.2%
Z Not Stated	123	2.7%	10	1.1%
Grand Total	**4637**	**100.0%**	**944**	**100.0%**

The following table shows leavers by disability status.

Figure 40:

Disability	Total Staff	Staff %	Leavers	Leavers %
No	3217	69.4%	673	71.3%
Not Declared	247	5.3%	66	7.0%
Undefined	1132	24.4%	201	21.3%
Yes	41	0.9%	4	0.4%
Grand Total	**4637**	**100.0%**	**944**	**100.0%**

The following table shows leavers by gender.

Figure 41:

Gender	Total Staff	Total Staff %	Leavers	Leavers %
Female	3648	78.7%	687	72.8%
Male	989	21.3%	257	27.2%
Grand Total	**4637**	**100.0%**	**944**	**100.0%**

The table below shows leavers by age band expressed as a percentage of staff in post. Staff in the age bands under 34 show the highest proportion of staff leaving. Age bands with the least proportion of leavers are 45 – 49, 50 – 54 and 55 – 59.

Figure 42:

Age Bands	Total Staff	Total Staff %	Leavers	Leavers %
16 - 20	27	0.6%	6	0.6%
21 - 25	429	9.3%	152	16.1%
26 - 30	653	14.1%	229	24.3%
31 - 35	499	10.8%	132	14.0%
36 - 40	528	11.4%	101	10.7%
41 - 45	617	13.3%	69	7.3%
46 - 50	570	12.3%	63	6.7%
51 - 55	559	12.1%	66	7.0%
56 - 60	458	9.9%	62	6.6%
61 - 65	215	4.6%	48	5.1%
66 - 70	63	1.4%	11	1.2%
71 & above	19	0.4%	5	0.5%
Grand Total	**4637**	**100.0%**	**944**	**100.0%**

The following table highlights leavers by Pay Band. It should be noted that many medical staff are employed on fixed term contracts as part of their training scheme.

Figure 43:

PSED Band	Total Staff	Staff %	Leavers	Leavers %
Band 1	21	0.5%	3	0.3%
Band 2	879	19.0%	137	14.5%
Band 3	454	9.8%	75	7.9%
Band 4	435	9.4%	72	7.6%
Band 5	858	18.5%	240	25.4%
Band 6	670	14.4%	87	9.2%
Band 7	468	10.1%	47	5.0%
Band 8	253	5.5%	30	3.2%
Band 9	3	0.1%	2	0.2%
Consultant	240	5.2%	9	1.0%
Director	12	0.2%	3	0.3%
Non-Exec	6	0.1%	0	0.0%
Other Medic	338	7.3%	239	25.3%
Grand Total	**4637**	**100.0%**	**944**	**100.0%**

(This does not include those that have returned or honorary, bank staff and no medics)
Reasons for leaving are set out in the following table (non-medical staff)

Figure 44:

Leaving Reason	Total
Voluntary Resignation - Other/Not Known	202
Voluntary Resignation - Relocation	186
End of Fixed Term Contract - Completion of Training Scheme	141
Voluntary Resignation - Work Life Balance	86
End of Fixed Term Contract	82
Retirement Age	69
Voluntary Resignation - Promotion	60
Voluntary Resignation - Lack of Opportunities	27
Voluntary Resignation - Child Dependants	13
Voluntary Early Retirement - no Actuarial Reduction	12
Voluntary Resignation - Health	12
Dismissal - Capability	11
Dismissal - Some Other Substantial Reason	8
Voluntary Resignation - Adult Dependants	8
Retirement - Ill Health	4
Death in Service	3
Dismissal - Statutory Reason	3
Voluntary Early Retirement - with Actuarial Reduction	3
Dismissal - Conduct	2
Initial Pension Ended	2
Voluntary Resignation - To undertake further education or training	2
End of Fixed Term Contract - End of Work Requirement	1
End of Fixed Term Contract - External Rotation	1
End of Fixed Term Contract - Other	1
Has Not Worked	1
Redundancy - Compulsory	1
Redundancy - Voluntary	1
Voluntary Resignation - Better Reward Package	1
Voluntary Resignation - Incompatible Working Relationships	1
Grand Total	**944**

(This does not include those that have returned or Honorary,bank staff and no medics)

4.8 Staff health and wellbeing

The Trust is committed to embedding good equality and diversity practice into all of its activities so that the trust becomes an even richer and more diverse place to work. Since publication of last year's PSED Report in September 2016, some of the immediate ED actions undertaken include:

- 1-day Recruitment & Selection training incorporating the impact of unconscious bias
- HR core skills training delivered to staff & managers to influence recruitment and people management practices
- Continued support to the multi-cultural staff network Connect which is set up to support BME staff
- disability-focused panel established
- Encouraging applications from disabled people through the 'Disability Confident' scheme
- Drop in session for disabled staff
- Bullying & Harassment (B&H) advisers made available to all staff
- B&H advisers allocated to specific divisions & hotspot areas
- Roll out of resolution guide which provides clearer support for staff
- Portal and suite of tools developed to support staff and managers on a range of ER issues

Roll out of new national NHS Workforce Race Equality Standard

The national NHS Workforce Race Equality Standard (WRES) came into effect in 2015. It is designed to improve the representation and experience of BME staff at all levels of the organisation – particularly senior management. There are a total of nine indicators that make up the WRES split across workforce data, the national NHS Staff Survey and Trust Board composition. The Trust's performance against all nine WRES indicators can be accessed here: **http://www.westhertshospitals.nhs.uk/about/equality.asp**

WRES Indictors:

Table 2:

1. Percentage of BME staff in Bands 8-9, VSM* (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce.	2. Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of BME staff accessing non mandatory training and CPD compared to white staff	5. KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	6. KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

7. KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	8. Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	9. Boards are expected to be broadly representative of the population they serve.

ED priority areas for improvement 2017-18

The Workforce Equality Forum, chaired by the Director HR & OD, has helped determine ED priorities for 2017-18 informed by the PSED, WRES & Staff Survey data. The Forum has agreed 4 strategic ED work-streams summarised in Table 3. Our approach will also involve targeted engagement to better understand the issues behind the data.

Table 3: 2017/18 Priority ED areas based upon PSED, WRES & Staff Survey data

Recruitment conversion	BME involvement in disciplinary process	Experience of staff with disabilities	BME representation at senior levels	Experience of patients with disabilities	Strengthening EIAs for policies
• Continue recruitment & selection training for all managers • Implement policy of at least 1 interview panel member trained • Develop interview tips for candidates to be published on trust website	• Scope options for creating panel of in-house mediators with input from ER & HR operational team • Managers investigating disciplinaries to be given training / guidance with a clear ED angle on core HR issues such as managing sickness, managing performance, conflict resolution.	• Raise staff / manager awareness of duty to make reasonable adjustments • Promote support services available to staff and managers • Engage with disabled staff via let me hear/see you panel • Assess experience of OH from a disabled employee's point of view • Apply and prepare for Disability Confident scheme level 2	• Showcase positive role models across the organisation • Proactively encourage BME staff for leadership/management development programmes • Scope options for reverse mentoring scheme • All adverts make clear commitment to ED • Round table discussion with staff side, let me hear /see you panel and Connect for solutions to address less positive staff survey results	• Produce and publish information on trust website for disabled patients and visitors to make hospital visit / stay easier • Guidance / tips for frontline staff on making adjustments & meetings needs of disabled patients / carers	• Training on EIAs • Produce good practice examples

Conclusion

Conclusion

In this report, the Trust aims to demonstrate that it is monitoring, reporting and publishing equality data in line with our statutory duties under the Public Sector Equality Duty. The Trust will continue to develop a culture which values each person equally as a unique individual within an inclusive fair and equal employment and care setting.

Public Sector Equality Duty Report 2016/17

A report detailing West Hertfordshire Hospitals NHS Trust's equality information as required by the Equality Act 2010

If you need this leaflet in another language, large print, Braille or audio version, please call **01923 217187** or email **pals@whht.nhs.uk**

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Trust Board Meeting
07 September 2017

Title of the paper:	**Strategy update**
Agenda item:	**18/51**
Lead Executive:	**Helen Brown - Deputy Chief Executive**
Author:	**Helen Brown - Deputy Chief Executive**
Trust aims :	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
Purpose:	The aim of this paper is to update the Board on the development of the Trust's strategy.
Link to Board Assurance Framework (BAF)	**PR9** Failure to develop a long term clinical, financial and estates strategy

Previously discussed:

Committee	**Date**

Benefits to patients and patient safety implication

Recommendations

The Board is asked to note the progress update

Agenda item: 18/51

Trust Board Meeting – 01 June 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. Updates on key pathways are provided below.

Gynaecology	The Trust is continuing to work with Hertfordshire Community Gynaecology service on the proposed integrated 'tier 3' community gynaecology service. The target go-live date has been revised to December 2017 for triage and full service from 8th January 2018. Our service is fully engaged and good progress is being made on the delivery and governance arrangements. Under the proposal the Trust will transfer more than 5000 outpatient contacts into the new service. Detailed work to model the financial impact of the changes and mitigation plans for the activity loss and associated income are being completed.
Diabetes	A revised final submission from the provider partnership was made to HVCCG in July 2017 setting out the proposed operating model and governance arrangements for the new integrated diabetes service. Formal feedback on the submission is awaited following review by the CCG commissioning Executive in late August. The partnership has successfully secured circa £800k additional funding over the next 2 years through the National Diabetes Treatment and Care programme to support three key service development priorities (structured patient education, recommended treatment targets – HBAC1 and blood pressure and reducing amputations (diabetic foot pathway). The programme has assured funding for the first year with funding for year 2 described as 'highly likely' on delivery of agreed milestones. A risk management plan has been developed should year 2 funding not be available. The National Diabetes Treatment and Care programme is effectively pump priming the developments listed above. The Diabetes partnership will need to fund the services within the total fixed budget for the service on a recurrent basis from April 2019, on the basis that these services will reduce overall demand once embedded.

Community Musculo-skeletal services.	The Trust is the lead / co-ordinating partner for a joint bid with HCT, the Herts Valley Physio Group, HertsOne GP Federation and the Royal Free London to develop a new community MSK service in line with the commissioning specification. This is a formal competitive procurement process. The service will operate within a fixed finance and activity envelope and a core requirement of the specification is to demonstrate a reduction in secondary care consultant led outpatient services. Partners have agreed a joint service model in response to the specification and have agreed partnership and governance arrangements to jointly the deliver the service. Demand, capacity, workforce modelling and a financial model have all been completed. The ITT was submitted in June, scenario presentations made in August. The expected outcome is now delayed until the 21st September 2017. The go live date for the successful bidder has also subsequently slipped by a month to 1st January 2018.
Dermatology.	The Trust's Dermatology team are working with HVCCG commissioning leads to identify opportunities to redesign dermatology pathways. The first phase of redesign will be the introduction of a teledermatology service which goes live on the 1st September 2017. The service will be formally audited in six months but will be kept under close review over that period to ensure that it is delivering the expected benefits. The service is working up proposals for further redesign of the full dermatology service as part of a Multi Provider Partnership Collaborative led by WHHT with the other two incumbent providers (HertsOne GP Federation & the Royal Free London). HVCCG would like to implement a fully capitated budget for the service but significant further work to understand future demand and capacity in redesigned pathways will be required before this can be achieved. The CCG is expected to issue a proposed activity and finance envelope along with a revised service specification in September 2017.
Discharge to Assess - FIRST	The Trust has commissioned HCT to provide home based care for patients who are ready for discharge from hospital but are waiting for either assessment for or delivery of a social care package to safely support them to go back home. The FIRST service opened in March 2017. An evaluation of the first six weeks of the service has been completed. The service has assisted in an improvement on the reportable delayed discharges (however we are still an outlier) and is core factor in closing the escalation beds on Castle ward. A sustainable funding solution needs to be agreed with partners across health and social care. A service specification for a substantive service has been developed but will be subject to a full business case before any substantive contractual arrangement is entered into.

Discharge to Assess - Transition HUB	The Trust has working with HCT to develop a non-acute residential assessment service for patients who have completed their acute care episode, are medically stable but are expected to require a permanent placement in nursing or residential care. Simpson Ward transferred to HCT on the 1st August 2017 as planned. Simpson ward has revised criteria for patient acceptance based on a Discharge to Assess methodology and KPIs have been agreed for evaluation. The ward is being managed alongside HCT's other community beds and fulfils the 'transition' role described above.
ENT and ophthalmology.	HVCCG have notified providers of their intention to commission new ENT and ophthalmology pathways during the course of this financial year. This will be undertaken via a formal competitive procurement process. Further details on the requirements and timeline are delayed with no timeline yet released.

In addition to those pathways listed above, the HVCCG QIPP programme has identified a number of further areas for potential redesign and / or changes to commissioning arrangements including respiratory, circulatory diseases, gastrointestinal medicine, critical care, end of life care and older people. Our clinical teams have been involved to varying degrees in preliminary work to scope potential in these areas and detailed proposals and timelines will be developed over the next 2-3 months.

The CCG is also currently engaging on a range of other commissioning changes including changes to eligibility criteria for surgery and PoLCE (procedures of limited clinical effectiveness) that will potentially have a significant impact on future levels of elective activity in future years.

2. Stroke Services Update

During 2015, HVCCG confirmed its intention to commission a full Hyper Acute Stroke service at Watford Hospital. In additional to delivering national performance indicators, the stroke commissioning specification is based on evidence that an appropriately staffed and skilled multi-disciplinary stroke unit is the cornerstone of the holistic care of people with stroke and leads to improved longer-term outcomes for stroke patients. Following detailed joint working between WHHT and HVCCG, it was agreed that a tariff uplift would be required, to fund the full acute stroke service model. At this time, the CCG also set out a plan to integrate the acute and community elements of the stroke pathway, with WHHT as overall lead provider for the pathway, in partnership with HCT. The expectation at the time was that all changes would be delivered by April 2017.

Unfortunately, funding constraints during 2016-17 have extended the anticipated timescale for delivering the new stroke model of care. Meanwhile, the hospital and community teams have continued to work increasingly closely together and the Stroke Service at WHHT has achieved an 'A-rating' against key national patient care standards and received local press recognition as a result. This significant achievement has been achieved by the successful establishment of Early Supported Discharge, promoting 7-day services and also largely as a result of staff dedication and goodwill, with the team 'going the extra mile' to drive improvements and bring the service closer in line with evidence-based recommendations.

Whilst still unable to fund a service that is fully in line with the commissioning specification, the CCG has indicated that stroke care remains a local priority for 17-18 and that the longer-term intention remains to progress towards meeting the full commissioning service specification.

HCT and WHHT were therefore asked to prepare a proposal as to how funding could best be allocated, in a phased way to improve acute stroke care and rehabilitation. This proposal was submitted and prioritises enhanced seven-day working and improving staffing ratios. Formal feedback is awaited from HVCCG.

3. Vascular

Following the Trust Board decision that WHHT would not bid to become the Vascular Hub for Hertfordshire, vascular specialised commissioners convened a review meeting to consider the bid submitted by East & North Hertfordshire Hospitals NHS Trust (E&NH), involving representatives from local CCGs, the Vascular Society and WHHT. The outcome of this review meeting is that specialised commissioners confirmed their preference for E&NH to be the Hertfordshire vascular hub, caring for complex vascular patients from across Hertfordshire and West Essex, in partnership with WHHT and with Princess Alexandra Hospital in Harlow.

A formal letter confirming this position has been received and the commissioner's expectation is that the majority of complex vascular patients from West Hertfordshire would receive their surgery (eg Aortic Abdominal Aneurysms, Carotids & other complex arterial surgery) at E&NH, though some patients in the south of the patch may flow to London instead.

On this basis dialogue is continuing with clinical and managerial colleagues at E&NH. The initial priorities are to finalise the clinical model across the network and confirm likely patient flows and activity volumes, so as to then confirm infrastructure requirements for E&NH and timescales for change. A joint project board has been established, with clinical representatives from all 3 of the acute trusts involved.

Further work is required to determine the optimum model for interventional radiology services (IR). Whilst a substantial element of IR provision relates to vascular patients IR also plays a key and developing role in other specialties. Improving out of hours access to IR for gastrointestinal and obstetric bleeds should be a priority. The Royal Free are working with providers in north central London to scope the development of a shared out of hours IR rota. WHHT has expressed an interest in participating in this rota; discussions are at an early stage. The interface with the development of the vascular hub at E&NHT needs to be considered, together with the potential for joint working between Hertfordshire and West Essex and the north central London vascular and IR networks.

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

The Board approved the strategic outline case at its meeting in February 2017. Formal support for the preferred way forward set out in the SOC was been confirmed by HVCCG. Hertfordshire and West Essex STP CEOS have also confirmed support, as has Hertfordshire County Council.

The Trust and HVCCG continue to liaise with NHS Improvement and NHS England to clarify national decision making processes in respect of the SOC. Formal review by NHS Improvement has commenced. Additionally the Trust has submitted the SOC to NHS E for review via the STP capital process. This is the route by which recently announced capital funding for the NHS can be accessed. A further submission is required by 6th September and work is underway to provide additional information requested in line with this process.

Mike Penning MP and representatives of the New Hospital Campaign (NHC) met with Jim Mackie (Chief Executive, NHS Improvement) to discuss their concerns regarding the preferred way forward set out in the SOC. Mike Penning, Anne Main and the new hospital campaign continue to press for further consideration to be given to the development of a new hospital on a new site. A formal response from NHS Improvement to Mike Penning and the NHC is expected.

Further updates will be provided to the Board as available.

5. Hemel Hempstead SOC

The Trust continues to work with HVCCG and partners through the Dacorum and Hemel Hempstead Hospital Project Group to develop plans for redevelopment of Hemel Hempstead Hospital. Clinical teams have been considering the opportunities for future provision at Hemel Hempstead and will share their thinking at a clinical model workshop that has been scheduled for the 28th September 2017. This workshop will inform the recommended clinical model that will underpin the design brief and estates option appraisal aspect of the SOC.

The target date for completing the SOC has been extended to allow for further work on the clinical model, including stakeholder engagement; the target date for completion for review and approval by Boards is now early 2018.

6. Car Parking Strategic Outline Case

The Car Parking strategic outline case has been submitted to NHS Improvement for review and approval. A dialogue has commenced with NHS Improvement finance and cash and capital teams to determine how this business case is best taken forward through to full business case and contract signature, assuming the SOC is approved. Additional work on the structure of a contract with a business partner responsible for developing the car park is underway. The structure will affect whether or not the car park could be classified as a trust asset and the ultimate affordability of the arrangements.

7. Theatres Outline Business Case

The theatres outline business case has been submitted to NHS Improvement for formal review. This review is now underway, including a final decision on whether the business case will require approval via NHS Improvement Resources Committee. The Trust has bid for capital for the theatres project as part of the STP capital bidding process; if this is unsuccessful loan finance will be required.

The Theatres Project Board is working with Kier Properties Ltd, the selected P22 partner for the Theatres project to agree a detailed work programme for the development of the business full case. 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 OBC approval and funding 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 joint programme board met for the second time in July 2017. A work programme is currently being developed and will be brought to the board for formal approval in October / November 2017. A draft of this work plan will be discussed in Part 2.
The Royal Free Hospital Group Medical Director attended the Trust clinical engagement event on the 6th July 2017. There was a good discussion about the group model approach to reducing unwarranted variation in clinical care and a high degree of interest from WHHT clinicians. A number of WHHT clinicians are participating in the RFH 'clinical practice groups' first phase of pathway redesign.
An all staff briefing was issued in August 2017 – see attached. A briefing has also been provided for STP partners.

10. Sustainability and Transformation Plan

Copies of July and August STP newsletters are attached for Board members information. WHHT senior leaders and clinicians continue to engage in STP workstreams.

Helen Brown
Deputy Chief Executive
September 2017

This month's STP update

Click here to view this email in your browser

A Healthier Future - issue two

August 2017

Welcome to the second edition of the newsletter for everyone interested in creating 'A Healthier Future' for Hertfordshire and west Essex.

This edition looks at some of the improvements that are already being made as we work together to tackle the big challenges identified by health and social care organisations in our Sustainability and Transformation Partnership plan, 'A Healthier Future'. These are:

- improving urgent and hospital services
- transforming primary and community services
- providing health and care more efficiently and effectively

The stories below are just a snapshot of some of the important and varied work of the STP, which has been organised into a number of key themes and projects, known as 'workstreams'. Each workstream is led by an executive director and a clinician or lead social care professional, helping to ensure that our efforts are always focused firmly on improving the wellbeing of our population.

You can find out more about these plans and projects and the priority actions that they have agreed for the year ahead here.

Thanks for reading,

Tom Cahill,
Sustainability and Transformation Partnership lead
Hertfordshire and west Essex

My Care Record now live across Princess Alexandra Hospital

People in west Essex and east and north Hertfordshire are now benefiting from more efficient, joined-up care in line with our *Healthier Future* aims. With patient's permission, *My Care Record* allows clinicians to view a patient's medical history over a secure network, delivering a more productive service, ensuring that there is more clinical time spent on patients, fewer tests, more accurate prescriptions and safe and secure decision-making. Plans are ongoing to widen *My Care Record* to include other hospitals in the next few months.
Click here to read more.

Red Bags smooth the way for hospital stays

A simple red bag is helping reduce the time care home residents spend in hospital – and making their stay less stressful, so that they can get back to normal as soon as possible.
The Red Bag procedure involves packing a bag with all the information, medication and personal belongings that someone might need when they are admitted to hospital from a care home. The bag is handed to ambulance staff who pass it on to hospital staff on arrival.
The initiative has been rolled out to all care homes in east and north Hertfordshire this month.
Click here to read more.

Work starts on Hemel Hempstead's new health and wellbeing centre

One of the aims of *A Healthier* Future is to provide more health

Ambulance handover times at the Lister now best in the Eastern region

Improving urgent and emergency care services is a key part of

Centre in Hemel Hempstead is currently being transformed into a modern, state-of-the-art building where both NHS mental and physical health services will be based. The programme will see both adult and children's physical and mental health services on the same site, helping staff to work closer together for the benefit of service users and patients.
This is a joint venture between Hertfordshire Partnership University NHS Foundation Trust (HPFT) and Hertfordshire Community NHS Trust (HCT).
Click here to read more.

patients from the care of paramedics into A&E departments causes concern for patients and means there are fewer ambulances available for new calls. Changes made at the Lister hospital's emergency department see 80% of ambulances now turned around within the national 30-minute standard, compared to 10% previously.
The majority of ambulances arriving at the Lister's emergency now have their patients' handover and ambulances ready to return to duty within 30 minutes of arriving.
Click here to read more.

STP commissioners' public consultations on proposals for service changes is underway

Local people are being consulted about their views on a series of proposals designed to make best use of the money available to the NHS, while helping as many people as possible to live healthier, longer lives and avoid preventable illnesses. National shortages of NHS staff mean that we have to make sure that doctors', nurses' and other specialists' time is used wisely.
These proposals are about:

- Tightening up existing rules so that people who smoke or whose weight is classified as 'obese' are required to make bigger improvements to their

- Limiting the routine prescription of food supplements, as well as medicines and products that can be bought without prescription for short-term conditions and minor ailments
- Restricting the prescribing of gluten-free foods
- Stopping NHS funding for female sterilisation procedures
- Reducing or stopping the availability of NHS-funded IVF (in vitro fertilisation) and specialist fertility services except in exceptional circumstances. West Essex CCG is also consulting its residents on this issue.

The consultation is running until 14 September 2017. To find out more or to complete the survey, go to www.healthierfuture.org.uk/NHSLetsTalk

If you haven't read our Sustainability and Transformation Partnership plan, 'A Healthier Future' yet, we'd be delighted if you could take a look and let us know what you think.

Click here to view the publication.

Share Tweet Forward +1

July 2017

A Healthier Future

Hertfordshire and west Essex STP

Tom Cahill: Leader's Update

As a senior member of staff in an STP organisation, you will understand that putting in place the health and care improvements that we want to see for our population is a real challenge.

Through my role as the lead officer for the area's sustainability and transformation partnership, I'm working with you and your organisation to ensure that our system addresses the three key issues identified by NHS England in the Five Year Forward View:

- Improving health and wellbeing
- Improving the quality of health and care services
- Providing efficient and affordable care

When you add in the differing pressures on our complex organisations – including growing demand, limited resources and outdated infrastructure – we have a significant task on our hands.

But that's what we have been challenged to do through our Sustainability and Transformation Partnership, and I'm pleased to report that across Hertfordshire and west Essex, professionals like you and your colleagues are rising to the challenge.

Through this update – I want to give you, as a senior leader in your organisation, a short but comprehensive briefing on the progress of the STP so far.

Looking at:

Our structure

After a considerable period of debate and deliberation, led by senior leaders from across our organisations and taking advice from independent experts, our initial Sustainability and Transformation 'Plan' has now become a functioning Sustainability and Transformation 'Partnership'.

The partnership is really starting to get stuck in, with project groups known as 'workstreams' now in place, each with an agreed clinical or professional lead, and including representation from across our system. The clinical focus is vital to ensure that our efforts are always focused firmly on improving the wellbeing of our population, using the most up-to-date evidence to guide our decision making.

Tom Cahill, STP lead and CEO of Hertfordshire Partnership University NHS Foundation Trust

The **workstreams** are as follows:

Clinical

- Urgent and Emergency
- Primary Care
- Planned Care
- Mental Health and Learning Disabilities
- Frailty
- Cancer
- Women's and Children

Enabling

- Clinical Support Services *(e.g. pharmacy, pathology and radiology improvements)*
- Prevention
- Collaborative Commissioning
- Place Based and Integrated care *(health and care organisations, fire service, voluntary services and district councils working closely with local communities to improve health and wellbeing)*
- Estates, Facilities and Capital
- Technology
- Communications and Engagement
- Workforce

Task & Finish

- Medicines Management
- Back Office
- Procurement
- POLCE and Exclusions
- Reduce Agency Spend

Each workstream has agreed a number of key priorities for the year ahead and detailed action plans have now been submitted for most of the workstreams. You can see a structure map and the key objectives for the eight **priority** workstreams on the Healthier Future website, here.

Our performance

NHS England and NHS Improvement are the two national organisations which oversee the development of integrated care across England. Working together, they have produced an assessment of the progress of STPs across the country. In a letter I received under strict embargo on Monday 17 July, our area's two regional directors, Dr Paul Watson and Dale Bywater, said:

"This is not a comment on the performance of STPs to date. Rather, it indicates the relative starting points on the road to better care, often driven by a range of historical factors that the NHS and local partners have struggled to resolve.

"Wherever each STP currently sits on this initial assessment, working together collaboratively as a system offers a greater chance of making the improvements the NHS has prioritised – taking the strain off of A&E, making it easier to get a GP appointment and offering improvements to mental health and cancer care."

The STP Progress Assessment provides headline ratings for STPs in four bandings. Our STP banding is a reflection of our collective position on a range of issues, including : A&E waiting times, percentage of cancers diagnosed at an early stage, and the recovery rate of people who use psychological (talking) therapies. These are important standards and it's fundamental that we work together to improve our performance in these areas across the STP.

Ratings range from:

- **1 - outstanding;**
- **2 - advanced;**
- **3 - making progress;**
- **4 - needs most improvement.**

Our Hertfordshire and west Essex STP has been rated in banding three – *'making progress'.* I think that this is a fair reflection on our progress, from a difficult starting point. When STP areas were first announced, it took a while for our organisations to start thinking and operating together collectively. We've come a long way since then and are really starting to get to grips with new ways of working together for the benefit of our population. In fact, our assessment says that "organisations are aware of the importance of effective system-level working and are taking action to drive integration."

Although there is still a long way to go – improvements are starting to work through to services 'on the ground'.

You can view the STP progress dashboard in detail here.

We'll be assessed again next year and have been advised to focus on Urgent and Emergency Care, A&E performance, cancer and mental health services in order to improve our banding. With your help, by then we'll be seeing many more service improvements and we will really have something to celebrate.

Like to get involved?

It's vitally important that each workstream group includes representation from professionals from a variety of backgrounds and organisations, representing the wide geographical area covered by our Sustainability and Transformation Partnership.

If there's an area of work which interests you and you would like lend your expertise to a workstream to help create a Healthier Future for us all, please contact Robert.Crerie@hpft.nhs.uk who will put you in touch with the relevant workstream lead officer.

We are currently recruiting for three **programme managers** who can use their extensive project management expertise to guide others through the service transformation we need to see in our STP area. If you would like to know more about these important and challenging roles, take a look at the job description and advert here. For an informal conversation about the roles, get in touch with Helen.Edmondson@hpft.nhs.uk

Coming soon … we will soon be recruiting a part-time clinical leader to support the workstreams. Details of this role will be circulated through your organisations shortly.

Our finances

The STP plans put together in autumn 2016 indicated that our Herts and West Essex STP had a likely financial deficit of £550 million by 20/21 if we do not change the way we work, with £300 million of this being held within health organisations. Our plans have been constructed to help address this major issue, with the aim of returning the system to financial balance at the end of the period.

So how well are we doing against these plans?

We closed the 2016/17 financial year with the system being over £95 million in deficit, a position that was better than our initial estimate.

As we enter the new financial year, our plans are to improve this position, reducing the

deficit to £40 million in 2017/18 with a further improvement in 2018/19 of a £25 imbalance.

This forecast improving position is due to a combination of targeted planning taking place in all of our organisations, together with cross-organisational workstream plans that are identifying money-saving opportunities across the health and care system.

Thank you for your ongoing support in helping to ensure that our limited NHS funds are used as efficiently and effectively as possible.

Improving our hospitals

Princess Alexandra Hospital NHS Trust and West Hertfordshire Hospitals NHS Trust have both developed 'Strategic Outline Cases' (SOCs) for proposed major improvements to their infrastructure. These outline schemes have now been approved by the governing bodies of their acute trusts, local CCGs and the STP's chief executives.

Princess Alexandra Hospital NHS Trust

- Previous work by KPMG has concluded the case for retaining acute services in the Harlow area is clear.
- 20 options were formulated as part of 'Outline Business Case' (OBC). The current preferred option is a new hospital on a green field site as part of a wider health and social care campus
- Out of hospital services will also have to be expanded to help reduce projected demand.
- Next stage is submission to NHS Improvement. If the plans get the go-ahead, work will be undertaken to support the development of an Outline Business Case
- If the OBC is approved it there will then need to be a Full Business Case.

West Hertfordshire Hospitals NHS Trust

- The SOC set out the acute transformation required to support 'Your Care, Your Future'
- Total of 8 options were considered from a long list of 14 (mixture of new build and refurbishment)
- It is recommended that new build and redevelopment options for Watford General and redevelopment of St Albans are explored at OBC
- Current Watford Hospital site historic underinvestment leading to maintenance backlogs
- An expansion of out of hospital services is necessary to help reduce projected demand
- Supported by HVCCG and district councils
- Not plan for any redevelopment to be operational until 2025

The next stage is for both organisations to produce more detailed Outline Business Cases.

NHS consultations – share your views

Our STP's three CCGs (East and North Hertfordshire, Herts Valleys and West Essex) have launched public consultations on a range of proposals designed to make the best use of NHS money, clinicians' limited time and encourage people to take more responsibility for their own health.

Using ideas from our local population, along with suggestions that have come from other areas, the proposals are about:

- Tightening existing rules on smoking and weight loss before non-urgent surgery –

unless a longer wait for surgery would be harmful (Hertfordshire CCGs only)

- Limiting the routine prescription of medicines and products that can be bought without prescription for short-term conditions (All STP CCGs)
- Restricting the prescribing of gluten-free foods (Hertfordshire CCGs only)
- Stopping NHS funding for female sterilisation procedures (Hertfordshire CCGs only)
- Reducing or stopping the availability of NHS-funded IVF (in vitro fertilisation) and specialist fertility services except in exceptional circumstances. (All STP CCGs)
- Stopping NHS funding for vasectomies (Herts Valleys CCG only).

The CCGs are working with Healthwatch, Patient Participation Groups, local community and voluntary organisations and special interest groups to make sure that as many local people as possible contribute their views before the consultations close on **14 September**.

We would like to ensure that your views and the views of your colleagues are reflected in the consultation too.

The easiest way to find out more and give your views is by completing the online consultation questionnaires at the following web address: www.healthierfuture.org.uk/NHSletstalk Details of public meetings are also available on this site.

If you would like someone from one of the CCGs involved to give a talk to staff at your organisation, please email either:

engagement@enhertsccg.nhs.uk for east and north Herts

enquiries.hvccg@nhs.net for west Herts

weccg.comms@nhs.net for west Essex.

Subscribe to the STP newsletter

If you want to be kept up to date with information and examples of ways in which the STP is already making a difference, why not subscribe to the regular e-newsletter? It features short, case-study examples of best practice from across the STP and is designed to be read by a general audience. The subscription link can be found at the bottom of the 'Healthier Future' website, which you can access here.

Trust Board Meeting
7th September 2017

Title of the paper	Corporate Risk Register Update
Agenda item	19/51
Lead Executive	Helen Brown, Director of Strategy and Corporate Services
Author	Leigh Gibson, Deputy Head of Risk
Executive summary **(including resource implications)**	The corporate risk register is discussed at each Risk Review Group (RRG). The last RRG was held on 15th August 2017. There are 12 new/escalated risks in this report and 3 de-escalated/closed risks. Data for this report was extracted from Datix on 24 August 2017.
Where the report has been previously discussed, i.e. Committee/Group	Risk Review Group reviews all corporate risk / escalations / de-escalations on a monthly basis.
Action required: • The Board/Committee/Group is asked to note the report for information.	
Link to Board Assurance Framework (BAF)	☒ **PR1** Failure to provide safe, effective, high quality care
Trust objectives	☒ To deliver the best quality care for our patients
Benefits to patients/staff from this project/initiatives Effective risk management frameworks and reporting provides a source of assurance that identified risks to patients are being identified, assessed and mitigated.	
Risks attached to this project/initiatives and how these will be managed Nil identified	

Agenda Item: 19/51

Trust Board meeting – 7th September 2017

Corporate Risk Register update

Presented by: Helen Brown, Deputy Chief Executive

1. Purpose

1.1 The aim of this paper is to provide a summary update of the status of the corporate risk register and corporate risk profile of the organisation.

2. Background

2.1 The Safety and Compliance Committee leads on the development and monitoring of risk and governance arrangements across the Trust to ensure that the organisation delivers key priorities and manages risk efficiently.

2.2 The Safety and Compliance Committee meets bi-monthly to review the overall corporate risk profile and seek assurance that risks are being appropriately identified and managed.

2.3 All corporate risks are mapped to one of the BAF principle risks and to a lead board sub-committee. Sub-committees receive risk updates monthly / bi-monthly according to the meeting cycle.

2.4 The Risk Review Group reviews all changes to risk scores for corporate risk entries including risks escalated to 15 or above and risks that are recommended for de-escalation due to effective mitigation or changes in circumstances.

3. Analysis/Discussion

3.1 The risk register is a live document recorded on Datix and risk leads regularly review and update entries.

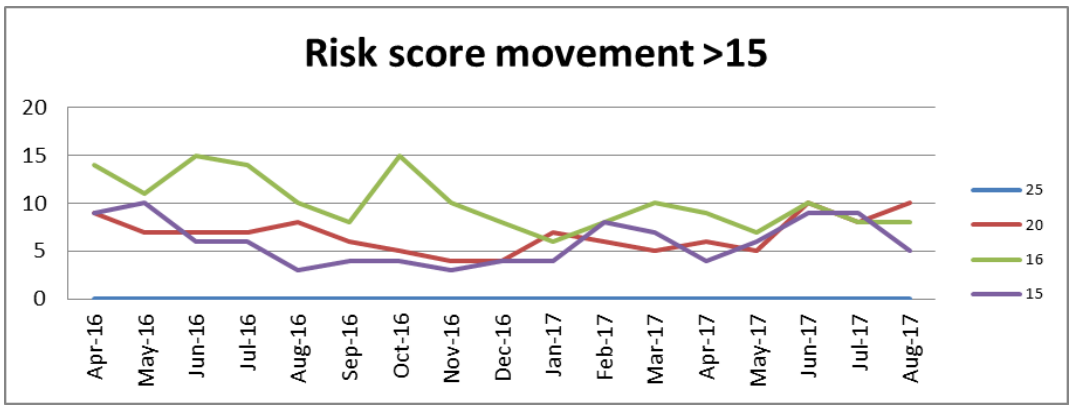
3.2 Data for this report was extracted from Datix on 24th August 2017. At this date 24 risks were recorded on the corporate risk register with a current score of 15 or more.

3.3 The chart below demonstrates the risk score movement on the corporate risk register from April 2016. From April 2016 to August 2017 there is an overall decrease of risks on the corporate risk register.

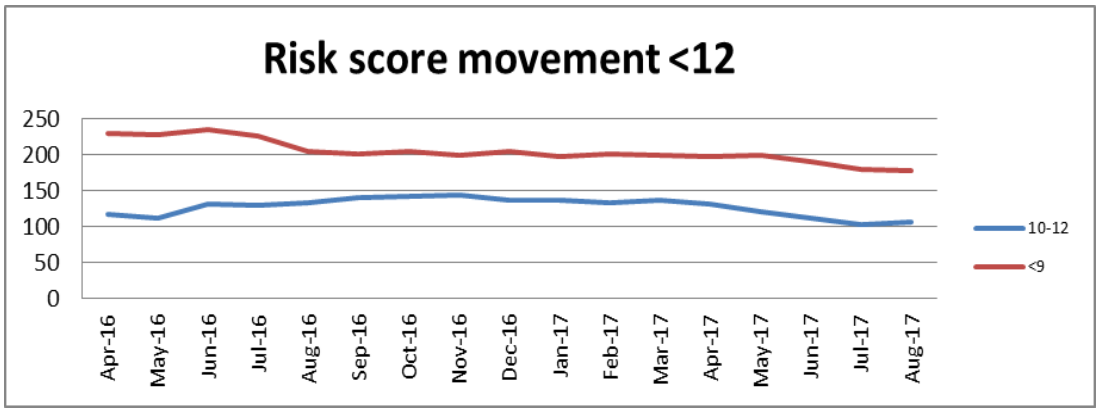
3.4 Work continues to further develop the quality of the information entered on to the risk register. The risk management section of the Trust induction e-learning system has recently been reviewed. The module includes information on how to report an incident or risk and describes what a risk assessment is and how to complete one using a step by step guide. Additionally it also displays identified common risks within our Trust and risk guidance and management.

3.5 In August 2017 a quarterly audit began to provide assurance regarding how well the controls, assurances and actions documented on the risk entries are being implemented in the local areas. The audit has been performed using a selection of risks with risks scores ranging from 20 – 4. The results will be presented at Risk Review Group in September 2017.

The chart below shows the risk score movement of all risks on the risk register from April 2016.



This month the graph above shows a reduction in 4 risks scored 15 and an increase of 2 scored 20.



This month the graph above shows a reduction of 3 in risks scored 10-12 and an increase of 2 in risks scored 9 and below.

Appendix 1 includes a summary of the current status of all risks on the corporate risk register.

4. Risks

4.1 The corporate risk register is an integral part of Trust risk management arrangements.

5. Recommendation

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

Helen Brown
Deputy Chief Executive

29 August 2017

Appendix 1

ID	The Risk	Update	Consequence (current)	Likelihood (current)	Rating (current)	Principal Risk (Primary)	Board Assurance (Primary)	Lead
ESCALATED RISKS								
3503	Hardware Support for McKesson Systems	The current cardiology imaging and archive system is no longer supported by the manufacturer. Mitigations had been put in place but service had flagged renewed concerns re. issues with image storage and retrieval and therefore re-escalated to RRG. The risk was accepted onto CRR by RRG but with a request for further review prior to the next meeting. Interim additional storage now in place. Image migration to carestream (new PACS system) underway in line with PACs deployment programme. Expected to complete by Sept / Oct 2017 at which point this risk will close.	Major	Certain	12 →20	PR4	Finance & Investment Committee	LE
3912	High turnover rate within Band 5 nursing population	29% turnover rate for band 5 nurses (location of Trust, age profile band 5 nurses contributory factor). A NHSI retention plan for band 5 nurses is being produced along with a CPD funding proposal.	Major	Likely	NEW 16	PR2	Patient and Staff Experience Committee	PdG
CURRENT CORPORATE RISKS								

3422	Potential low levels of workforce engagement will negatively impact retention and productivity	The next set of extended local engagement pulse checks is currently taking place. The Trust is joining new NHSI programme to look at improving retention rates which will be complete by April 18. A new staff engagement programme has commenced in emergency care services to improve staff and patient experience; this will be completed by Oct 18. Targeted work with Environment division is currently being scoped.	Major	Likely	16	PR2	Patient & Staff Experience	PdG
3773	The trust is at risk of not meeting regulatory requirements when responding to concerns and complaints raised	Performance has improved in the first quarter of 17/18. All mandatory fields have been created for recording KPIs set by the CCG and will be reported upon from the 1st August 2017. Risk to be reviewed at next risk review group.	Moderate	Certain	15	PR1	Safety & Compliance Committee	TC
3825	Workforce and Finance risks linked to the introduction of the Apprentice Levy	Phase One procurement started June 2017 will complete September 2017 Mapping of TNA agreement for the Apprentice Levy has commenced but the risk remains the loss of central funding which means there will not be sufficient funding to meet all training needs of our future workforce.	Moderate	Certain	15	PR2	Patient & Staff Experience	PdG
3870	Non Compliance with Regulatory Refore (Fire Safety) Order 2005 (AAU)	All 4 fire doors now replaced. Risk to be reviewed for closure at next RRG.	Catastrophic	Possible	15	PR1	Safety & Compliance Committee	KH
3501	Non-Compliance with HTM 00 - Provision of a Safe System of Work	Significant progress with appointment of AEs and implementation of audits. Estates Transformation Group has oversight. Risk for de-escalation at next RRG.	Major	Likely	16	PR3	Safety & Compliance Committee	KH

3845	CCG financial situation and consequent impact on WHHT - 2017/18	External advisory support engaged to strengthen contract management arrangements, recommendations made. Efficacy of this work currently under assessment together with a review of whether further actions required.	Catastrophic	Likely	20	PR7	Finance & Investment Committee	DR
3742	Failure to achieve sufficient efficiencies to support Annual and longer term plans	Divisional Heads of Finance support divisions with identifying, quantifying and tracking delivery of CIP and dedicated CIP finance resource within SDO team in place. Additional SDO support for planned care - September 2017. 2 year CIP plan to be developed – Oct 17.	Catastrophic	Likely	20	PR7	Finance & Investment Committee	DR
3744	Inability to secure sufficient capital funds to meet investment plans in the Annual and Strategic Plans.	Funds have been received to meet 65% of capital spend set out in the Trusts original 2016/17 plan. £2m carry forward & £4m depreciation allocation to agreed priority 1 schemes for 2017/18. ITFF application for capital funding of £17.0m for priority 2 2017/18 schemes completed July 2017. NHSI review underway.	Major	Likely	16	PR7	Finance & Investment Committee	DR

3120	Patient Medical Notes missing, Delayed or poor condition.	FIT: Location based tracking project has been delayed and currently a 'go live' date is scheduled for November 2017. Once in place this will provide efficiency within the department improving availability of notes. Business case for off site medical records solution is currently being finalised. Target date for TEC review has slipped to September 2017 (Board review via FIC date TBC). Electronic Health Record: EHR Project Plan needs to be set up following centralisation of library. This needs to be jointly led by IT and Health Records and commence as soon as health records case completed. Remit of outpatient programme board to be expanded to include medical records. (August 2017) Please note this risk has been remapped to PR1 / S&C committee from PR4 / FIC. This is largely an operational management issue at this stage; pending longer term EHR project.	Major	Certain	20	PR1	Safety & Compliance	LE
3786	Emergency Care Pathway / patient flow	Unscheduled Care Improvement Plan in pace. Expert advisory support to improve operational processes secured. £1m capital project to create CDU in progress to deliver additional assessment capacity. Continued focus on patient flow and partnership working to reduce DTOCS. Noted increased concerns re delays with non-emergency patient transport – new separate (but linked) risk entry to be made to capture this risk and associated controls / assurances and remedial actions.	Major	Certain	20	PR5	Trust Executive Committee	ST

3781	Unscheduled Care medical workforce - gaps in rota	3 additional physician's assistant posts filled - AAU / medical wards. Advertising 2 additional registrar posts in Emergency Department Surge SOP in place that sets out staffing arrangements for surge areas. Daily review by DD / CD unscheduled care of surge in use and workforce deployment. Unscheduled care action plan sets out key milestones to address workforce. Monitored via ED transformation group. Aim to have 50% new posts recruited by March 2018.	Major	Likely	16	PR2	Patient & Staff Experience	PdG
3741	Risk of failure to achieve financial plan resulting from failing to meet all Sustainability and Transformation Fund conditions.	Compliance with STF conditions are reported and assessed at each Finance & Investment Committee through a detailed Finance Report and an Integrated Performance Report. Both reports also deal with operational matters and the interaction of all types of indicator to ensure the Trust achieves the right results. Operational performance requirements changed for Q1 (GP streaming and A&E only). The Trust focuses on the right measures for its patients at all times, but will also bear in mind financial impacts as necessary, and will do so as STF performance measures are confirmed.	Major	Likely	16	PR7	Finance & Investment Committee	DR
3737	Risk of failing to deliver the Annual Plan due to changing clinical capacity in an unplanned way	Trust Executive to enforce time limited approvals for emergency changes and the need for recovery plans. (TEC, with immediate effect) Develop private pricing models suitable for the current Trust environment, with suitable clinical engagement, ultimately resulting in revised / established contracts with private providers. (SJD lead, review point end September 2017, implementation during FY18)	Major	Likely	16	PR7	Finance & Investment Committee	DR

3485	Unsafe Chimney Stacks on Boiler House - Hemel Hempstead	The chimney stacks at Hemel Hempstead boiler house have been identified as unsafe. 120k has been agreed for repairs as part of priority one capital for 2017/18. Business case approved by CPFG. Work to be completed by Oct 17.	Catastrophic	Possible	15	PR3	Safety & Compliance Committee	KH
3899	ICT Trust Bleep System	£48k invested to secure immediate improvement in resilience. 2017/18 Capital Programme has allocated funding to produce an outline business case (OBC) to replace the current system. OBC to feed into 2018/19 capital programme.	Catastrophic	Likely	20	PR4	Finance & Investment Committee	LE
3897	Internal, external malicious or unintentional breaches of, or attacks on information systems resulting in loss of Information and Communication Technology (ICT) services, data or both.	Work has taken place to update firewalls and anti-virus software and an awareness campaign is ongoing to highlight potential risks to end-users. August 2017 Recruiting to Information Security role Improvements in the process of Server & EUD patching routine and response to CareCERT notifications	Major	Likely	16	PR4	Finance & Investment Committee	LE
3896	ICT Data Networks reduced availability, poor reliability & performance	August 2017 third party assessment of network performance undertaken, issues recorded, remedial actions being agreed. Weekly progress review.	Major	Certain	20	PR4	Finance & Investment Committee	LE

3895	ICT End-user Devices (EUD) reduced availability, poor reliability & performance	EUD rollout is on track with new milestone date (80% rollout by mid-August, 90% by end September 2017). Risk for de-escalation at next RRG.	Major	Certain	20	PR4	Finance & Investment Committee	LE
3894	ICT Applications reduced availability, poor reliability & performance	August 2017 Recruiting an Applications Manager to focus on Applications Portfolio Management	Major	Certain	20	PR4	Finance & Investment Committee	LE
3893	ICT Servers reduced availability, poor reliability & performance	July 2017 reset Make IT Happen programme plan & contractual milestones – specific deliverables set out. Weekly progress review.	Major	Certain	20	PR4	Finance & Investment Committee	LE
3892	ICT Data Centres reduced availability, poor reliability & poor performance	Discussion with CGI about hosting applications at the WGH Data Centre & how to manage the environmental risks.	Major	Likely	16	PR4	Finance & Investment Committee	LE
3890	Limited ability to Dispose of Biological Hazard Group 2 and 3 Organisms in the Microbiology Department	Lease purchase of two new autoclaves at WGH approved by Finance – awaiting delivery date.	Catastrophic	Possible	NEW 15	PR1	Safety & Compliance Committee	KH

CLOSED/DE-ESCALATED RISKS								
3458	Failure of the "Make IT Happen" ICT Transformation Programme to de-risk IT Business Continuity & Realise key Benefits	This risk has been split into smaller, more focused risk entries.	Major	Certain	20→CLOSED	PR4	Finance and Investment Committee	LE
3433	Risk of harm through failure to recognise and manage appropriately the deteriorating patient	Risk level has been reduced from 15 to 12 in view of increased awareness from ward nurses around news, embedding of safety huddles, 24hour outreach from critical care and joint working of outreach with hospital at night, recently commenced. Recent audit evidences improved compliance with controls.	Catastrophic	Possible	15→12	PR1	Clinical Outcomes & Effectiveness	MvdW
3861	Lift 9 – Failures	Mitigations in place – increased maintenance and business continuity SOP in place.	Major	Possible	16→12	PR3	Safety & Compliance Committee	KH
3859	Non Compliance with HTM 03 01 - WGH Theatre ventilation	Mitigating actions taken to manage risk – immediate improvements to theatre 5 and operational process changes (laying up in theatres).	Unlikely	Likely	16→10	PR3	Safety & Compliance Committee	KH
3867	Increased failure of IT infrastructure impacting on Infoflex	This risk has been subsumed into IM&T risk entries related to IT network, applications, servers, EUD etc.	Moderate	Certain	15→CLOSED	PR4	TEC	LE

3874	Inability to access IEP and 4WHC cube	Additional Memory installed on the N3 Firewall Server 3 on 22/06/2017.	Moderate	Certain	15→CLOSED	PR1	Safety & Compliance Committee	LE

Agenda item: 20/51

Report to:	Finance and Investment Committee
Title of report:	Finance and Investment Assurance Report to Trust Board
Date of board meeting:	07 September 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 27 July 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.

<u>Financial Performance</u>

1. I&E Deficit
   The deficit in June of £1.3m was £0.4m better than budget, resulting in a Q1 deficit of £9.3m, £0.2m worse than budget.

   The Committee noted that the Q1 deficit would have been £0.4m lower had it not been for a post-budget decision by NHS to impose a retrospective reduction of 20%, £1.4m, of the current year's planned CQUIN revenue of £7.0m, for failing to achieve last year's deficit budget, and questioned the rationale and equity of the decision.

   The Committee also queried a late change to the conditions for receiving the full STF funding of £1.6m in Q1 which resulted in a reduction of £0.2m relating to A&E performance.

The Committee supported the Executive in challenging both of the above NHS decisions, without which the Q1 deficit would have been £0.4m better than budget, as opposed to £0.2m worse.

The Committee's focus was on the very challenging plans to reduce the rate of deficit for the remainder of the year to deliver the full year budget of £15.0m.

The Committee's main concern is the Trust's ability to achieve the budget target for CIPs of £21.9m, including an £8.2m stretch above the original plan of £13.7m. There are firm plans in place for delivering £9.0m of the £13.7m, and following review, the Committee's expectation is that the balance will be delivered. However the Committee is not assured of delivering the £8.2m. The increased social care funding to local authorities was expected to free up 22 beds in the Trust, contributing £3m of the savings but this will not now happen, adding to the challenge. There will be a further in depth review of all CIP opportunities and plans at the August FIC.

The Committee expressed its concern at the level of pay costs which to date are £0.5m above budget at £57.9m, and asked to review the recovery plan and actions to bring pay costs back to budget, or lower, at the next meeting. The Committee noted that Q1 agency costs of £5.0m were on track to come within the control total of £24.4m, and were still planned to meet the Trust's lower target of £17.0m.

The Committee also discussed the risks to the revenue plan for the year, in particular the challenge of reducing costs as a result of lower revenues from planned QIPPs. Developments here are a standing item on each month's agenda.

2. Back office savings update

The Committee reviewed the plans for reducing back office costs. The Carter Report calls for corporate and admin costs not to exceed 7% of revenues by April 2018, reducing to 6% by 2020. The Trust's costs of £24.6m in 2016/17 were 7.6% of revenues.

The Committee reviewed the plans underway to outsource/ share payroll costs with a target of formalising contracts by January 2018. The plans for reducing other areas within

the Finance function were discussed and progress will be reviewed by the Committee each month along with the developing plans in other corporate and admin areas.

The Committee reinforced the necessity to realise significant cost efficiencies in these areas, recognising that the benefits will be primarily from 2018/19 onwards.

3. Capital Expenditure
Capital spend in Q1 was £0.7m. The Committee was assured that commitments are being managed within the existing authorised spend of £7.0m for the year and that safety remains the number one priority.

4. Capital Funding
The Committee noted the final ITFF funding paper seeking approval for funding the remaining £16.0m of capital spend in the full year's budget of £23.0m. The draft submission was submitted earlier in July following review by the June Committee and approval by the July Board. There is no indication yet as to when approval is expected and the Committee expressed concern that essential spend would be compromised if approval is again delayed till late in Q4 as it was last year.

5. Revenue Funding
Funding of net revenue spend is subject to monthly approval and following review the Committee recommends to the Board the approval of an £8.3m NHS loan to cover funding requirements in July.

<u>Clinical service pathways under Transformation Service</u>

Redesign to provide care which is locality based and community focused is one of the key strands of Your Care Your Future and is encompassed within HVCCG's QIPP plans. Most of the redesigns will lead to reduced revenues at the Trust, which will need to manage all associated costs of delivery to offset the revenue reduction.

The Committee reviewed a paper on the status of four planned transformations, Musculoskeletal (MSK), Gynaecology, Diabetes and Dermatology. The revised pathway for each is planned to be in place by the end of December 2017, and the Committee will receive regular reports on progress on revenue impact and cost mitigations.

ICT infrastructure programme update

The CIO presented a paper updating the Committee on progress of the infrastructure improvement plan, following delays caused by the impact of the requirements to respond to two recent cyber-security threats (during May and June), and a high number of priority one incidents which occurred during May. The Committee was asked to note further progress in terms of rollout of end user devices to the three Trust sites, with a new target set to complete 80% of this activity by mid-August 2017. Clinical feedback was provided regarding improvements now being seen.

The Committee will be provided at its meeting in August with the newly baselined programme milestone dates, with a summary regarding the corresponding cost and benefit impacts.

Corporate Risk Register

The Committee reviewed the 13 risks that were recommended for inclusion at the June Committee and approved at the July Board, and was assured by the mitigating actions in place.

The CIO provided the Committee with a report regarding currently ICT risks, which included a 'deep dive' on the corporate level risk relating to cyber security. This described the controls and assurances in place, and the actions being taken to mitigate any gaps in controls and assurances

Risks to refer to risk register

None

Issues to escalate

The Committee recommends the following:

To Part 1 of the July Board for ratification:

i. The interim revenue support loan application of £8.3m to cover revenue funding requirements for June.

Attendance record

Attended
John Brougham, Non-Executive Director (Chair)
Sally Tucker, Chief Operating Officer
Lisa Emery, Chief Information Officer
Mike van der Watt, Medical Director
Phil Townsend, Non-Executive Director
Jeremy Livingstone, Divisional Director, Surgery, Anaesthetics & Cancer
Katie Fisher, Chief Executive
Glen Rogers, Assistant Director for Contracts & Income
Onali Mohamedali, Financial Controller
Soheb Rafiq, Head of Financial Management

Apologies
Don Richards, Chief Financial Officer
Helen Brown, Director of Strategy & Corporate Affairs
Stephen Dunham, Assistant Director of Finance & Commercial Development
Prof. Steve Barnett, WHHT Chair
Tom Drabble, Patients' representative
Freddie Banks, Associate Medical Director for Clinical Strategy
Kevin Howell, Director of Environment
Lesley Headland, Chair of Staffside

Clerk
Clare Ransom, Executive Assistant

Agenda Item 20/51

Report to: Finance and Investment Committee

Title of Report: Finance and Investment Assurance Report to Trust Board

Date of meeting: 7 September 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 31 August 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.

<u>Financial Performance</u>

1. 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 July of £6.1m was £1.4m worse than budget resulting in a year to date deficit of £15.4m, £1.6m worse than budget.

   The Committee noted that there were out of period impacts adding to the deficit in July and year to date. In July £0.8m of unbudgeted charges were accounted for relating to last year's performance, and payable to HVCCG. £0.7m relates to contract penalties determined post year end, and £0.1m relating to the post budget decision by NHS to reduce this year's budgeted CQUIN income by 20 per cent for Trusts that failed to meet their 2016/17 I&E budgets, which for WHHT, equates to £0.5m year to date and £1.4m in the year.

The Committee also noted that these out of period charges resulted in the Trust failing to meet the deficit budget in the month, which in turn led to the loss of budgeted STF revenue of £0.7m. Together these three items account for all of the adverse deficit variance in July of £1.4m from the planned £4.7m, and for the year to date variance, with a deficit of £15.4m, £1.6m more than budget.

The out of period charges add to the challenge built into the budget to reduce the rate of deficit for the remainder of the year to deliver the full year budget of no more than £15.0m, and the Committee reviewed the actions underway and planned to drive down costs, and the risks of revenue loss.

Although not yet fully secured, the Committee was encouraged by the progress made in underpinning delivery of the original budgeted CIPs of £13.7m in the year, but were still not assured that the extra £8.2m CIP stretch built into the plan would be.

The Committee reviewed both pay and non-pay cost reduction plans which to date are higher than budget by £1.2m and £1.1m respectively.

The Committee also reviewed revenue risks. Excluding STF and out of period reductions, underlying revenues to date are £2.5m above budget, which is offsetting the cost variances, but these revenues are expected to come back to budget for the full year.

The Committee reviewed the status of QIPP plans for the year which will reduce revenues below budget and demand offsetting cost reductions to avoid an increase in deficit.

The Committee was not assured that the budgeted deficit for the year would be achieved and recommends that progress is reviewed again at the September Committee and a paper on cost reduction actions and revenues risks be presented to Part 2 of the September Board.

2. Back Office Savings
Due to holidays in August the regular review of back office savings was deferred to September.

3. Capital Expenditure/ Funding
The Committee noted that capital spend and commitment continues to be prioritised on safety and is being contained

within the authorised allocation of £6.7m whilst the Trust's funding application for the full budgeted £23.0m spend awaits approval. The Committee remain concerned that a prolonged delay in approval would mean that essential capital expenditure in the Trust would be even further delayed.

The Committee was very pleased to hear that the outline business case to upgrade the surgical theatre complex at Watford, which was approved by the Board in June, has been approved by NHSI to proceed to the final business case stage.

4. Revenue Funding
Funding of net revenue spend is subject to monthly approval and following review the Committee recommends to the Board the approval of a £1.3m NHS loan to cover funding requirements in August.

ICT infrastructure programme update

The Committee reviewed a paper on progress of the infrastructure improvement plan. The Committee noted the progress in the rollout of end user devices to the three Trust sites, citing achievement of the target to complete 80% of this activity by mid-August 2017. The Committee also noted developments with network remediation and telephony.

The Committee also reviewed a report summarising progress against delivery of the benefits documented in the infrastructure improvement full business case, and supported a recommendation to increase resources to support delivery of the 2017/18 business cases objectives.

Corporate Risk Register

Of the existing 13 FIC related risks on the Register, one change was recommended, to downgrade the risk, from 20 to 9, of unavailability of end user devices leading to poor reliability and performance across the Trust. The Committee supported the recommendation as the new device rollout has now reached 80% completion, subject to final confirmation by the Risk Review Group

Review of Policies

The Committee was assured that of the 36 Trust policies, 6 Finance and 30 IM&T, under its remit all but 2 IM&T policies are

currently up to date, and by October all would be up to date.

Internal Audit

The Committee reviewed a report on controls within Estates, with a deep dive on a refurbishment project. The audit found that controls were lacking in a number of areas and management have accepted all the audit recommended actions which are being implemented. The Committee asked that the lessons learned from the deep dive should be applied across Estates, with the help of Finance, and that there would be appropriate follow up of implementation by both the FIC and Audit Committee.

The Internal Auditor also presented an advisory paper on contingency management on capital projects carried out by Estates. The Committee supported the recommendations on achieving best practice which have been accepted by the CFO to lead on.

BAF Action Tracker

The Committee reviewed the Tracker and requested a number of changes, mainly relating to correcting alignment of principal risks to responsible Board sub Committees, before submission to the September Board.

Risks to refer to risk register

No new risks, see comments above.

Issues to escalate

The Committee recommends the following:

To Part 1 of the July Board for ratification:

i. The interim revenue support loan application of £1.297m, to cover revenue funding requirements for August

To Part 2 of the September Trust Board for review

ii. a paper on cost reduction actions and revenue risks

Attendance record

Attended

John Brougham, Non-Executive Director (Chair)
Don Richards, Chief Financial Officer

Helen Brown, Director of Strategy & Corporate Affairs (for item 13)
Jeremy Livingstone, Divisional Director, Surgery, Anaesthetics & Cancer
Katie Fisher, Chief Executive
Kevin Howell, Director of Environment (for item 13)
Lisa Emery, Chief Information Officer
Mike van der Watt, Medical Director
Phil Townsend, Non-Executive Director
Prof. Steve Barnett, WHHT Chair
Sally Tucker, Chief Operating Officer
Stephen Dunham, Assistant Director of Finance & Commercial Development
Tom Drabble, Patients' representative
Sam Abbas, RSM Risk Assurance Services LLP (for item 13)

Apologies
Freddie Banks, Associate Medical Director for Clinical Strategy
Lesley Headland, Chair of Staffside

Clerk
Clare Ransom, Executive Assistant

Agenda Item: 21/51

Report to:	The Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	07 September 2017
Recommendation:	For information and assurance
Chairperson:	Paul Cartwright, Non Executive Director

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Audit Committee at its meeting on 13 July 2017

Background

The Committee meets bi monthly and provides assurance to the Board:

- on all aspects of internal and external audit
- that effective assurance controls, structures, systems and processes for integrated governance, risk management and internal controls are in place
- on the appointment of the internal and external auditors

Business undertaken

<u>Assurance report on work of the Remuneration Committee</u>

The Committee was updated on the work of the Remuneration Committee; providing assurance that it was meeting its terms of reference and working effectively.

The broad range of issues reviewed by the Committee included:-

- Review of VSM remuneration
- Overall VSM approach
- Review of the top 15 earners
- Succession planning
- Review of compromise agreements
- Clinical leadership
- Formal review of the CEOs performance.

In-Depth review of Tender/Waiver Register

A full in-depth review of the tender/waiver register had been completed. The report identified 13 waivers between 01 April 2017 and 30 June 2017. A breakdown of the reviews highlighted areas for improvement. A process with improved control measures is being undertaken by procurement.

Audit Committee Annual report 2016/17

The committee discussed and reviewed its annual report for 2016/17. Grant Thornton to forward update on opinion statement once annual letter has been agreed. The report will be taken to the Board in September (agenda item 21a)

Anti-Bribery Policy

The Committee reviewed the updated Anti-Bribery Policy. It was noted that this policy had yet to be approved by the appropriate committee or the policy review group. The committee agreed that further work was needed to be undertaken to ensure the policy was bought more up to date. It was agreed that this policy would be updated and reviewed outside of the meeting, and would be subjected to Chair's action to ensure it was in place by mid August 2017.

Audit Committee Self Assessment 2016/17

The Audit Committee completed the self assessment checklist 2 relating to committee function and effectiveness.

Risks to refer to risk register

None

Issues to escalate

- Annual report to provide assurance to the Board that the Audit Committee is working efficiently and effectively and meeting its terms of reference
- Anti-bribery policy to be approved by Chair outside of meeting schedule
- Audit annual self assessment check list completed

Agenda item 21a

Audit Committee Annual Report 2016/17

1. Introduction

The Audit Committee is a senior independent Non-Executive Committee of the Board.
The Committee has prepared this report which summarises the activities undertaken by the Committee to satisfy its terms of reference for the year 01 April 2016 to 31 March 2017.

2. The role and operation of the Audit Committee

The NHS Code of Conduct and Accountability and the NHS Audit Committee Handbook requires that an Audit Committee is established to provide an independent and objective view to the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes and securing economy, efficiency and effectiveness (value for money).

The establishment and constitution of the Audit Committee is mandated by the Trust's Standing Orders, which were updated and endorsed by the Board in on 01 September 2016.

2.1 Governance, establishment and duties

2.2 Membership of the Committee

Members of the Audit Committee are appointed by the Board and the Chair to ensure that the Non-Executive Directors have sufficient knowledge to indentify key risk areas and to challenge both line management and the auditors on critical and sensitive matters.

The members of the Committee disclosed their conflicts of interest at each meeting. The following were the interests declared as at April 2017, however it should be noted that these may have changed during the reporting year:

Paul Cartwright, Non-Executive Director and Chair of Audit Committee

- Treasurer for St Peter's Church, St Albans
- Trustee and Chair of Finance and Audit Committee for The Church Lands, St Albans.
- Charitable Funds for West Hertfordshire Hospitals NHS Trust

John Brougham, Non-Executive Director

- Non Executive Director and Chair of the Audit Committee of Technetix Ltd

A further Non-Executive Director was nominated as a reserve to ensure that all meetings were quorate.

Other Non-Executive Directors were able to attend the Audit Committee meetings and key senior staff, internal audit and external audit were also in attendance. The Chief Financial Officer, Medical Director, Deputy Chief Executive also regularly attended Audit Committee meetings during the year. The Trust Secretary provided support to the Chair and the Committee members.

2.3 Meetings and attendance

The Audit Committee met five times during 2016/17 on regular business and twice to consider and approve the Annual Accounts, Annual Report, Annual Governance Statement and Quality Account. All meetings were quorate and chaired by a Non-Executive Director. A breakdown of attendance of meetings is presented below:

Paul Cartwright, Non-Executive Director (Chair) (attended 5 out of 7 meetings)
John Brougham, Non-Executive Director (attended 7 out of 7 meetings)

2.4 Terms of reference

The Committee's terms of reference (appendix 1) were reviewed against the NHS Audit Committee handbook and adopted by the Board on 05 May 2017. The term of reference were extended in 2016/17 to take on the accountability and reporting arrangements for the Auditor Panel, which was established to advise and oversee the appointment of the external audit function. In September 2016, following a tender and evaluation process, the Board approved a recommendation by the Audit Panel that Grant Thornton UK LLP be awarded a two year contract for external audit services.

2.5 Reporting to the Committee

The work of the Committee was delivered around a structured work plan (appendix 2), aligned with its terms of reference and endorsed by the Board on 05 May 2017. Each meeting agenda included the standing items listed below, with the exception of a meeting in June 2016, which focused on the development and approval of the Annual Report, Annual Accounts, Annual Governance Statement and Quality Account.

- Chief Financial Officer's overview
- Internal audit progress report and follow-up report
- Local counter fraud report
- External audit progress report
- Review of the following:
    - Tender waiver register
    - Losses and compensation register
    - Review of salary overpayments
    - Hospitality and gifts register
    - Central register of interests
    - Trust seal

The following reports were also received by the Committee during 2016/17:

- Review of Standing Financial Instructions, Standing Orders and Scheme of Delegation
- Annual Accounts and Annual Report, including Annual Governance Statement
- Quality Account
- Regulations around the establishment of an Auditor Panel to appoint external auditors
- Risk and governance arrangement, including the development of the Board Assurance Framework
- Clinical Audit update
- Report on the process for Freedom to Speak Up/whistleblowing
- Directors' liability insurance
- Corporate governance structure

The Audit Committee also gained assurance on behalf of the Board that other Committees were operating effectively and appropriately controlling risk. On a rolling programme, each Committee presented a summary of the work undertaken over the previous year to meet its terms of reference and the progress and actions taken specifically to manage risks within the Board Assurance Framework.

The Committee noted that, despite a number of additional controls being introduced, there had not been a significant reduction in the number of tenders, losses and compensations and salary overpayments during the year. Therefore, this would continue to be an area of focus for the committee in 2017/18.

2.5.1 Reporting from the Committee

The Committee reported to the Board following each meeting and escalated areas of concern and underperformance.

3. Independence Assurance

3.1 Internal Audit

RSM were appointed as the Trust's Internal Auditors for 2016/17 and a structured audit plan was approved by the Audit Committee on 28 June 2016. In year, RSM provided progress reports on the delivery of the plan at each meeting. All internal audits were aligned to an executive lead and were mapped to an assurance committee.

In 2016/17, the following reports provided a level of partial assurance:

- Information security and data protection
- Budgetary control and financial reporting
- IT asset and configuration management
- Data quality, accident and emergency, four hour wait key performance indicators
- Procurement and contract management
- Key financial controls – accounts payable and payroll
- Cost improvement plans

To further strengthen the process in 2016/17, the Committee asked for final audit reports to be presented to a lead committee prior to review by the Committee. Recommendations were discussed and agreed with an executive lead to ensure full ownership. The Committee monitored the Trust's system for tracking internal audit recommendations, which included monthly review by the Trust Executive Committee. The Committee received a full report at each meeting on progress towards implementing the improvements, with particular attention paid to overdue actions.

3.2 External Audit

External audit services were provided by Grant Thornton UK LLP (GT) in 2016/17. GT completed a full and thorough audit of the Trust's Accounts for 2016/17. External audit opinion stated:

"We are satisfied that, in all significant respects, West Hertfordshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017".

In addition to the opinion on the financial statements, GT also considered the consistency of other information published with the financial statements. Based on a review of the Trust's Annual Report, which included the Annual Governance Statement, GT was satisfied that it met

the requirements of the Department of Health Group Manual for Accounts and was consistent with the audited financial statements and, whilst GT recommended some amendments to both reports to improve the disclosure, they found the reports to be well presented overall.

3.3 Local counter fraud service

Local counter fraud services (LCFS) were provided by RSM in 2016/17. At the end of 2016/17, the counter fraud team reported a total of 16 potential fraud and bribery referrals from a range of sources at the Trust. This was a notable increase compared to the number of referrals (3) received by the previous counter fraud provider during 2015/16, demonstrating a significant improvement in fraud and bribery awareness and confidence in reporting amongst Trust staff. The counter fraud referrals fell under the following key themes: working elsewhere whilst on sickness absence, failure to work contracted hours, false qualifications, false expenses, private work in NHS time and immigrations offences.

The Committee was encouraged to note that a self review tool had shown an overall rating for LCFS work as 'amber', which was an improvement on the previous year's assessment of 'red'.

The Committee received an update on the management of counter fraud cases at each meeting.

4. Internal assurance

4.1 Audit Performance

The Committee met in private to discuss the performance of internal and external audit. The Committee considered that there were no issues which would affect internal or external Audit's ability to support the Committee in discharging its duties.

In line with the NHS Audit Committee handbook recommendation, the Audit Committee undertook a self-assessment of its performance to measure its effectiveness in April 2017. The outcome of the self-assessment revealed that the Committee was meeting its terms of reference. Please see appendix 3.

5. Conclusion

In conclusion, the Audit Committee is of the view it took appropriate steps to perform its duties delegated by the Board in 2016/17 and it has no cause to raise any issues of significant concern arising from its work during this time.

The Committee will continue with its programme of work to gain assurance over the Trust's internal control processes.

6. Recommendation

The Audit Committee is recommended to present this Annual Report to the Board for approval.

Paul Cartwright
Chair, Audit Committee

July 2017

Appendix 1. Terms of reference 2016/17
Appendix 2. Work plan 2016/17
Appendix 3. Audit Committee self-assessment

West Hertfordshire Hospitals NHS Trust

Appendix 1

AUDIT COMMITTEE
TERMS OF REFERENCE 2016-17

Status:	Committee of the Trust Board
Chair	Non-Executive Director
Clerk	Trust Secretary
Frequency of Meetings	6 times a year (plus an extra-ordinary meeting to consider and approve the Annual Accounts, Annual Report (including the Annual Governance Statement) and Quality Account
Quorum	The Committee would be quorate with two Non-Executive Directors

1. Constitution

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee. The Committee is a Non Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Board to investigate any activities within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

1.3 In undertaking its responsibilities the Committee will assist with the discharging of the responsibilities of the Trust's Accountable Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament, by the Public Accounts Committee, for the overall stewardship of the organisation and the use of its resources.

2. Purpose

2.1 The purpose of the Committee is to provide the Board with assurance concerning all aspects of internal and external audit, integrated governance and internal control and to ensure that they are in place and functioning to support the achievement of the organisation's objectives.

2.2 To provide assurance to the Board through liaison with other subcommittees as necessary that the structures, systems and processes for effective integrated governance, risk management and internal control are in place and functioning to support the organisation's activities that supports the achievement of the organisations objectives.

2.3 To assure the Board that, where there are issues of internal control that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way through the Trust Leadership Executive Committee.

2.4 To exercise the functions set out in part 3, section 9 of the Local Audit and Accountability Act 2014 (as detailed below).

3. Membership

3.1 The Committee will be appointed by the Board and its membership shall consist of

- A minimum of two Non-Executives Directors;
- A nominated deputy Non-Executive Director.

The Trust's Chair should not be a member of the Committee or attend meetings.

3.2 The following members of the Executive team will attend on a regular basis; however, they will not be formal members of the Committee:

- Chief Financial Officer;
- Director of Strategy and Corporate Services
- Medical Director.

Executive members should nominate an appropriate deputy to attend in their absence. The named Executive should not routinely allocate attendance at the Committee to their nominated deputy and should only happen as a result of planned or unforeseen absence by the named Executive. It should be noted that nominated deputies should be specifically identified and should not be different for each meeting of the Committee that they attend.

3.3 In addition representatives from the following organisations will be required to attend each meeting of the Committee:

- Internal Audit
- External Audit
- Local Counter Fraud Specialist

3.4 Nominated Deputy Non-Executive Directors will not regularly attend meetings. They can however attend at their own discretion.

3.5 The Chief Executive has a standing open invitation to attend as an observer any meetings of the Committee and to have access to the agenda and papers on request from the Trust Secretary.

4. Duties and responsibilities

4.1 Governance, risk management and internal control

4.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, to ensure that they are in place and functioning to support the achievement of the organisation's objectives.

4.1.2 The Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification (including for compliance with registration requirements of CQC);

- The effectiveness of the arrangements in place by which staff may, in confidence, raise concerns about possible improprieties in matters of finance reporting, financial control or any other matter and for appropriate follow-up actions;

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service;

- The procedures for whistle blowing and ensure that arrangements are in place by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting, financial control or any other matters.

4.1.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, Local Counter Fraud Service, Clinical Audit and other assurance functions, but will not be limited to these Audit functions. It will also seek reports and assurances from executive directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the Audit and assurance functions that report to it.

4.2 **Internal audit**

4.2.1 The Committee shall ensure that there is an effective internal Audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision and appointment of the Internal Audit service, the cost of the Audit and any questions of resignation and dismissal;

- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the Audit needs of the organisation as identified in the Assurance Framework;

- Consideration of the major findings of internal Audit work (and management's response and follow-up and implementation of all recommendations);

- Ensuring co-ordination between the Internal and External Auditors to optimise Audit resources;

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

- Annual review of the effectiveness of internal Audit.

4.3 **External audit**

4.3.1 The Committee will review the work and findings of the External Auditor and will consider the implications and management responses to their work. This will be achieved by:

- Discussion and agreement with the External Auditor, before the Audit commences, of the nature and scope of the Audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;

- Review all External Audit reports, including agreement of the annual Audit letter and any work carried outside the annual Audit plan, together with the appropriateness of management responses.

4.4 Local counter fraud service

4.4.1 The Committee should satisfy itself that adequate arrangements are in place to counter fraud in the Trust. The Committee will ensure that the counter fraud work and findings of the LCFS are effective within the Trust, and that the work is compliant with NHS Protect's framework of standards for countering fraud, bribery and corruption (See NHS Protect's 'Standards for Providers 2014/15', NHS Anti-Fraud Manual and other relevant NHS Protect guidance). Counter fraud work undertaken by the LCFS should be sufficiently effective within the Trust as to provide a level of assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision and appointment of the LCFS service and the cost of this service;

- Ensuring the LCFS is fully accredited (ACFS) as well as compliant with NHS Protect standards, and has followed the procedure for official nomination of LCFS function within the Trust;

- Reviewing and approving LCFS strategic work plans / programmes of proactive work for counter fraud, ensuring this is consistent with the needs of the Trust and is compliant with NHS Protect's framework of standards for providers;

- Consideration of the effectiveness of investigations undertaken by LCFS into allegations of fraud and corruption, including all recommendations made, including scrutinising interim reports / full reports made to the Director of Finance and the recommendations made therein;

- Ensuring coordination between LCFS and Internal Audit to optimise any resource crossover and identify patterns and trends for further review.

- Chair of the Audit Committee meeting annually with the LCFS to ensure there is a clear understanding of fraud issues and risks.

4.5 **Other assurance functions**

4.5.1 The Audit Committee will review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This includes, but is not limited to, Care Quality Commission (CQC) and

National Health Service Litigation Authority (NHSLA) and professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges, accreditation bodies, etc);

4.5.2 In addition, the Committee will review the work of other committees within the organisation to ensure they are meeting their terms of reference, in particular with regard to the monitoring and maintenance of the Board Assurance Framework.

4.6 **Management**

4.6.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation as may be appropriate to the overall arrangements.

4.7 **Financial reporting**

4.7.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

4.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

4.7.3 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- Review the process for the producing the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparation of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation;
- Qualitative aspects of financial reporting.

4.8 The Committee will review:

- the entries recorded in the register of interests;
- the entries recorded in the hospitality register;
- the entries recorded in the Trust seal register;
- the entries recorded in the tender/quotation waiver register;
- the losses and compensation schedule.

5. Auditor Panel

5.1 The Committee's responsibilities have been extended to act as the Auditor Panel. The terms of reference for the Auditor Panel are appended to these terms of reference (appendix 1)**.**

5.2 Auditor Panel business will be conducted at the end of the Audit Committee agenda, and the agenda sectioned so as to make it clear that what follows is Auditor Panel business.

5.3 The minutes of the Auditor Panel meetings will be formally recorded and The chair of the auditor panel must draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

6. Other matters

6.1 The Committee may, under powers delegated to it by the Board, review and approve the annual accounts and all supporting documents and report this to the Board. Where is does not feel able to approve the accounts and supporting documents the Chairman of the Committee will raise this with the Chairman of the Board in the first instance and agree the most appropriate action to be taken.

7. Required attendance

7.1 The Committee members will be required to attend a minimum of 70% of all meetings.

7.2 The Committee may request attendance by relevant staff at any meeting.

7.3 The Committee should meet privately with External and Internal Audit at least once per year.

8. Accountability and reporting arrangements

8.1 The Committee shall be directly accountable to the Trust Board.

8.2 The Chair of the Committee shall prepare a summary report to the Board detailing items discussed, actions agreed and issues to be referred to the Board.

8.3 The minutes of the Audit Committee meetings shall be formally recorded.

8.4 The Committee shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any aspect of its work.

8.5 The Committee will report to the Board annually on its work in support of the audit agenda and Trust objectives, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

9. Review and monitoring

9.1 The Committee will undertake and evidence an annual review of its performance against the NHS Audit Committee Handbook's self-assessment checklist in order to evaluate its effectiveness, the fulfilment of its functions in connection with the terms of reference and achievement of duties. This report will be provided to the Trust Board as part of its Audit Committee Annual Report.

9.2 Terms of Reference will be reviewed annually and approved by the Board.

Terms of Reference Ratified by:	Trust Board
Date of Ratification	April 2016
Date of Review	April 2017

AUDIT COMMITTEE WORK PLAN 2016/17 Appendix B

		April (26th)	April (29th) *WHHT only*	May (31st) *Extra-ordinary*	June (28th)	August (23rd)	October (25th)	December (20th)	February (21st)
1.	**Introduction and administration**								
1.1	Apologies for absence	√	√	√	√	√	√	√	√
1.2	Declaration of Interests	√	√	√	√	√	√	√	√
1.3	Minutes of the last meeting	√	√		√	√	√	√	√
1.4	Matters arising/action log	√	√		√	√	√	√	√
1.5	Review agenda against agreed work plan	√	√		√	√	√	√	√
2.	**Governance**								
2.1	Sub-Committee assurance programme *(see appendix 1 for schedule 2016/17)*	√			√	√ IRGC	√ CFC	√ FIPC	√ WKFC
2.2	Audit Committee self assessment *(undertaken in Feb 2016)*								
2.3	Review internal audit and external audit performance						√		
2.4	Review of Non-Executive Director training requirements								√
2.5	Approve the quality account and recommend Board adoption			√					

2.6	Standing orders, standing financial instructions and scheme of delegation review/approve					√			
2.7	Review the Audit Committee annual report				√				
2.8	Review the process for production of quality account								√
2.9	Review terms of reference and work plan for forthcoming year for Board adoption								√
2.10	Review Committee structure and membership				√				
3.	**Finances**								
3.1	Receive the Chief Financial Officer overview (verbal)	√			√	√	√	√	√
3.2	Review the process for the production of annual accounts and annual report (including annual governance statement)								√
3.3	Review and approve accounting policies and significant judgements		√						
3.4	Review and approve unadjusted and adjustments to the statements		√						
3.5	Technical accounting issues update		√						
		April (26th)	April (29th)	May (31st) Extra-	June (28th)	August (23rd)	October (25th)	December (20th)	February (21st)

			Special	ordinary					
3.6	Approve the annual accounts and annual report (including the annual governance statement) and recommend Board adoption			√					
4.	**Internal audit**								
4.1	Receive internal audit progress report	√			√	√	√	√	√
4.2	Receive internal audit annual report and Head of Internal Audit Opinion	√							
4.3	Review outstanding auditors recommendation	√			√	√	√	√	√
4.4	Review internal audit annual plan for forthcoming year								√
5.	**Local counter fraud**								
5.1	Receive Local counter fraud progress report	√			√	√	√	√	√
5.2	Review counter fraud self assessment prior to submission						√		
5.3	Review counter fraud annual plan for forthcoming year								√
6.	**External audit**								
6.1	Receive external audit progress report	√			√	√	√	√	√
6.2	Review annual fee letter	√							
6.3	Receive annual audit findings					√			

6.4	Receive annual audit letter					√			
6.5	Receive audit of quality account					√			
6.6	Review external audit plan								√
7.	**Internal control processes**								
7.1	Review of losses and compensation register	√			√	√	√	√	√
7.2	Review of waiver/tender register	√			√	√	√	√	√
7.3	Review of staff salary overpayments	√			√	√	√	√	√
7.4	Review of the gifts and hospitality register	√			√	√	√	√	√
7.5	Review of register of declarations of interests	√			√	√	√	√	√
7.6	Update on the use of the Trust seal	√			√	√	√	√	√
7.7	Review of governance compliance framework				√				
7.8	Review whistle blowing / Freedom to Speak process					√			
7.9	Review of risk and governance arrangements						√		
7.10	Review clinical audit annual report				√				
7.11	Review process for maintaining and reviewing the Board Assurance Framework							√	
7.12	Review of insurance policies							√	

8.	**Private meetings**								
8.1	Meeting of Non-Executive and Executives	√			√	√	√	√	√
8.2	Meeting with Internal and external auditors							√	
9.	**Auditor Panel**								
9.1	Update on arrangements for appointing external auditors	√			√	√	√	√	√
10.	**Administration**								
10.1	Draft agenda for the next meeting	√			√	√	√	√	√
10.2	Items for escalation to the Board	√		√	√	√	√	√	√
10.3	Any other business	√			√	√	√	√	√

Last updated June 2016

APPENDIX 3

AUDIT COMMITTEE SELF ASSESSMENT CHECK LIST ONE

Area/Question	Yes	No	Comments/Actions
Composition, establishment and duties			
Does the audit Committee have written terms of reference that adequately define the Committee's role in accordance with relevant guidance (for example fro, the Department of Health; NHS England; NHS Trust Development Authority or Monitor?)	✓		
Have the terms of reference been adopted by the governing body?	✓		
Are the terms of reference reviewed annually to take into account governance developments and the remit of other Committees within the organisation?	✓		
Are Committee members independent of the management team?	✓		
Are the outcomes of each meeting; the actions taken and the Committee's view on the organisation's systems of internal control reported to the next governing body meeting?	✓		
Does the Committee prepare an annual report of its work and performance in the preceding year for considering by the governing body?	✓		On workplan for the Audit Committee to receive 2016/17 in May 2016
Does the Committee assess its own effectiveness periodically?	✓		Self assessment carried out 02/03/16
Has the Committee established a plan of matters to be dealt with across the year?	✓		
Are Committee papers distributed in sufficient time for members to give them due to consideration?	✓		
Has the Committee been quorate for each meeting this year?	✓		
Compliance with the law and regulations governing the NHS			
Does the Committee review assurance and regulatory compliance reporting processes?	✓		
Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	✓		Trust secretary is the dedicated clerk to the Audit Committee and internal and external auditors attend each meeting
Internal control and risk management			
Has the Committee formally considered how it integrates with other Committees that are reviewing risk - for example, risk management, quality and clinical governance Committees?	✓		
Has the Committee reviewed the robustness and effectiveness of the content of the organisation's assurance framework?	✓		
Has the Committee reviewed the robustness and content of the draft annual governance statement before it is presented to the governing body?	✓		
Is the Committee's role in reviewing and recommending to the governing body the annual report and accounts clearly defined?	✓		
Does the Committee consider the external auditor's report to those charged with governance including proposed adjustments to the accounts?	✓		
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives, responsibilities and reporting lines?	✓		Charter is included within the internal audit plan
Does the Committee review and approve the internal audit plan at the beginning of the financial year?	✓		Plan reviewed by AC in April 2016
Does the Committee approve any material changes to the plan?	✓		
Is the Committee confident that the audit plan is derived from a clear risk assessment process that links closely to the assurance framework?	✓		
Does the Committee receive periodic progress reports from the Head of Internal Audit?	✓		
Does the Committee effectively monitor the implementation of management sections arising from internal audit reports?	✓		
Does the Head of Internal Audit have a right of access to the Committee and its Chair at any time?	✓		
Is the Committee confident that the internal audit is free of any scope restrictions and, if not, has it considered the impact of these on the annual Head of Internal Audit opinion?	✓		
Is the Committee confident that internal audit is free from any operational responsibilities or conflicts of interest that could impair its objectivity?	✓		
Does the Committee hold periodic private discussions with the Head of Internal Audit?	✓		
Has the Committee evaluated whether internal audit complies with the Public Sector Internal Audit Standards?	✓		IA demonstates compliance within the annual plan/report
Has the Committee agreed a range of internal audit performance measures to be reported on a routine basis?	✓		
Does the Committee receive and review the Head of Internal Audit's annual opinion?	✓		

Area/Question	Yes	No	Comments/Actions
External audit			
Do the external auditors present their audit plans and strategy to the Committee for agreement and approval?	✓		
Does the Committee receive and monitor actions taken relating to prior years' reviews?	✓		
Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?	✓		
Does the Committee review the external auditor's value for money conclusion?	✓		
Does he Committee review the external auditor's opinion on the quality account when necessary	✓		
Does the Committee hold periodic private discussions with external auditors?	✓		
Does the Committee assess the performance of external audit?	✓		
Does the Committee require assurance from external audit about its policies for ensuring independence?	✓		
Has the Committee approved a policy to govern the nature and value of non-audit work carried out by the external auditors?	✓		
Does the Committee receive information on all non-audit work undertaken by external audit?	N/A		No non-audit work undertaken
Does the Committee review the proportion of audit and non-audit work every time the external auditors change?	N/A		No non-audit work undertaken
Clinical audit			
Is the Committee clear about where clinical audit assurances are received and monitored?	✓		Monitored by the Safety and Quality Committee. Assurance received on process by Associate Medical Director for Clinical Standards and Audit
If the Committee is NOT the main Committee receiving direct feedback from clinical audit, does it receive a report from the relevant Committee on the progress made by clinical audit during the year along with a clear view on the outcome of the annual work plan?	✓		Assuance report received from Safety and Qualtiy Committee
If the Committee receives reports from clinical audit has it: • Reviewed an annual plan which is clearly linked to the clinical risks and clinical assurance needs? • Received regular process reports? • Monitored the implementation of management actions resulting from clinical audit reviews? • Received a report over the quality assurance processes covered by clinical audit activity?	 ✓ ✓ ✓ ✓		 Two reports received Monitored by Safety and Quality Committee Report received in October and February 2017
Counter (or anti-) fraud and security			
Is the Committee aware of NHS protect requirements in relation to counter fraud and security activity?	✓		
Does the Committee review the planned counter fraud and security work at the beginning of the financial year and in particular scope and coverage?	✓		
Does the Committee satisfy itself that the work plan is derived from clear processes based on risk assessments and that coverage is adequate?	✓		
Does the Committee receive notification of any material changes to the plan?	✓		
Does the Committee receive notification of any material changes to the plan?	✓		
does the Committee receive periodic reports about counter fraud and security activity?	✓		
Does the Committee effectively monitor the implementation of management actions arising from counter fraud and security reports?	✓		
Do those working on counter fraud and security activity have a right of direct access to the Committee and its Chair?	✓		
Do those working on counter fraud and security activity have the necessary technical knowledge and experience to ensure that work is carried out as it should be?	✓		
Does the Committee receive and review an annual report on counter fraud and security activity?	✓		
Does the Committee receive and discuss reports arising from inspections by NHS protect in relation to the quality of the counter fraud (and security) provision?	✓		

Annual report and accounts and disclosure statements			
Is the Committee's role in approval of the annual report and accounts clearly defined?	✓		
Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?	✓		
Does the Committee specifically review: • Changes in accounting policies? • Changes in accounting practice due to changes in accounting standards? • Changes in estimation techniques? • Significant judgements made in preparing accounts? • Significant adjustments resulting from the audit? • Explanations for any significant variances?	✓		
Does the Committee ensure it receives explanations for any unadjusted errors in the accounts founded by the external auditors?	✓		
Does the Committee receive and review a draft of the organisation's annual governance statement?	✓		
Does the Committee receive and review a draft of the organisation's annual report and accounts?	✓		
Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements (for example, as set by the Care Quality Commission, Monitor and the NHS Trust Development Authority)?	✓		
Other issues			
Does the Committee provide a summary report of its meetings to the next available governing body meeting?	✓		
Has the Committee reviewed its performance in the year for consistency with its: • Terms of reference? • Programme for the year?	 ✓ ✓		

AUDIT COMMITTEE SELF ASSESSMENT -CHECKLIST 2

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/action
Theme 1 - Committee focus						
The Committee has set itself a series of objectives it wants to achieve this year.		✓				
The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.		✓				
Committee members contribute regularly across the range of issues discussed.		✓				
The Committee is fully aware of the key sources of assurance and who provides them in support of the controls mitigating the key risks to the organisation.		✓				
The Committee clearly understands and receives assurances from third parties the organisation uses to manage/operate key functions - for example, financial services operated by NHS Shared Business Services, other NHS bodies, commissioning support units or private contractors.		✓				
Equal prominence is given to both the quality and financial assurance.		✓				
Theme 2 - Committee team working						
The Committee has the right balance of experience, knowledge and skills to fulfil the role described in the NHS Audit Committee Handbook.		✓				
The Committee has structured its agenda to cover, quality, data quality, performance targets and financial controls.		✓				
The Committee ensures that the relevant executive director/manager attends meeting to enable it to secure the required level of understanding of the reports and information it receives (i.e. the right executive lead is there to discuss risk and internal matters in their area of responsibility rather than the Committee haven't to rely on the CFO to act as conduit to the executive team).		✓				
Management fully briefs the Committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'.		✓				
Other Committees provide timely and clear information in support of the Committee thereby eradicating the potential for 'surprises'.		✓				
I feel sufficiently comfortable within the Committee environment to be able to express my views, doubts and opinions.		✓				
I understand the messages being given by the organisation's assurance advisors (external audit/internal audit/counter fraud specialists).		✓				
Internal audit contributes to the debate across the range of the agenda and not just on the papers they present.		✓				
Members hold their assurance providers to account for late or missing assurances.		✓				
When a decision has been made or action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.		✓				

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/action
Theme 3 - Committee effectiveness						
The quality of Committee papers received allows me to perform my role effectively.		✓				
Members provide real and genuine challenge - they do not just seek clarification and/or reassurance.		✓				
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.		✓				
Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.		✓				
At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.		✓				
The Committee provides a written summary report of its meetings to the governing body.		✓				
The governing body challenges and understands the reporting from this Committee.		✓				
There is a formal appraisal of the Committee's effectiveness each year which is evidence based and takes into account my views and external views.		✓				
Theme 4 - Committee engagement						
The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.	✓					
The Committee is clear about the complementary relationship it has with other governing body Committees that play a role in relation to clinical governance, quality and risk management.		✓				
The Committee receives clear and timely reports from other governing body Committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.		✓				
I can provide two examples of where we as a Committee have focused on improvements to the system of internal control as a result of assurance gaps identified.						Waivers and Internal Audit reports
Theme 5 - Committee leadership						
The Committee Chair has a positive impact on the performance of the Committee.		✓				
Committee meetings are chaired effectively and with clarity of purpose and outcome.		✓				
The Committee chair is visible within the organisation and is considered approachable.		✓				
The Committee chair allows debate to flow freely and does not assert his/her own views too strongly.		✓				
The Committee Chair provides clear and concise information to the governing body on the activities of the Committee and the implications of all identified gaps in assurance/control.		✓				

Agenda item: 22/51

Report to:	**Trust Board**
Title of Report:	**Assurance report from Clinical Outcomes and Effectiveness Committee**
Date of Board meeting:	**07 September 2017**
Recommendation:	**For information and assurance**
Chairperson:	**Jonathan Rennison, Chair**
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Clinical Outcomes and Effectiveness Committee at its meeting on 27 July 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 Committee's 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, infection prevention and control measures, and the application of learning from complaints, serious incidents, claims and litigation in order to ensure improved practice, quality and outcomes for patients.

Clinical Audit Strategy and Annual Report

The Committee reviewed two papers relating to clinical audit and was assured that the forward strategy was robust and appropriate. Assurance was received that current gaps in the operational plan would be addressed. These mainly concerned the identification and the mechanism through which specific activity streams would be monitored and confirming the status of activities towards completion. The Committee was assured that this was in progress and would be incorporated into future versions of the operational plan document.

The Clinical Strategy Annual reported provided great detail on the activities completed in the past year, including incomplete activities from previous years. The report demonstrated a high degree of compliance with national audits, learning from audits and also demonstrated how learning has been applied within the Trust. The Committee sought additional assurance on the process by which outstanding audits were followed up and completed and also the process by which learning was taken forward from completed audits, where this was an outstanding action for the Trust. The report highlighted that the Trust was unable to participate in a number of audits due to its IT infrastructure – either it could not interface with the national systems, or the resource required to manually complete actions was prohibitive. The Committee sought assurance of actions to improve the situation in the Trust's planned ICT works. The Committee was advised that the issue was continually monitored on the risk register and recruitment had taken place to help with the resources required and analyst support was also being sought to aid the audit process.

Research & Development Report 2016/17

The annual report on research activities within the Trust was presented to the Committee. The report demonstrated that research activity in the Trust is growing steadily, as has associated income from research. This had benefits in terms of staff development and retention, innovation, learning, and developing new treatments and practices for improved outcomes for patients. Additionally, publications and presentations arising from this research enhanced the reputation of the Trust and demonstrated that it was a forward looking organisation seeking to improve and develop the best possible care for its patients. The report highlighted that there were some reductions forecast for funding for research in the coming year and in future years. This may have a direct impact on the level of research activity in the Trust. The Committee asked if alternative research income had been identified through independent trusts and foundations, using the West Herts Hospital's Charity. The Committee was assured that the Trust would continue to proactively seek out research opportunities and associated income.

Risks Register

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. The Committee also received a report on risks scoring 12 or lower. This was the first time the Committee had reviewed these risks and was assured that these risks were being appropriately managed and mitigated. The Committee noted that the risks had target scores and review dates. Many of the review dates had passed, but the scores had not changed or reduced towards their target score. The Committee requested that the narrative for these risks be updated to reflect whether the reviews had taken place and to note the decision to keep the risk at the current score, or where changes had taken place to note why.

BAF Action Tracker

The Committee reviewed the BAF action tracker for the actions assigned to it. The Committee sought assurance that actions were on schedule and being delivered and, where actions had been completed, that there was a process for ensuring changes were monitored to ensure they became embedded. The Committee was assured that all the actions were either completed or where on schedule to be completed within the required timeframe.

Infection Prevention and Control Annual Report

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. There are a few points which the Committee wishes to highlight to the board:

a) Clostridium Difficile infection rate – the Trust had a total of 20 cases in the last year against a target of 23 cases. Additionally, the infection rate was lower than the East of England and England rates, meaning that nationally the Trust is performing better than other trusts. The Committee acknowledged and congratulated the team for their hard work to achieve this performance and encouraged them to continue with this excellent performance this year.

b) MRSA – the Trust did not achieve its target of zero cases, by reporting one case in this period. While this result was disappointing, the Committee acknowledged that the infection rates were below the average rates for England and the East of England.

c) The Committee was assured that where there are cases of infection or infection outbreaks (such as flu or norovirus) that appropriate processes were in place to contain and manage the outbreaks and prevent it spreading. Additionally, the Committee was assured that robust investigation processes were in place, that the Trust liaised with relevant partners and external agencies, and that learning from all cases was clearly documented with associated action plans resulting in changes in policy, guidance, practice and training being implemented for staff where appropriate. It was clear from the report that there was a proactive approach to training in infection prevention and control in the Trust, with training being taken to the wards when staff may not be able to get away and attend classroom sessions.

d) The report highlights some of the challenges that the general condition and age of the physical environment of the Trust poses – ventilation issues, water safety, lack of side rooms to mention a few. The Committee was assured that that there are robust procedures in place to manage these issues, with a clear focus on the safety of patients and staff at all times. Assured was provided that appropriate action plans were in place to both manage and remedy any issues identified and that there were clear processes in place to identify, respond to and manage issues as they arise in the future.

e) The Committee reviewed the summary of IPC policies and was encouraged to note that, with the exception of one policy, are all up-to-date. One policy is due for review in July and the Committee was assured that this was on target and would be reviewed as planned.

f) It was reported that the IPC team use a manual system for the surveillance and management of infection prevention and control. This was extremely time consuming and resource intensive. The Committee enquired if there were plans to address this and asked for an explanation of the benefits of an electronic recording system. It was recommended that an appropriate electronic system be invested in and the Committee was assured that an infection control database was being investigated and the live bed state system would also support the work of the department.

End of Life Care Annual Report

The Committee 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 being then supported to achieve their preferred place of death.

The Trust achieved its CQUIN target for this activity. The end of life team are proactively engaging with external partners and networks to learn from their experience as well as sharing learning with them. This focus on learning was helping to drive change and improve the service. The Committee was assured that the future activity for this area of work would continue to improve end of life care. Further assurance was received from evidence that complaints had reduced in this area due to embedded learning. The Committee requested some specific editing changes to the report before final publication.

Quality Strategy Update

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

a) Through a competitive process the Trust had selected a consultant to develop its approach and strategy for continuous quality improvement. The company appointed is Gate One.

b) The Trust has developed an initial timetable for development of its strategy, which is as follows:

- Undertake a baseline assessment of current quality processes, systems and governance by the end of September 2017.
- Develop a clear vision, outcomes and framework for quality and quality improvement, including key capabilities, enablers, changes and the required investment by December 2017.
- Have a finalised quality improvement strategy, methodology and detailed implementation plan ready by the end of February 2018.
- A summary of key risks that had been identified was also presented. The Committee asked that these be reviewed and recommended as the programme progresses, with appropriate scoring, controls and assurances.

Learning from Deaths – Action plan update

The Committee received an update on the Trust's action plan on Learning from Deaths in response to the CQC national review of the way that NHS Trusts review and investigate deaths. The action plan showed that the Trust was on target to achieve all agreed activities and the Committee was assured on the processes which would be put in place to embed learning.

Risks to refer to risk register

None

Issues to escalate to Board

- End of Life Care Annual Report 2016-17
- Infection Prevention and Control Annual Report 2016-17

Attendance	John Brougham, Non-Executive Director Tracey Carter, Chief Nurse & DIPC Rachael Corser, Deputy Director of Governance & Associate Chief Nurse Mike van der Watt, Medical Director Jane Shentall, Director of Performance Lisa Emery, Chief Information Officer Phil Downing, Head of Nursing Medicine Jo Fearn, Head of Nursing Women and Children's Jean Hickman Trust Secretary Anna Wood, Associate Medical Director of Clinical Standards and audit Arla Ogilvie Divisional Director Medicine Jackie Birch, Head of Risk, Assurance and Compliance Paula King, Head of Nursing SAC Linda Tarry, Executive Assistant to Chief Nurse (minutes)
In attendance for Specific Items	Michelle Sorely, Lead Nurse Cancer & Palliative Care Liz Sumner, CNS Palliative Care Fiona Smith, Associate Director, Research & Development

Agenda item: 23/51

Report to:	Trust Board
Title of Report:	Safety & Compliance Committee Assurance Report to Trust Board
Date of board meeting:	07 September 2017
Recommendation:	For information and assurance
Chairperson:	Phil Townsend, Non Executive Director

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Safety and Compliance Committee at its meeting on 10 August 2017.

Background

The Committee meets bi-monthly and provides assurance on:

- CQC standards
- Compliance with external bodies, eg. NHS Litigation Authority, Health and Safety Executive, Health Service Ombudsman
- Actions taken and lessons learnt in response to adverse clinical incidents, complaints and litigation
- Compliance with clinical and non-clinical governance, standards and guidance
- Risk and governance strategy
- Board Assurance Framework

Business undertaken

Performance Report

The committee reviewed the May and June data in the July 2017 performance report and noted the areas of good performance and areas requiring performance improvement.

Corporate Risk Register and Risks aligned to Safety & Compliance Committee

The Committee received a report on the 24 risks open on the corporate risk register aligned to the Board sub-committees for assurance and a report on the risks aligned to the Safety & Compliance Committee with progress against the action plan.

Board Assurance Framework action tracker

The Committee reviewed the status and progress of actions in the Board Assurance Framework, designated to the committee, which was well received.

Premises Assurance Model (PAM)

The committee was updated on the progress against the implementation of the Premises Assurance Model (PAM) and the associated action plan, and noted the significant improvement in the overall PAM scoring achieved over the last 12 months.

Fire Safety Update

The committee received a verbal update and would receive a further written update which will then be considered at TEC.

Medicines Optimisation Annual Report

The committee was provided with an update on progress against the Medicines Optimisation Strategy.

Annual Complaints and Patient Advice and Liaison Service Report

The committee received the Annual Complaints and Patient, Advice and Liaison Service (PALS) report and reviewed the analysis of all complaints received and contacts received through PALS from April 16 to March 17.

RSM Internal Audit Report on Incidents & Complaints including Duty of Candour Lessons

The committee received the RSM Internal Audit Report on Incidents and Complaints, including Duty of Candour – Lessons Learnt, which had been rated as 'reasonable assurance'.

Safe Staffing Bi-annual Establishment Review – Adult Inpatient

The committee reviewed the Safe Staffing Bi-annual Establishment Review and were assured that ward establishments were safe and that staffing was provided at appropriate levels of care to patients.

Quality Improvement Plan

The committee received information and assurance on the delivery performance of the quality improvement plan (QIP) submitted to the Care Quality Commission and were assured by the progress and preparation ahead of the CQC inspection at the end of August.

Quality Compliance Framework Update

The committee was assured that the organisation is meeting its statutory and non-statutory obligations in relation to safety and quality.

CQC Maternity outlier alert for rates of Emergency Caesarean sections

The committee received the response from WACs to the CQC alert on the Trust's consistently high C-section rates and were assured that a plan of action was in place and that a continuous caesarean section audit will monitor trends and facilitate appropriate and timely intervention to reduce rates.

Safeguarding Annual Report April 2016 - March 2017

The Committee received the Safeguarding Annual Report April 2016 - March 2017 detailing safeguarding activity and key areas of achievement and members were ensured that the organisation is fulfilling its obligations.

Review of Level 3 Safeguarding Children training

The Committee received the papers which reviewed the current provision of Level 3 Safeguarding Children within the Trust, following the recommendations made in the CQC report following the inspection in September 2016.

Emergency Preparedness, Resilience & Response Annual Assurance

Members received and approved the self-assessment for submission to NHS England.

Risks to refer to risk register	There are 5 risks on the corporate risk register alighed to the Safety and Compliance Committee (scored at 15 and over).
Key decisions taken	Recommendation for approval of the EPRR self-assessment for submission to NHS England.
Issues to escalate	1. Approval of the EPRR self-assessment for submission to NHS England. 2. 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.
Challenges and exceptions	None

Future exceptional items None

Attendance record
Phil Townsend, Non-Executive Director Paul Cartwright, Non-Executive Director Katie Fisher, Chief Executive Mike van der Watt, Medical Director Kevin Howell, Director of Environment Anna Wood, Deputy Medical Director/Associate Medical Director of Clinical Standards and Audit Anthony Divers, Divisional Director, Clinical Support Dr Gloria Rowland, Associate Director for Midwifery and Gynaecology Marcellina Coker, Consultant Obstetrician and Gynaecologist Jackie Birch, Head of Risk Assurance and Compliance Maxine McVey, Deputy Chief Nurse Paula King, Head of Nursing, Surgery, Anaesthetics and Cancer Marissa Ruppersburg, Lead Nurse Medicine Jean Hickman, Company Secretary Lisa Morris, Executive Assistant (minute taker) *For individual items:* Paddy Hennessey, Head of Engineering Estates & Facilities Tim Duggleby, Director of Environment Ian Stephens, Head of Litigation, Claims, Serious Incidents and PALS

Agenda Item 24/51

Report to:	Trust Board
Title of Report:	Patient and Staff Experience Committee Assurance Report to Trust Board
Date of meeting:	07 September 2017
Recommendation:	For information and assurance
Chairperson:	Ginny Edwards, Non-Executive Director

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Patient and Staff Experience Committee at its meeting on Thursday 31st August 2017.

Background

The Committee meets bi-monthly and provides assurance on:

- Patient and staff experience measures, i.e. outcomes of surveys and audits
- Staff engagement
- Progress against the patient experience and workforce strategies
- Organisational development
- Workforce performance (IPR), including training, appraisals, revalidation, recruitment and retention
- Equality and diversity
- Health and wellbeing
- Lessons learnt through comparison of best practice between services

Business undertaken

Workforce Report

The Committee received August's workforce report which covered key workforce metrics for July 2017. It noted that the Trust's vacancy rate now stood at 12.3%. Of particular concern is the band 5 nurse vacancy rate which currently stands at 23.7%, although this figure is forecast to fall to 19.9% over the next 3 months with 64 candidates currently within the Trust's recruitment pipeline. The committee asked for a paper on the national and local retention strategy for the Band 5 nurses to be presented to the December meeting.

Sickness absence reduced from 3.1% to 3.0% and it was noted that this was partially down to the fact that there were 420 live absence cases currently under formal management.

Agency spend increased from £1.6m to £1.7m, which whilst disappointing it was agreed was a good performance given the current vacancy rate amongst band 5 nurses. It was noted that following improvements to IT systems within the HR function the average 'offered to clear' time to hire figure had fallen from 31 days to 25 days.

The committee also welcomed the significant improvements seen within appraisal rates which had increased to 90%, whilst compliance with

	mandatory training requirements had also increased to 92%. It was noted that all HR policies are now in date. The Committee reviewed a high level summary of progress being made to complete local staff survey action plans and noted some good progress.
	Workforce and Staff Experience Risk Register The committee received an update on all current workforce related risks. It was noted that currently there are four risks scoring 15 or above on the corporate risk register. In addition it was noted that since the last meeting 15 risks had been closed.
	Patient Experience Performance Report The Committee reviewed the Patient Experience & Carer Strategy dashboard which provides a visual picture of the progress being made against this strategy. It was noted that whilst there were improvements in the number of patients responding to the FFT within ED and Maternity, the target rate of recommendation at 95% was not being met. However the results are above 90% and provide some assurance that the patients are happy with the care and treatment they receive. The Committee noted that whilst the number of complaints and PALS concerns has risen this month, the overall rate has fallen when measured against the national rate (per 10000 bed days). The Committee welcomed the adoption of new approaches for gaining feedback from patients in Medicine and Unscheduled care, such as aftercare telephone conversations and enhanced use of volunteers. The report also linked patient and staff experience to begin to build a picture across the organisation and support where to focus and give a source of assurance. The committee agreed this should be brought to every other committee and to further develop the key metrics and outline by December committee.
	Bullying & Harassment Strategy Update The committee received a paper with an update of the work that has been undertaken on implementing the actions identified in the 2015 Bullying & Harassment strategy. The Committee noted that there had been 31 cases commenced since September 2016, whilst limited the benchmarking undertaken suggested that this was a higher number than seen by a comparator Trust. However the Committee agreed that measuring the effectiveness of the Trust's approach to bullying and harassment simply by the number of cases undertaken was very limited in its usefulness. It was noted that of these cases, 12 had been informally resolved and it was generally agreed that where this could be done this was a good option. The Committee discussed plans for future communications around bullying and harassment and in particular noted the intention to focus upon the negative impact of 'everyday' inappropriate/inconsiderate behaviour which would be captured by a forthcoming anti-bullying

	campaign entitled 'Be kind to each other'.
	Unscheduled Care Workforce Update Following a request by the Committee, it received an update from the Unscheduled Care Division regarding an organisational development exercise it is currently undertaking to help drive engagement across ED and AAU. The division described how it had undertaken a large number of engagement events with its staff and how this had led to a number of changes such as the creation of localised values and improved communication. The Committee very much welcomed the fact nursing numbers were now recruited to full establishment levels for band 5, 6 and 7's in ED. In addition the division also outlined steps it was undertaking to fill gaps within its medical workforce. This includes the creation of hybrid roles combining emergency medicine with a chosen speciality. A second phase of this work is being undertaken and is being led by the Divisional General Manager.
	Health and Wellbeing CQUIN 2016 – 2018 Performance Update The committee received a paper on the Health and Wellbeing CQUIN performance for 2016-17 and for this year's CQIN. It was noted that the Trust had not received full payment for last year's H&WB CQIN and this was highly disappointing. A discussion around the reasons for this was then held. However it was felt that the approach being undertaken to this year's assessment was far more objective and based upon improvements in staff perception of a number of health and well-being related questions within the staff survey.
	Leadership and Management Development Update The committee received a paper on current leadership and management development interventions provided by the Trust. It noted that the Trust worked with a range of providers on leadership development, as well as having its own in house management development team. The Committee welcomed the work being undertaken but felt that more work was required to enhance the overall management skills of the Trust's manager's at all levels. This was less about leadership and more upon ensuring that all managers had good basic management skills e.g. good report writing skills, people management, conflict management It was agreed that the Director of Workforce would bring back a proposal on how this might be achieved.
	National Cancer Patient Survey Results The committee received a briefing on the results of the 2016 National Cancer Patient Experience Survey (NCPES). From a survey of 50 questions, it was noted that as a Trust compared to the nation average, it scored higher in 18 questions and although it scored lower than the national average in 26 questions, overall the Trust's score had improved in 11 of them.

	The areas which saw an improvement included support for people with cancer, treating patients with dignity and respect and families being offered support and receiving adequate information. Areas in which the trust scored lower than in the previous year included hospital staff ensuring they did everything to help control pain and giving patient's family the opportunity to talk to a doctor.
	National A& E Survey Results The committee received a paper providing a briefing on the results of the National Emergency Department 2016 survey. The results of the survey identified those areas which respondents were most satisfied with including being treated with respect and dignity, having confidence and trust in the doctors/nurses and believing the department was fairly clean/very clean. Areas where the Trust performed less well included lack of communication, waiting for pain relief, overall waiting time in the department and not enough time to speak with a doctor or nurse and lack of information on discharge. It was noted that that the survey identified no real areas of improvement however it is anticipated with the change in leadership, the strengthened divisional structure and the further work being undertaken in ED some real improvements will be made and a repeat survey will be undertaken in early 2018.
	Children's and Young Peoples Inpatient and Day Case Surgery 2016 Survey Briefing The committee received a paper providing results of the National Children's and Young Peoples Inpatient and Day Case Survey. The purpose of the survey was to understand what young people and their families thought of the healthcare provided by the Trust. It was noted that the Trust felt disappointed that the overall results showed little improvement since the last survey. However it was equally noted that many of the results were already of a high standard and so for example 91% of parents rated care as being 7 or more out of 10, 90% of children stated that they had been cared for quite or very well and 79% of parents always had confidence and trust in the members of staff treating them. Where the Trust did less well as compared to other comparator trusts included parents feeling that staff did not keep them fully informed as to what was happening, parents feeling that their child was not always given enough privacy when receiving care and children not completely liking hospital food. An action plan has been devised to focus on those areas with the highest problem score with priorities being around improving communication, reviewing the care environment for families to ensure privacy and dignity at all times and ensuring that facilities for food and play are appropriate.

	The committee were asked to note the following: **Talent Management Update** The committee received a paper outlining the Trust's approach to Talent Management as part of implementing the Trust's workforce and development strategy 2016-19. The paper summarised national and STP contexts; what is in place, strengths and challenges. **Consultant Job Planning Overview at year end 2016/17 and progress to date 2017/18** The committee received a paper updating them on year end status for consultant's job planning for 2016/17 and progress with 2017/18 job plans to date. It was noted that at the end of 2016/17 year 92.7% of overall job plans had been agreed and signed off, year to date this figure stands at 76%. **In Patient Survey & Patient Experience Report** The committee received a paper on In patient survey and patient experience report. This paper provided information on the inpatient survey 2016 and other sources of feedback from patients in the Trust. It is intended to provide assurance that patient feedback is being used to progress improvements in patient and carer experience. It highlighted gaps within this domain and actions that are being taken to address the areas highlighted by patients. **Patient Experience Group Minutes** The committee were asked to note the minutes from the Patient Experience Group. **Medical Revalidation Annual Organisational Audit 2016/17** The committee received a paper detailing the findings of Medical Revalidation Annual Organisational Audit which detailed medical revalidation performance data and is intended to provide assurance around systems for appraisal and responding to concerns. The paper showed that of the 358 doctors with a prescribed connection to the Trust, for 2016/17, 341 (95.2%) doctors received an appraisal. 6 (1.6%) doctors had appraisals which at the time of counting were incomplete, or had been missed with approval (e.g. maternity leave, long term sickness) and 11 (3.0%) missed their appraisal without approval. Of the 11 doctors with a prescribed connection to the Trust who missed their appraisal during 2016/17 without approval, 9 have now completed. 6 of these doctors fell out of time close to the cut-off date for counting. Of the remaining 2, 1 has had their appraisal postponed to June (this was agreed after the submission was made) and 1 booked and then cancelled an appraisal. This case is being pursued. The Committee congratulated the Trust in its performance in this area. **Freedom to Speak Up Update (FTSU)** The committee received a paper providing an update relating to the Trust's approach to Freedom to Speak Up and to ensure that the main recommendations of the National Guardians Office have been identified and implemented. The paper reported on its progress in a number of key

	areas of activity. Out 13 target areas in 2015 only 4 had been rated as being 'green' with 3 'reds'. This year's position is that there are now 10 areas rated as 'green' and no 'reds'. The Committee noted that there had been 8 cases commenced since June 2016, with two cases being formally investigated, 4 cases resolved informally and 2 cases currently open. **Health Education East of England quarterly report (Non Medical Education)** The committee received a paper providing an update on delivery streams and assurances ensuring governance arrangements are in place and robust enough to meet our obligations with Health Education England (HEE) and the LDA contract that is in place. **Flu Vaccination Programme** The committee received a paper providing an overview of this year's seasonal flu campaign which includes the approaching being undertaken, communications approach and trajectories for vaccination. **AOB** The committee noted the submission of the stakeholder engagement plan. Which would be reviewed at the October meeting as scheduled.
Risks to refer to risk register	There were no issues referred to the risk register.
Key decisions taken	The Committee recommended the 2016-17 Medical Revalidation Annual Organisational Audit to the board for its approval.
Issues to escalate	There were no issues for escalation.
Challenges and exceptions	None
Future exceptional items	None

Attendance record
Ginny Edwards, Non-Executive Director Tracey Carter, Chief Nurse & Director of Infection Prevention and Control Paul da Gama, Director of Human Resources Paul Cartwright, Non-Executive Director Jonathan Renison, Non-Executive Director Sally Tucker, Chief Operating Officer Maxine McVey, Deputy Director of Nursing Lesley Headland, Chair of Staffside Angela White, Head of Nursing, Unscheduled Care Paula King, Head of Nursing, Surgery, Anaesthetics and Cancer Phil Downing, Head of Nursing, Medicine Jo Fearn, Head of Nursing (Children's Services) Gill Balen, Patient Representative Dr Emmanuel Quitst-Therson, Associate Medical Director for appraisal and revalidation In attendance: Michelle Sorley, Lead Cancer & Palliative Care Nurse

Agenda item: 28/51

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	**Nursing and midwifery and allied health professional strategy update**	For information	Safety and Compliance	Chief Nurse	Paper
12/52	**Bi-annual establishment review - maternity**	For information	Safety and Compliance	Chief Nurse	Paper
13/52	**Annual report on complaints and PALs**	For information	Safety and Compliance	Chief Nurse	Paper

14/52	**Bi-annual trend analysis of communications key performance indicators**	For information		Director of Communications	Paper
GOVERNANCE					
15/52	**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					
16/52	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
17/52	**Assurance report from Audit Committee**	For information and assurance	Audit Committee	Committee Chair/Chief Financial Officer	Paper
18/52	**Assurance report from Clinical Outcomes and Effectiveness Committee**	For information	Clinical Outcomes and Effectiveness	Chief Nurse	Paper
REPORTS TO CORPORATE TRUSTEES					
19/52	**Assurance report from Charitable Funds Committee**	For information and assurance	Charitable Funds Committee	Committee Chair/ Director of Communications	Paper
20/52	**Charity annual report and accounts**	For information and assurance	Charitable Funds Committee	Committee Chair/ Director of Communications	Paper
ANY OTHER BUSINESS					
21/52	**Any other business previously notified to the Chairman**	N/A	N/A	Chair	Verbal
QUESTION TIME					
22/52	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
23/52	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
24/52	**Draft agenda for next board meeting**	To approve	N/A	Chair	Paper
25/52	**Date of the next board meeting in public:** 02 November 2017, Terrace Executive Meeting Room, Watford Hospital	To note	N/A	Chair	Verbal