TRUST BOARD MEETING IN PUBLIC
AGENDA

02 November 2017 at 9.30am – 12.00noon

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

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

Item ref	Title	Objective	Previously presented	Lead	Paper or verbal
01/53	**Opening and welcome**	To note	N/A	Chair	Verbal
02/53	**Briefing on the work of the Paediatric Carers Support Team**	To receive	N/A	Chief Nurse	Presentation
OPENING					
03/53	**Apologies for absence**	To note	N/A	Chair	Verbal
04/53	**Conflict of interests**	To note	N/A	Chair	Paper
05/53	**Minutes of the meeting held on 05 October 2017**	For approval	N/A	Chair	Paper
06/53	**Board action log from 05 October 2017 and previous meetings and decision log**	To note	N/A	Chair	Paper
07/53	**Chair's report**	To note	N/A	Chair	Paper
08/53	**Chief Executive's report**	To note	N/A	Chief Executive	Paper
PERFORMANCE					
09/53	**Integrated performance report – month 6**	For information	Trust Executive Committee	Chief Operating Officer	Paper
SAFE EFFECTIVE CARE (BAF RISK 1)					
10/53	**Quality improvement plan update**	For information and assurance	Safety and Compliance Committee	Chief Nurse	Paper
UNDERDEVELOPED INFORMATICS INFRASTRUCTURE (BAF RISK 4)					
11/53	**General data protection regulation update**	For approval	Trust Executive Committee	Chief Information Officer	Paper

DELIVER A LONG TERM STRATEGY (BAF RISK 9)					
12/53	**Strategy update – month 7**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
13/53	**Hertfordshire health concordat**	For approval	Trust Executive Committee	Deputy Chief Executive	Paper
GOVERNANCE					
14/53	**Summary report on corporate risk register**	For information and assurance	Trust Executive Committee	Deputy Chief Executive	Paper
15/53	**Board assurance framework update**	For approval	Trust Executive Committee	Deputy Chief Executive	Paper
COMMITTEE REPORTS					
16/53	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
17/53	**Assurance report from Audit Committee**	For information and assurance	Audit Committee	Committee Chair/Chief Financial Officer	Paper
18/53	**Assurance report from Safety and Compliance Committee**	For information and assurance	Safety and Compliance Committee	Committee Chair/ Medical Director	Paper
19/53	**Assurance report from the Patient and Staff Experience Committee**	For information and assurance	Patient and Staff Experience Committee	Committee Chair/Director of Human Resources	Verbal
ANY OTHER BUSINESS					
20/53	**Any other business previously notified to the Chairman**	N/A	N/A	Chair	Verbal
QUESTION TIME					
21/53	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
22/53	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
23/53	**Draft agenda for next board meeting**	For approval	N/A	Chair	Paper
24/53	**Date of the next board meeting in public:** 07 December 2017, Terrace Executive Meeting Room, Watford Hospital	To note	N/A	Chair	Verbal

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

The Carer Support Team
Children's Services, Watford General Hospital

Dr Amanda Equi
CST Honorary Head
Consultant Paediatrician

Becky Platt
Matron, Children's Services

Suzanne Boon
Manager, The Carer Support Team

CARER SUPPORT TEAM
STARFISH WARD

West Herts Hospitals Charity

Key principles

1. Financed by the Community
2. Management
3. Able and Purposeful Volunteers
4. Engagement with NHS Staff (Nurses + Voluntary Services)

CARER SUPPORT TEAM
STARFISH WARD

West Herts Hospitals Charity

What difference do we make?

CARER SUPPORT TEAM
STARFISH WARD

West Herts Hospitals Charity

"I have been on my own during the recent admission with my child and the support of CST has been INVALUABLE.

It has been a tough week but the half hour walk in the sunshine, lunch in the café, cry on the shoulder, listening ear, smile, no medical questions….has made my life bearable. Thank you CST."

Carer 2014

What difference do we make?

"The best team of just lovely people who understand, listen, provide support, sanity and warmth – to be able to pop out for a drink and fresh air is all you need to keep going. The volunteers provided that and more!"

Carer 2017

West Herts Hospitals Charity

What difference do we make?

- **Care Quality Commission 2015**. "Outstanding practice…Parents we spoke with told us the practical and emotional support provided by the volunteers was valued by them."

- **Care Quality Commission 2016**. CST was a noted example of public engagement with the Hospital.

West Herts Hospitals Charity

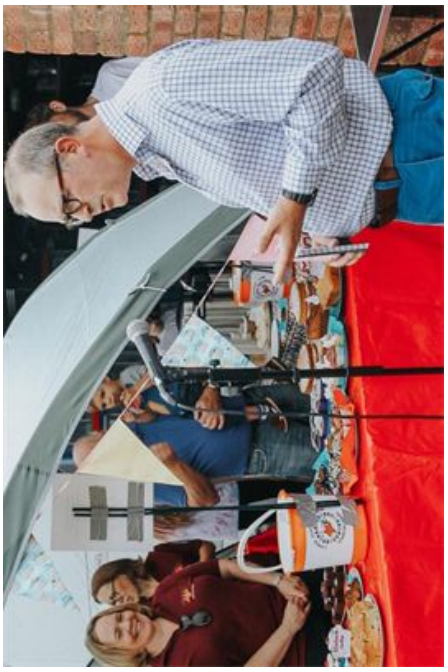
What have we learned since 2014?

1. Engagement is Essential
2. Misconceptions about Volunteers
3. Good IT systems help us Value Volunteers
4. Goodwill in the Community

CARER SUPPORT TEAM
STARFISH WARD

West Herts Hospitals Charity

Annual Summer Fundraiser



Ambitions and Next Steps

"The kindness of Lynne and Martina (from CST) brought tears to my eyes. ***We have been in and out of hospitals for the past month and this is the first team of its kind I have come across. I wish all hospitals had a carer support team.*** *The volunteers were kind and caring with kids. I have benefited enormously from their visit. Thank you."*

Carer 2016

CARER SUPPORT TEAM
STARFISH WARD

West Herts Hospitals Charity

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Declaration of Board members and attendees conflicts of interest
02 November 2017

Agenda item: 04/53

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

Last updated 24 October 2017

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

Last updated 24 October 2017

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 Public Trust Board meeting

05 October 2017 at 9:30am - 12.00noon

Terrace executive meeting room, Watford Hospital

Agenda item: 05/53

5

Chair	Title	Attendance
Professor Steve Barnett	Chair	Yes
Members		
John Brougham	Non-Executive Director	Yes
Helen Brown	Deputy Chief Executive	No
Professor Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	No
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	No
Dr Mike van der Watt	Medical Director	No
In attendance		
Dr Tammy Angel	Divisional Director, Unscheduled Care	No
Paul da Gama	Director of Human Resources	Yes
Lisa Emery	Chief Information Officer	Yes
Jean Hickman	Trust Secretary (notes)	Yes
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	Yes
Dr Arla Ogilvie	Divisional Director, Medicine	No
Sally Tucker	Chief Operating Officer	No
Dr Anna Woods	Deputy Medical Director and Associate Medical Director of Clinical Standards and Audit	Yes
Observing		
Louise Halfpenny	Director of Communications	Yes
3 members of the public	N/A	N/A

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/52	**Opening and welcome**		
01.01	The chair opened the meeting and welcomed the board and members of the public.		
02/52	**Dementia awareness**		
02.01	The chair introduced Dr Tammy Angel and invited her to update the board on developments in dementia care and the outcome of a national dementia audit. Dr Angel also took the opportunity to run over the mandatory training module on dementia awareness.		
02.02	Dr Angel explained the dementia pathway and the current service available. She reported that the 2016 national dementia audit had benchmarked the trust fourth out of 198 trusts. She advised that although the trust welcomed the positive results of the audit, work was underway to improve the service further, including additional reporting, clinical developments, enhanced discharge planning processes and the introduction of customer care training.		
02.03	Ginny Edwards thanked Dr Angel for the presentation and the excellent results of the dementia audit. She asked if the service was clear on what good looked like and enquired on the timescale for seeing the impact of the action being taken. Dr Angel responded that discharge planning from the front door and better recording was key to achieving significant improvements to the patient experience. She advised that a group from a wide range of specialities was working together to improve discharge planning and, in addition, a taskforce had been established to specifically focus on actions required to strengthen the dementia service. The chief executive commented that issues with discharge planning had also been highlighted in the results of the national patient survey and an action plan had been developed to improve in this area. The chief nurse commented that the hospital at night team would be able to offer further support to the dementia service.		
02.04	In response to a question from Ginny Edwards, Dr Angel advised that the national dementia audit would be repeated on an annual basis.		
02.05	Paul Cartwright thanked Dr Angel for her excellent, informative presentation and queried on the accuracy of the number of patients with unknown dementia quoted in the presentation. Dr Angel replied that the exact number was unknown, however it was considered to be an under estimation as many patients with dementia went undiagnosed.		
02.06	Ginny Edwards asked how the expertise in the dementia service could be expanded to support other specialty areas. The director of surgery, anaesthetics and cancer advised that the key areas for suspected dementia were post-stroke and fractured neck of femur, both of which had experienced geriatricians but no specialists in dementia. He assured the board that the elderly care service cross-referred patients to the dementia service and noted that the dementia service offered an outreach service to wards, however the director of surgery, anaesthetics and cancer acknowledged that this could be increased.		
02.07	The chairman thanked Dr Angel for her excellent presentation and asked her to pass on the board's appreciation of the work and excellent audit results to the dementia team.		
OPENING			
03/52	**Apologies for absence**		
03.01	Apologies were received from Phil Townsend, the chief operating		

Agenda item	Discussion	Lead	Dead-line
	officer, the deputy chief executive, the medical director, the divisional director for unscheduled care and divisional director for medicine.		
04/52	**Conflicts of interests**		
04.01	No further conflicts were raised from those circulated prior to the meeting.		
05/52	**Minutes of the meeting held on 07 September 2017**		
05.01	John Brougham asked minute 09.06/51 to be reworded to ensure it accurately reflected the current financial position.		
05.02	The chief nurse advised that the minute 14.02/51 should read the safer nursing care tool and not health tool.		
05.03	The director of human resources updated the board on a discussion at the July meeting relating to the trust's no smoking policy. He advised that patients and visitors would now be permitted to vape on site following a review and overturning of a previous decision.		
05.03	Resolution: Subject to the above changes, the board agreed the minutes to be a true record of the meeting.		
06/52	**Board action log from and previous meetings and decision log**		
06.01	Action 09.04/49. The chief information officer advised that discussions were underway with committees to map indicators in the integrated performance report to a specific committee. The board noted that a number of areas of work overlapped several committees and it was agreed that this would be considered in the forthcoming governance structure review.		
06.02	Action 08.05/51. It was noted that an update on delays to non-emergency patient transport was reported in the chief executive's report.		
06.03	Action 11.02/48. The deputy medical director advised that a policy for learning from deaths had been published.		
07/52	**Chair's report**		
07.01	The chair presented his report to the board. He highlighted a new initiative by NHS Providers to support sustainable transformation partnerships The chief executive confirmed that the trust was not currently working with NHS Providers on this programme.		
07.02	It was reported that the trust's annual general meeting on 21 September 2017 had been well attended. The chair thanked the communications team for arranging the event and for the publication of an excellent annual report and review.		
07.03	The chair advised that he had attended a successful cancer event on 03 October 2017 hosted by the Macmillan cancer service.		
07.04	The board recognised the staff and teams mentioned in the report for their outstanding work.		
07.05	Resolution: The board noted the report.		
08/52	**Chief Executive's report**		
08.01	The board received a report from the chief executive. She highlighted concerns around a significant issue with non-emergency patient transport which had resulted in a profound negative impact on patient experience. The chief executive thanked staff for maintaining services and minimising the distress and disruption to patients. In particular, she highlighted the outstanding efforts of outpatient staff that had worked extra hours to contact patients and make alternative arrangement for		

Agenda item	Discussion	Lead	Dead-line
	them to attend appointments. Colleagues at Herts county council were thanked for their support in locating available vehicles to transport patients home from hospital. The board was advised that the non-emergency patient transport contract was managed by NHS England and procured across clinical commissioning groups (CCGs). The service was currently being managed by the east of England ambulance trust whilst longer term arrangements were being discussed. The chief executive advised that as the patient transport was such a critical service, the trust had asked to be centrally involved in future procurement discussions. The chief executive assured the board that the issue was being closely managed internally and reported that there had been no safety incidents or patient appointments cancelled to date. Ginny Edwards enquired whether the trust had considered using volunteer drivers to support the service. The chief executive responded that the trust was using volunteers and a wide range of other private transport services. In a response to a question by Paul Cartwright, the board was assured that all costs were being picked up by the Herts valleys clinical commissioning group.		
08.02	The human resources team was thanked for its work in establishing a smoke free policy and the board recognised the clear benefits for patients, visitors and staff.		
08.03	The chief executive highlighted the introduction of the annual flu vaccination programme which was actively encouraging staff and patients to have the vaccination. She advised that the trust was in discussion with the CCG on offering the vaccination to all patients attending the emergency department, including children. The chair reminded the board that the flu vaccination would be available to members following the board meeting.		
08.04	The chief executive advised the board that the national staff survey was underway and staff were being strongly encouraged to complete the survey.		
08.05	Resolution: The board noted the report.		
PERFORMANCE			
09/52	**Integrated performance report - month 5**		
09.01	In the absence of the chief operating officer, the chief information officer presented the latest position with regard to performance and highlighted areas of good practice and areas which required attention.		
09.02	John Brougham brought the board's attention to complaints performance and asked for clarification on the number of long standing complaints. The chief nurse advised that currently two complaints over six months old were being worked through and assured the board that complaints were a clear focus at divisional performance reviews. The board asked for the number of complaints over three months to be included in future safety and compliance committee integrated performance reports.	LE/TC	12/17
09.03	John Brougham commented that the report did not clearly describe the relationship between new harms and harm free care. The chief nurse explained that the overall safety thermometer was an important indicator for the board to monitor; this demonstrated that the trust benchmarked positively nationally on harm free care. The board asked for harm free care data to be presented in a clearer format in future reports.	LE/TC	12/17

Agenda item	Discussion	Lead	Dead-line
09.04	The board was assured that the patient and staff experience committee was closely monitoring a high vacancy level of band five nurses, including looking at the actions being taken nationally to address the issue.		
09.05	Paul Cartwright asked for clarification on a reported high level of stranded patients. The chief executive explained how the data was calculated and assured the board that a 'red to green' initiative was underway which was aimed at addressing this issue. The board was advised that from November 2017 it would receive a new performance management control report which was presented monthly to NHS England and NHSI as part of regional escalation meetings.		
09.06	The chair reminded the board that the care quality commission inspection team had highly praised the trust's IPR.		
09.07	The board acknowledged that sickness absence, mandatory training, bank pay and appraisal performance was improving. It was also recognised that the trust was third in the region for cancer performance and had been praised by NHS Improvement.		
09.08	The chief financial officer updated the board on the latest financial position. He advised that year to date (YTD) the trust's deficit was higher than the agreed control total of £15m (£20.5m M5 YTD) and reminded the board that the financial position was expected to become more challenging as the year progressed. The chief financial officer explained the suspension of operations due to staff shortages, theatre ventilation issues and control of infection regarding orthopaedic operations has negatively impacted on the financial position.		
09.09	The chief financial officer advised that the savings plan had fallen behind plan and currently only £9.5m of schemes had been identified. He assured the board that the trust was redoubling its efforts to bring the savings plan back on target.		
09.10	The board was advised that agency spend of £340k was above plan and was assured that a steering group was working closely with divisions to drive initiatives forward which would allow the trust to achieve its agency spend target of £17m.		
09.11	The chief financial officer reported that the trust was not currently in a position to be able to pay suppliers within the thirty day requirement.		
09.12	As the trust was not on track to meet its agreed end of year deficit, the board was advised that it would discuss a revised financial forecast and recovery plan in the private session of the meeting.		
09.13	Resolution: The board noted the report.		
SAFE EFFECTIVE CARE (BAF RISK 1)			
10/52	**Quality improvement plan update**		
10.01	The chief nurse presented a paper which provided the board with assurance on the delivery of the quality improvement plan (QIP). She advised that the overall status at the end of August 2017 and the forecast for September 2017 were green. Two projects were rated red; both relating to IT. This was reported to be due to the impact of a cyber-attack, resource conflicts due to a raised number of service incidents requiring remediation and issues with suppliers. The chief nurse confirmed that the QIP would continue in its current format until the end of March 2018, at which time the board would receive the quality strategy for approval and the QIP would be rebranded to deliver the strategy.		

Agenda item	Discussion	Lead	Dead-line
10.02	Ginny Edwards enquired when the IT projects were expected to get back on track. The chief information officer responded that, although the roll-out of end user devices was well underway, there were other significant challenges which were negatively impacting on progressing IT projects. However, she assured the board that she was confident that the programme would be back in track by the end of December 2017.		
10.03	The chief nurse updated the board on the actions being taken following the CQC inspection in September 2017. She advised that the CQC had praised the trust for meeting all information request deadlines which had only been achieved by one other trust. It was reported that the draft report was expected in early November 2017 to check for factual accuracy and the final report would be published in December 2017.		
10.04	Resolution: The board noted the report.		
11/52	**Annual report on complaints and patient advice and liaison service 2016/17**		
11.01	The board received a report on complaints and PALS concerns which had been received in 2016/17. The chief nurse assured the board on improvements to leadership and staffing during the year and advised that a number of measures had been introduced to improve the service, including holding staff learning events, a new approach to triaging, new techniques for reporting information and monitoring complaints and better scrutiny. The chief nurse advised that there had been a key focus on improving complaint letter response rates and noted that the trust had received positive reviews from commissioners. The board was further advised that the management of complaints was closely monitored by the safety and compliance committee.		
11.02	Paul Cartwright welcomed the improvement in complaints performance and asked for a trajectory when the board could expect to see further improvement. The chief nurse confirmed that the aim was to achieve 65% by the end of December 2017 and for this to be maintained for the remainder of the financial year.		
11.03	The director of workforce brought the board's attention to the high rate of complaints in the Women's and Children's division and asked if this should be an area of concern for the board. The chief nurse responded that although maternity was a well-known specialty across the NHS that experienced a high level of complaints, the trust had seen a positive improvement in its friends and family test results. She advised that strengthening working relationships with the local maternity services liaison committee and learning from feedback from the friends and family test would help to improve the service and reduce the number of complaints.		
11.04	Resolution: The board noted the report.		
DELIVER A LONG TERM STRATEGY (BAF RISK 9)			
12/52	**Strategy update**		
12.01	The chief executive presented the strategy update in the absence of the deputy chief executive. She highlighted that the trust had not been successful in its bid to submission to tender for community MSK services. The chief executive advised that the trust was working to understand the full impact of this outcome and would be learning from other NHS organisations that had been in a similar position. Paul Cartwright enquired why the trust had been unsuccessful and whether it		

Agenda item	Discussion	Lead	Dead-line
	could challenge the decision. The chief executive responded that she was not aware of all the detail, but could confirm that the successful offer was financially better. She advised that the board would discuss this further in the private session of the meeting. Ginny Edwards asked if the trust would be monitoring any changes in demand and was assured that these would be closely tracked. In response to a further question from Ginny Edwards, the chief executive confirmed that the successful bidder was a well-established, experienced specialist MSK and physiotherapy provider.		
12.02	The board was updated on a strategic options appraisal to modernise pathology services. It was reported that this work would produce a strategic outline business case which would be reviewed by the finance and investment committee in October 2017 and presented to the board for approval in November 2017 prior to submission.		
12.03	Resolution: The board noted the report.		
COMMITTEE REPORTS			
13/52	**Assurance report from the Finance and Investment Committee**		
13.01	John Brougham presented an assurance report from the finance and investment committee. He advised that the committee had recommended that the board ratify an interim revenue support loan for £1.4m and approve plans to make optimum use of £1m A&E capital expenditure funding from the Department of Health.		
13.02	The board was also advised that it would receive papers in the private session of the board meeting on the financial recovery action plan and on a small land sale at St Albans hospital.		
13.03	Resolution: The board noted the report and ratified a £1.4m interim revenue support loan and approved £1m capital expenditure funding for the redevelopment of the A&E department.		
14/52	**Assurance report from the Clinical Outcomes and Effectiveness Committee**		
14.01	The board received an assurance report from the clinical outcomes and effectiveness committee from Ginny Edwards. She reported that the committee had welcomed an increased focus on emergency standards and work that had been undertaken by the maternity service on perinatal mortality. Ginny Edwards advised that the committee had reviewed principal risk (PR) 1 (failure to provide safe, effective, high quality care) and PR5b (inability to deliver and maintain emergency performance standards) and recommended that the RAG ratings remained the same. However, the committee recommended to the board that the RAG rating of PR5b be raised from Amber to Amber/Red to reflect a deterioration in RTT performance.		
14.02	Resolution: The committee noted the report.		
REPORT TO CORPORATE TRUSTEE			
15/52	**Assurance report from the Charitable Funds Committee**		
15.01	Ginny Edwards presented an assurance report on the charitable funds committee. She advised that the committee had agreed that administration support would be sought to manage the charity whilst important decisions were made regarding the future management of the charity.		
15.02	The corporate trustee was advised that the outcome of a tender process for an investment advisor would be presented in the private session of the meeting.		

Agenda item	Discussion	Lead	Dead-line
15.03	Resolution: The corporate trustee noted the report.		
16/52	**Charity annual report and accounts**		
16.01	The corporate trustee was advised that the committee had reviewed and approved the annual report and accounts. Jonathan Rennison said he was pleased to report that the charity's income had increased over the year; however it had slowed down in recent months due to the absence of a head of charity.		
16.02	Jonathan Rennison reported that the sign-off process for the annual report and accounts had not followed the agreed plan which had led to the accounts being prepared and published without the inclusion of an independent auditor opinion. As this was a legal requirement, he assured the corporate trustee that the annual report/accounts would be updated and re-published on the website and with the Charity Commission.		
16.03	Resolution: The corporate trustee noted the report and, subject to the inclusion of an independent auditor opinion, the annual report and accounts were approved.		
ANY OTHER BUSINESS			
17/52	**Any other business**		
17.01	No other business was raised.		
QUESTION TIME			
18/52	**Questions from Hertfordshire Healthwatch**		
18.01	There was no representative from Hertfordshire Healthwatch at the meeting.		
19/52	**Questions from our patients and members of the public**		
19.01	There were no questions raised.		
ADMINISTRATION			
20/52	**Draft agenda for next board meeting**		
20.01	The draft agenda was approved.		
21/52	**Date of the next board meeting**		
21.01	The next board meeting will be held at 9.30am on 02 November 2017 in the Terrace Executive Meeting Room, Watford hospital.		

Commitment Care Quality

NHS West Hertfordshire Hospitals NHS Trust

Agenda item 06a/53

Action log Part 1 – 02 November 2017
(from meeting held on 05 October 2017 and earlier Boards if outstanding)

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	09/02.52	The number of complaints over three months to be included in future safety and compliance committee integrated performance reports.	LE/TC	12/17	Due December 2017
2	09.03/52	Harm free care data to be presented in a clearer format in future reports.	LE/TC	12/17	Due December 2017

Agenda item: 06b/53

BOARD AND CORPORATE TRUSTEE
DECISION LOG PART 1

Board meeting/decision date	Decision reference (from minutes)	Item presented to Board for action	Comments/outcome
4/7/2016	16/36	The Board received corporate aims and objectives for 2016/17	Approved, subject to inclusion of comments from Board
4/7/2016	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
7/7/2016	.09/39	The quality account 2015/16	Approved
7/7/2016	16/39	Funding for external advisory support to develop a strategy outline case (SOC) for the configuration of acute hospital service	Approved
7/7/2016	17/39	Infection prevention and control annual report 2015/16	Approved for publication
7/7/2016	18/39	The end of life care strategy	Approved
7/7/2016	19/39	The Board received the updated terms of reference and work plans for the Safety and Quality Committee and the Trust Board	Approved
7/7/2016	21/39	Updated Board Assurance Framework	Approved
9/1/2016	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
9/1/2016	23/40	Terms of reference for the Trust Executive Committee	Approved
10/7/2016	07/41	Recommendation to increase the number of scheduled Board meetings to eleven per annum.	Approved
10/7/2016	14/41	Recommended changes to the BAF 2016/17.	Approved
11/3/2016	12/42	Patient experience and carer strategy	Approved
11/3/2016	13/42	Statutory annual public sector equality duty report 2015	Approved
11/3/2016	18/42	The gifts, hospitality and sponsorship policy	Approved
11/3/2016	19/42a	Recommendation to reduce the frequency of Integrated Risk and Governance Committee meetings	Approved
11/3/2016	19/42c	Update to terms of reference for the Board	Approved
11/3/2016	19/42b	Draft Board and Committee meeting schedule 2017/18	Approved
12/1/2016	10/43	Nursing, midwifery and allied health professions strategy	Approved

1/12/2017	15.2/44	counter fraud policy	Approved
2/2/2017	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
2/2/2017	12.01/45	An interim revenue support loan of £2.3m to cover February 2017 revenue cash requirements	Approved
2/2/2017	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
3/6/2017	13.07/46	A graded approach to workforce metrics for future reporting.	Approved
3/6/2017	15.02/46	An interim loan of £4m to cover cash flow requirements in February and March 2017 Approved	Approved
3/6/2017	15.02/46	The conversion of an IRWCF loan of £26.8m to an ISLF loan.	Approved
3/6/2017	17.02/46	Recommendation to delegate responsibility to the Audit Committee to sign off the Annual Accounts, Annual Report and Annual Governance Statement.	Approved
3/6/2017	18.02/46	The 2017/18 Board and Committee structure and meeting schedule	Approved
4/6/2017	11.04/47	Hospital Pharmacy Transformation Plan	Approved as direction of travel for pharmacy service.
4/6/2017	14.02/47	Aims, objectives and principle risks.	Approved
4/6/2017	16.02/47	Interim capital support facility agreement £7.5m	Rattified
4/6/2017	16.02/47	Deficit control totals for 2017/18 of £15.4m	Approved
5/4/2017	15.02/48	An interim revenue support loan of £1.964k	Approved
5/4/2017	20a.03/48	West Herts charity strategy	Approved
5/4/2017	20b.02/48	Discretionary resources policy	Approved
6/1/2017	14.04/49	Outline business case for theatre reconfiguration	Approved option E
6/1/2017	15.03/49	Proposed monitoring arrangements for aims and objectives	Approved the approach
6/1/2017	17.01/49	NHS self-certification 2017/18	Approved condition G6 (3)
6/1/2017	18.02/49	Assurance report from Finance and Investment Committee	Ratified the terms and conditions of a £42m interim revenue support loan
7/6/2017	16.04/50	The terms of reference and work plans for the board and committees	Approved
7/6/2017	18.02/50	The board approved the annual accounts, annual report, governance statement and quality account 2016/17.	Approved
7/6/2017	22.05/50	The corporate trustee approved the recommended way forward to the future management of the charity	Approved
9/7/2017	10.02/51	The board aproved the NHS England emergency preparedness, resilience and response annual assurance.	Approved
9/7/2017	13.02/51	The board approved the infection prevention and control annual report 2016/17 for publication on the Trust website	Approved
10/5/2017	13.03/52	Assurance report from Finance and Investment Committee	Ratified a £1.4 interim revenue support loan
10/5/2017	13.03/52	Assurance report from Finance and Investment Committee	Approved £1m capital expenditure funding for the redevelopment of the A&E department

Trust Board Meeting
02 November 2017

Title of the paper	**Chair's report**
Agenda item	**07/53**
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: 07/53

Trust Board Meeting – 02 November 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

Care quality commission update

2.1. The Care quality commission has pushed back the completion of its programme of next phase inspections by three months to July 2019 due to delays to the start of the roll out caused by the general election and purdah period.

2.2. The CQC is continuing with its programme of 20 local system reviews under Section 48 of the Health and Social Care Act 2007 looking at how health and social care providers and commissioners work together. The first on-site review began in August 2017 and the report was published in October 2017.

2.3. Performance against the CQCs target to publish 90% of inspection reports within 50 working days remains at 26%. CQC expect this to improve in line with a new reporting process as part of the next phase of inspections.

2.4. The CQC is considering a proposal to replace the existing paper based national patient experience survey programme with a digital collection method and to extend the coverage of the surveys over new care models. This strategy aims to reduce the cost of running the programme for trusts and allow the CQC to potentially increase the frequency and sample sizes with minimal cost impact.

2.5. The CQC published its report on the state of health care and adult social care for 2016/17 in October 2017. Overall the report explained that the quality of care had been maintained despite the challenges facing the system, thanks to the hard work and dedication of staff and leaders. However, future quality is precarious, therefore long term solutions are needed to secure a sustainable health and care system.

NHS Improvement update

2.6. NHS Improvement (NHSI) has recently established a new quality committee to enhance its quality oversight and governance arrangements. The committee will be chaired by non-executive director, Sarah Harkness and the membership will include Lord Darzi.

2.7. NHSI is currently reviewing the indictors used under the quality of care theme in the Single Oversight Framework.

2.8. NHSI has announced that it is satisfied with the overall progress of its operational productivity programme and confident that the programme will achieve its milestones. The expansion of the programme from acute, non specialist trusts to include mental health, community, ambulance and specialist trusts has begun and is due to be completed by March 2018.

2.9. NHSI will establish a national cancer expert team by December 2017 to support the delivery of the cancer 62 day standard by providing bespoke support, tools, guidance and best practice across the country.

2.10. NHSI has launched a new scheme called Midlands and East executive talent (MEET) which is designed, alongside key partners such as NHS IMAS and the Leadership Academy, to support trusts in recruiting to executive-level interim positions. The scheme will integrate with the regional talent management approach currently being developed through the regional talent board, which is chaired by Nick Carver, CEO at East and North Hertfordshire NHS Trust.

Survey on sustainability transformation funding

2.11. NHS Providers published a report in October 2017 called Recovering provider deficits: has it worked and at what cost? This draws on survey responses from 109 trust chief executives and finance directors and is the first report to look at the detailed operation of the sustainability and transportation funding (STF) and control total regime since it was introduced in December 2015.

2.12. The report finds that use of control totals and STF have played a key role in helping the provider sector stabilise its financial position, reducing the sector deficit from £2.45 billion in 2015/16 to £791 million in 2016/17.

2.13. However, the report argues that the STF and control total regime has not addressed the financial un-sustainability of the sector; has masked the underlying financial problems providers face; and that the £1.8 billion STF has become a key part of provider sector finances.

2.14. The report calls on the government to confirm that the £1.8bn STF will continue to be directly allocated to providers beyond 2018/19, when current commitments on the use of the fund will run out.

National workforce reforms

2.15. The secretary of state for health announced in October 2017 a wide-ranging reform to increase nurse training places and retain staff. A 25% increase in training posts for nurses is part of a range of measures to ensure the NHS meets current and future nursing workforce needs, improve working conditions and provide new routes into the profession.

2.16. The government will provide funding for clinical placements required for an additional 5,170 pre-registration nurse degrees from 2018. This builds on the commitment announced in August 2017 of 10,000 more training places for nurses, midwives and allied health professionals.

Developments in access to healthcare information

2.17. The secretary of state announced in October 2017 a series of new initiatives relating to online access to healthcare information. The new online services are expected to be in place by the end of 2018/19 and include an app or online access for all patients to the NHS 111 service.

2.18. All patients will be able to access their own GP medical record through an app, and use online means to detail the ways in which they do and do not want their information shared.

2.19. In the longer term, the aim is to marry medical records and apps to allow patients to have access to an informed question and answer service and provide more accurate and quicker diagnosis. This would also be a more cost efficient service.

2.20. The creation of 20 more digital inclusion hubs over the next three years was also announced. The hubs are designed to help more people benefit from online health services.

3. LOCAL NEWS AND UPDATE

Hemel Hempstead hub

3.1. Senior leaders from the trust attended a clinical engagement event in October 2017 led by Herts Valley Clinical Commissioning Group (CCG). Attendees debated what services might look like for a future Hemel Hempstead hub. Colleagues from primary care and Herts Community Trust, plus key players from the New Hospital Campaign joined in group discussions around young people's services, frailty, urgent care and long term conditions.

Consultation on over-the-counter medications

3.2. Following a consultation by East and North Hertfordshire and Herts Valleys CCGs on the prescribing of certain medications that are available over-the-counter, there is now a national consultation being undertaken on the same topic.

3.3. The full consultation document and a link to the survey can be found on NHS England's website.

3.4. The consultation closes on 21 October.

Hate Crime Awareness Week

3.5. The trust supported hate crime awareness week in October 2017 with a talk by the hate crime officer for Watford and Three Rivers council and police constable support officers. They talked to patients, visitors and staff about what constitutes a hate crime, the difference between a hate crime and non-hate crime, ways to report any incidents and the support services available.

New wheelchairs

3.6. Thank you to the League of Friends for the kind donation of 15 new wheelchairs in October 2017. These will be invaluable in helping to move patients around the hospitals.

Celebrating our staff

3.7. Congratulations to Ruth Connelly, assistant divisional manager for emergency care on being a runner up for 'Volunteer of the Year' at Watford's Audentior Awards 2017. Ruth has worked as a volunteer for 25 years in a youth group called Watford Woodcraft Folk.

3.8. Congratulations to the Maternity team for being shortlisted in the workforce category in the HSJ awards.

4. BOARD UPDATE

Board business workshop

4.1. A board business workshop was held on 19 October 2017. The board discussed its responsibilities around new general data protection regulations which will come into force on 25 May 2018. The board reviewed the learning from recent cyber-attacks and the risk of future attacks and was updated on the progress being made towards achieving the trust's IT strategy.

NExT director scheme

4.2. The trust will be offering a unique insight into the role and responsibilities of a NHS non-executive director to a possible future non-executive director, as part of a new scheme launched by NHSI.

4.3. The NExT director scheme provides support to senior people from groups who are currently under-represented on trust boards with the skills and expertise necessary to take that final step into the NHS board room. Following a successful pilot in London, the scheme is now being expanded to trusts across the Midlands and East, where the focus will be on supporting women and in London where it will be on people from BAME communities.

5. KEY MEETINGS

- Attended the living well with and beyond cancer event
- Chaired an appointment panel to recruit a new dermatology consultant
- Chaired a board business workshop
- Met with Healthwatch Hertfordshire
- Presented ACE ward certificates
- Presented volunteer awards

6. RECOMMENDATION

6.1. The Board is asked to note the report.

Professor Steve Barnett
Chair

November 2017

Trust Board Meeting

02 November 2017

Title of the paper	**Chief Executive's report**
Agenda item	**08/53**
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 overview of the work and key decisions taken by the trust executive committee since the previous board meeting.
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.

8

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)
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Benefits to patients/staff from this project/initiatives	
Risks attached to this project/initiatives and how these will be managed	

8

Agenda Item: 08/53

Trust Board Meeting – 02 November 2017

Chief Executive's report

Presented by: Katie Fisher, Chief Executive

1. PURPOSE

1.1. The aim of this paper is to provide an overview of the work and key decisions taken by of the trust executive committee since the previous board meeting.

2. LOCAL NEWS AND DEVELOPMENTS

Progress week

2.1. The trust ran a 'progress week' from 12 – 19 October 2017 which aimed to better understand and enable earlier discharge from wards to improve the experience of patients and carers who can often be unnecessarily delayed for hours waiting for routine processes to be completed and to help free up spaces for new patients.

2.2. The initiative particularly focused on processes on the wards, team working, medicines to take home and the discharge lounge.

2.3. This was a very useful exercise which helped to understand how discharge is currently working across the wards. A full review is underway and actions to tackle delays and speed up discharges will be agreed by the Clinical Advisory Group.

Non emergency patient transport

2.4. East of England Ambulance Service has been awarded a caretaker contract to provide non-emergency patient transport in Bedfordshire, Luton and Hertfordshire. This comes after Her Majesty's Revenue and Customs issued a winding up order in October 2017 to the Private Ambulance Service following concerns relating to patient care and staff welfare.

2.5. The new caretaker contract is aimed at bringing reassurance to patients after a period of uncertainty and to ensure continuity of service, which will be a key priority during the transition.

2.6. The trust is working closely with the East of England Ambulance Service NHS Trust to ensure that disruption is kept to an absolute minimum during this transition. However, some non-urgent appointments may need to be rescheduled while the new contract establishes to allow priority to be given to patients who are being discharged from hospital or attending appointments for cancer treatments and dialysis.

Pathology service

2.7. The trust executive committee considered a draft strategic outline case (SOC) in October 2017 on the future provision of pathology services. The case concluded that the current form of provision for pathology services was unsustainable over the longer term, with the primary drivers for change being a national focus on driving more efficiencies by increasing the level of consolidation across NHS pathology services, the assumptions within the trust's own development plans regarding pathology and a need to capitalise on technological advancements in pathology to provide the quality of services required of a more demanding population.

2.8. The SOC will be presented to the board in the private session of the meeting for consideration and approval.

Supporting leadership development

2.9. The trust will be working with the Institute for Healthcare Improvement (IHI) on a leadership development programme. IHI will support the trust to develop a structured approach to assess what leadership capability and capacity are needed in order to successfully deliver the trust's quality strategy.

New orthopaedic elective ward

2.10. The trust executive committee considered and approved a change to the configuration of surgical elective beds at Watford in order to create a ring fenced orthopaedic elective ward and improve infection prevention and control.

2.11. Taking into account infection control, fire regulations, the bed base required for elective orthopaedic patients and the necessary building works, a section of Flaunden ward was considered to be the most suitable location for the orthopaedic elective ward.

2.12. Work was undertaken to create a clean utility, kitchen, staff and sisters office and a partition between Flaunden and Letchmore wards and the new orthopaedic elective ward opened in September 2017.

Redevelopment of the emergency department

2.13. Following receipt of £1m funding to improve the trust's emergency department facilities, as part of the national £100m fund to make improvements ahead of winter, the trust executive committee considered and approved a tender evaluation for the creation of a new eight bedded clinical dependency unit (CDU). The CDU will be used for patients who are admitted under the care of the ED team and who need further investigation and observation.

2.14. The design of the new unit was clinically led by the ED team with input from local partners and is set for completion in December 2017.

Improvements to the patient archiving and communication system (PACS)

2.15. Over the last four months, the trust executive committee has closely monitored the work being carried out to replace the Trust's PACS system and associated infrastructure and radiography hardware. PACS is medical imaging technology used for storing, retrieving, presenting and sharing images, such as x-ray, CT scan, MRI and ultrasound machines.

2.16. The updated system and hardware has now been successfully implemented and now in full use by clinicians across all three hospitals.

2.17. Thank you to everyone involved in bringing this complex project to a successful conclusion.

Vascular hub update

2.18. NHS England's Specialised Commissioners for the Midlands and East has announced East and North Hertfordshire NHS Trust as the specialised vascular hub and network lead with West Hertfordshire Hospital NHS Trust and The Princess Alexandra Hospital NHS Trust as integrated members of the network. This announcement followed a lengthy commissioning review process undertaken by the specialised commissioning team.

2.19. Work has begun to establish a vascular network development board, which will oversee the development of a business case for the new service. The development board will report into each trusts' executive committees and will also report into the Hertfordshire and West Essex sustainability and transformation partnership's planned care work stream.

New medical appraisal and consultant job planning system

2.20. The trust executive committee approved the commissioning of a new medical appraisal and consultant job planning online support system in October 2017. The clinical advisory group had previously reviewed and recommended the proposed system, which will provide a comprehensive job planning and appraisal system.

2.21. The new system will be in operation from June 2018.

Smoke free hospitals

2.22. The trust is now a smoke free environment and early signs are that the hospital sites are much cleaner. Following a review of national guidance, it has been agreed that patients and visitors will be allowed to vape; however staff are not permitted to smoke or vape on hospital premises.

Emergency preparedness exercise

2.23. Operation Heron, an exercise to test the local emergency preparedness to manage critical and major incidents was held in October 2017. As well as the trust, the exercise involved Hertfordshire Constabulary, members of the fire and rescue service and members of the ambulance service, working together to respond to a firearms incident. The simulation started with a traffic incident outside Watford football ground before becoming a mass casualty exercise within the football ground.

2.24. Mock firearms were discharged as part of the training and the fracture clinic at Watford hospital was setup as an A&E department for the purpose of the exercise. A number of volunteers acted as injured to make the exercise as real as possible for those being trained.

2.25. The results of the exercise will be used to further improve how the trust's responds to major incidents.

Temporary staffing

2.26. The trust has made important changes to its temporary staffing policy to incorporate a new collaborative shared bank with East & North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust.

2.27. The shared bank allows staff to work bank shifts at East & North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust without having to undertake any additional training or pre-employment checks, making it easier to work bank shifts at these trusts.

Extended service in paediatric emergency department

2.28. A three month pilot aimed at improving the patient experience for families using the paediatric emergency department commenced in October 2017. The expansion of assessment areas will mean that staff will be able to treat a large number of patients and send them home, thus avoiding the need for patients to be admitted to a ward unnecessarily.

2.29. The outcome of the pilot will be considered by the trust executive committee in January 2018 and a decision taken on whether to continue the new approach.

Good governance

2.30. The trust executive committee undertook an annual review of its standing financial instructions (SFI), scheme of delegation (SoD) and standing orders (SO). These three documents fulfil the role of protecting the trust's interests and protecting staff from possible accusation that they have acted less than.

2.31. The governance documents are designed to ensure that all the trust's transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

2.32. The SFIs, SoDs and SOs were also reviewed by the Audit committee in October 2017 and, subject to some minor changes, were recommended to the board for approval.

New learning management system

2.33. A new self-service learning management system has now been implemented across the trust. The new system will allow trust staff and new starters to access e-learning and to book classroom training through a web-based portal that is accessible outside of the trust. Substantive and non-substantive new starters can access Acorn to complete their e-learning before they commence employment.

2.34. The Acorn system will support the trust to maintain a 90% compliance rate for core and essential training by sending out notifications to inform staff when training requirements are due which they can address from any device.

2.35. The e-Learning platform can connect with national NHS learning repositories' to offer staff a greater range of learning subject matter.

Extending opening hours of main reception desk

2.36. The opening hours of the main reception desk at Watford have been extended. The reception desk will now open on a Saturday and Sunday (excluding bank holidays) from 1.30pm to 8pm and as from 06 November it will be open from 8am to 8pm on a Monday to Friday.

Flu vaccination programme

2.37. NHS England, Public Health England, the Department of Health and NHS Improvement have unveiled measures to boost the uptake of flu vaccinations along with a package of new contingency actions to respond to pressures on frontline services this winter.

2.38. The trust's high profile staff flu vaccination programme is well underway. Staff are being actively encouraged to have the vaccination to protect themselves and their patients, particularly vulnerable patients, from flu. There is an even greater importance this year as influenza levels are predicted to be especially high.

2.39. A flu vaccination team is holding daily drop-in sessions and is out and about across all areas of the hospitals to make it as easy as possible for staff to access the vaccine. Ward staff can also receive the vaccine from a peer vaccinator.

New electronic echo tracking system

2.40. The trust has implemented a new electronic echo tracker which aims to make the service more efficient and free up time to scan additional patients. The new system has been in operation throughout October 2017 and initial feedback has been positive.

Staff survey

2.41. The national 2017 staff survey opened on 25 September 2017 and staff are being actively encouraged to compete the survey, the results of which are used to improve the working environment for staff

2.42. The survey will close on the 1 December 2017 and the results are expected to be published in April 2018.

Visitor and staff food tasting

2.43. The trust executive committee had a food tasting session in October 2017 to test the hot food options available to visitors and staff. The committee provided feedback on the tasting session which will be used by Medirest, the provider, to improve the service.

3. COMMUNICATIONS REPORT

Media

3.1. The trust received coverage on a variety of topics during September 2017. A number of letters were published in The Watford Observer and The Hemel Gazette and Express on plans to redevelop the hospitals in the trust.

3.2. Commenting on redevelopment plans, Professor Steve Barnet of West Hertfordshire Hospitals NHS Trust said: “The bottom line is that we are committed to providing patient care from the best buildings and facilities possible. Local residents have waited a long time for much-needed improvements to our estate and we are keenly awaiting an update on the approvals process.”

Other articles in the media during September included:

- The Watford Observer featured a GMB protest outside our AGM against the ‘poverty pay’ of porters and other support staff and the current uncertainty about the contract with Medirest.

- The Watford Observer printed a letter from a patient, Richard Chapman. Mr Chapman, who was treated for a hernia at Watford General and St Albans, compliments the “wonderful treatment” he received at both hospitals.

- The Hemel Hempstead Gazette and Express published a letter from a local parish chairman criticising the patient transport service and the running of the trust as a whole. The following week the paper published a response from the Trust’s chief operating officer explaining that the trust was also concerned about the current unacceptable delays and that it had raised concerns with both the CCG and the private ambulance service.

September 2017	**Positive coverage**	**Neutral coverage**	**Negative coverage**	**Rebuttals/not run**
National coverage	0	0	0	0
Coverage (Watford)	1	6	8	0
Coverage (Dacorum)	0	0	0	0
Coverage (St Albans)	0	0	0	0
Other local	0	0	0	0
Letters coverage	3	1	1	0

Website

September 2017	Month’s Figures 17/18	Month’s Figures 16/17	Total Quarter 1 (April – June)	Total Quarter 2 (July – Sept)	Running total 17/18	Total 16/17
Total Page Views	445,403	395,538	1,364,707	1,414,842	2,779,549	4,901,513
Number of unique visitors	38,658	37,073	106,195	107,937	214,132	370,658

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

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

Internal Communications

	September 17/18	Total Quarter 1 (April - June)	Total Quarter 2 (July – Sept)	Running total 17/18
Number of news stories shared with staff on intranet	5	10	15	25
Number of e-newsletters (e-update)	8	15	26	59
Number of CEO briefings	6	12	19	44
Number of Herts & Minds newsletters	0	1	1	3

Freedom of Information

	September 17/18	Total Quarter 1 (April – June)	Total Quarter 2 (July – Sept)	Running total 17/18	Total 16/17
Number of FoIs received	45	153	169	322	662
Compliance within 20 day deadline	88.1%	95.0%	88.6	90%	94.3%
No of FoIs received from media outlets	7	24	24	48	100

Social Media

Twitter	Followers	Posts	Likes	Retweets
September 2017	5855	91	232	192

The trust posted 91 times, which is an increase from last month (41 times). Posts received more engagement from followers this month than the previous month; posts this month received 232 likes and 192 retweets.
The most popular Tweet was *"We are thrilled to announce that our Maternity team has been shortlisted for the workforce category in the HSJ awards,"* with 10 likes and 26 retweets.

Facebook	Followers	Posts	Likes	Comments
September 2017	1250	39	668	79

The trust posted 39 times in September. Like Twitter, the posts received more engagement in September than the previous month (668 likes and 79 comments from followers).
The most popular post was *"A huge congratulations to our staff award winner Antonio, A&E staff nurse," with 240* likes. This is the most liked post the trust has ever received on Facebook.

4. LEADERSHIP

4.1. Kevin Howell, director of environment will be leaving the trust in December 2017 to take up a new appointed as the director of estates and facilities at St George's University Hospitals Foundation NHS Trust. Patrick Hennessey, the current deputy director of environment, will provide interim cover until new arrangements are in place. Kevin joined the trust in March 2014 and has worked hard to keep the trust's ageing sites safe as well as delivering major improvements and expansions.

4.2. Phil Downing, Head of Nursing left in October 2017 to take up a senior position in Manchester. Phil's leadership has been instrumental in the development of nursing across the medical wards.

4.3. Gloria Rowland, Associate Director of Midwifery and Gynaecology will leave in December 2017 to take the post of the Director of Midwifery at Barts Health. Gloria has led many changes within the maternity unit which has enabled the unit to move from 'inadequate' to 'Good' at the last CQC inspection.

4.4. Rachael Corser, Deputy Director of Governance and Associate Chief Nurse will leave in January 2018 to take up the position of Director of Nursing and Patient Experience at East and North Herts NHS Trust. Rachael has led on a number of succesful initiatives around nursing practice and quality improvement.

5. RECOMMENDATION

5.1. The Board is asked to note the report.

Katie Fisher
Chief Executive

October 2017

Trust Board Meeting
02 November 2017

Title of the paper	**Integrated Performance Report**
Agenda item	**09/53**
Lead Executive	**Sally Tucker, Chief Operating Officer**
Author	**Lisa Emery, Chief Information Officer**
Executive summary **(including resource implications)**	The Integrated Performance Report covers the October reporting period (September 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 was one never event (none in August, now two year to date) • There was one medication error causing serious harm (previously 0 YTD) • Combined (elective and non-elective) emergency readmissions within 30 days improved to 6.5% (7.8% in August) • New harms increased to 24.2% (21.7% for August) but remains significantly under the national average of 36.1% • Complaints performance improved to 51.4% (45.9% in August), with excellent performance for early contact (within 3 working days) with patients Responsive: • RTT (incomplete) performance again dropped slightly to 88.0%* (88.8% in August) • ED 4 hour wait performance dropped to 81.6% (82.5% in August) • Ambulance turnaround times (both indicators) decreased slightly from August • The cancer 62 day (77.0%) and 62 day cancer screening (65.0%) were *provisionally* below the standard • Formal delayed transfers of care increased to 6.9% (3.7% in August) • The number of patients not treated within 28 days of last minute cancellation reduced to 2 (12 in August) Well Led: • Appraisal (89.5%) and mandatory training (89.1%) fell to just below target • Staff turnover (rolling 3 months) increased to 17.7% (16.0% in August) • % agency pay rose slightly above target to 8.3% (7.4% in June) • Staff FFT response rate fell to 11.8% (15.7% in August) however % who would recommend remained consistent 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

9

Where the report has been previously discussed	Trust Executive Committee (Performance)

Action required:

- The report is provided for information.

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

Benefits to patients/staff from this project/initiatives

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

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

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

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

October 2017

(September data)

NHS West Hertfordshire Hospitals NHS Trust

Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Effective Caring

Reporting sub committees – COE and S&C

Areas of good performance

- Mortality indicators show sustained excellent performance *(pages 3 & 13)*
- Patients spending 90% of their time on the stroke unit was better than the performance standard *(pages 4 & 14)*
- The percentage of patients receiving a caesarean section was better than the performance threshold (pages 4 & 22)
- Clostridium difficile was better than the monthly threshold (zero cases recorded) and better than the year to date threshold (6 vs 16) *(pages 3 & 17)*
- There were no cases of MRSA bacteraemia *(pages 3 & 17)*

New to category this month:
None

	Achieving
Sep-17	10
Aug-17	13
Jul-17	10

	Better than national average
Sep-17	11
Aug-17	11
Jul-17	11

Areas requiring performance improvement

- VTE risk assessment was below threshold *(pages 4 & 19)*
- Admissions to stroke ward within 4 hours was below the performance standard but better than the national average *(pages 4 & 14)*
- There were 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 and behind the internal improvement trajectory *(pages 3 & 15)*

New to category this month:

- One never event was reported *(pages 4 & 17)*
- Maternity FFT % positive indicator was worse than the performance standard *(pages 3 & 34)*
- There was one medication error causing serious harm *(pages 4 & 18)*

	Not achieving
Sep-17	11
Aug-17	8
Jul-17	11

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

Responsive

Reporting sub committee – TEC

Areas of good performance

- The 2WW and breast symptomatic cancer indicators achieved the performance standard (provisional) *(pages 5 & 25)*
- Cancer 31 day first , 31 subsequent drug and surgery 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:
None

	Achieving
Sep-17	9
Aug-17	12
Jul-17	11

	Better than national average
Sep-17	6
Aug-17	9
Jul-17	9

Areas requiring performance improvement

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

New to category this month:

- The 62 day GP indicator was provisionally worse than the standard *(pages 5 & 27)*
- The 62 day screening indicator was provisionally worse than the standard *(pages 5 & 27)*
- Diagnostic wait times did not achieve the performance standard *(pages 5 & 24)*

	Not achieving
Sep-17	12
Aug-17	9
Jul-17	10

	Worse than national average
Sep-17	8
Aug-17	5
Jul-17	5

Well led

Reporting sub committee – PSE

Areas of good performance

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

New to category this month:
None

	Achieving
Sep-17	5
Aug-17	8
Jul-17	7

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

Areas requiring performance improvement

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

New to category this month:

- Appraisals was worse than target *(pages 7 & 31)*
- Mandatory training was worse than target *(pages 7 & 31)*
- Agency pay was worse than target *(pages 7 & 30)*

	Not achieving
Sep-17	11
Aug-17	8
Jul-17	8

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

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

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

NHS West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain	Indicator	Target	Jul-17	Aug-17	Sep-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	✓ 80.6	✓ 77.7	✓ 84.7			MD	Jun-17	Y	National	100	Jun-17		G	
	Crude Mortality Rate (Non elective ordinary)**	3.5%	✓ 2.2%	✓ 2.9%	✓ 2.7%	✓ 2.6%	3.5%	MD	Sep-17	Y	National	2.75% (East of Eng.)	May-17		G	
●	30 Day Emergency Readmissions - Combined *	4.0%	✗ 7.6%	✗ 7.8%	✗ 6.5%	✗ 7.2%	4.0%	MD	Sep-17	Y	National	11.4%	2011-12		G	£ Marginal tariff reimbursement, possible penalties
	30 Day Emergency Readmissions - Elective *	n/a	3.9%	3.3%	2.6%	3.1%	n/a	MD	Sep-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
	30 Day Emergency Readmissions - Emerg *	n/a	10.7%	11.6%	9.9%	10.9%	n/a	MD	Sep-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties^
	Number of patients with a length of stay > 14 days *	tbc	333	319	328	2020	tbc	MD	Sep-17		Local	n/a			G	£ Reduction in reimbursement vs largely fixed costs. No penalty levied.
	Staff FFT % recommended care	tbd NHSI^	N/A	61.5%	51.1%	51.1%	tbd NHSI^	DoW	Jun-17	Y	National	n/a			G	
	Inpatient Scores FFT % positive	95%	✗ 90.6%	✗ 91.0%	✗ 94.0%	✗ 92.9%	95%	CN	Sep-17	Y	National	95.9%	Aug-17		G	
	A&E FFT % positive	95%	✗ 90.5%	✗ 93.3%	✗ 94.4%	✗ 91.9%	95%	CN	Sep-17	Y	National	87.5%	Aug-17		G	
	Daycase FFT % positive	95%	✓ 98.8%	✓ 98.2%	✓ 97.8%	✓ 98.4%	95%	CN	Sep-17	Y	National	n/a			G	
	Maternity FFT % positive	95%	✗ 92.8%	✓ 96.5%	✗ 94.6%	✗ 94.7%	95%	CN	Sep-17	N	National	96.0%	Aug-17		G	
●	% Complaints responded to within one month or agreed timescales with complainant	85%	✗ 50.9%	✗ 45.9%	✗ 51.4%	✗ 52.9%	85%	CN	Sep-17	N	Local	n/a			R	
	Complaints - rate per 10,000 bed days	tbd NHSI^	31.3	48.2	34.9	36.1	tbd NHSI^	CN	Sep-17	N	National	n/a			R	
	Reactivated complaints		6	9	8	45	n/a	CN	Sep-17	N	Local	n/a			R	
	Proportion of complaints with verbal communication at the beginning of the		N/A	58.5%	66.7%	61.9%		CN	Sep-17	N	Local				R	
●	Mixed sex accommodation breaches	0	✗ 10	✗ 12	✗ 10	✗ 51	0	CN	Sep-17	N	National	44 Trusts breaching	Aug-17		G	£ Penalties from CCG. £250 per day per service user.
	Clostridium Difficile	2	✓ 0	✓ 0	✓ 0	✓ 6	16	CN	Sep-17	Y	National	2.6 average	Aug-17		G	£ Penalties from CCG, fines from other statutory authorities. £10,000 per case above threshold.
	MRSA bacteraemias	0	✗ 1	✓ 0	✓ 0	✗ 1	0	CN	Sep-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	8	3	2	18	tbc	CN	Sep-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.

Exception indicators key
● Red for a minimum of two data points and amber for one, out of the latest three data points
◆ Red for the latest data point

Data Quality RAG key
Red – Data accuracy is not known, it is incomplete and inconsistent with relevant standards
Amber – Data is assumed to be complete and accurate, although there may be limitations or unresolved queries
Green – Data is complete, accurate and consistent with the standards set for the specific indicator

NHS West Hertfordshire Hospitals NHS Trust

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Indicator	Target	Jul-17	Aug-17	Sep-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	✗ 1	✗ 2	0	MD	Sep-17	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities, prosecution^
		Serious incidents - number*	tbd NHSI^	3	3	5	19	tbd NHSI^	MD	Sep-17	Y	National	n/a			G	
		% of patients safety incidents which are harmful*	n/a	9.7%	9.9%	13.3%	11.2%	n/a	MD	Sep-17	Y	National	n/a			G	
	◆	Medication errors causing serious harm *	0	✓ 0	✓ 0	✗ 1	✗ 1	0	MD	Sep-17	Y	National	n/a			G	
	●	CAS Alerts: Number issued each month	n/a	5	16	5	5	n/a	CN	Sep-17	Y	National	n/a			G	
		CAS alerts not acknowledged within 48 hours	0	✓ 0	✓ 0	✓ 0	✓ 0	0	CN	Sep-17		National	n/a			G	
		Number of falls*		100	114	96	603		CN	Sep-17	Y	Local				G	
		Number of falls with harm*		24	20	19	124		CN	Sep-17	Y	Local				G	
	●	Harm Free Care*/**	95.0%	✗ 89.6%	✗ 88.4%	✗ 89.0%	✗ 90.9%	95.0%	CN	Sep-17	Y	National	94.3%	Sep-17		G	
		% New Harms (Safety Thermo - New/All Harms)*/**	tbd NHSI^	21.0%	21.7%	24.2%	19.9%	tbd NHSI^	CN	Sep-17	Y	National	36.1%	Sep-17		G	
		Pressure Ulcers New Harms*/**	tbd NHSI^	4	5	5	21	tbd NHSI^	CN	Sep-17	Y	National	WHHT 0.83 vs 0.83	Sep-17		G	
		Falls New Harms*/**	tbd NHSI^	1	3	4	10	tbd NHSI^	CN	Sep-17	Y	National	WHHT 0.66 vs 0.48	Sep-17		G	
		Catheter & UTI New Harms*/**	tbd NHSI^	5	4	3	15	tbd NHSI^	CN	Sep-17	Y	National	WHHT 0.5 vs 0.35	Sep-17		G	
		VTE New Harms*/**	tbd NHSI^	3	3	4	18	tbd NHSI^	CN	Sep-17	Y	National	WHHT 0.66 vs 0.44	Sep-17		G	
	●	VTE risk assessment*	95.0%	✗ 91.9%	✗ 90.9%	✗ 91.1%	✗ 91.4%	95.0%	MD	Sep-17	Y	National	95.2%	Q1 2017		A	
		Caesarean Section rate - Combined*	28.0%	✓ 26.8%	✓ 24.3%	✓ 25.7%	✓ 26.8%	28.0%	MD	Sep-17	Y	Local	26.7%	Apr15-Aug15		A	
		Caesarean Section rate - Emergency*	15.0%	16.9%	13.0%	15.5%	15.7%	15.0%	MD	Sep-17	Y	Local	15.3%	Apr15-Aug15		A	
		Caesarean Section rate - Elective*	11.0%	9.9%	11.3%	10.2%	11.1%	11.0%	MD	Sep-17	Y	Local	11.4%	Apr15-Aug15		A	
		Maternal deaths	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Sep-17	N	National	n/a			G	
	●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 64.7%	✗ 72.1%	✗ 63.6%	✗ 66.8%	90.0%	COO	Sep-17	Y	National	54.8%	Mar-17		G	
		Stroke patients spending 90% of their time on stroke unit *	80.0%	✓ 88.2%	✓ 88.4%	✓ 87.9%	✓ 83.6%	80.0%	COO	Sep-17	Y	National	82.7%	Mar-17		A	

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

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

Exception indicators key
● Red for a minimum of two data points and amber for one, out of the latest three data points
◆ Red for the latest data point

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NHS West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	Jul-17	Aug-17	Sep-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%	✗ 80.0%	✗ 72.7%	✗ 69.6%	✗ 73.0%	90.0%	COO	Sep-17	Y	Local	75.8%	Aug-17		G	
	●	Referral to Treatment - Non Admitted*	95.0%	✗ 90.1%	✗ 89.5%	✗ 86.2%	✗ 89.2%	95.0%	COO	Sep-17	Y	Local	90.0%	Aug-17		G	
	●	Referral to Treatment - Incomplete*	92.0%	✗ 90.0%	✗ 88.8%	✗ 88.0%	✗ 89.7%	92.0%	COO	Sep-17	Y	National	89.4%	Aug-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	Sep-17		National	1729 (all Trusts)	Aug-17		G	
	◆	Diagnostic wait times	99.0%	✓ 99.2%	✓ 99.0%	✗ 97.8%	✓ 99.0%	99.0%	COO	Sep-17	Y	National	97.8%	Aug-17		G	£ CCG penalty of £200 in respect of each excess breach above the threshold
	●	ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 82.9%	✗ 82.5%	✗ 81.6%	✗ 82.8%	95.0%	COO	Sep-17	Y	National	89.7%	Sep-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	Sep-17	Y	National	78 (all Trusts)	Sep-17		G	£ CCG penalty £1,000 per incidence
	●	Ambulance turnaround time between 30 and 60 mins	0	✗ 395	✗ 466	✗ 443	✗ 2,341	0	COO	Sep-17	Y	Local	n/a			R	£ CCG penalty £200 per service user waiting over 30 mins
	●	Ambulance turnaround time > 60 mins	0	✗ 174	✗ 169	✗ 163	✗ 1,059	0	COO	Sep-17	Y	Local	n/a			R	£ CCG penalty £1,000 per service user waiting over 60 mins
		Cancer - Two week wait *	93.0%	✓ 94.7%	✓ 95.4%	✓ 94.1%	✓ 94.7%	93.0%	COO	Sep-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%	✗ 88.3%	✓ 97.4%	✓ 97.6%	✗ 92.2%	93.0%	COO	Sep-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%	✓ 98.0%	✓ 99.3%	✓ 96.3%	✓ 98.6%	96.0%	COO	Sep-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	Sep-17	Y	National	99.3%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
		Cancer - 31 day subsequent surgery *	94.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 98.8%	94.0%	COO	Sep-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%	✓ 88.6%	✓ 86.2%	✗ 77.0%	✓ 87.2%	85.0%	COO	Sep-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%	✓ 94.1%	✗ 65.0%	! 90.4%	90.0%	COO	Sep-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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NHS West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	Jul-17	Aug-17	Sep-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	Sep-17	Y	National	n/a			G	
	●	Number of patients not treated within 28 days of last minute cancellation	0	✗ 7	✗ 12	✗ 2	✗ 36	0	COO	Sep-17	Y	National	8 (avg. all Trusts)	Q1 17/18		G	
	●	Delayed Transfers of Care (DToC)*	3.5%	✗ 6.7%	✗ 3.7%	✗ 6.9%	✗ 6.0%	3.5%	COO	Sep-17	Y	National	6.0%	Feb-16		G	£ Marginal tariff reimbursement, possible penalties
		Delayed Tranfers of Care (DToC) beddays used in month		1,364	1,163	1,150	8,140		COO	Sep-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
	●	Outpatient cancellation rate	8.0%	✗ 11.1%	✗ 11.3%	✗ 12.1%	✗ 11.5%	8.0%	COO	Sep-17	Y	Local	n/a			G	
		Outpatient cancellation rate within 6 weeks^	5.0%	✓ 3.7%	✓ 4.0%	✓ 4.9%	✓ 4.1%	5.0%	COO	Sep-17	Y	Local	n/a			G	
	●	Patient initiated cancellations (all)		13.0%	13.1%	12.9%	12.9%		COO	Sep-17	Y	Local				G	
		Hospital + Patient initiated cancellations (all)		24.1%	24.4%	25.0%	24.4%		COO	Sep-17	Y	Local	n/a			G	

^ Excluding valid cancellations (cancellations to provide earlier appointments or where appointment no longer required, 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*

West Hertfordshire Hospitals NHS Trust

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NHS West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	Jul-17	Aug-17	Sep-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Well Led	●	Staff turnover rate (rolling 12 months)	12.0%	✗ 16.1%	✗ 16.2%	✗ 16.0%	✗ 16.2%	12.0%	DoW	Sep-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Staff turnover rate (rolling 3 months)	12.0%	✗ 13.7%	✗ 16.0%	✗ 17.7%	✗ 14.6%	12.0%	DoW	Sep-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Nurse Band 5 Turnover Rate			✗ 25.8%	✗ 26.5%	✗ 26.3%		DoW	Sep-17	Y	Local	n/a			G	
		% staffleaving within first year (excluding medics and fixed term contracts)		18.6%	18.6%	17.7%	18.8%		DoW	Sep-17	Y	National	n/a			G	
		Sickness rate	3.5%	✓ 3.0%	✓ 3.0%	✓ 2.8%	✓ 3.1%	3.5%	DoW	Sep-17	Y	National	3.8% (EoE orgs)	Dec-15		A	£ Payments made to staff for nil productivity
	●	Vacancy rate	9.0%	✗ 12.3%	✗ 12.7%	✗ 11.8%	✗ 12.6%	9.0%	DoW	Sep-17	Y	National	11% (local survey)	Dec-15		G	£ Costs saved in short term for nil productivity
	◆	Appraisal rate (non-medical staff only)	90.0%	✓ 90.0%	✓ 91.2%	✗ 89.51%	✗ 89.5%	90.0%	DoW	Sep-17	Y	National	85% (local survey)	Dec-15		G	
	◆	Mandatory Training	90.0%	✓ 91.7%	✓ 90.1%	✗ 89.1%	✓ 90.0%	90.0%	DoW	Sep-17	Y	Local	86% (local survey)	Dec-15		G	
		% Bank Pay**	8% - 12%	✓ 9.1%	✓ 9.3%	✓ 9.5%	✓ 9.6%	8% - 12%	DoW	Sep-17	Y	Local	n/a			G	£ Costs at established rates rather than premium
	◆	% Agency Pay**	8.0%	✗ 9.0%	✓ 7.4%	✗ 8.3%	✗ 8.4%	8.0%	DoW	Sep-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%	✓ 18.6%	✓ 17.3%	✓ 18.3%	✓ 18.5%	22.6%	DoW	Sep-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)*		✓ 8.5%	✓ 6.9%	✓ 7.7%	✓ 7.7%		DoW	Sep-17	Y	National	n/a			G	£ Premium payments of various types vs established rates
	●	Inpatient FFT response rate	50.0%	✗ 21.9%	✗ 30.9%	✗ 21.9%	✗ 23.0%	50.0%	CN	Sep-17	Y	National	26.4%	Aug-17		G	
	●	A&E FFT response rate	15%	✗ 5.7%	✗ 6.3%	✗ 5.3%	✗ 4.8%	15.0%	CN	Sep-17	Y	National	13.6%	Aug-17		G	
		Daycases FFT response rate	tbd NHSI^	39.2%	25.4%	27.5%	30.3%	tbd NHSI^	CN	Sep-17	Y	National	n/a			G	
	◆	Staff FFT response rate	50%	N/A	✗ 15.7%	✗ 11.8%	✗ 11.8%	50%	DoW	Jun-17	Y	National	n/a			G	
		Staff FFT % recommended work	66%	N/A	✗ 58.5%	✗ 59.0%	✗ 59.0%	66%	DoW	Jun-17	Y	National	n/a			G	
		Maternity FFT response rate	35%	✓ 52.5%	✓ 42.8%	✓ 37.1%	✓ 39.2%	35%	CN	Sep-17	N	National	22.7%	Aug-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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Detailed reports

Finance (Overview)

Financial Overview as at 30 September 2017

Month 6 Income & Expenditure

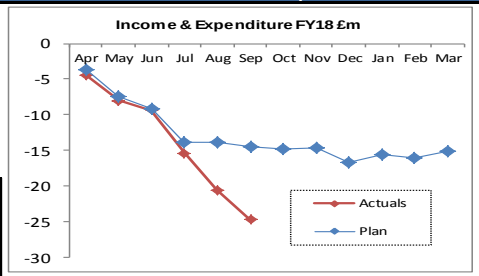
£m	Plan	Actual	Var
Surplus / (Deficit)	(0.7)	(4.1)	(3.5)

£m	Year to Date		
Surplus / (Deficit)	(14.5)	(24.7)	(10.2)

Statutory / Regulatory Duties

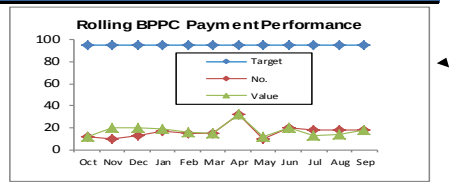
Breakeven	The Trust has a deficit plan of £15m for FY18.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 30/09/17 equated to 5 days' spend	R
BPPC	Month 6 performance - 18% (95% target)	R

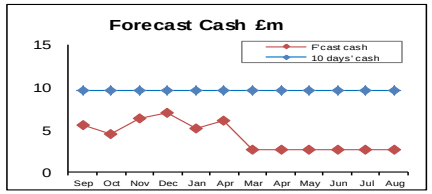
Financial Risk Rating	**FY18**	3

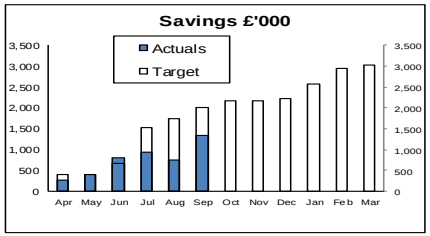


FY18 YTD Variance by Division

	£m	% Budget
Medicine	(0.1)	(8)
Unscheduled Care	(2.1)	(27)
Surgery	(3.7)	(62)
Women's	(0.4)	(4)
Clinical Support	0.2	6
Estates & Facilities	(0.0)	0
Corporate	0.3	1
Other	(4.4)	
Total	**(10.2)**	







Savings and outlook for FY18

Savings achieved at £4.54m up to M6, slightly ahead of plan by £0.11m, i.e. projects costed vs actual delivery), and behind target by £2.26m (where we wanted to be at this point in the year). 2017/18 Trust savings target is £21.9m, of which £13.7m has so far been assigned to divisions and £9.7m identified, i.e. £12.2m to find.

A number of risk areas are being addressed within the context of focused SD & PMO assistance plus existing channels.

Operational performance

Control total of £15.0m deficit accepted by the Trust and currently being reforecast with NHSI – Full details to follow in a separate paper. Deficit of £24.7m YTD M6 (£20.5m M5) includes CQUIN & STF adjustments relating to missing the prior year control total.

Recovery plans have been identified in a number of areas and will be implemented as soon as is practical.

Finance (I&E)

Statement of Comprehensive Income (I&E)

Month 6 (Sep) Budget	Month 6 (Sep) Actual	Month 6 (Sep) Var		FY18 Budget	YTD Budget	YTD Actual	YTD Var	Prior Year Actual
			Volumes					
3,693	3,676	(17)	Elective	42,806	21,605	21,517	(88)	3,444
4,227	4,103	(124)	Non elective	49,525	24,723	24,975	252	4,369
39,855	36,172	(3,683)	Outpatient	433,803	230,358	219,416	(10,942)	36,512
10,054	9,639	(415)	A&E	117,791	58,803	58,850	47	9,823
£000's	£000's	£000's	**NHS REVENUE**	£000's	£000's	£000's	£000's	£000's
4,706	4,124	(581)	Elective	55,461	27,486	25,207	(2,279)	27,106
8,619	8,836	217	Non elective	100,978	50,410	51,915	1,505	47,917
6,015	5,555	(460)	Outpatient	70,191	34,884	33,516	(1,368)	35,341
1,368	1,356	(12)	A&E	16,032	8,003	8,054	51	7,392
1,176	1,203	27	Critical care	13,781	6,880	6,696	(184)	7,014
3,668	3,344	(324)	Other NHS revenue	42,978	21,455	20,059	(1,396)	20,446
25,552	**24,419**	**(1,133)**	**TOTAL NHS REVENUES**	**299,421**	**149,118**	**145,447**	**(3,671)**	**145,216**
22	2	(20)	Private Patients	259	129	93	(36)	136
781	349	(432)	Other non-NHS clinical income	11,306	3,956	2,277	(1,679)	6,789
802	**351**	**(452)**	**TOTAL Non NHS Clinical**	**11,565**	**4,085**	**2,370**	**(1,715)**	**6,925**
931	895	(36)	Education & Training	9,020	4,510	4,562	52	4,195
1,264	1,424	160	Other Revenue	15,409	7,783	8,291	507	8,194
2,194	**2,318**	**124**	**TOTAL OTHER REVENUE**	**24,429**	**12,293**	**12,853**	**559**	**12,389**
28,549	**27,088**	**(1,461)**	**NET HOSPITAL REVENUE**	**335,414**	**165,497**	**160,670**	**(4,827)**	**164,530**

Outlook for FY18

Income is currently being re-assessed as part of a formal process with NHSI.

This reflects all known and anticipated pressures, including the outcome of the recent MSK tender and any STF income forgone as a result of missing the overall control total of a £15m full year deficit.

Engagement with Commissioners

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

Operational performance

NHS income was £3.7m below plan YTD (£1.1m below in month), with a favourable variance in Non-Elective (£1.5m) offset by Elective (£2.3m, primarily Surgery), Outpatients (£1.4m) and Other (£1.4m). Other income was £1.2m adverse YTD (£0.3m in month) primarily due to STF income assumptions offset by favourable car parking income.

Finance (I&E)

Statement of Comprehensive Income (I&E)

Month 6 (Sep) Budget	Month 6 (Sep) Actual	Month 6 (Sep) Var		FY18 Budget	YTD Budget	YTD Actual	YTD Var	Prior Year Actual
18,513	17,774	739	Permanent / Bank Staff	222,586	111,792	106,071	5,722	97,179
545	1,609	(1,064)	Agency	6,355	3,141	9,772	(6,631)	14,038
(807)		(807)	Unidentified pay savings	(8,964)	(2,131)		(2,131)	
18,252	**19,383**	**(1,131)**	**TOTAL PAY**	**219,978**	**112,801**	**115,842**	**(3,041)**	**111,217**
1,784	1,918	(134)	Drugs	21,330	10,450	11,214	(764)	10,754
2,556	2,292	264	Clinical services	32,411	16,025	15,037	988	15,794
6,060	6,808	(748)	Non-clinical services	71,096	36,150	38,255	(2,105)	34,911
(331)		(331)	Unidentified non-pay savings	(5,278)	(914)		(914)	
10,069	**11,018**	**(949)**	**TOTAL NON-PAY**	**119,559**	**61,712**	**64,506**	**(2,794)**	**61,459**
228	**(3,313)**	**(3,541)**	**EBITDA**	**(4,123)**	**(9,016)**	**(19,677)**	**(10,661)**	**(8,146)**
709	610	99	Depreciation & Amortisation	8,500	4,254	3,658	596	3,810
129	139	(10)	Interest	1,545	776	894	(119)	824
73	75	(2)	Dividends Payable	872	438	438	-	1,384
(683)	**(4,137)**	**(3,454)**	**Surplus / (Deficit)**	**(15,040)**	**(14,484)**	**(24,669)**	**(10,185)**	**(14,164)**

Outlook for FY18

Costs are currently being re-assessed as part of a formal process with NHSI.

Mitigating actions, including use of the Model Hospital and close work with NHSI and the internal SDO are at various stages of progress.

Operational performance

Pay costs were £3.0m adverse YTD (Medical £1.3m adv, Other Clinical £0.7m adv, Sci / Tech / Prof £0.4m adv & Unidentified CIP £2.1m, offset by Non-Clinical £1.5m fav). Focus on agency management continues agency cost trend established in FY17, £0.6m behind plan YTD (see following slide).

Non-pay costs were £2.8m 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.

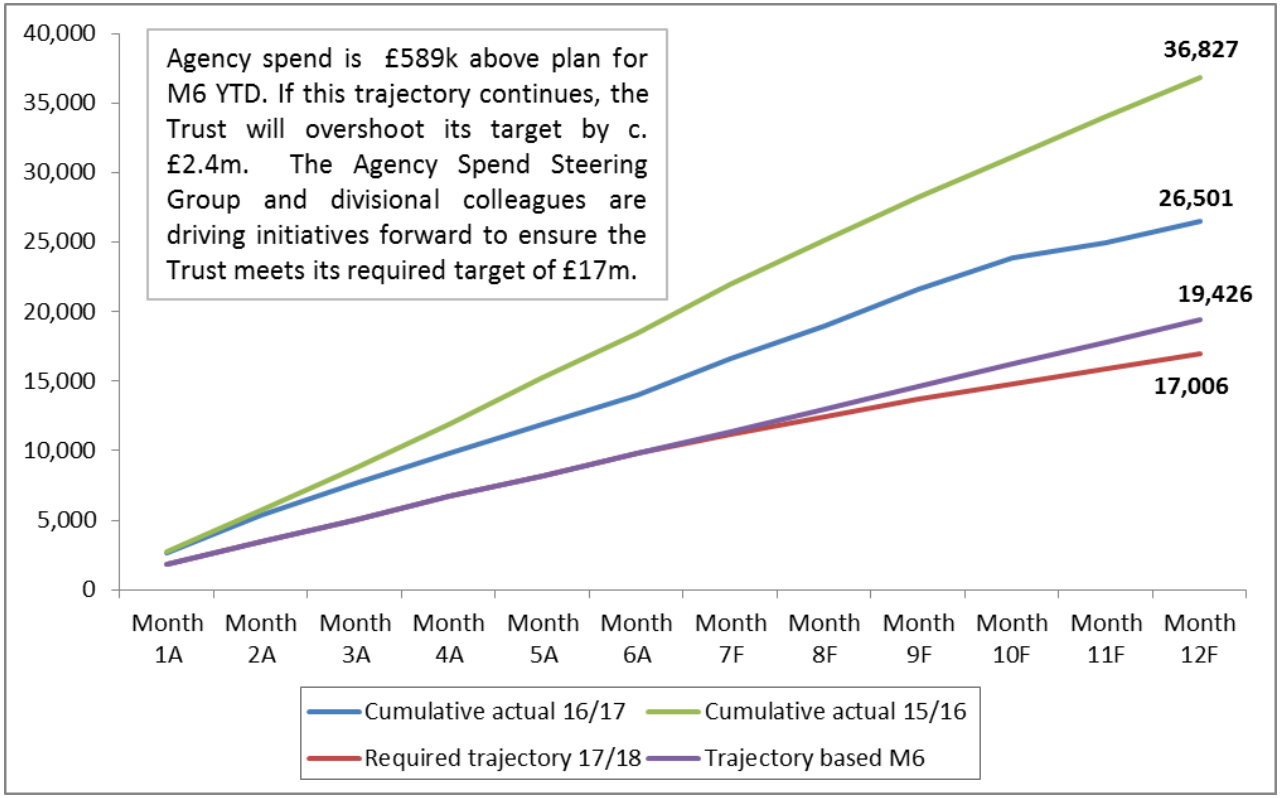
Targeted assistance from SD & PMO colleagues for a period of 6-8 weeks from October is intended to result in a greater range of CIP ideas alongside the means and expertise to implement them in the best possible way.

Finance (Agency)

Agency spend trajectory

	Month 1A	Month 2A	Month 3A	Month 4A	Month 5A	Month 6A	Month 7F	Month 8F	Month 9F	Month 10F	Month 11F	Month 12F
Required trajectory 17/18	1,860	3,438	4,996	6,741	8,163	9,772	11,204	12,467	13,729	14,821	15,914	17,006
Trajectory based M6	1,860	3,438	4,996	6,741	8,163	9,772	11,381	12,990	14,599	16,208	17,817	19,426
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

Required trajectory 17/18	1,860	1,578	1,558	1,745	1,422	1,609	1,432	1,262	1,262	1,092	1,092	1,092
Trajectory based M6	1,860	1,578	1,558	1,745	1,422	1,609	1,609	1,609	1,609	1,609	1,609	1,609
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 on 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 M6 were £0.6m behind plan with plans being implemented to maximise the chances of achieving FY18 targets. The **Purple** line shows what may happen if M6 spend persists.

Safe, effective, caring

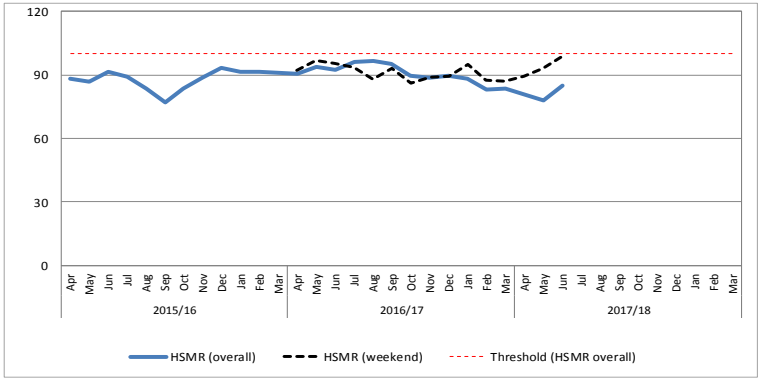
Reporting sub committee - S&C & COEC

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

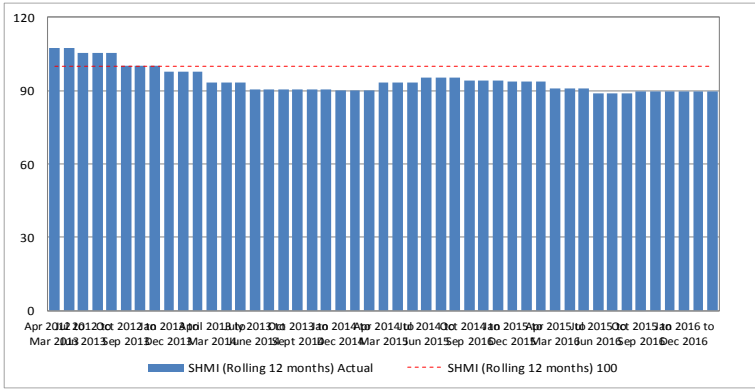
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Sep-17	4	4
Aug-17	3	5
Jul-17	4	4

West Hertfordshire Hospitals NHS Trust

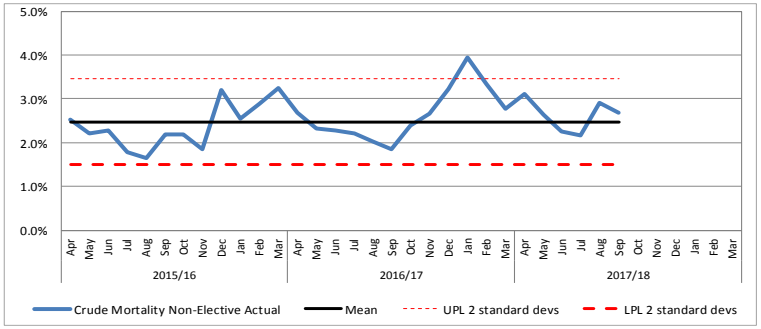
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



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

For the 12 month period (July 2016 to June 2017), the Trust's HSMR of 91.1 was in the 'lower than expected' range. Nationally, WHHT had the 27th lowest HSMR out of 136 non specialist trusts, placing the Trust in the top 20% when compared across England. The Trust has the third lowest HSMR within the East of England region.

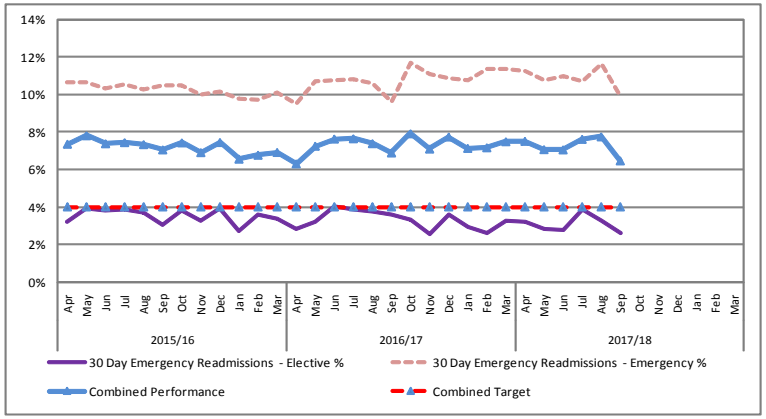
There was a peak in crude mortality over the winter period which was mirrored nationally.

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

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

West Hertfordshire Hospitals NHS Trust

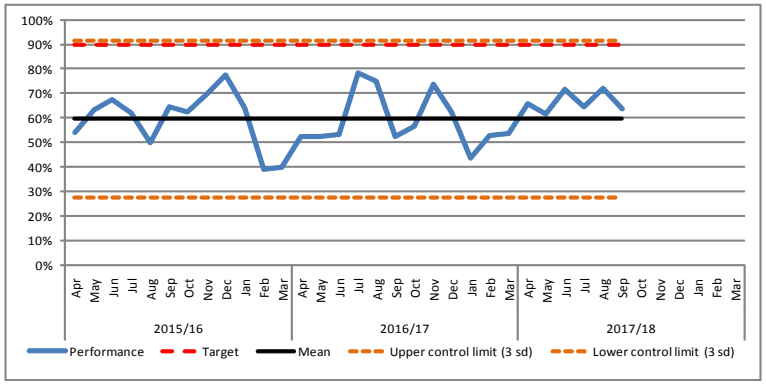
% Emergency re-admissions within 30 days following an elective or emergency spell*



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

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

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



Stroke
Performance for September was 63.6% for 4 hour admission to the Stroke Unit, which is above the national average. The latest reporting quarter results for SSNAP (April – July 17) shows the national average as 60.2%.

The 90% stay target was achieved with 87.9% patients spending 90% of their stay on the stroke unit, against a target of 80%.

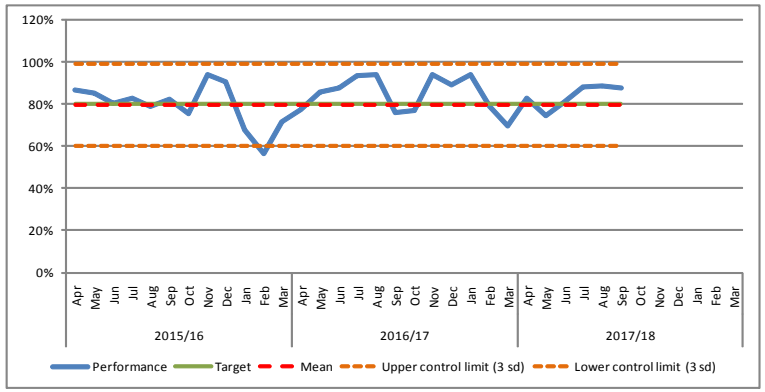
Patients that arrive via a pre-alert ambulance are seen immediately on arrival by the stroke team. However, other potential stroke patients who, during times of increased pressure, experience longer waits in A&E are not always admitted to the stroke unit within 4 hours. When waiting times to be assessed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

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

The latest SSNAP results for the reporting quarter April – July 2017, shows that Watford Stroke services have continued to maintain an "A" rating.

The annual national average for admission within 4 hours to the stroke unit for April 2016 – March 2017 is reported as 57.4%.

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

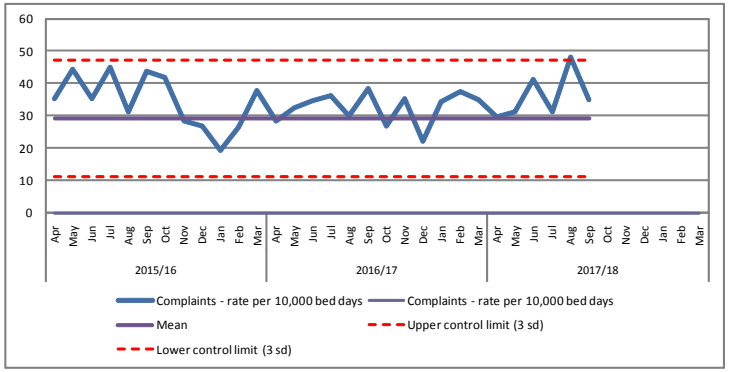


Stroke 60 mins, stroke care and STeMI 150 mins* (to follow)

Safe, effective, caring (continued)

West Hertfordshire Hospitals NHS
NHS Trust

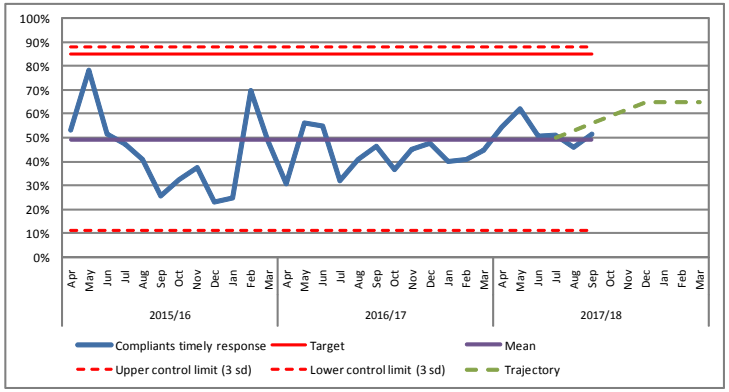
Complaints - rate per 10,000 bed days



Complaints rate per 10,000 bed days

67 new complaints were received in September, of which 36% (24) relate to Surgery, Anaesthetics and Cancer (SAC), 27% (18) relate to Unscheduled Care (USC), 16% (11) relate to Women's and Children's (WACS), 13% (9) relate to Medicine, 3% (2) relate to environment, 1 relate to corporate and 1 relates to Clinical Support. Trust wide the most common themes were clinical care (37%), admissions, appointments and waiting times (21%) of which half of these were discharge alone and the other half cancelled surgeries, appointment cancellations/delays accounted for 12% of all complaints, specifically around outpatients being cancelled and then a further appointment not being organised.

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

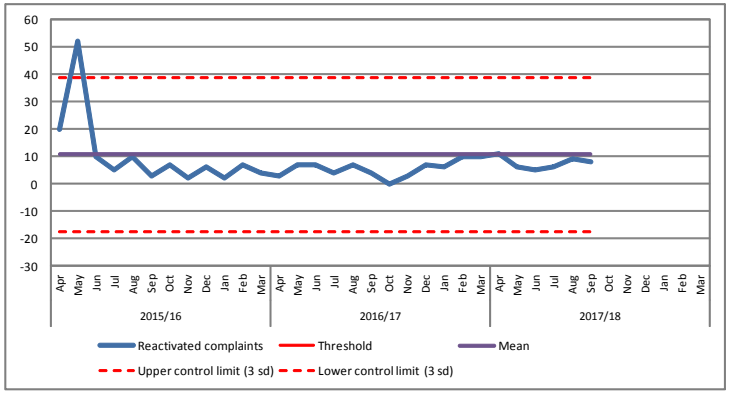


% Complaints responded to within one month or agreed timescales with complainant

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 September 51% (36) of complaints were responded to on time. 48 responses were sent in total. Complaints responded to on time, by division, is as follows:

	Jun - 17	Jul - 17	Aug - 17	Sept – 17
Trust wide	52%	51%	46%	51%
Medicine	67%	67%	100%	100%
USC	31%	33%	25%	29%
SAC	57%	57%	60%	48%
WACS	42%	31%	20%	14%
Environment	67%	33%	60%	78%
CSS	100%	100%	67%	100%
Corporate	50%	N/A	33%	33%

Number of reactivated complaints



	Target	Sep 17
% of complainants with verbal communication at the beginning of process (called within 3 working days of receipt of complaint)	95% by Q4	100%
% of complaints acknowledged within 3 working days	100%	97%
% of complaints taken longer than 6 months to investigate (figure taken at the end of September	<5%	5%

There are 6 complaint responses that are more than 6 months overdue (5%), the oldest of which dates back to January 2017 due to the complexity of issues raised. Three will be closed in October.

Eight complaints were reactivated in September; in four cases complainants were dissatisfied with the original response and wanted more action taken. Two of these have been long standing complaints where all the appropriate steps have been taken.
N/A denotes – no complaints valid for reply to this month.

Intentionally blank

Safe, effective, caring

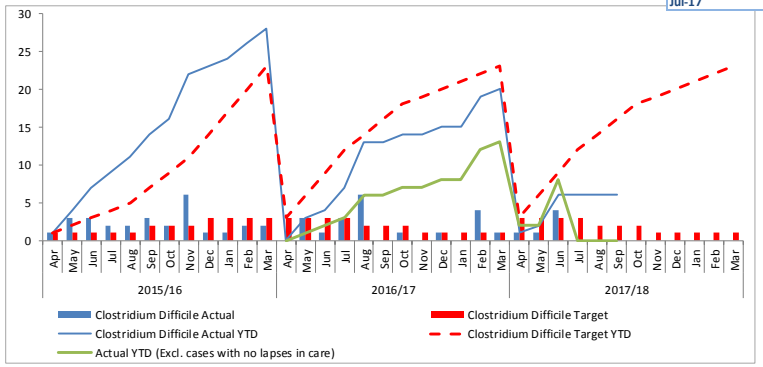
Reporting sub committee - S&C & COEC

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

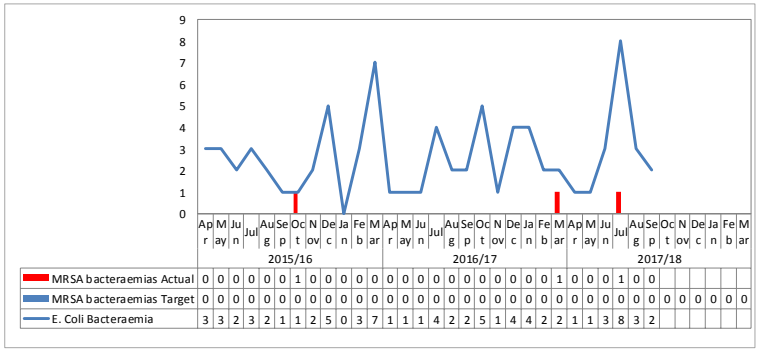
Performance relative to targets/ thresholds	Achieving	Not achieving
Sep-17	2	4
Aug-17	4	2
Jul-17	3	3

West Hertfordshire Hospitals NHS Trust

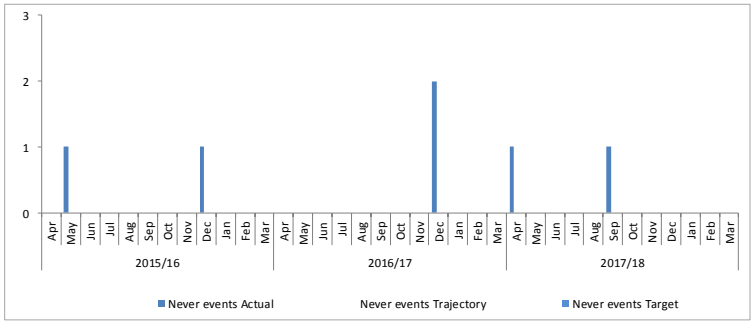
Clostridium Difficile



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 September. This is a significant improvement as no CDI cases reported for 3 months consecutively 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. The other five CDI cases have been sent to the C.*diffile* Appeal panel meeting on 18th Oct 2017 and the outcome will be provided in due course. IPCT continue with antimicrobial rounds, weekly *Clostridium difficile* rounds, and targeted training. There is also increased IPC support to key clinical areas.

MRSA bacteraemia (MRSAb)

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

E. Coli bacteraemia (*E colib*)

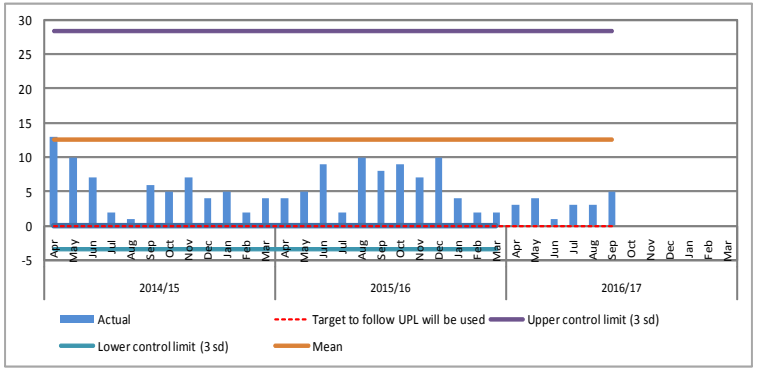
2 cases of post 48hrs E. colib were reported in September. The target set for the CCG this year is a 10% reduction which equates to 36 cases. There is no target for WHHT. The IPCT is represented on the WHHT continence group. This group supports the review of post 48hrs E.colib RCA's, the outcome of which will influence WHHT's focus to support the reduction of the Trust's apportioned *E colib* cases. A new process for undertaking the RCAs has been implemented where the clinician looking after the patient will lead on the investigation.

Never event

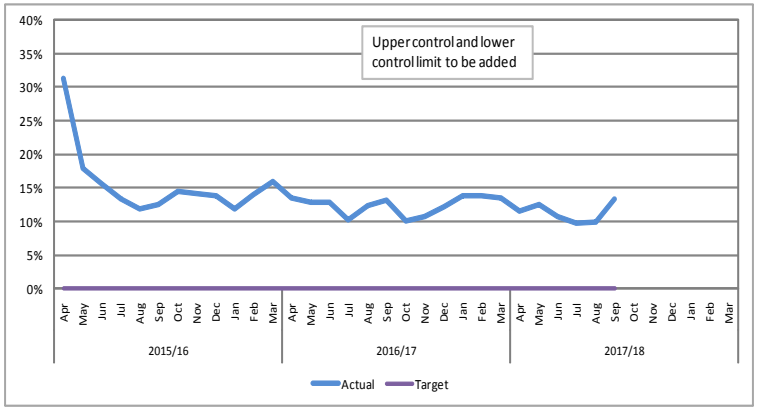
1 never event was reported in September 2017 relating to wrong route administration of medication. A number of immediate actions were taken to prevent a similar incident occurring and an SI investigation commenced. Monitoring of the investigation and implementation of actions will be progressed in accordance with the Trust SI investigation process.

West Hertfordshire Hospitals NHS Trust

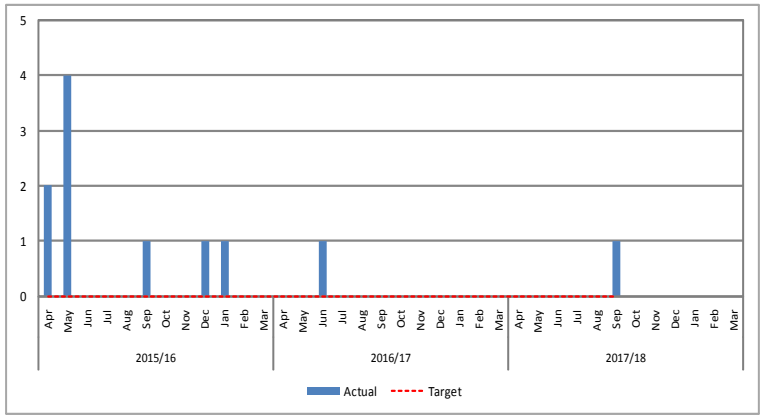
Serious incidents



% of reported patient safety incidents that are harmful



Medication errors causing serious harm*



Serious Incidents

There were 5 Serious Incidents (SIs) declared in September 2017 (3 in August 2017). These were:
2 in the Unscheduled Care Division (hospital acquired pressure ulcer and delayed treatment)
1 in the Surgery, Cancer & Anaesthetics Division (wrong route administration of medication – never event)
1 in the Surgery, Cancer & Anaesthetics / Unscheduled Care Divisions (issues with treatment and transfer to tertiary centre)
1 in the Women's and Children's Division (incident relating to a baby)

At the end of September 2017 the Trust had 22 open SIs. Investigations are complete for 10 of these which are with Commissioners pending formal closure on StEIS. At the end of September 2017 there were 12 ongoing SI investigations, one of which is overdue for completion as the investigation is ongoing and the remaining 11 are within deadline for completion.

Learning from SIs

The following actions and processes are in place to ensure learning from SIs and provide assurance that learning has taken place and changes have been implemented:
•45 day review meetings allow the SI draft report to be discussed and challenged by the relevant clinical and management teams prior to the action plan being completed.
•Each action plan is developed, signed off and monitored by the division leading the investigation into the incident.
•The SI review group (SIRG), chaired by the Medical Director, review all closed SI action plans where senior divisional representation provides assurance and evidence that actions have been implemented before the SI is formally closed internally.
There were two 45 day meetings held in September 2017.

A SIRG meeting was held on 19 September 2017. Eight action plans were reviewed and 4 of these were closed; the outstanding evidence for those action plans which were not closed will be followed up as part of the SIRG action log. A further 4 action plans were closed in the SIRG action log – these are action plans which had been discussed at SIRG before but not closed at the time due to outstanding evidence.

% of patient safety incidents which are harmful

13.30% of incidents reported in September2017 were recorded as harmful, which has increased from 9.89% in August 2017. Incidents reported as harmful had shown a decrease in recent months. The increase in incidents reported as harmful in September 2017 is noted and will be reviewed to determine if there is an underlying theme.
The level of harm may change following investigation of an incident and charts will be updated for each report to Board to reflect this. 26 incidents were scored as moderate or above in September2017 of which 14 still require harm validation and therefore are subject to change. This is a slight increase from 21 recorded within August 2017.

Medication incidents causing serious harm

There was 1 medication error reported as causing serious harm in September 2017 . An SI investigation has commenced and monitoring of the investigation and implementation of actions will be progressed in accordance with the Trust SI investigation process.

Safe, effective, caring

Reporting sub committee - S&C & COEC

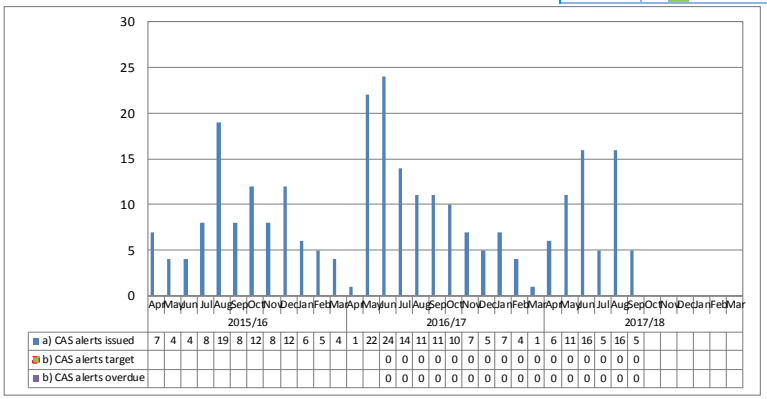
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

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

West Hertfordshire Hospitals NHS Trust

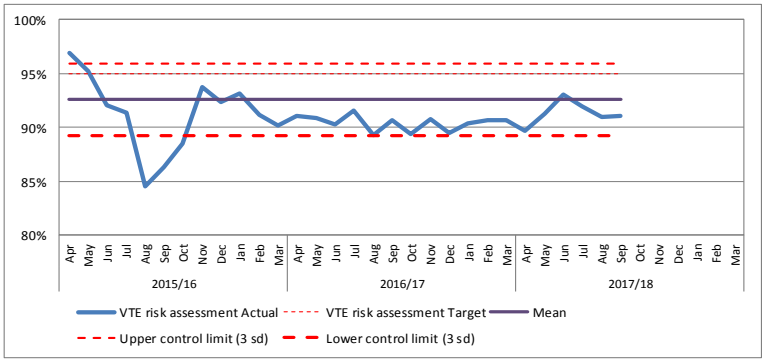
CAS alerts:

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)



	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
a) CAS alerts issued	7	4	4	8	19	8	12	8	12	6	5	4	1	22	24	14	11	11	10	7	5	7	4	1	6	11	16	5	16	5						
b) CAS alerts target															0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						
b) CAS alerts overdue															0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						

VTE risk assessment*



CAS alerts

All alerts issued by CAS in September 2017 were acknowledged within the 48hr deadline. There were 5 alerts in total issued in September 2017, 3 of which were Medical Device alerts and 1 Estate & Facilities alerts all of which were sent to the Divisions and Procurement.

1 Patient Safety alert was also issued and the designated lead has been appointed and actions are now underway.

All 3 Medical Device Alerts have been reviewed, were not applicable to our Trust and have been signed off. The 1 Estate & Facilities alert requires action and is currently ongoing

There were no breaches during September 2017 and all alerts with deadlines were closed on time

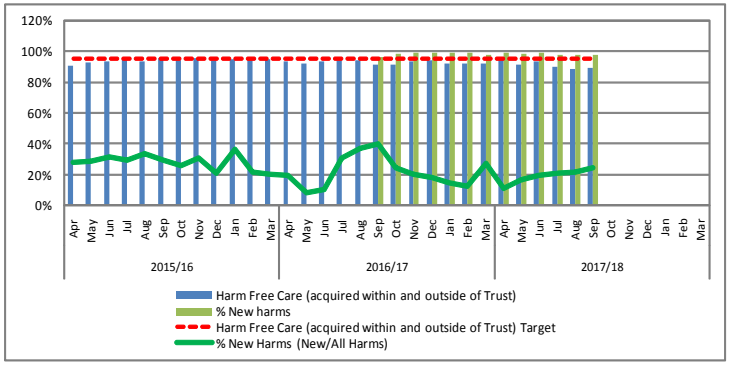
Issued by CAS	5
Breached in month	0
Currently overdue	0
CAS alerts not acknowledged within 48hrs	0

VTE

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

NHS West Hertfordshire Hospitals NHS Trust

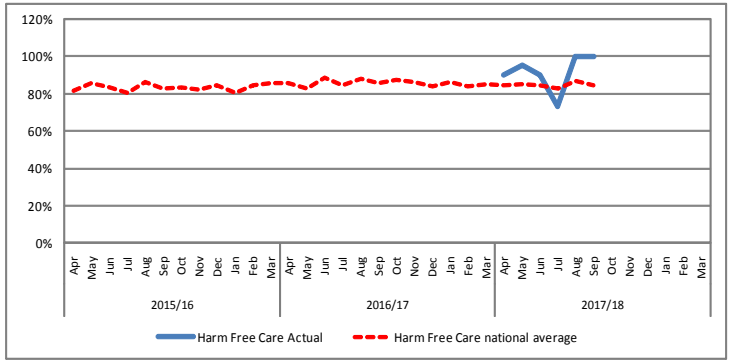
Adult Safety Thermometer: Harm Free Care and New Harms



Adult Safety Thermometer: Harm Free Care and New Harms

September 2017	National	WHHT	Milton Keynes	East and North	The Hillingdon
New Harm Free	97.93	97.34	98.65	98.40	98.90
Pressure Ulcers - New	0.83	0.83	0.23	0.18	0.27
Catheter & New UTI	0.35	0.50	0.23	0.53	0.27
Catheters	13.52	16.45	20.32	20.60	18.13
Falls with Harm	0.48	0.66	-	-	-
All New VTEs	0.44	0.66	0.90	0.89	0.55

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 is 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 September Harm Free Care was 89%, below the national average of 94.3%. This includes harms acquired both inside and outside of the Trust. However overall new harm free care performance is still improved from this period versus the previous two years (see chart opposite). New Harm Free care (harms acquired in the Trust) for September 2017 was 97.44 %, below the national average of 97.93%.

All new and all harms percentage for safety thermometer remains better than the national average of 36.1% versus 26.2% with an overall performance ytd of 19.9%.

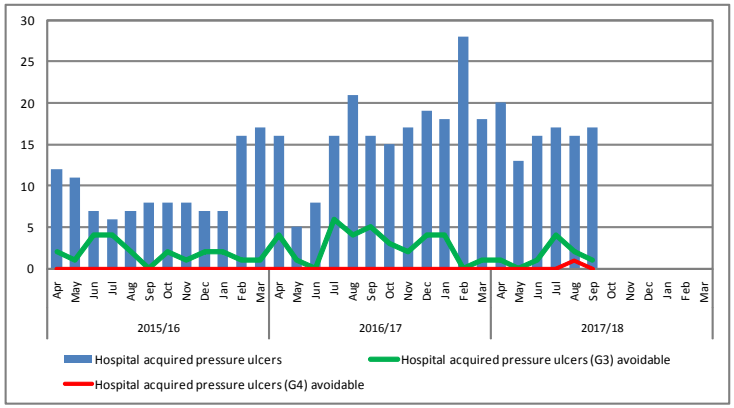
Children and Young People's Services Safety Thermometer
Harm includes patients with a PEWS completed: triggered but not escalated, extravasation, patients in pain at point of survey and any pressure ulcer or any moisture lesion. Harm free care was 100% in September for Acute Children's Services compared to 85.7% nationally. An analysis of the September 2017 survey demonstrated that all patients had a set of observations and had been assessed for an Early Warning Score in the last 12 hours. Of those patients with an intravenous (IV) device, extravasation (leakage of a fluid out of its container) was not observed in any a patient . There were no reports of pressure ulcers or moisture lesion. No patient reported pain at the point of survey.

Harm Free Actions

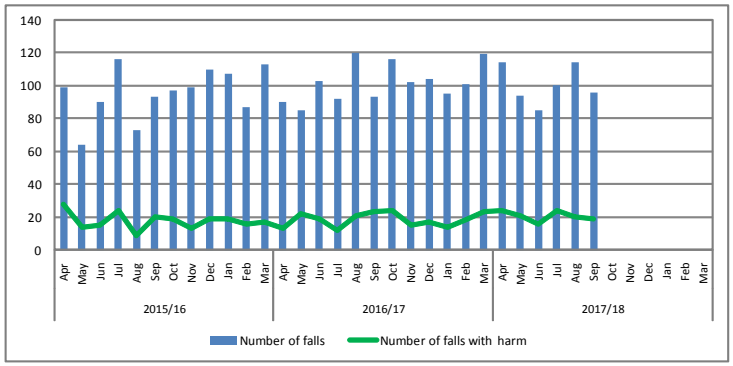
- Urology Steering group established to drive best practise with urinary catheters and monitor E-coli in conjunction with Infection Prevention and control . Data will be monitored through the group.
- Focus on the Pressure Ulcer improvement plan with Divisions.
- Collaborative working with community on harms.
- Falls collaboration with community teams
- Harm free Care focus on Fridays, prior to Safety Thermometer audits raising awareness.
- Harm free Care tweets on Thursdays and Tuesdays with key messaging
- Targeted ward teaching
- Implemented pain assessment recording on PEWs charts.

NHS
West Hertfordshire Hospitals
NHS Trust

Hospital acquired pressure ulcers



Falls and falls with harm



Hospital acquired pressure ulcers
In September there were 19 new pressure ulcers, 16 grade 2 and 3 grade 3, of which 5 were reported in the point prevalent safety thermometer audit as shown in the indicator summary.

One Grade 3 pressure ulcer has been deemed avoidable with further validation through the root cause analysis process being undertaken for the remaining grade 3 pressure ulcers.

The grade 2 pressure ulcers are validated by the Matrons for the clinical areas but not differentiated between avoidable and unavoidable.

A trust wide improvement plan is in place to continue the focus on reducing pressure damage as part of harm free care. Some significant improvements have been made with a >58% reduction in grade 3 pressure ulcers developed during April – September 17.

Falls and falls with harm
In September there were 96 falls with 20 resulting in low harm.
In relation to the numbers of falls – falls with harms remains low.

The campaign to address falls continues with the Fall Champions, and with the multidisciplinary falls group.

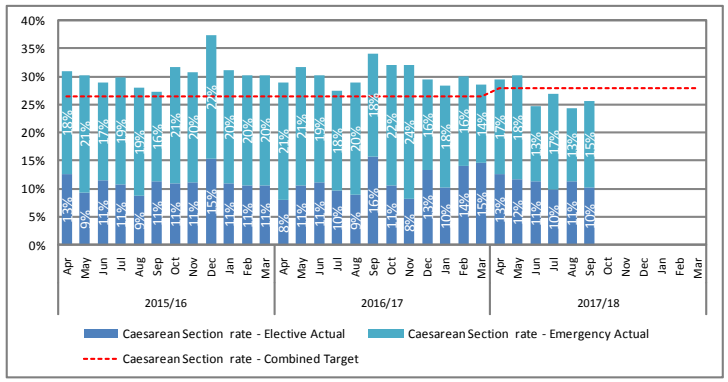
There is joint working with the Community teams looking at falls and common themes.

Support is provided to specific clinical areas in relation to falls and devising resource packs for staff

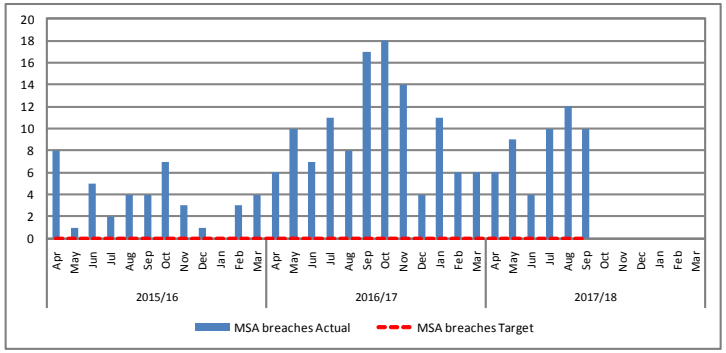
NHS
West Hertfordshire Hospitals
NHS Trust

West Hertfordshire Hospitals NHS Trust

C-section rate



Mixed sex accommodation



C-section rate

The Section rate remains within target.

A meeting has been held to stream line the MDT and processes with the core team. An Induction MDT runs alongside the C Section MDT appropriate management of inductions will also help reduce the emergency sections due to failed inductions.

A very positive meeting has been held between clinicians and midwives to address issues with referrals and women's expectations. Staff have agreed to participate in the MDT more proactively.

The new Booking Notes for Mums will have stickers on them highlighting that the Trust hospital does not offer a choice of delivery by C section. This will demonstrate that it is only a clinical decision which drives the decision.

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.

West Hertfordshire Hospitals NHS Trust

Responsive

Reporting sub committee - TEC

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

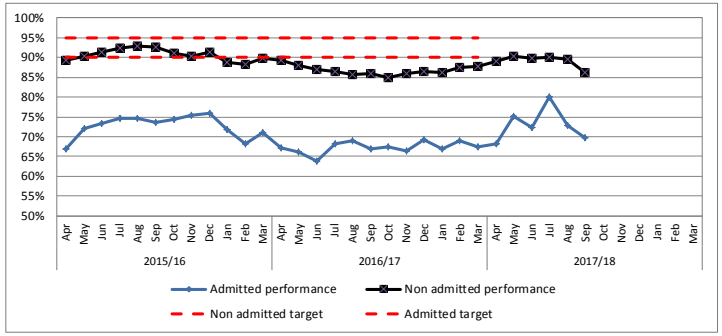
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Divisional Managers

Performance relative to targets/ thresholds

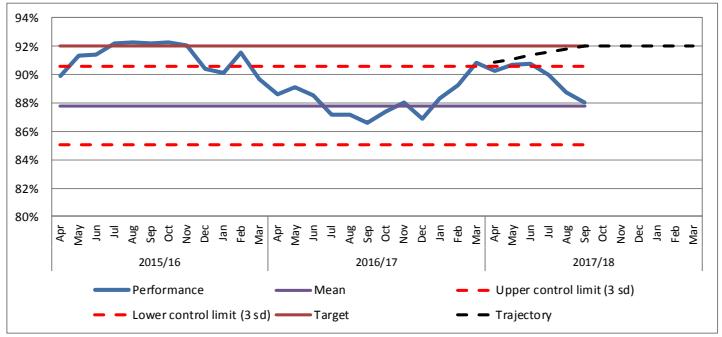
	Achieving	Not achieving
Sep-17	5	2
Aug-17	5	2
Jul-17	5	2

West Hertfordshire Hospitals NHS Trust

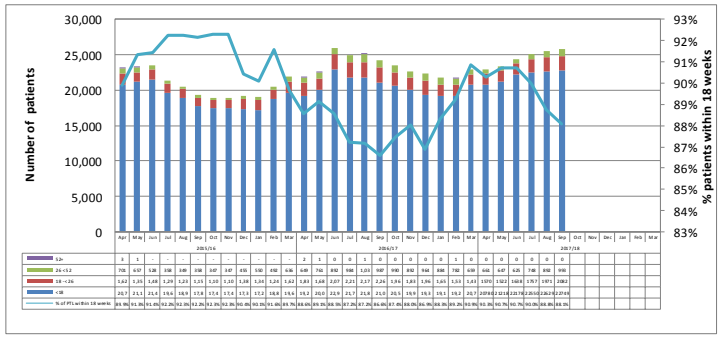
Completed pathways within 18 weeks



Incomplete pathways within 18 weeks



Incomplete pathways WL profile



RTT

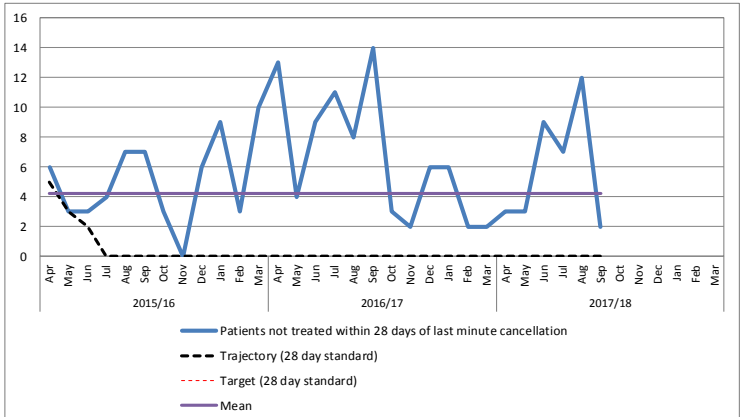
Performance for September was 88.1%, a further decrease on the previous month (88.8%). The most recent national data available (August) shows that the Trust's performance in August was below the national average (89.4%) with 92% achieved at L&D but not at RFH (87.4%) or E&NH (85.7%). The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was worse than the national position (7.4 vs 7.1 weeks) and worse than the 92nd percentile wait time (20.7 vs 20.5 weeks).

Elective Medicine remains compliant at 94.5%, WACS performance is 96%, and in Surgery 83% was achieved.

Service	18 Weeks Plus	% Under 18 Weeks
CRITICAL CARE MEDICINE	2	33.33%
OPHTHALMOLOGY	602	75.72%
ORTHODONTICS	24	76.92%
VASCULAR SURGERY	34	78.75%
PAIN MANAGEMENT	148	78.83%
ENT	413	80.52%
TRAUMA & ORTHOPAEDICS	719	82.48%
UROLOGY	173	85.51%
NEUROLOGY	146	86.74%
GENERAL SURGERY	234	86.76%
ORAL SURGERY	117	88.81%
PAEDIATRIC EPILEPSY	3	91.43%
PAED GASTROENTEROLOGY	6	91.78%
UPPER GI SURGERY	4	92.16%
PAED OPHTHALMOLOGY	7	92.39%
RESPIRATORY MEDICINE	45	93.83%
COLORECTAL SURGERY	30	94.09%
DERMATOLOGY	134	94.83%
CARDIOLOGY	84	94.88%
PAEDIATRIC UROLOGY	7	94.93%
PAEDIATRICS	42	95.13%
PAED ENDOCRINOLOGY	2	95.45%
CLINICAL HAEMATOLOGY	12	96.03%
RHEUMATOLOGY	14	96.54%

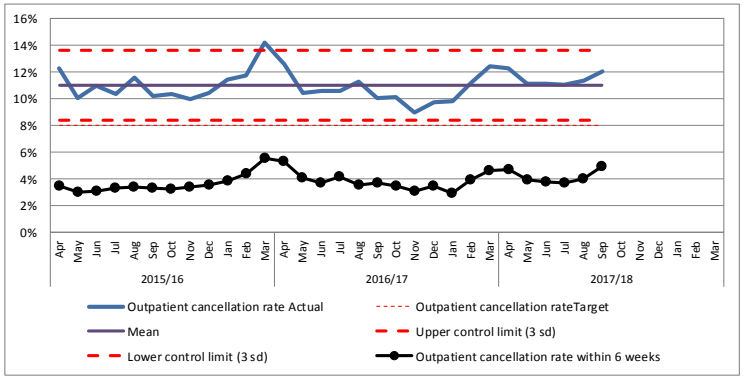
Service	18 Weeks Plus	% Under 18 Weeks
GYNAECOLOGY	29	96.72%
NEPHROLOGY	3	96.84%
OTHER	1	97.22%
ORTHOTICS	5	97.60%
PAED CARDIOLOGY	1	97.62%
ENDOCRINOLOGY	6	97.98%
GASTROENTEROLOGY	22	98.05%
PAED DERMATOLOGY	1	98.11%
BREAST SURGERY	6	98.20%
GENERAL MEDICINE	0	100.00%
GERIATRIC MEDICINE	0	100.00%
PAED CLINICAL HAEMATOLOGY	0	100.00%
HEPATOLOGY	0	100.00%
DIABETIC MEDICINE	0	100.00%
STROKE MEDICINE	0	100.00%
TRANSIENT ISCHAEMIC ATTACK	0	100.00%
RESPIRATORY PHYSIOLOGY	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
OBSTETRICS	0	100.00%
GYNAECOLOGICAL ONCOLOGY	0	100.00%
ORTHOPTICS	0	100.00%
CLINICAL ONCOLOGY	0	100.00%
Total	3076	88.09%

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

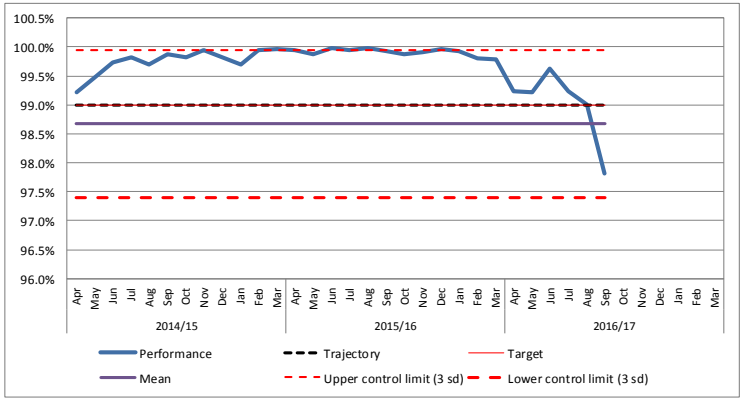


Hospital outpatient cancellations all and % cancelled* within 6 weeks

*Excluding valid cancellations (cancellations to provide earlier appointments or where appointment no longer required, 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)



Diagnostics



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

There were 2 breaches of the 28 day rebooking requirement (12 in previous month) – in Gynaecology and Oral Surgery. Both were originally dated within the 28 day period but subsequently deferred by the patient.

Hospital cancellations – patients cancelled within 6 weeks and overall

Short notice, hospital initiated cancellation remains below the Trust tolerance (5%) at 4.9% (excluding valid cancellations and patient initiated cancellations).

Total cancellations: 25.1%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
12.1%	4.9%	13.0%	10.2%

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

Diagnostic wait times

Performance has entered a period of expected non-compliance as a result of the significant increases in demand within Cardiology, the impact of changes in a community model.

Additional diagnostic sessions are in place to facilitate a return to compliance and progress against the plan/trajectory is monitored on a weekly basis to provide assurance of this.

Responsive

Reporting sub committee - TEC

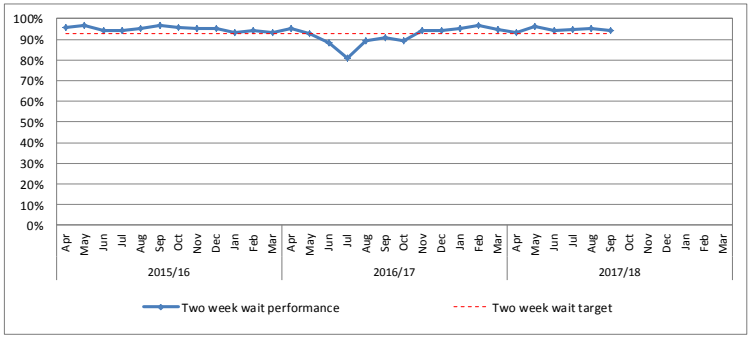
CWTs

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

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

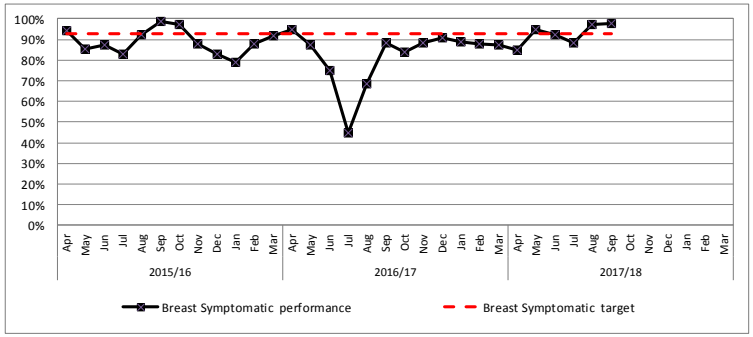
West Hertfordshire Hospitals NHS Trust

Two week standard



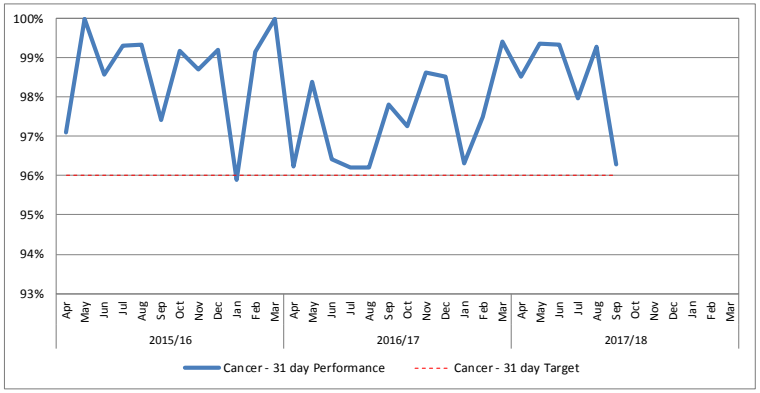
2ww
The provisional position for September is compliant at 94.1%.

Breast symptom two week standard



Breast symptomatic
The provisional position for September is compliant at 97.6%.

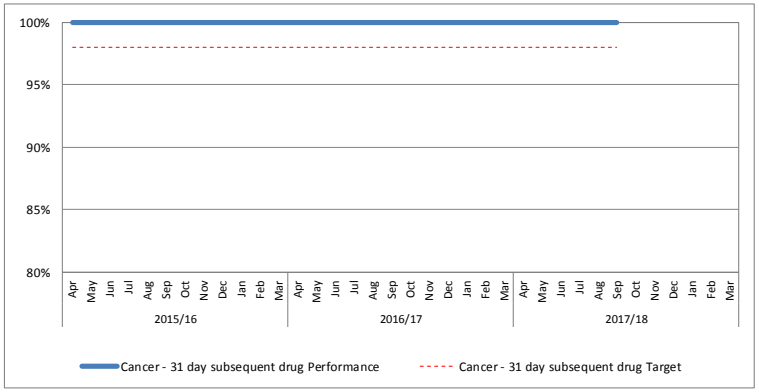
31 day standard



31 day first
The position is provisionally compliant at 96.3% . 109 pathways are currently reported for this standard, lower than the average monthly case load (approx 140) but further information is awaited from tertiary treatment centres, which may result in a change in performance.

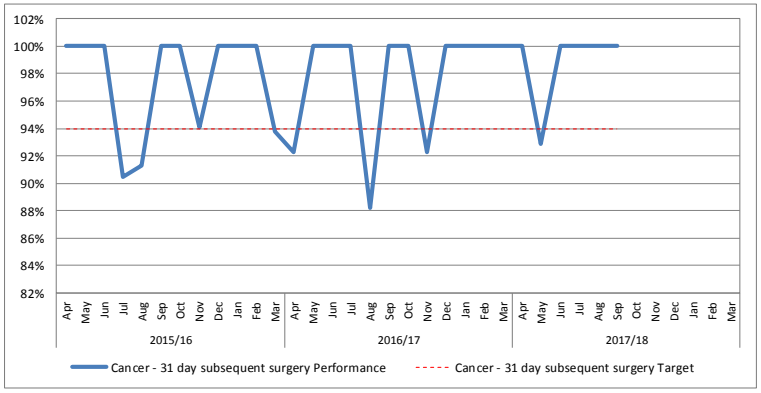
There are currently 4 breaches:
3 x Lower GI
1 x Skin

31 day subsequent drug standard



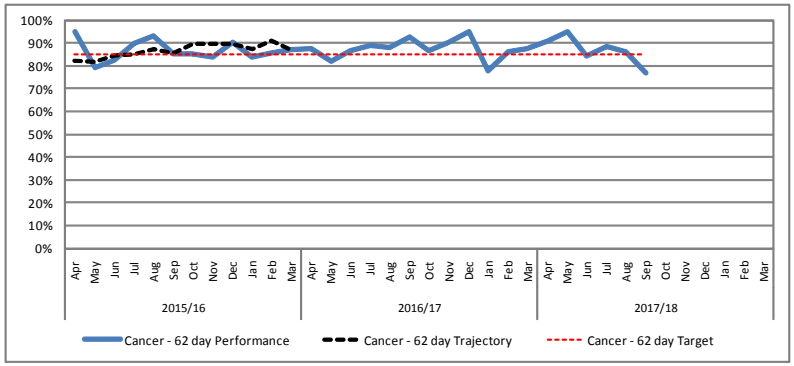
31 Day subsequent - Drug
The position is provisionally compliant at 100%

31 day subsequent surgery standard

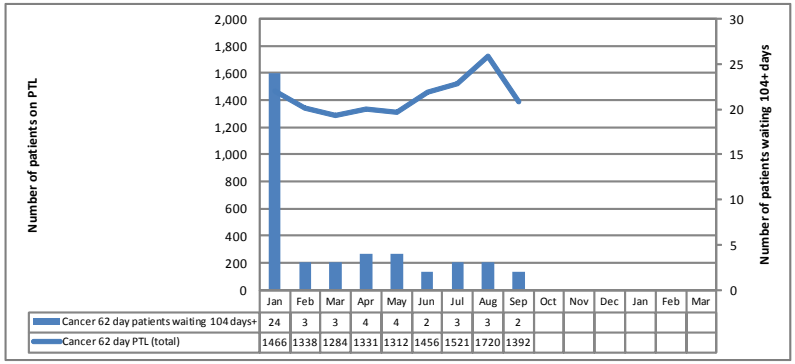


31 day subsequent –Surgery
The position is provisionally compliant at 100%

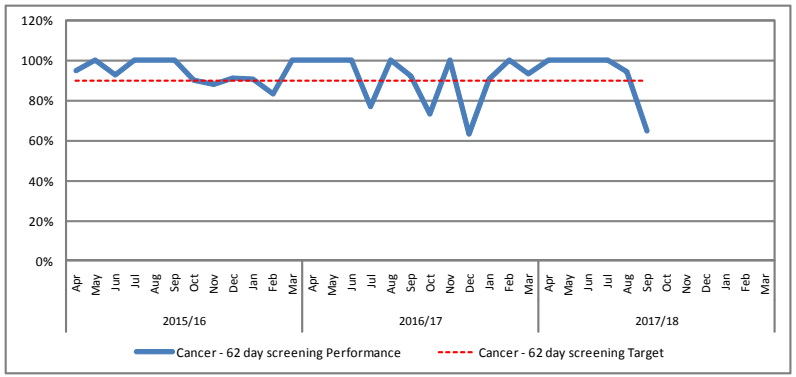
62 day standard



62 day standard number of 104+ day waiters



62 day screening standard



62 day GP – urgent

The provisional position for Sept is non compliant at 77.0%.
Further information is awaited from tertiary treatment centres, which will result in a change to the final number of total pathways and performance.
There are currently 13 breaches.

Tumour type	Jul	Aug	Sep (prov.)	Q3 prov.
Breast	96.8	92	94.1	94.4
Gynaecological	91.7	93.3	68.4	82.6
Haematological	100	100	80	88.9
Head and Neck	100	100	20	60
Lower Gastrointestinal	80	57.1	60	64.7
Lung	66.7	69.2	50	62.5
Other	100	0	0	25
Skin	95.8	100	100	98.2
Upper Gastrointestinal	83.3	100	85.7	89.5
Urological	80	78.9	80	79.6
Total	**88.6**	**86.2**	**77.0**	**84.7**

104 day waits

In September, there were 2 open pathways with a wait over 104 days.
1 Lung: complex medical pathway.
1 Skin: tertiary centre surgical capacity issues.

5 pathways were closed with a wait over 104 days.
1 haematology: complex diagnosis
1 urology: delay due to patient choice and oncology capacity
1 lung: breach reasons not yet available.
2 Head & Neck: administrative delays.

62 day screening

The provisionally position is provisionally non compliant at 65% due to 2 delayed pathways as a result of patient choice.

Responsive

Reporting sub committee - TEC

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

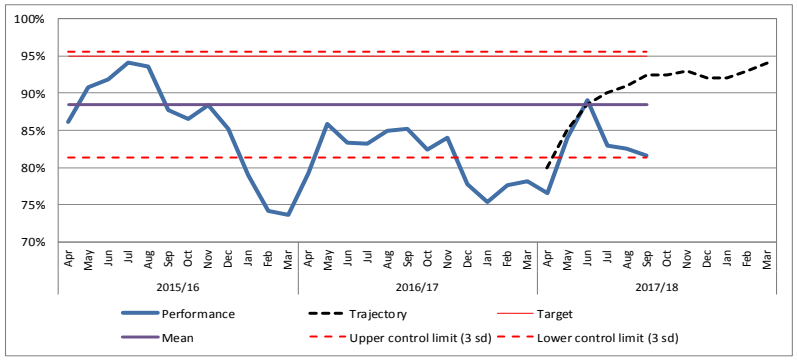
Executive lead	Clinical lead	Operational lead
Sally Tucker	Dr David Gaunt	Divisional managers

Performance relative to targets/ thresholds

	Achieving	Not achieving
Sep-17	1	4
Aug-17	1	4
Jul-17	1	4

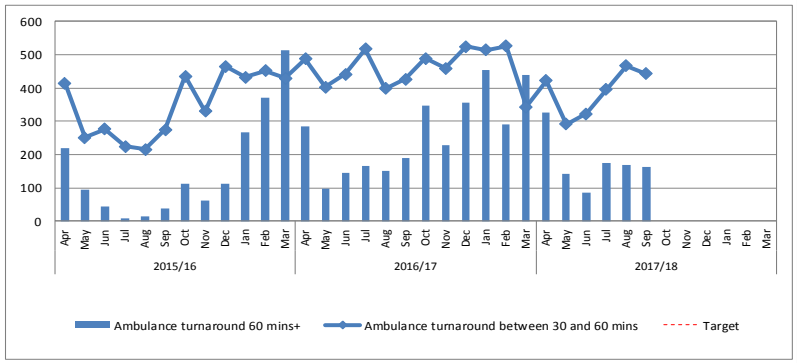
West

A&E



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

Ambulance turnaround time



A&E performance in September was 81.6% (July 82.9% and August 82.5%). Minors performance improved further in September to 94.9% from 90.6% in July and 93.4% in August. CED experienced a high volume of attendances linked to respiratory illness with a drop in performance to 93.1% from 96.9% in August.

An external turnaround team began work in the Trust in July, supporting improving emergency care performance. Work has taken place to clarify pathways and response times (Internal Professional Standards) for A&E patients for specialty teams. Dedicated administrative support is in place to track patient flow accurately and record response times to A&E. An A&E Performance Manager started in September, working with clinicians to provide a more consistent and responsive approach to waiting times for assessment and treatment. The number of breaches due to delays in assessment and treatment in A&E is reducing however the number of breaches related to capacity issues has increased.

There is a continuing focus on ensuring full use is made of assessment areas (Emergency Surgical Assessment Unit (ESAU), Medical Assessment Area (MAU), Ambulatory Care, Frailty). However there were a number of days when there were overnight patients in Ambulatory Care and ESAU in September, impacting on flow.

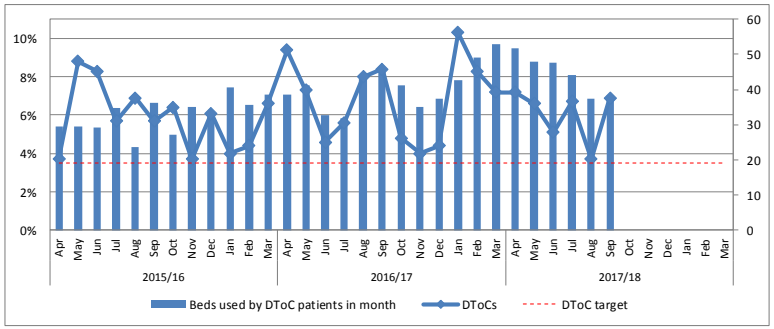
The number of ambulances waiting between 30 and 60 minutes has started to improve. The number of ambulances waiting over 60 minutes remains at a similar level over the last 3 months. The Trust has increased the resource available to care for patients in the corridor during periods of significant demand, so it can respond flexibly to any queue of ambulances to enable earlier release of crews.

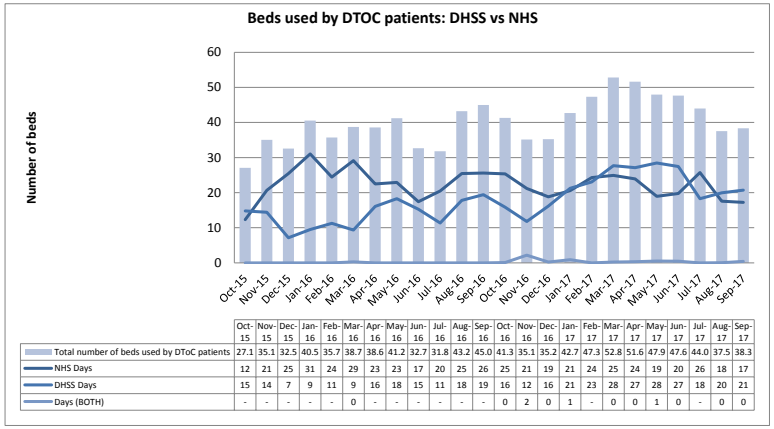
An activity comparison of the current financial period with the same period last year has shown:

- Type 1 attendances are down marginally by 0.2%.
- Ambulance arrivals are down by 4.1%.
- Admission rate from A&E (excluding ambulatory and frailty) is up by 7.7%.
- Discharges (Trust wide) are up by 13.7%

West Hertfordshire Hospitals NHS Trust

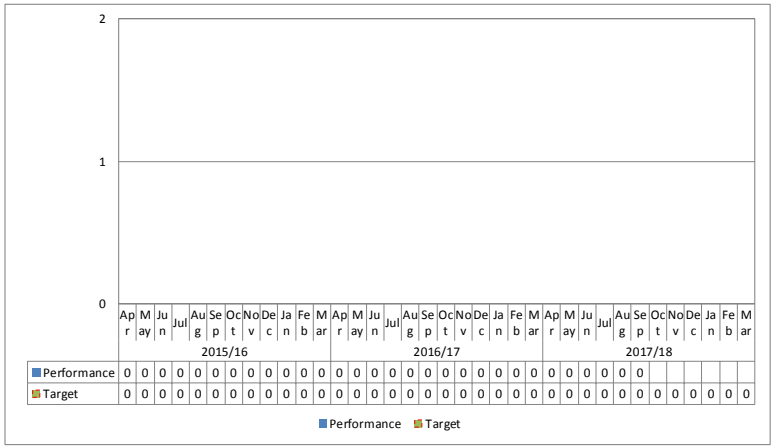
Delayed Transfers of Care (DToC)





	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Total number of beds used by DToC patients	27.1	35.1	32.5	40.5	35.7	38.7	38.6	41.2	32.7	31.8	43.2	45.0	41.3	35.1	35.2	42.7	47.3	52.8	51.6	47.9	47.6	44.0	37.5	38.3
NHS Days	12	21	25	31	24	29	23	23	17	20	25	26	25	21	19	21	24	25	24	19	20	26	18	17
DHSS Days	15	14	7	9	11	9	16	18	15	11	18	19	16	12	16	21	23	28	27	28	27	18	20	21
Days (BOTH)	-	-	-	-	-	0	-	-	-	-	-	-	0	2	0	1	-	0	0	1	0	-	0	0

12 hour trolley waits



Delayed Transfers of Care

DToC patients represented 6.9% of occupied beds in September, 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 September DToC patients consumed 1150 bed days, the equivalent of 38.3 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

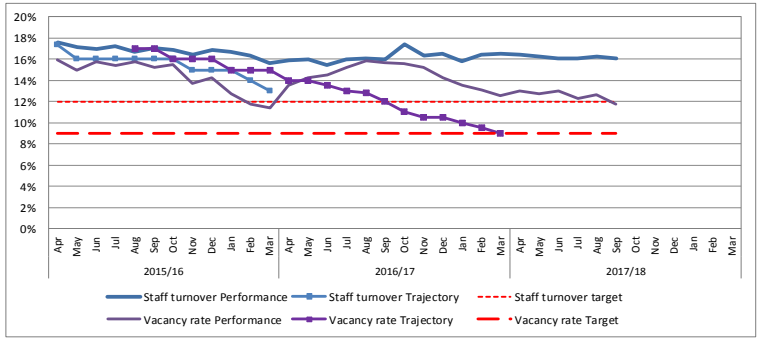
Reporting sub committee - PSE

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

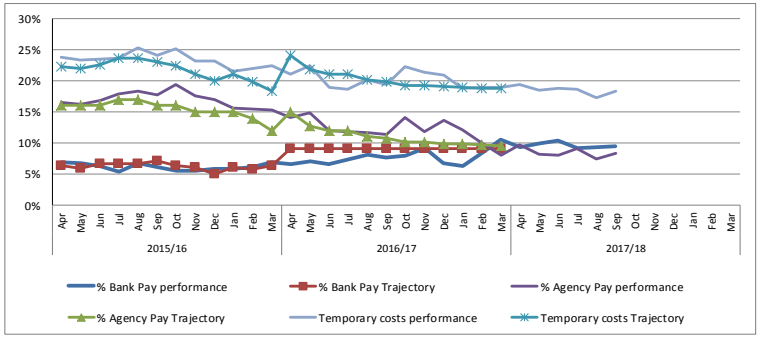
Executive lead	Clinical lead	Operational lead
Paul da Gama		

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

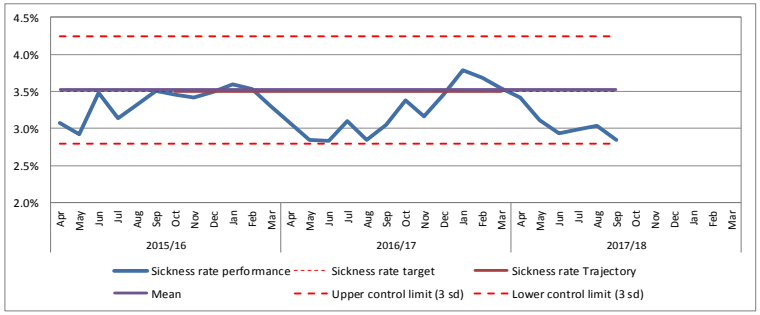
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate



Turnover and Vacancies

At the end of September the overall Trust vacancy rate had decreased from 13.0% in June, to 11.8%. The trend has been one of a falling vacancy rate over the last 12 months, from a peak of 15.9% in August 2016, and with the rate falling 11 months out of the last 14. The current rate is the lowest since April 2016. Whole time equivalent (wte) staff-in-post increased by 33 during September, which saw the highest ever figure for the Trust, at 4,245 wte's. Within the overall figure, the vacancy rate for qualified Nursing & Midwifery posts reduced from 17.6% to 15.5%. Recruitment activity has built up a large pipeline of new N&M recruits (currently 262 registered nurses), including a recent recruitment drive in the Philippines in October which has resulted in another 75 job offers. However, many staff in the pipeline are from overseas with long lead-in times, and over the next few months, the vacancy rate for Nursing and Midwives is expected to rise , largely due to the transition al time needed for nurses to register with the NMC. The Trust currently has 96 such nurses awaiting registration. In addition, WHHT is particularly challenged with the turnover rate within Band 5 nursing (around 27%), where it is significantly higher than the overall Trust average. The Trust is participating in a national initiative looking at ways to address this issue, presenting a project plan to NHSI which was well received. There The 12-month rolling turnover rate reduced in September from 16.2% to 16%; 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 shown a modest downward trend, although Band 5 nursing as noted above is relatively high.

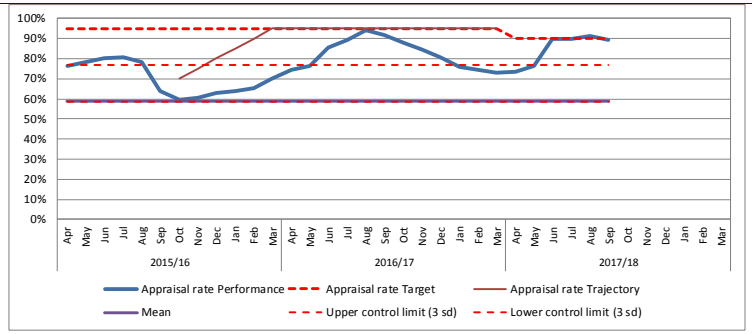
% Bank and Agency Expenditure

Agency spend in August reduced from £1.75m to £1.4m but increased in Sept to £1.6m. This spend represented 8.3% of the overall pay-bill , above the target of 8%. Agency spend has reduced considerably however over the last couple of years, with spend in 2016/17 being £10m less than 2015/16. Work continues on keeping 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.

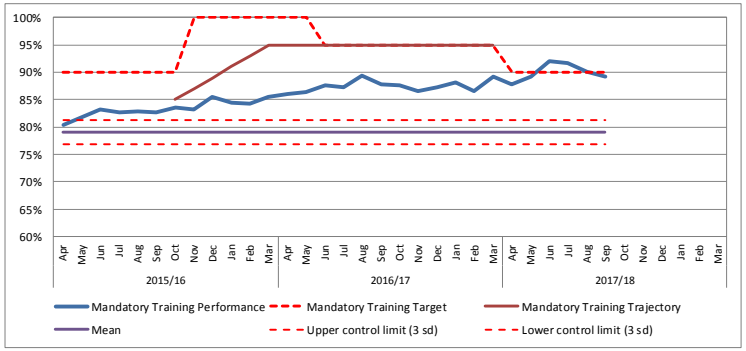
Sickness rate

The sickness absence rate remained low at 2.8% in September, and is comfortably below the Trust target of 3.5%. The Trust is currently well below the Herts & Beds average, which stood at 4% at the end of Quarter 1. Over the last 2 years, sickness absence has fluctuated 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 around 3.0% in the current year to date.

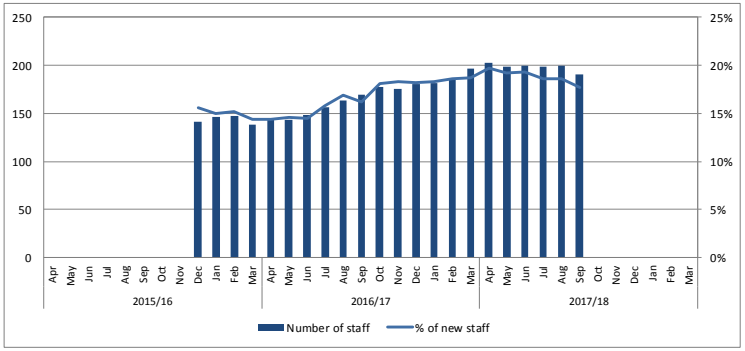
Appraisal rate
(non medical staff only)



Mandatory training



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



Appraisal – non medical staff

Appraisal rates are currently 89.5%, with an underlying general improvement trend since April 2017. There is a significant challenge to maintain focus and ensure appraisal dates are aligned to staff increments to further improve organisational performance. HRBPs continue their work with Divisions to develop trajectories and monitor performance and ensure that performance is consistently above the 90% target. HR Business Partners are also working with managers with bi-weekly reports to support the transition to effective alignment of appraisals to increments and to plan the completion of all outstanding appraisals.

Mandatory training

Mandatory training compliance is currently at 89.1% (90% last month). The focus here is to sustain and better compliance rates. All substantive current Trust staff and new starters are able to access e-learning and book core & essential classroom training through a web-based portal that is accessible outside of the Trust.

Acorn, the new self-service Learning Management System, has now been implemented across the trust to all staff. Every current member of staff employed by the Trust has received an introductory letter and user guide, providing step by step instruction to enable them to access and use this new system. Substantive and non-substantive new starters can access Acorn to complete their eLearning, even before they commence employment. The next stage of the Acorn rollout involves sending out guidance to 1,000 line managers to enable them to see at a glance, which of the staff in their team(s) are compliant

Number of staff leaving within first year

The overall rate has reduced from 19.3% in June to 17.7% in September
The Trust is closely monitoring staff leaver information, particularly data regarding reasons for leaving, via the web-based exit leaver system. The reconnect sessions continue, following corporate induction, which bring new starters back together and offering an opportunity to resolve any issues and gather information to further improve staff experience in the first year in post. Key work is also under way to support retention of Band 5 nurses which is the group with the highest turnover. This also forms a part of the Nursing retention project with NHSI, where Band 5 nursing leavers have been identified as a key workforce to reduce leavers overall.

Workforce BAF scorecard

Workforce Indictors ~ Progress Table

Progress against target - Sept 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	13.30%	15.7%	13.0%	11.8%	9.0%	2.8%	↘	31%
Turnover	15.37%	16.0%	16.1%	16.0%	12.0%	4.0%	↘	33%
Total Sickness	4.06%	3.1%	2.9%	2.8%	3.5%	-0.7%	↘	-20%
Sickness Short Term		1.6%	1.3%	1.2%	1.75%	-0.6%	↘	-31%
Sickness Long Term		1.5%	1.7%	1.6%	1.75%	-0.2%	↘	-9%
Non-Medical Appraisal	83.00%	92.0%	90.0%	89.5%	90.0%	-0.5%	↘	1%
Medical Appraisal		99.0%	99.0%	99.0%	99.0%	0.0%	→	0%
Core Skills Framework	86.00%	88.0%	92.0%	89.0%	90.0%	-1.0%	↘	1%
Agency as a % of Paybill	7.68%	11.3%	8.0%	8.3%	8.0%	0.3%	↗	4%
Friends and Family Test (Work)	60.00%	57.0%	53.7%	53.9%	66.0%	-12.1%	↗	18%
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

Explanatory Notes - Benchmarking Information

Vacancy	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q416/17 - Local Survey
Turnover	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q4 16/17 - Local Survey
Sickness	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q4 16/17 - Local Survey
Appraisal	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q416/17 - Local Survey
Core Skills Framework	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q4 16/17 - Local Survey
Friends and Family Test	Based on FFT Survey Feb / March 2017 -

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

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

There are 8 (8 last month) indicators rated Green, with performance of 80% or over towards targets. There are 2 indicators within 60% to 80% of the target. (Turnover and Vacancies). Vacancy rates have improved from 15.7% a year ago to 11.8% currently.

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

Appraisals were just below target at 89.5% and mandatory training compliance is 89%.

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 8%, in line with the target.

12 month turnover rates are 16.0%, less than the figures of 3 months and one year ago.

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

Benchmark averages are taken from Q1 17/18 data and are from 12 nearby NHS organisations.

West Hertfordshire Hospitals NHS Trust

Safe, effective, caring

Well led

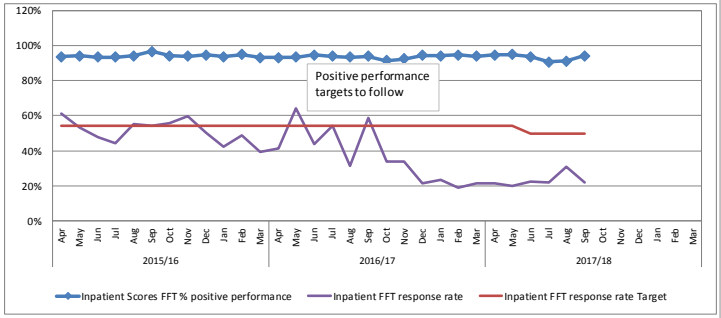
Reporting sub committees - PSQ and PSE

Friends and family

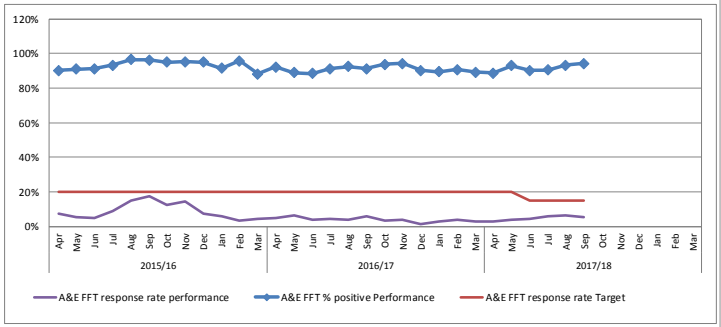
Executive lead	Clinical lead	Operational lead
Tracey Carter and Paul Da Gama		

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

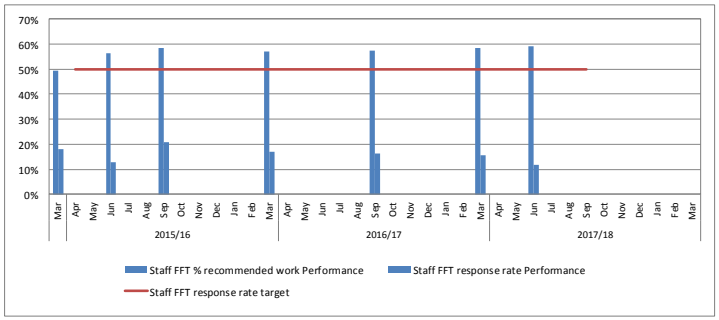
Inpatient scores (% positive and negative) and response rate



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



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



Inpatients

The response rate has reduced this month but more patients would recommend the Trust. The themes from the feedback focused on Discharge, Communication, Staff attitude and multiple ward moves.

A&E

The response rate has decreased this month but the number of patients recommending the Trust has increased, with a reduction in the number of negative responses. Patients most commonly commented positively about the caring nature of the staff but felt the waiting time to be seen was too long. Training for staff using the Meridian system is being agreed with the ED Matrons to encourage ownership of the FFT at a local level

Staff

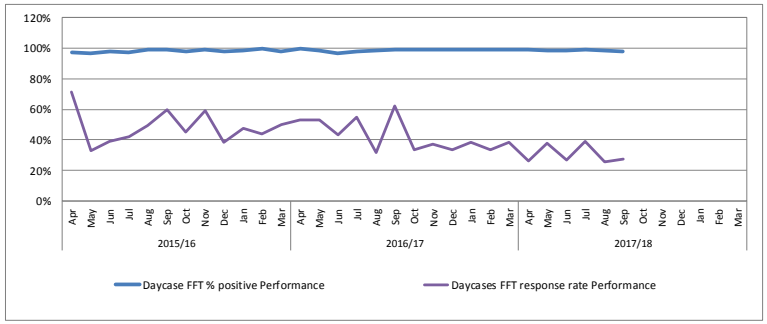
The Staff Friends and Family Test for quarter 2 ran from 21st August to 11th September 2017. There were 901 responses which is an increase of 63% on the number of responses in Quarter 1. The overall Trust engagement score has remained the same as the last quarter at 3.55. In summary, compared to the last quarter, slightly more staff would recommend the Trust as a place for treatment and to work. Day to day issues as a source of frustration have decreased. The number of staff that would recommend this organisation as a place to work was 59%. The number of staff that would recommend this organisation if friends and family needed care was 64.5%.

Trust Totals - FFT Questions - Work Q2 17/18

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

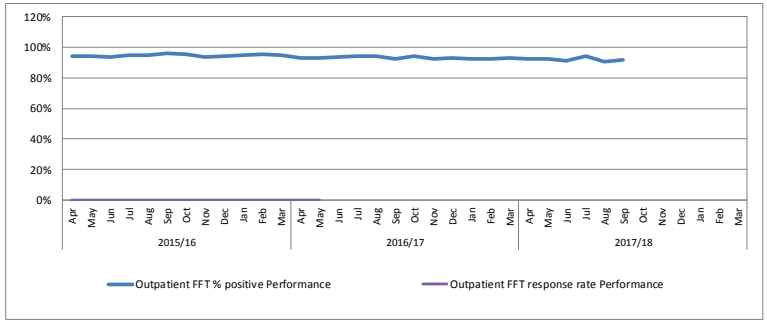
West Hertfordshire Hospitals NHS Trust

Daycases scores (% positive and negative) and response rate



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

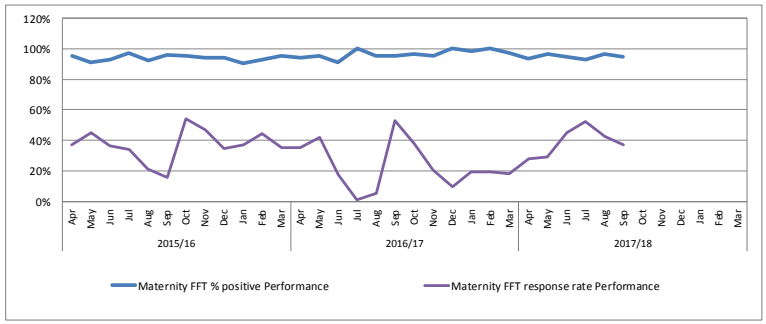
Outpatient scores (% positive and negative) and response rate



Outpatients
The total number of responses has reduced further this month with an equal increase in the number of patients recommending the Trust and those who would not recommend the Trust.

The Outpatient comments were all about excessive waiting times, parking (cost and availability) and poor signage.

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

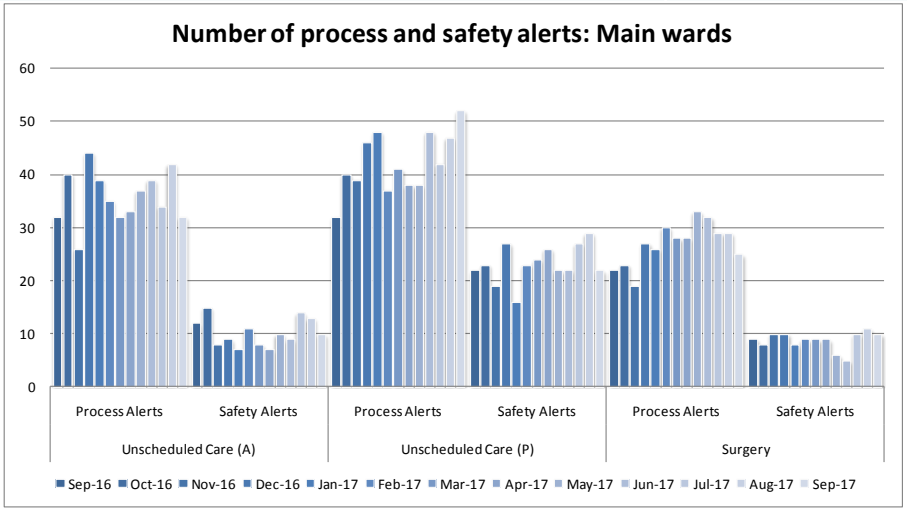


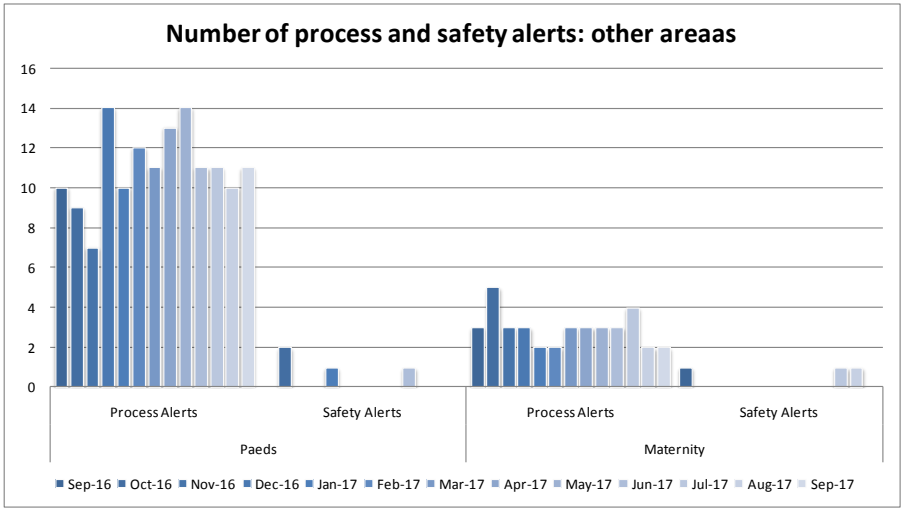
Maternity Question 2
The rate of response and number of patients recommending the Trust has reduced this month and the number not recommending the Trust has increased. A review of feedback for all areas has been completed but no themes were identified.

A remedial action plan has been developed to address the patient FFT performance issue plus other measures, to include a review of the forms and a reduction in the number of questions being asked of patients.

Ward scorecard

Indicator	Performance (September)	Last month
Number of safety alerts	42	54
Number of process alerts	122	130





What is causing the variance

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

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

Summary:

- Paediatrics have no safety alerts
- Maternity have no safety alerts.
- There are fewer safety alerts across the Divisions for September
- There are fewer process alert across the Divisions for September
- Three clinical areas are demonstrating higher trend of alerts , Two have improvement plans in place.

What actions have been taken to improve performance

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

West Hertfordshire Hospitals NHS Trust

Ward Scorecard September 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	7 / 30	1 / 30	6 / 33	7 / 29				3 / 29	6 / 32				29 / 33		30 / 33	21 / 28	15 / 29	n/a		
	Safety					9 / 34	7 / 29	13 / 29			0 / 36	0 / 34	13 / 34		0 / 32					Safety	Process
Division	Ward	Matron Quality Checks/Patients	Matron Quality Checks/Staff	TYC Overall	TYC/TVN section	Pressure Ulcers	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital acquired C.diff	Hopsital acquired MRSA isolate	% Extremely Likely>90	FFT Response >54%	Red Flag Number of shifts less than 2 RN's on shift	Red Flag Number of shifts more than 8 hours less than planned	% of Supervisory filled Hours	Overall Fill Rate	Care hours per patient		
Unscheduled Care	AAU B/Y 3	! 89%	✓ 96%	✓ 93%	! 86%	✗ 1	✗ 6	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	✗ 27%	✓ 0	✗ 29	! 86%	! 92%	7.31	4	6
	AAU B1	✓ 91%	✓ 93%	✓ 94%	✓ 96%	✓ 0	✗ 7	✗ 1	✓ 100%	✗ 76%	✓ 0	✓ 0	No Resp	✗ 0%	✓ 0	✗ 12	✗ 0%	! 91%	7.83	2	5
	AAU G1	✓ 91%	✓ 96%	✓ 98%	✓ 100%	✓ 0	! 1	✓ 0	✓ 100%	✓ 90%	✓ 0	✓ 0	✓ 91%	✗ 10%	✓ 0	✗ 9	! 76%	✓ 95%	8.27	0	3
	AAU P1	✓ 94%	✓ 100%	✓ 92%	✓ 94%	✓ 0	! 1	✓ 0	✓ 100%	✗ 77%	✓ 0	✓ 0	✓ 100%	✗ 10%	✓ 0	✗ 30	✗ 0%	✗ 82%	8.50	0	5
	AAU Y1	✓ 90%	✓ 100%	! 89%	! 87%	✓ 0	! 2	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 8%	✓ 0	✗ 27	✗ 22%	✗ 84%	7.19	1	6
	CCU/ P/G 3	✓ 93%	✓ 100%	✓ 98%	✓ 96%	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 99%	✗ 48%	✓ 0	✗ 38	✓ 93%	✓ 96%	6.82	0	2
	A&E	✓ 93%	✓ 90%	✓ 96%	✓ 100%	✓ 0	! 1	✗ 1	✗ 75%	✓ 100%	✓ 0	✓ 0	! 86%	✗ 2%	✓ 0	✗ 25	NA	NA	NA	2	3
	MIU	Not done	Not done	✓ 94%	Not done	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✗ 67%	✗ 1%	✓ 0	✓ 0	NA	NA	NA	1	1
	UCC	Not done	Not done	✓ 96%	Not done	✓ 0	✓ 0	✓ 0	✓ 100%	NA	✓ 0	✓ 0	✓ 96%	✗ 12%	✓ 0	✓ 0	NA	NA	NA	0	1
	Frailty	Not done	Not done	✓ 99%	✓ 92%	✓ 0	✓ 0	✓ 0	✓ 100%	Not done	✓ 0	✓ 0	✓ 90%	✓ 59%	NA	NA	NA	NA	NA	0	0
Medicine	Aldenham	✓ 91%	✓ 100%	✓ 97%	✓ 96%	✗ 3	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 95%	✗ 40%	✓ 0	✗ 32	✗ 48%	✓ 97%	6.42	1	3
	Bluebell	! 80%	✓ 96%	! 79%	✗ 66%	✓ 0	✗ 17	✗ 4	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 14%	✓ 0	✗ 11	✗ 57%	✓ 96%	11.14	2	6
	Cassio	✓ 93%	✓ 100%	✓ 97%	✓ 95%	✓ 0	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 31%	✓ 0	✗ 39	✗ 65%	✗ 89%	4.82	0	4
	Croxley	✓ 95%	✓ 92%	✓ 97%	✓ 97%	✓ 0	✗ 5	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 3%	✓ 0	✗ 22	! 76%	! 94%	6.11	1	4
	Heronsgate & Gade	✓ 92%	✓ 97%	! 88%	✗ 79%	✗ 1	✗ 7	✗ 1	✓ 100%	! 83%	✓ 0	✓ 0	! 86%	✗ 13%	✓ 0	✗ 17	✗ 71%	! 93%	5.60	4	7
	Oxhey	! 89%	✓ 96%	✓ 93%	✓ 93%	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 82%	✗ 46%	✓ 0	✗ 3	✗ 67%	✓ 95%	7.69	1	4
	Red	✓ 91%	✓ 93%	✓ 96%	! 88%	✗ 1	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 83%	✗ 39%	✓ 0	✗ 13	✗ 38%	✓ 106%	6.24	2	4
	Sarratt	✓ 95%	✓ 100%	! 86%	! 86%	✗ 8	✗ 6	✗ 2	✓ 100%	! 85%	✓ 0	✓ 0	✓ 100%	✗ 11%	✓ 0	✗ 8	✗ 69%	✓ 100%	6.38	3	6
	Stroke	✓ 97%	✓ 96%	✓ 100%	✓ 100%	✗ 2	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 32%	✓ 0	✗ 17	✗ 67%	✓ 96%	7.47	3	3
	Tudor	! 88%	✓ 98%	✗ 76%	✗ 45%	✗ 1	! 2	✗ 1	✗ 75%	✓ 100%	✓ 0	✓ 0	! 86%	✗ 15%	✓ 0	✗ 21	✗ 45%	✓ 96%	7.15	3	7
	Winyard	! 81%	✓ 96%	✓ 95%	✓ 96%	✓ 0	! 3	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 89%	! 50%	✓ 0	✗ 22	! 81%	✓ 115%	7.05	2	4
Surgery	Cleves	✓ 99%	✓ 98%	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 80%	✗ 10%	✓ 0	✗ 15	✗ 57%	✗ 90%	5.69	1	4
	DLM	✓ 100%	✓ 97%	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 99%	✗ 45%	✓ 0	✗ 52	✓ 93%	✗ 64%	10.87	0	3
	Flaunden	✓ 98%	✓ 100%	✓ 96%	✓ 100%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 94%	✓ 61%	✓ 0	✗ 46	✗ 57%	✗ 78%	6.25	0	3
	ICU	! 87%	✓ 93%	✓ 96%	✓ 100%	✗ 1	! 3	✓ 0	✗ 75%	✓ 100%	✓ 0	✓ 0	! 83%	✓ 75%	✓ 0	✗ 29	✓ 100%	! 93%	23.88	2	4
	Langley	✓ 100%	✓ 100%	✓ 98%	✓ 94%	✗ 1	! 3	✗ 1	✓ 100%	Not done	✓ 0	✓ 0	✓ 95%	✗ 27%	✓ 0	✗ 20	✓ 95%	✓ 98%	5.46	2	2
	Letchmore	✓ 100%	✓ 100%	✓ 98%	✓ 97%	✓ 0	! 2	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	! 89%	✗ 8%	✓ 0	✗ 13	✓ 95%	✓ 127%	5.03	2	2
	Ridge	✓ 98%	✓ 100%	✓ 95%	✓ 91%	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 94%	✗ 24%	✓ 0	✗ 34	✗ 29%	✓ 99%	5.86	0	3
	Elizabeth	✓ 97%	✓ 100%	✓ 97%	✓ 92%	✓ 0	✗ 5	✗ 1	✓ 100%	Not done	✓ 0	✓ 0	! 88%	✗ 30%	✓ 0	✗ 24	✗ 62%	! 91%	4.53	3	4
Paeds	SCBU	! 88%	! 83%	✓ 94%	✓ 98%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 119%	✓ 0	✗ 34	NA	✗ 85%	8.16	0	4
	Starfish	✓ 98%	✓ 100%	✓ 96%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 11%	✓ 0	✗ 13	✓ 91%	✗ 89%	9.06	0	3
	CED	✓ 99%	✓ 96%	✓ 94%	NA	NA	NA	NA	NA	! 88%	✓ 0	✓ 0	✓ 95%	✗ 6%	✓ 0	✗ 15	NA	NA	NA	0	3
	Safari	✓ 100%	✓ 100%	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 17%	✓ 0	✓ 0	✓ 100%	NA	NA	0	1
Maternity	Delivery Suite	NA	NA	! 87%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 95%	NA	NA	NA	NA	✓ 95%	21.15	0	1
	Katherine	NA	NA	NA	NA	✓ 0	NA	NA	NA	✓ 95%	NA	NA	✓ 94%	NA	NA	NA	NA	! 90%	4.68	0	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		

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West Hertfordshire Hospitals NHS Trust

Ward Scorecard (Other/ Non Adult Inpatient) September 2017

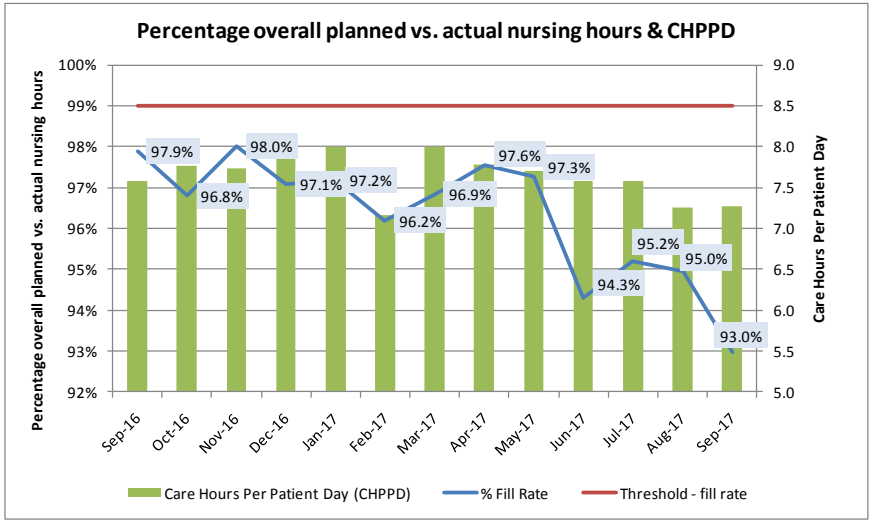
Alert Trigger Point		<90%	<90%	>0	>4	>0	<90%	<90%	>0	>0	<90%	<54%	>0	>1	<90%	<95%	n/a	Number of Alerts	
Number of Alerts	Process	3 / 26	0 / 3				1 / 3	1 / 8				6 / 7		4 / 7	0 / 2	3 / 4	n/a		
	Safety			0 / 9	0 / 3	1 / 3			0 / 9	0 / 9	5 / 27		0 / 7						
Division	Ward	TYC Overall	TYC/TVN section	Pressure Ulcers	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital acquired C.diff	Hopsital 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	A&E	✓ 96%	✓ 100%	✓ 0	! 1	! 1	✗ 75%	✓ 100%	✓ 0	✓ 0	! 86%	✗ 2%	✓ 0	✗ 25	NA	NA	NA	2	3
	MIU	✓ 94%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✗ 67%	✗ 1%	✓ 0	✓ 0	NA	NA	NA	1	1
	UCC	✓ 96%	NA	✓ 0	✓ 0	✓ 0	✓ 100%	NA	✓ 0	✓ 0	✓ 96%	✗ 12%	✓ 0	✓ 0	NA	NA	NA	0	1
Paeds	SCBU	✓ 94%	✓ 98%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 119%	✓ 0	✗ 34	NA	✗ 85%	8.16	0	2
	Starfish	✓ 96%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 11%	✓ 0	✗ 13	✓ 91%	✗ 89%	9.06	0	3
	CED	✓ 94%	NA	NA	NA	NA	NA	! 88%	✓ 0	✓ 0	✓ 95%	✗ 6%	✓ 0	✗ 15	NA	NA	NA	0	3
	Safari	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 17%	✓ 0	✓ 0	✓ 100%	NA	NA	0	1
Maternity	Delivery Suite	! 87%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 95%	NA	NA	NA	NA	✓ 95%	21.15	0	1
	Katherine	NA	NA	✓ 0	NA	NA	NA	✓ 95%	NA	NA	✓ 94%	NA	NA	NA	NA	! 90%	4.68	0	1
	Community	✓ 92%	NA	✓ 0	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	ABC	✓ 92%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 94%	NA	NA	NA	NA	NA	NA	0	0
clinical support	Radiology WGH	! 87%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 93%	NA	NA	NA	NA	NA	NA	0	1
	Radiology HHGH	Not done	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Radiology SACH	Not done	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Radiology AAU	! 86%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	1
Medicine	Outpatient WGH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 92%	NA	NA	NA	NA	NA	NA	0	0
	Outpatient SACH	✓ 95%	NA	NA	NA	NA	NA	NA	NA	NA	! 88%	NA	NA	NA	NA	NA	NA	1	0
	Outpatient HHGH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	! 89%	NA	NA	NA	NA	NA	NA	1	0
	Endoscopy HHGH	Not done	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Endoscopy WGH	Not done	NA	NA	NA	NA	NA	NA	NA	NA	✓ 94%	NA	NA	NA	NA	NA	NA	0	0
	Cath lab WGH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology WGH	✓ 97%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 96%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology SACH	✓ 94%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology HHGH	✓ 93%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 91%	NA	NA	NA	NA	NA	NA	0	0
	Helen Donald WGH	✓ 100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
Surgery	Day surgery SACH	✓ 99%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 98%	NA	NA	NA	NA	NA	NA	0	0
	Opthalmology WGH	✓ 97%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 95%	NA	NA	NA	NA	NA	NA	0	0
	Pre Op HHGH	✓ 94%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Theatres WGH	✓ 96%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres SACH	✓ 94%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres Delivery WGH	✓ 90%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Pre Op WGH	✓ 94%	NA	NA	NA	NA	NA	NA	NA	NA	! 89%	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		

NHS West Hertfordshire Hospitals NHS Trust

Safer staffing

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



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	84.1%	100.8%
	Night	92.8%	103.3%
Care hours per patient day	All	4.5	2.8

What actions have been taken to improve performance

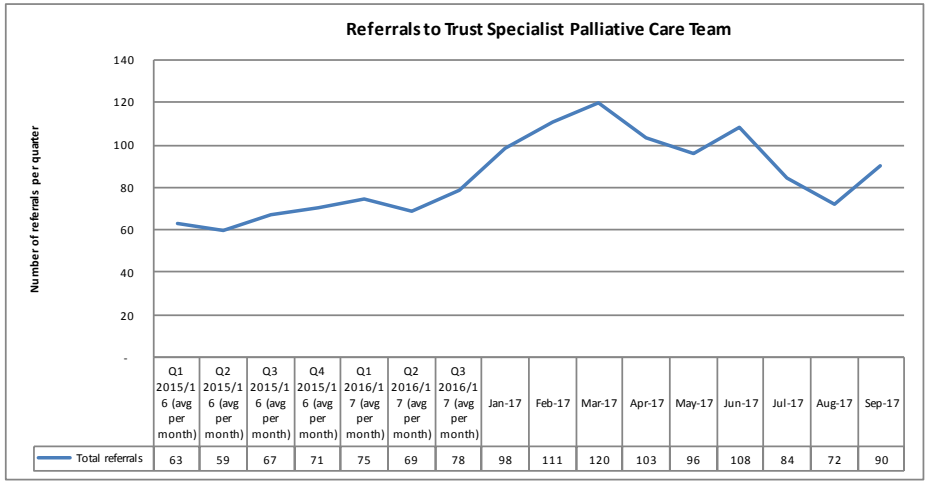
- Enhanced care needs team commenced 13 May 2017 – recruiting to the team continues, bank and agency supports the team.
- Local and international recruitment initiatives continue. Trust Recruitment Group formed chaired by Director of HR and Chief Nurse
- Shared bank approach across four Trusts commenced 31st July.
- Project plan to address the retention rate of band 5s is in place chaired by Executive Director.

What is causing the variance

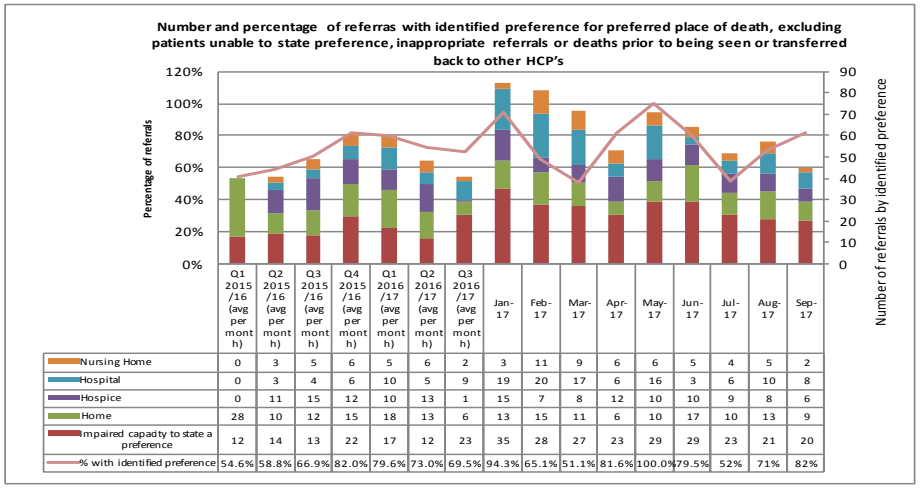
Overall the Trust % fill rate for September was 93.0%, a decrease of 2% from last month and below the national threshold. The fill rate within the medicine/USC division was 95.0%, a decrease of 0.8%. Within Surgery, the fill rate was 89.6%, a decrease of 3.4%. Overall the fill rate in WACS was 91.8%, a decrease of 1.5%. This can be broken down further to show maternity fill rates at 94.7% and paediatrics at 86.4%. The percentage of Trust shifts days and night RAG rated green was 70.5%, a decrease of 1.5% from last month, shifts day and night RAG rated amber was 29.1%, up 1.5% from last month. There were 9 shifts day and night RAG rated red - 0.4%, in UCC, Sarratt, Heronsgate & Gade, Beckett, Letchmore, ESAU (2) and Neonatal Unit (2), all reported on Datix. No harm was reported and mitigations were put in place such as moving staff to the areas and band 7s working in the numbers in order to maintain patient care and safety. There were no red flagged shifts of less than 2 registered nurses in September. However the number of shifts red flagged for registered nurses more than 8 hours less than planned was 670 (29.4%), a decrease of 74 (3%) from last month. The variability showing on De La Mare and Beckett in regard to the fill rates -registered nurses (54.7% days and 62% nights) and for care support workers (73.2% days and 78.3% nights) is predominantly due to shortfall of registered nurses on the weekends and the lower occupancy at St Albans. In September there were 7765 shifts requested via NHSP for bank and agency fill, and the fill rate was 77.6%, with 1736 shifts not filled (22.4 %) an increase of 1.5% from last month.
On the 18 September the surgical wards at Watford were reconfigured. The current band 5 turnover rate is 26.5%, an increase of 0.8%. A recruitment and retention group has been formed, chaired by the Director of HR, as part of an NHSI support programme a number of initiatives are being taken forward. During the month over 283 patients were identified as having enhanced care needs. The overall Trust Supervisory Hours Lost in September was 32.6%, up 5% from last month. CHPPD continues to be reported monthly.

End of Life Care

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



	Q1 2015/16 (avg per month)	Q2 2015/16 (avg per month)	Q3 2015/16 (avg per month)	Q4 2015/16 (avg per month)	Q1 2016/17 (avg per month)	Q2 2016/17 (avg per month)	Q3 2016/17 (avg per month)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Total referrals	63	59	67	71	75	69	78	98	111	120	103	96	108	84	72	90



	Q1 2015/16 (avg per month)	Q2 2015/16 (avg per month)	Q3 2015/16 (avg per month)	Q4 2015/16 (avg per month)	Q1 2016/17 (avg per month)	Q2 2016/17 (avg per month)	Q3 2016/17 (avg per month)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Nursing Home	0	3	5	6	5	6	2	3	11	9	6	6	5	4	5	2
Hospital	0	3	4	6	10	5	9	19	20	17	6	16	3	6	10	8
Hospice	0	11	15	12	10	13	1	15	7	8	12	10	10	9	8	6
Home	28	10	12	15	18	13	6	13	15	11	6	10	17	10	13	9
Impaired capacity to state a preference	12	14	13	22	17	12	23	35	28	27	23	29	29	23	21	20
% 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%	52%	71%	82%

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 September, the number of referrals to the Trust Specialist Palliative Care Team was 90. The number of patients seen by the Specialist Palliative Care Team with an identified preferred place of death (PPD) was 27 out of the 33 patients who had capacity and were appropriate to have this discussion. This equated to 82%.

There was one patient who died at West Herts with home as their preferred place of death. This was due to an unexpected deterioration in their condition.

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

Trust data quality, by exception

Data Quality RAG key

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

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

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

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

Trust Board Meeting

02 November 2017

Title of the paper	**Quality Improvement Plan Update (September data)**
Agenda item	10/53
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 11 projects reported through the one QIP programme reporting cycle this month. The overall status for the QIP at the end of September is green; the forecast status for October is also green. Two projects are rated red (ICT), with nine red actions (largely relating to the ICT projects).For the month of September 9 actions were closed, resulting in a total of 28 open actions for this reporting period. The progress updates and indicators contained in this report reflect September data, providing the Committee with the most up to date information with regards to QIP delivery.
Where the report has been previously discussed, i.e. Committee/Group	Strategy Delivery Board (TEC) 11th October 2017 Safety and Compliance 12th October 2017
Action required: The Trust Board are asked to accept this paper for information and assurance.	

10

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.	

10

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda item: 10/53

Trust Board – 2 November 2017

Quality Improvement Plan Update (September)

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 is now being used for all major projects.

2. Background

2.1 To date (including this reporting period), fifteen 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, Medicine Management, Urgent and Emergency Care, Environment 2016 CQC Review Action Plan projects.

2.2 The QIP is designed to deliver improvements in outcomes and key performance measures.

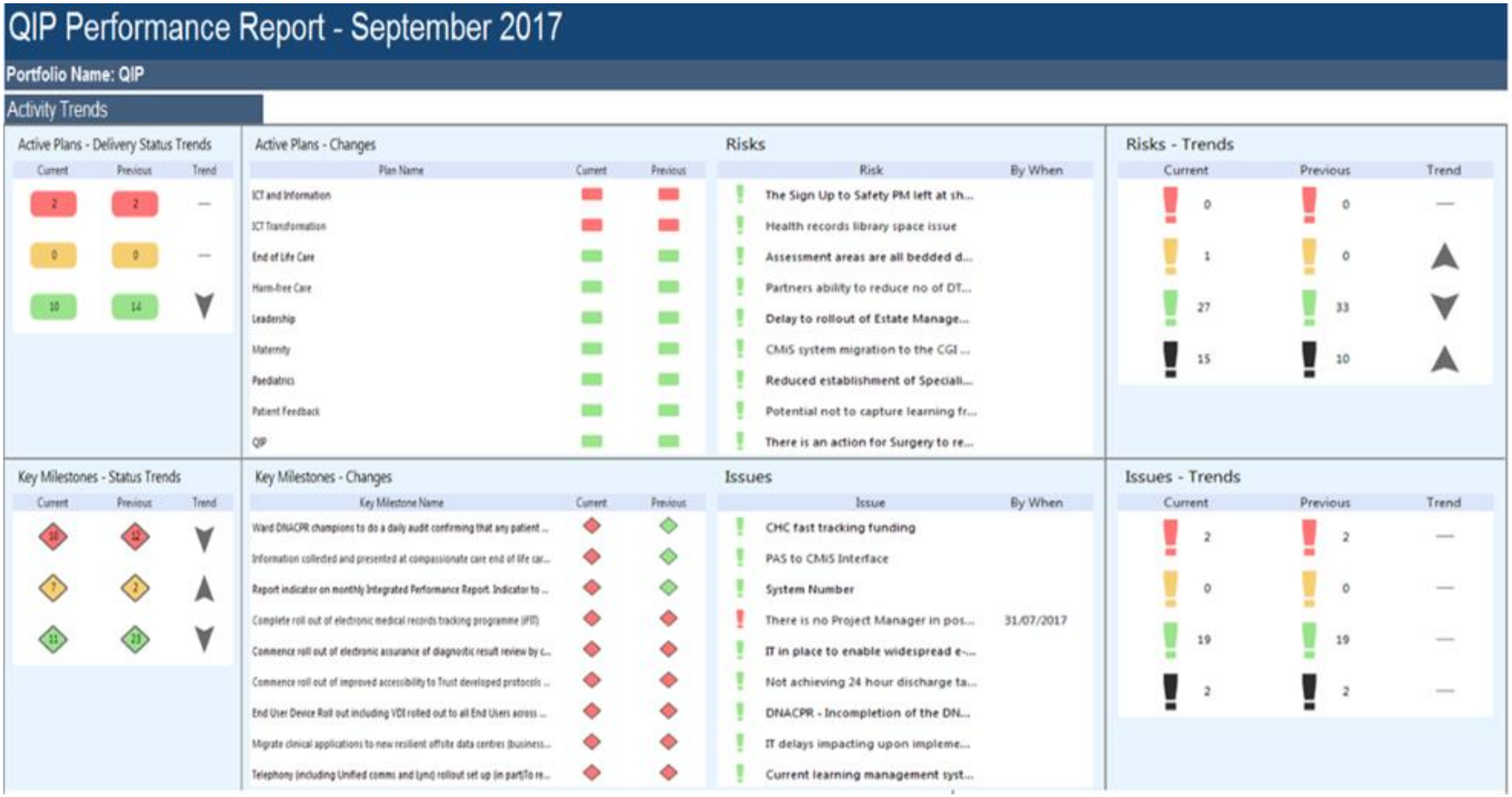
2.3 This report summarises the progress of the QIP projects at the end of September 2017 and is reported using the Red, Amber and Green (RAG) rating.

2.4 There are 11 projects reported through the one QIP programme reporting cycle this month. The overall status for the QIP at the end of September is green; the forecast status for October is also green.

2.5 At the time of this report, the number of SI submitted to CCG had not been received and therefore missing from Appendix 1.

3.0 QIP Programme Analysis

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



QIP Performance Report - September 2017

Portfolio Name: QIP

Activity Trends

Active Plans - Delivery Status Trends

Current	Previous	Trend
2	2	—
0	0	—
10	14	▼

Active Plans - Changes

Plan Name	Current	Previous
ICT and Information		
ICT Transformation		
End of Life Care		
Harm-free Care		
Leadership		
Maternity		
Paediatrics		
Patient Feedback		
QIP		

Risks

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

Risks - Trends

Current	Previous	Trend
0	0	—
1	0	▲
27	33	▼
15	10	▲

Key Milestones - Status Trends

Current	Previous	Trend
10	12	▼
7	2	▲
11	23	▼

Key Milestones - Changes

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

Issues

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

Issues - Trends

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

3.1 Activity Trends

3.2 In the current reporting period there are 11 QIP projects and 1 QIP Programme making a total of 12 active plans this reporting period.

3.3 Four QIP projects have been closed this month.

- Clinical Training
- Environment 2016 CQC Review Action Plan
- Medicine Management
- Urgent & Emergency Care

3.4 Of the 11 active QIP projects reported against in September 2017, there are 9 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).

3.5 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.

3.6 There are currently 2 projects with completed action plans, Safeguarding and Surgery, both remain as active projects as futher actions are due to be added to the projects

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

3.8 Key Milestones – Status Trends

3.9 There are 28 open actions within the QIP in this reporting period, this is a reduction from the 37 open actions last reporting period. 11 of the 28 actions are currently rated as green and are on track to deliver as agreed in the milestones, 7 milestones are rated amber, and 10 of the 28 open actions are rated as red; compared to 2 amber actions and 12 red actions in the previous reporting period. Projects with red milestones include:-

- ICT Transformation
- ICT Information
- End of Life Care

9 actions have been completed in the month of September and closed.

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

Project Activity Details

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

4.1 The table above shows the current RAG status of each of the 11 live QIP projects and 1 QIP Programme. The table also details expected completion month by Project. Projects with no completion month are either red project 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 inspection

5.1 Draft report for factual accuracy expected in November 17 and planning underway with the divisions and the pathway teams to undertake this process.

5.2 Final report expected in December 17 and a quality summit date to be agreed with the inspection team.

6.0 Recommendation

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

Tracey Carter
Chief Nurse and Director of Infection Prevention and Control

October 2017

Appendix 1

Oversight Metrics Performance Challenges

A&E performance *(WGH time to initial assessment % within 15 mins) No baseline however, A&E performance declined again this month from 89.0% in July, 88.9% in August to 85.5% in September. This continues to be below the target of 95%*

Mandatory training compliance has declined slightly from 91.7% in July, 90.1% in August to 89.1% in September. HR continues to implement the new e-learning system although the 95% target has not been achieved in April as planned.

Outpatients Appointments:

Cancelled appointments increased in September to 4.9% from August's figure of 4.1%. This is just below the target of 5%

Vacancy rate:

The vacancy rate has improved this month from 12.7% in August to 11.8% in September. Vacancy rate continues to be behind the trajectory.

Harm Free care (Test Your Care):

Compliance with equipment checks (Test Your Care excluding Maternity, Oxhey and Gade) continues to be above target at 93.7% in July to 94% in August to 96.7% in September (Target is 90%). Accurate Record Keeping continues to improve slightly this month from 92.0% in July, 92.4% in August to 93.6% in September.

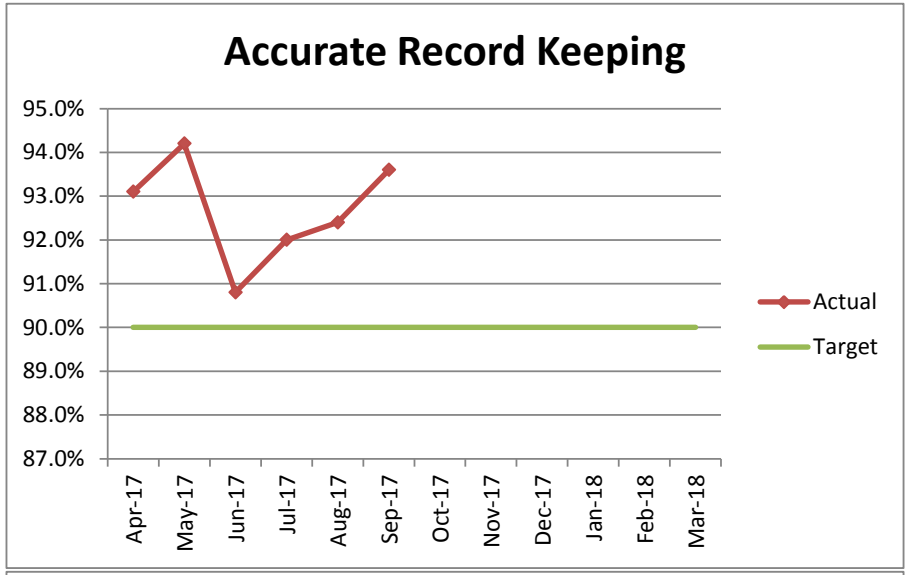
Appendix 1 – Oversight Metrics – September data

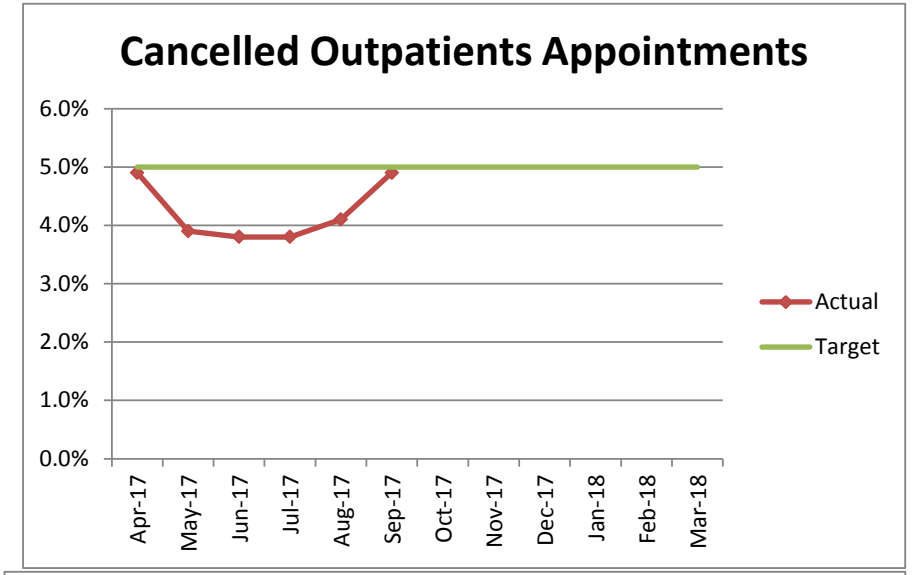
Theme	Project	Metric	Target	Performance																Trend
				Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	
Our People	Leadership and People Development	Mandatory Training	90.00%	86.0%	86.4%	87.7%	87.4%	89.4%	87.9%	87.7%	86.6%	87.2%	88.1%	86.5%	89.1%	87.7%	89.2%	92.1%	91.7%	90.1%	89.1%	
Our People	Recruitment and Induction	Vacancy rate	9.0%	13.5%	14.2%	14.5%	15.2%	15.9%	15.7%	15.6%	15.2%	14.3%	13.5%	13.1%	12.5%	13.0%	12.7%	13.0%	12.3%	12.7%	11.8%	
Our People	Leadership and People Development	Appraisal rate (non-medical staff only)	90.0%		76.5%	85.7%	89.2%	94.0%	91.7%	87.9%	84.6%	80.9%	75.9%	74.6%	73.2%	73.3%	76.5%	90.0%	90.0%	91.2%	89.5%	
Our People	Safe Staffing	Red rated shifts (8 RN hours+ less then planned)	<20%	8.6%	6.4%	8.8%	15.8%	19.4%	16.4%	14.2%	10.8%	17.2%	20.1%	16.6%	20.8%	21.0%	18.1%	19.3%	24.3%	32.4%	29.4%	
Getting the Basics Right	Information Governance	IG breaches - Level 1	5	3	5	4	5	5	3	4	4	3	4	2	8	3	5	15	10	7	5	
Getting the Basics Right	Information Governance	IG breaches - Level 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Getting the Basics Right	Harm Free Care	Compliance with equipment checks (Test Your Care excluding Maternity, Oxhey and Gade)	90%	88.6%	90.1%	93.2%	93.6%	93.4%	93.3%	91.4%	94.0%	94.4%	92.2%	94.6%	94.9%	94.8%	96.5%	94.0%	93.7%	94.0%	96.7%	
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%	88.9%	85.5%	
Patient Focus	Caring for our acutely ill patients	Returns to ITU within 48 hours		2	3	2	5	2	2	4	400.0%	7	1	5	7	3	4	2	5	3	3	
Patient Focus	Outpatients	Cancelled appointments with less than 6 weeks' notice by the hospital^	5%	5.3%	4.1%	3.8%	4.2%	3.7%	3.8%	3.7%	3.2%	3.6%	3.1%	4.1%	4.8%	4.9%	4.0%	3.8%	3.8%	4.1%	4.9%	
Infrastructure	Environment, Estates and facilities	Completed Fire and H&S risk assessments	95%	98.9%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Infrastructure	Environment, Estates and facilities	Security - completed checkpoints	95%	92.2%	92.0%	87.7%	96.1%	99.5%	99.8%	99.0%	1	98.0%	99.0%	98.0%	99.0%	99.0%	100.0%	98.0%	97.0%	98.0%	99.0%	
Governance, risk management and informed decisions	Quality Governance	Accurate record keeping (Test Your Care excluding Maternity, Oxhey and Gade)	90%	84.7%	85.6%	89.3%	90.0%	89.7%	89.5%	89.6%	1	91.6%	89.5%	92.2%	91.9%	93.1%	94.2%	90.8%	92.0%	92.4%	93.6%	
Governance, risk management and informed decisions	Quality Governance	Number of SIs submitted to the CCG within time	95%			88.9%				66.7%	33.0%	83.0%	60.0%	50.0%	67.0%	29.0%	0.0%	100.0%	25.0%	100.0%		
Governance, risk management and informed decisions	Risk Processes	Risk - Completed SIs and complaints investigations with documented actions on Datix.	90%			100.0%				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

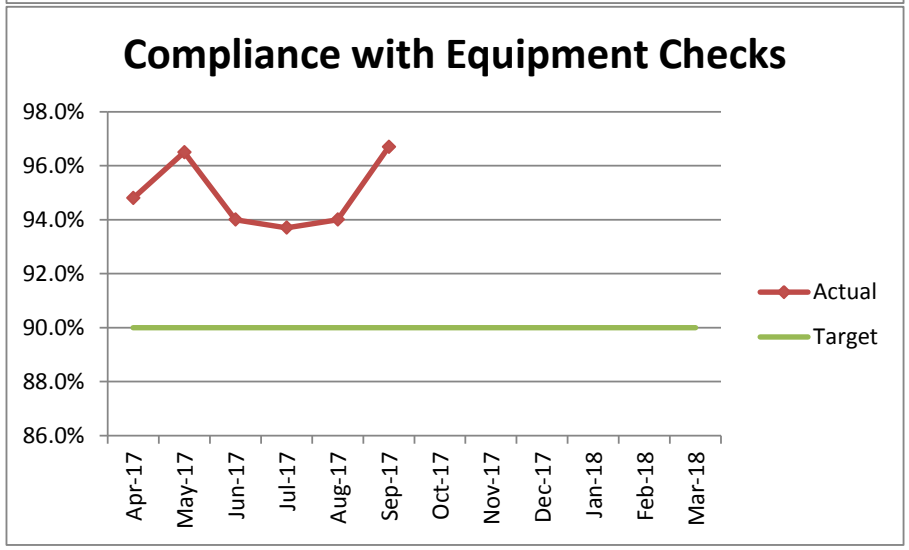
^ Excluding valid cancellations (cancellations to provide earlier appointments, cancellations due to where patients have died and cancellations to appointments made in error)
NB. Where national avg. blank - information not currently available

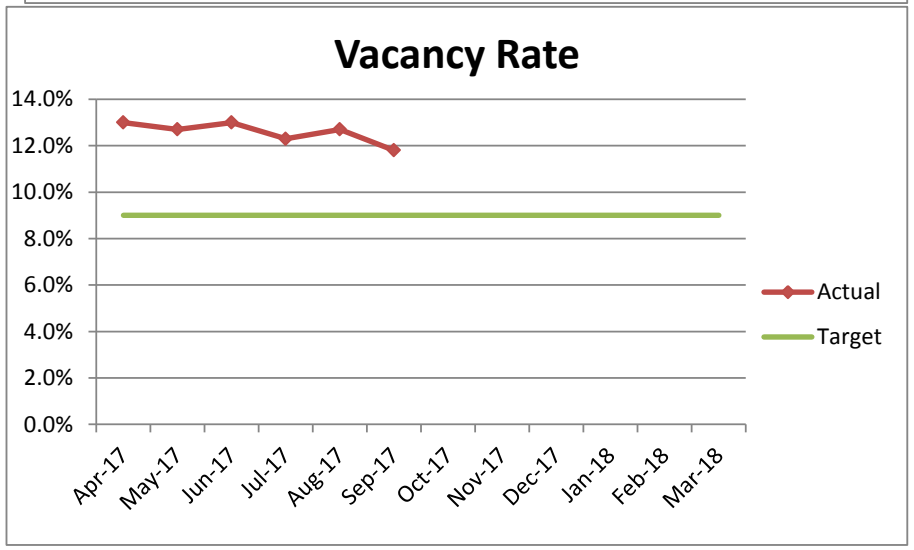
** Indicator measured using response sections: Infection Control, Privacy and Dignity and Resuscitation Trolley. Community Midwifery and Maternity Delivery Suite Care Indicators excluded along with new wards included on TYC in 16/17, Oxhey and Gade.*
** Note that targets for mandatory training, appraisal and vacancy rate have been amended to reflect new Board-agreed levels*

Oversight Metrics Target v Actual – September Data









Appendix 2

REFERRAL TO TREATMENT PERFORMANCE IMPROVEMENT

September 2017 (August performance)

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

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

Submitted performance

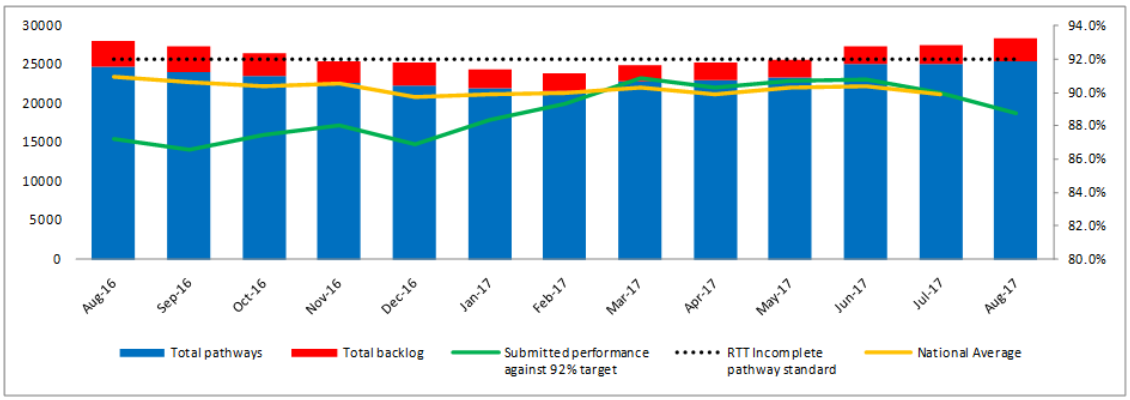
Performance against the 92% RTT incomplete pathway standard in August was 88.8%. The most recent national data available (July) shows that the Trust's performance in July (90.0%) remained above the national average (89.9%).

Recovery has been adversely affected largely as a result of several simultaneous operational challenges which have impacted elective theatre and bed capacity. Theatre ventilation breakdown at Watford severely impacted activity in the month with loss of activity for 10 days. Pressure from the emergency pathway with limited bed capacity resulted in some on the day cancellations but also cancellations prior to admission. Concerns regarding surgical site infection in Orthopaedics lead to curtailment of most major orthopaedic procedures on the Watford site while further investigation and discussions took place. A plan to provide a discrete ward and nursing workforce for Orthopaedics has been agreed and implementation is underway with an expected completion date of 18 September 2017.

Recovery trajectory 2017/18

	Apr-07				May-17					Jun-17				Jul-17					Aug-17			
Week commencing	03/04/2017	10/04/2017	17/04/2017	24/04/2017	01/05/2017	08/05/2017	15/05/2017	22/05/2017	29/05/2017	05/06/2017	12/06/2017	19/06/2017	26/06/2017	03/07/2017	10/07/2017	17/07/2017	24/07/2017	31/07/2017	07/08/2017	14/08/2017	21/08/2017	28/08/2017
Week	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9
Operational standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual performance	89.6%	90.2%	89.9%	89.5%	89.5%	90.0%	90.5%	90.4%	90.2%	89.8%	89.7%	89.5%	89.9%	90.0%	89.8%	89.3%	89.1%	88.9%	88.5%	88.0%	88.4%	88.4%
Backlog to clear to achieve 92%	587	464	539	643	634	504	391	406	473	578	606	674	559	541	607	737	782	831	974	1,109	1,001	1,016

Performance and PTL 2017/18



10

Trust Board
02 November 2017

Title of the paper	**General Data Protection Regulation (GDPR) Update**
Agenda item	**11/53**
Lead Executive	**Lisa Emery - Chief Information Officer**
Author	**Nicola Bateman – Information Governance Manager**
Executive summary **(including resource implications)**	Following a detailed presentation and briefing on upcoming changes to the Data Protection Act at a board business workshop on 19 October 2017, the purpose of this report is for the Board to formally note the key changes required and approve an implementation plan. In general, the principle of data protection remains similar; however there are some key changes which the Board needs to be aware of. These are listed in the report. The implementation plan will be regularly updated and monitored by the safety and compliance committee. The appointment of a designated Data Protection Officer (DPO) will be reviewed by the safety and compliance committee in December 2017.
Where the report has been previously discussed, i.e. Committee/Group	Trust Executive Committee (October 2017) Board Business Workshop (October 2017)

Action required:

- The Board is asked to note the key changes required and approve the implementation plan.

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

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	☐ **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 On the whole, the rights individuals will enjoy under the GDPR are the same as those under the Data Protection Act but with some significant enhancements.	
Risks attached to this project/initiatives and how these will be managed The Trust is required to be compliant with the requirements of GDPR. This will be managed through a detailed action plan which will be regularly updated. The Trust Board will be informed of progress and of any identified risks bi-monthly.	

Agenda item: 11/53

Trust Board 02 November 2017

General Data Protection Regulation (GDPR) Update

Presented by: Lisa Emery, Chief Information Officer

1. Purpose

1.1 The purpose of this report is to update the Board on upcoming changes to the Data Protection Act, the implementation of the General Data Protection Regulation (GDPR) and to ask the Board to endorse the Trust's implementation plan.

2. Background

2.1 The GDPR, which was approved in 2016 and comes into force on 25th May 2018, will be directly applicable as law in the UK. It will replace the Directive that is the basis for the UK Data Protection Act 1998, which will be repealed or amended. It is expected that the provisions of the GDPR will remain in force post-Brexit, and for the foreseeable future.

2.2 In general, the principle of data protection remain similar; however there is greater focus on evidence-based compliance with specified requirements for transparency, more extensive rights for data subjects and considerably harsher penalties for non-compliance.

2.3 The GDPR introduces a principle of 'accountability' which requires organisations to be able to demonstrate compliance with the regulations.

3. Key Changes

3.1 The key changes which will take effect under GDPR are listed in brief below.

Change[1]	Impact
Awareness	Data Controllers should make sure that decision makers and key people in your organisation are aware that the law is changing to the GDPR. They need to appreciate the impact this is likely to have. Regular updates through committee and SIRO reporting
Information you hold	Data Controllers must maintain internal records of processing

Change[1]	Impact
	activities. They must document what personal data you hold, where it came from and who you share it with. You may need to organise an information audit across the organisation or within particular business areas to identify the data that you process and how it flows into, through and out of the organisation.
Privacy Notices	When you collect personal data you currently have to give people certain information, such as your identity and how you intend to use their information. This is usually done through a privacy notice. Under the GDPR organisations must explain their lawful basis for processing the data and how long it will be retained.
Individuals' Rights	On the whole, the rights individuals will enjoy under the GDPR are the same as those under the DPA but with some significant enhancements.
Subject Access Requests (access to records)	Information must be provided at no charge, with tighter timeframes to comply with requests.
Lawful Basis for Processing Personal Information	A lawful basis must be identified for all data processing activities involving personal and sensitive personal information.
Consent	Consent under the GDPR must be a freely given, specific, informed and unambiguous indication of the individual's wishes. There must be some form of clear affirmative action – or in other words, a positive opt-in – consent cannot be inferred from silence, pre-ticked boxes or inactivity. Consent must also be separate from other terms and conditions, and organisations will need to provide simple ways for people to withdraw consent.
Children	The GDPR will bring in special protection for children's personal data, particularly in the context of commercial internet services such as social networking. If organisations' offer online services ('information society services') to children and relies on consent to collect information about them, then they may need a parent or guardian's consent in order to process their personal data lawfully.
Data Breaches	The 72-hour requirement for reporting serious data breaches will be mandatory across all sectors. Financial penalties may be up to 4% of organisations' worldwide turnover (current limit is £500,000).
Privacy by Design and Data Protection Impact Assessments	Undertaking Data Privacy Impact Assessments where processing is likely to pose a high risk to individuals' rights and freedoms and incorporating data protection measures by default in the design and operation of information systems and processes.
Data Protection Officers	The appointment of a suitably qualified and experienced Data Protection Officer that must report directly to the highest

Change[1]	Impact
	management level of the organisation.
International	Cross-border processing agreements will require determination of the supervisory authority – whether this is ICO or equivalent authority in other countries.

[1] These are based on the Information Commissioner's Office 12 steps for preparing for GDPR, available at https://ico.org.uk/media/1624219/preparing-for-the-gdpr-12-steps.pdf.

4. Next Steps

4.1 A recent CEO Briefing advised that all health organisations should consider the development and implementation of action plans to achieve this demonstrable compliance and that they are formally endorsed by the most senior level of management.

4.2 The Trust Information Governance team has developed an action plan (see Appendix One) detailing the milestones to GDPR compliancy before 25th May 2018. The action plan will be regularly updated and the Board will be informed of progress and of any identified risks bi-monthly.

4.3 The Trust Board received a detailed presentation and briefing on GDPR at its Business Workshop on 19 October 2017. It also reviewed and commented on the draft implementation plan, and discussed risks associated with implementation, which will be documented and managed following the Trust's risk governance processes.

4.4 The Trust is required to appoint a designated Data Protection Officer (DPO). A recommendation will be brought to the relevant Board sub-committee by December 2017.

5. Recommendation

5.1 The Board is asked to formally note the key changes and approve the implementation plan.

Lisa Emery
Chief Information Officer

25 October 2017

Appendix One: Trust GDPR Implementation Plan (October 2017)

Milestone Code	Milestone Name	Planned End Date	Additional Involvement	Completed %
LB01	Review Data Mapping templates to ensure they are GDPR compliant.	10/09/2017		100%
AW01	A session on GDPR at the October 19th Board Development Day	19/10/2017		100%
AW02	Produce GDPR paper and GDPR report for the Board meeting on 2nd Nov 2017	02/11/2017	SIRO	100%
LB02	Send out Data Mapping Returns to all departments across the Trust. Identify the 'Legal Basis' for all outbound Data Mapping returns for 2017-18	30/11/2017		50%
LB03	Identify any data flows that have previously relied on 'legitimate Interests' as a legal basis for processing	31/12/2017		75%
IN01	Identify all routine data flows outside the EU for 2017-18 and ensure they are GDPR compliant.	31/12/2017		50%
IN02	Ensure there is a comprehensive, accurate and up-to-date asset register of ICT systems	31/12/2017	ICT Supplier, ICT	25%
SA01	Set-up meeting with Litigation & Claims to discuss how they will handle SAR requests within the new timescales.	31/12/2017	Litigation & Claims	25%
SA02	Notify all other relevant departments that handle requests about the changes and arrange a meeting e.g. X-Ray, Physiotherapy	31/12/2017	Radiology, Physiotherapy	25%
DP01	The Board must decide who under GDPR should be the designated Data Protection Officer (DPO).	31/12/2017		0%
DP02	Create/amend DPO job descriptions to ensure GDPR compliant	31/12/2017	IG/Human Resources	25%
IN03	Undertake gap analysis to identify systems and data in use that has not been through ICT approval process	31/12/2017	ICT Suppliers	0%
PR03	Consider whether our notices have to accommodate “child friendly requirements” (see Children Work stream)	31/12/2017	ADM Children Services / Clinical Director for Paediatrics	0%
CH01	Identify if any services are offered directly to a child and ensure information notices are drafted specifically for a child	31/12/2017	ADM Children Services / Clinical Director for Paediatrics	0%
CH02	Identify if the Trust offers Information Society services directly to children and assess which rules apply under GDPR	31/12/2017	ADM Children Services / Clinical Director for Paediatrics	0%
PI01	Create a Data Privacy Impact Assessment questionnaire, template and policy. Integrate methodology into ICT project documentation	31/12/2017	Projects / ISM	50%

Milestone Code	Milestone Name	Planned End Date	Additional Involvement	Completed %
AW03	Produce GDPR report for the Board meeting on 7th Jan 2017	07/01/2018	SIRO	0%
CO01	Review and update the SOP for Obtaining and Documenting Informed Consent in Research to ensure GDPR compliancy	30/01/2018	Research & Development	0%
CO02	Identify whether the Trust relies on consent to process personal data for scientific research and ensure this is GDPR compliant	30/01/2018	Research & Development	0%
AW04	Produce GDPR report for the Board meeting on 1st Mar 2018	15/02/2018	SIRO	0%
AW05	Incorporate GDPR into the wallet size IG booklets (Also refer to SAR work stream)	28/02/2018		0%
AW06	Redraft Information Sharing Agreements (ISA) to include GDPR responsibilities for third party processors and data controllers	28/02/2018	`	0%
AW07	Review existing Contracts and Service Level Agreements (SLA) to ensure they comply with GDPR	28/02/2018	Procurement, ADMs	0%
SA02	Amend SAR Policy, and all other documentation to incorporate new timescales and that the Trust can no longer charge for complying with an SAR	28/02/2018	Litigation & Claims	0%
SA03	Update IG online training and wallet size booklets to ensure they incorporate changes to SAR under GDPR	28/02/2018		0%
IR01	Identify if portability applies; consider which systems and data are covered by this.	28/02/2018	Information Asset Owners / Departmental Managers	25%
IR02	If portability applies, identify if systems can easily be exported in structured, machine readable formats.	28/02/2018	Information Asset Owners, Research & Development, PALS, Audit	25%
IR03	Identify if the right to be forgotten could apply and adopt a process to meet the requirement.	28/02/2018	Research & Development, PALS, Audit	25%
IR04	Determine if ICT systems are able to meet the requirements to mark data as restricted whilst complaints are resolved.	28/02/2018	Systems Integration, PAS	0%
IR05	Identify if the right to object applies - Individuals have the right to object to: - processing based on legitimate interests or the performance of a task in the public interest/exercise of official authority (including profiling); -direct marketing (including profiling); and processing for purposes of scientific/historical research and statistics.	28/02/2018	Research & Development / Charities (Fundraising)	25%
IR06	Identify if any automated decisions are carried out on all IT systems and document a process to meet the requirement	28/02/2018	Information Asset Owners	75%
PN01	Review and update patient leaflets 'Your Information - Your Health Records' so they are GDPR compliant	31/03/2018	Medical Illustration	25%
PN02	Review and update employee and applicant forms to ensure GDPR compliancy	31/03/2018	Human Resources	0%

Milestone Code	Milestone Name	Planned End Date	Additional Involvement	Completed %
IR07	Update the Data Protection policy to include all the rights individuals have under GDPR	31/03/2018		0%
CO03	If a data flow relies on Consent as the primary legal basis for processing personal information, ensure quality of consent meets new requirements. Review methods for seeking, obtaining & recording to ensure compliance	31/03/2018		0%
CO04	Ensure all fundraising activities across the Trust are compliant with guidance published by the ICO and the fundraising regulators.	31/03/2018		0%
AW08	Review and update IG online mandatory training module to ensure it is GDPR compliant	30/04/2018		0%
AW09	Update the IG intranet page with information relating to GDPR	30/04/2018		25%
SA04	Update intranet page and website to incorporate new changes regarding SAR	30/04/2018	Litigation & Claims	0%
DA01	Update Incident Reporting Policy and Procedure to meet new requirements for data breach reporting	30/04/2018	Risk Management	0%
DA02	Ensure all IG related policies are compliant with the new rules for data breach reporting under GDPR	30/04/2018		0%
DA03	Ensure ISA and third party contracts include clauses and procedures to meet the new rules for reporting breaches	30/04/2018	Procurement	0%
AW10	Produce a section for eUpdate on GDPR	14/05/2018	Communications	0%

Note: milestone codes relate to ICO 12 step guidelines

Trust Board Meeting
02 November 2017

Title of the paper	**Strategy update**
Agenda item	**12/53**
Lead Executive	**Helen Brown, Deputy Chief Executive**
Author	**Helen Brown, Deputy Chief Executive**
Executive summary **(including resource implications)**	This report provides an update on the current position in relation to a range of longer-term service changes and strategic developments. It will briefly outline progress regarding the following: 1. Your Care Your Future ~ integrated care and pathway re-design. 2. Stroke 3. Vascular 4. Strategic Outline Case for the Redevelopment of Acute Hospital Services 5. Hemel Hempstead Strategic Outline Case 6. Car Parking Strategic Outline Case 7. Sustainability and Transformation Partnership Separate papers are also being submitted to the November Board meeting in relation to the future of pathology services and the Royal Free London Partnership.
Where the report has been previously discussed, i.e. Committee/Group	Updates on specific issues have been provided to the trust executive committee and other relevant forums.

Action required:

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

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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

- Continuous improvement in care pathways.
- Improved physical environment from which care is provided.

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

- Financial risks relating to pathway redesign: detailed mapping is being undertaken and a standard methodology developed.
- Limited funding availability to support the development costs of major capital business projects: progress will be limited until funding sources are confirmed and so, where possible, internal resource is being deployed to support these programmes.

West Hertfordshire Hospitals NHS Trust

Agenda item: 12/53

Trust Board Meeting – 02 November 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.
   Brief updates on all active workstreams are provided in appendix one.

2. **Stroke**

   HVCCG has confirmed that it would like WHHT to take the overall co-ordinating lead across a WHHT and HCT provider partnership for the delivery of an integrated stroke pathway.
   As previously reported it is recognised that additional investment would be required for WHHT to make further progress towards the delivery of the full hyper-acute stroke service specification. Detailed discussion with HVCCG and with HCT on mobilising the lead provider model will continue, including review of the financial envelope available.

3. **Vascular**

   E&NHT are leading the development of a vascular network for Hertfordshire and West Essex, with a hub at the Lister Hospital and 'spokes' at Watford General Hospital (WGH) and Princess Alexandra Hospital (PAH). Work is currently underway to confirm the potential implications for all organisations. A programme board has been established by E&NH and a Memorandum of Understanding drafted. Internally, a paper is being drafted for initial review by the Clinical Advisory Group regarding potential care pathway implications. A more detailed update will be provided for the December 17 Trust Board.

4. **Your Care, Your Future - Strategic Outline Case for the Redevelopment of Acute Hospital Services**

   The main acute transformation / redevelopment SOC is currently being reviewed by NHS Improvement following the standard business case review process. Given the scale of investment required Department of Health review and approval will also be required. There is no firm timeline as yet for this review process to complete.

A joint meeting with NHS Improvement, NHS England and HVCCG is being convened with a view to getting a clear shared understanding of the timeline for formal decision on the SOC and any issues that require clarification to enable decision making to proceed. Future governance arrangements and resourcing will also be discussed.

Meanwhile, a proposed governance structure to oversee the next stage of planning is being worked up, following an initial meeting in October. This will be brought to the December Trust Board meeting for review.

5. Hemel Hempstead Strategic Outline Case (SOC)

A stakeholder workshop was convened on 28th September to consider the future clinical model needed in Dacorum. This event was well-attended by WHHT clinicians and by other local stakeholders and patient representatives. The November 17 Hemel Hempstead Project Delivery Group meeting will consider the outcomes of the stakeholder workshop in detail, with the intention of completing a Strategic Outline Case (SOC) early in 2018. A programme of stakeholder engagement and communications will continue throughout the development of the SOC.

6. Car Parking Strategic Outline Case

The Car Parking strategic outline case has been submitted to NHS Improvement for review and approval. The Trust has provided a comprehensive response to a series of clarification questions. Our understanding is that the SOC is now with the national NHS Improvement 'cash and capital' team for review prior to submission to the relevant NHS Improvement Committee for formal approval.
[NB – no change to October reported position]

7. Pathology

See separate paper. (Strategic Outline Case for approval).

8. Royal Free London partnership
See separate paper. (Work Plan for approval)

9. Sustainability and Transformation Partnership (STP)
Highlights this month include:

- Work continues to update the STP wide finance and activity analysis (due for completion in October)
- A clinical engagement workshop is scheduled for 31st October 2017.

All organisations within the STP are also being asked to sign up to a 'Memorandum of Understanding' (MOU) that formalises our commitment to working together to deliver the STP priorities. A detailed paper is included in the Part 2 Board Agenda.

An STP newsletter is attached for information.

Helen Brown
Deputy Chief Executive

November 2017

Appendix 1.

Pathway	Type of pathway redesign	Key partners developing models	Development stage	Expected date of service commencement	Next key milestone
Community Musculoskeletal Service	Open market competitive tender 3years +2 contract	• A WHHT led service in partnership with Hertfordshire Community Trust, HertsOne GP Federation, Herts Valley Physio Group the current 17 AQP providers) & the Royal Free London NHS Foundation Trust (RFL). • Collectively we have called ourselves the Herts Musculoskeletal Collaborative (HMSKC)	• Invitation to Tender submitted 16/06/17. • Presentation & interviews completed 02/08/17. • Contract awarded to Connect Healthcare. • Detailed analysis of impact on income and expenditure completed • Connect have approached WHHT to provide the Rheumatology service on a sub contracted basis. Proposal received and being evaluated on a clinical, strategic and financial basis	CCG contract with Connect expected to commence January 2018.	Service line plans being worked through to reduce capacity as activity reduces and to mitigate against retaining costs as income reduces.
Community Dermatology	Multi Provider Partnership Collaborative (MPPC) 3years +2 contract (tbc)	• A WHHT led service in partnership with the two other incumbent providers, HertsOne GP Federation & Royal Free London NHS Foundation Trust (RFL).	• Teledermatology commenced on 01/09/17 as planned as a 6month pilot. • MPPC launch expected by CCG October 2017. • Analysis by diagnosis of potential community activity by WHHT in partnership with GP Federation lead	• 01/09/17 for Teledermatology • Full MPPC requested by HVCCG from December 2017 but to be agreed based on service scope	Launch of MPPC (expected by CCG October 2017). Nothing received as at 25/10/17 but work proceeding internally in anticipation
Community Gynaecology	Most Capable Provider 3 year contract	• Lead provider is Hertfordshire Community Gynaecology Practice owned by the Drs Kedia. Subcontracting with WHHT, RFL & Luton & Dunstable University Hospital.	• Finalisation of activity and finance and standard operating procedure as part of mobilisation. • Quality schedule and governance framework for the community service agreed	• 01/12/17 for triage. • Full service delivery from 08/01/17	CCG are refreshing the data with the lead provider. Impact for WHHT needs to be understood. Development of the subcontract between the lead provider and WHHT after baseline activity agreed. Now delayed by CCG refresh (was expected

					by end of October 2017). Revised date tbc.
Community Diabetes	Multi Provider Partnership Collaborative (MPPC) 5year contract	• Now to be a WHHT led service in partnership with Hertfordshire Community Trust and HertsOne GP Federation	• Assurance document returned to HVCCG 21/07/17. • Awaiting confirmation by HVCCG of proposed service model and associated contract variation • CCG confirmed the proposal for a WHHT led integrated diabetes service. Significant comments received from CCG on the HCT submission which have been responded to by WHHT	Original plan was for Oct 2017, however delays in response to MPPC proposal by CCG will see start date pushed back. New mobilisation plan in development and will be completed by 15/11/17.	Awaiting CCG response to WHHT update on MPPC proposal (which includes the contract form to be a 1 year shadow to baseline data and the significant changes required in primary care elements of the pathway – not in the direct control of the MPPC partners and so presents a significant risk which is mitigated by a shadow year.
	National Diabetes Treatment and care programme (foot health, structured patient education & recommended treatment targets) 2 years funding with only 1st year confirmed	• As with the MPPC arrangement but a separate contract	• MOU with national programme agreed. Working groups for service delivery in place	From October 2017 (staged delivery of programme)	• Foot group to agree start date of service based on recruitment of team. • EDEN diabetes training programme commences Oct 2017

Integrated Community and Secondary Care Respiratory Service for Herts Valleys	Service led redesign ahead of Multi Provider Partnership Collaborative (MPPC) planned for Oct 2019	• WHHT in collaboration with Central London Community Healthcare (CLCH)	• Phase 1A - Development of Respiratory Hot Clinics to support prompt assessment of acutely unwell patients, minimise need for admission and facilitate safe early discharge, ensure appropriate follow up on the right clinical pathway	November 2017	Finalisation of clinical model and development of contractual arrangement
			• Phase 1B - Referral management including referrals filtered by disease specific pathways, advice and guidance and advice and guidance plus (includes virtual consultation and investigations)	April 2018	Finalisation of clinical model, agreement on preferred electronic system to support
			• Phase II -Develop and implement the full integrated acute and community model for Respiratory Services	April 2019	Development of Integrated Respiratory Service Specification and Pathways by April 2018
Lower GI Telephone Assessment Clinic (TAC)	Service led redesign	WHHT	• Implementation of nurse led telephone assessment clinic (TAC) service enabling 'straight to test' for 2ww patients	To be finalised but will be this calendar year	Finalisation of tariff for service with HVCCG and staff recruitment
Integrated Heart Failure Service (to include Cardiac Rehabilitation)	Multi Provider Partnership Collaborative (MPPC)	HVCCG requesting a WHHT led model in partnership with HCT	• Letter of intent issued to WHHT. Awaiting scope of service with finance and activity information from HVCCG • HVCCG have withdrawn the notice that they served HCT for Heart Failure and Cardiac Rehab Services	To be agreed	HVCCG to identify activity and assumptions for inclusion and update position with HCT service

			as they have realised that the service re-provision and integrated pathways are going to be more complicated than they originally thought		
FIRST (Facilitating Integrated Re-enablement to Support Transition)	Service redesign with a block contract to test a care model before moving to a bundle based approach	WHHT commissioning HCT to provide the service	• Pilot service in place, further evaluation being completed. • Service specification developed by WHHT in partnership with HCT & the Integrated Discharge team	In delivery as a pilot	Agree future service model and associated funding streams

Oct 2017

A Healthier Future

Hertfordshire and west Essex STP

Tom Cahill: Leader's Update

Welcome to the second edition of the STP Leader's Update.

This month you will find updates from a number of the STP's workstreams. It's clear from these reports that colleagues from across the system are really getting stuck into making changes that will improve services for residents and job satisfaction for health and care staff.

In this update you will learn more about developments within our cancer workstream, including an update on the bids put forward to support the early diagnosis of cancer, as well as increasing our capacity to treat patients.

You can read about technological developments and the work being done to achieve a truly joined-up approach to patient care through shared information.

There's also news about the workforce workstream's focus on drawing in talented staff and equipping them with the skills they need to deliver our vision.

I hope that you find this update informative. Please do forward it on to colleagues in your organisation who might find it interesting. If you have any comments or questions, please don't hesitate to get in touch,

Tom

Contents

- Date for your diary
- Introducing the cancer workstream
- Tech talk
- Workforce – attraction and recruitment
- Extra support to deliver STP priorities
- In the next edition

Diary date

STP director and senior clinical lead workshops – choice of two sessions at The Colonnades, Hatfield:

- **31 October**, 1pm - 4pm
- **14 November**, 9.30pm -12.30pm

These sessions are designed to give you the time and space to find out more about key developments across the STP, as well as the opportunity to give your views and insights.

To register your interest in either session, contact robert.crerie@hpft.org.uk.

The agenda for the workshops will be circulated later in October.

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Diary date

Vanguard showcase

2 November, 10am – 3pm, the Fielder Centre, Hatfield

East and North Hertfordshire CCG, Hertfordshire County Council and the Hertfordshire Care Providers Association will be showcasing the learning from their Care Home improvement Vanguard at the Fielder Centre in Hatfield.

This event will allow delegates to learn from the scheme's successes, benefit from lessons learned and take away practical ideas to integrate Vanguard best practice into a range of improvement programmes.

Innovations from the Vanguard have a wide-ranging relevance to a number of STP workstreams. With national funding for the Vanguard drawing to a close in spring 2018, it is important that best practice from this scheme spreads beyond the east and north Hertfordshire to benefit patients and improve system-wide working across our STP area.

The day will begin with a national overview on Vanguard learning, from William Roberts, National Lead, Enhanced Health in Care Homes, New Care Models Programme.

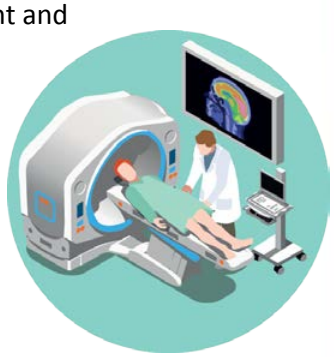
This will be followed by four themed workshops:

1. **Improving hospital discharge processes** - the role of the 'Impartial Assessor' and the care home 'Red Bag' scheme (co-hosted by Sutton care home Vanguard)
2. **Multi-disciplinary working** - Medicine Optimisation in care homes and the East of England Ambulance Service Trust's Early Intervention Vehicle
3. **Technology in care homes** - NHS.net and real-time GP access to patient records
4. **Workforce development** – up-skilling care home staff to prevent avoidable hospital admissions.

Lunch will be provided and there is free parking at the conference centre.

As there is a limit on numbers, please book early using this link: **https://enherts-care-homes-vanguard-showcase.eventbrite.co.uk**

Introducing: the cancer workstream



Improving cancer treatment and patient outcomes for patients in our area is vitally important, which is why the assessment of our overall performance as an STP is influenced by the effectiveness of the area's cancer services. The STP's cancer workstream is prioritising the planning, development and implementation of the transformational changes required to implement the National Cancer Taskforce Strategy, as well as delivering the East of England Cancer Alliance work programme.

The group has good representation from providers, commissioners, third sector organisations and the East of England Cancer Alliance. The programme board has appointed a clinical lead - Dr Christine Moss, who works for West Essex CCG - and a dedicated programme manager, Debbie Adger (who is based at the East and North Hertfordshire NHS Trust) to support this work.

A delivery plan has been developed around nine key work streams including: prevention;

early diagnosis; supporting people living with and beyond cancer through the implementation of the recovery package and risk-stratified pathways, and patient experience. The clinical and managerial leads for each workstream are currently being finalised. The next step will be to develop detailed plans with clear key performance indicators and deliverable outcomes.

Cancer funding update: The Cancer Alliance has asked the STP to submit project briefs to support a number of bids for funding for equipment, pathway re-design and improved facilities to treat cancer patients across our area. Guidance received from the Alliance stresses that bids should support the early diagnosis of cancer, not just increase the capacity to treat patients.

Bids include a request for £800,000 for an MRI scanner for East and North Hertfordshire NHS Trust, £1.2m for the construction of a new MRI room, £90,000 for resequencing lung cancer pathways at Princess Alexandra Hospital in Harlow and £85,000 for a new radiology information system. We will update you when the outcome of these bids is known.

Tech talk

The STP technology workstream has a diagram showing its links to numerous projects within other STP workstreams. It makes spaghetti junction look like a simple roundabout!

Identifying the many different IT systems in use across the STP is at the heart of achieving a truly joined-up approach to patient care through shared information. The STP tech workstream has been working to persuade the suppliers behind the various systems that their commercial interests are better served by helping us collaborate. So, instead of a competing collection of IT suppliers, the workstream is pushing towards a network of providers who are being driven hard to create sustainable links between our organisations in order to improve intelligence-based decisions across patient pathways.

Lots of work is happening to collaboratively provide improvements in technology. This might be linking the Wi-Fi in use across NHS and social care premises to enable smoother, seamless working for staff across different locations, to sharing information and practice around cyber security to ensure we are best prepared as a whole system against potential cyber-attacks.

The technology workstream also hopes to find new ways (both tools and teams) of analysing data from across health and social care to understand our citizens, profile them against certain health risks and commission more targeted services.

The group is taking a closer look at Assistive Technology – understanding the art of the possible and working with clinical leaders to identify what solutions would be most appropriate and powerful for citizens. One of the many projects that the technology workstream is investigating is 'MedePi', a telehealth system funded and being trialled by NHS Digital. The pilot will cover 50 patients across three services (heart failure, cardiac rehabilitation and community nursing) with evaluation by Leeds University. The aims of the project are to:

- determine if patients can simply and reliably take their own health readings – such as blood pressure for example

- determine if those measurements can be used by clinicians
- reduce the number of interventions and visits to patients in the trial

Similar initiatives build on excellent work in the Vanguard programme, which empower care homes to manage citizens where they live, rather than triggering excessive visits to health settings.

The STP tech group also wants to see if telehealth could be used to extend the interaction between telehealth devices and mainstream assistive technology devices within the home.

Learning from popular health technology already in use, such as smart watches and fitbits, the group will also be exploring the possibility of using telehealth devices to remind and encourage patients about healthy living options and activities.

Workforce – attraction and recruitment

Drawing in the next generation of talented staff and equipping them with the skills they need to deliver our vision is a key focus for the STP's workforce workstream.

As well as planning a careers event aimed at 15 and 16 year-olds in March 2018, the workforce attraction subgroup is exploring the potential to improve the appeal of a career in health and social care through the creation of a career 'passport'. This would make it easier for staff to change roles either within or between STP organisations, fostering talent and retaining ambitious staff in the local area. Improving the benefits on offer to staff is also under consideration – drawing on the experiences of Trusts in other areas, which have offered discount vouchers for everyday shopping through a salary sacrifice scheme.

Other activities underway include:

- a work experience scheme being planned by deputy Directors of Nursing
- exploring the potential for the digital marketing of careers opportunities
- streamlining the recruitment of health and care apprentices.

More information on the innovative Masters-style 'Physician's Associate' course which has just launched at the University of Hertfordshire will follow in the next update.

Extra support to deliver STP priorities

In the last edition we publicised opportunities for staff to join the core STP project team for a year. This was in response to requests from workstream leads, who felt that they needed additional support to make the improvements our health and care system needs.

After a successful recruitment process, we are delighted to welcome three colleagues who have been seconded to work on a variety of STP projects for a year, from October onwards:

Shirley Potter, who currently works as a business change project manager for Princess Alexandra Hospital, will be initially supporting the estates and prevention workstreams

Melissa Martin, who currently works as a transformation lead and area manager for Hertfordshire Community NHS Trust, will be initially supporting the clinical support services and pharmacy and medicines optimisation workstreams.

Keith Bringloe, who works for East and North Hertfordshire CCG as an ICT project manager, will initially support the urgent and emergency care and procurement workstreams.

We are looking forward to welcoming Shirley, Melissa and Keith to the team – there will certainly be plenty for them to get their teeth into in the year ahead.

In addition, we have received a number of high-quality applications from senior clinicians, for the new part-time role of STP clinical lead. All of the applicants have been contacted and we are working through a process to determine how best to harness the clinical talent within our STP area for the benefit of our 1.5 million residents.

Flu Vaccination

As senior leaders we all have a role in preventing the spread of flu by having and promoting the flu vaccination.

We all know flu can have serious and even fatal consequences, especially for vulnerable patients and service users. It is equally concerning that the flu virus can be transmitted by individuals who are asymptomatic and unaware they are carrying the virus.

We should lead by example, and act as role models to our clinical and non-clinical colleagues, patients and service users. By being vaccinated ourselves, and endorsing the flu vaccination for high risk groups in the community, we can help raise awareness and highlight the importance of the flu vaccination.

I've had my flu vaccination – and here is the photographic evidence! When will you have yours?

In the next edition:

- Improvements to the NHS 111 advice service in Hertfordshire
- An update on the STP- wide consultation into the provision of NHS-funded IVF and other topics
- Physician's Associates – what are they and how will they improve patient care?
- More workstream updates from around the STP

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.

Want to see your workstream featured here?

Speak to your communications workstream lead or contact nuala.milbourn@enhertsccg.nhs.uk

www.healthierfuture.org.uk

Trust Board Meeting
02 November 2017

Title of the paper	**Hertfordshire Health Concordat**
Agenda item	**13/53**
Lead Executive	**Helen Brown**
Author	**Hertfordshire Overview and Scrutiny Committee**
Executive summary **(including resource implications)**	Legislation requires that scrutiny committees must be consulted in the event of a substantial development or variation of services. The Concordat sets out expected ways of working between NHS bodies and the Hertfordshire County Council Overview and Scrutiny Committee in relation to changes to services, with a core principle of 'no surprises'. All NHS bodies in Hertfordshire have been asked to sign up to the Concordat, essentially giving a commitment to close working and regular dialogue with the Scrutiny Committee. The Concordat also sets out expectations in relation to consultation on substantial variations to services, based on the Government's 'Consultation Principles – 2016'.
Where the report has been previously discussed, i.e. Committee/Group	Trust Executive Committee confirmed its support for signing up to the Concordat.

Action required: *[*

- The Board is asked to confirm its willingness to sign up to the Concordat and to working within the principles set out.

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

Appropriate engagement of patients and stakeholders can help to ensure that benefits to patients from planned service changes are optimised. Appropriate and early engagement with the Health Scrutiny Committee will help to ensure that the Trust is fulfilling its statutory duties to engage and facilitate timely decision making.

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

- Service changes are made without appropriate engagement – this may mean that benefits for patients are not optimised and / or that the Overview and Scrutiny committee deem that changes are not in the interests of local residents.

The Trust's patient and carer's experience strategy sets out how the Trust currently engages with patients and carer's in the development of services and the actions being taken to further strengthen our approach to engagement.

All service change proposals are reviewed by TEC. TEC will give consideration will be given to ensuring appropriate engagement with patients and stakeholders and whether the change is significant enough to require discussion with the overview and scrutiny committee.

Helen Brown – Deputy Chief Executive, will take the lead role on behalf of the Trust in liaising with the Overview and Scrutiny Committee. Regular meetings will be scheduled to ensure an open dialogue is maintained in line with the 'no surprises' principle.

26 Oct 2017

HERTFORDSHIRE HEALTH CONCORDAT

BETWEEN HERTFORDSHIRE COUNTY COUNCIL, LOCAL NHS ORGANISATIONS & HEALTHWATCH HERTFORDSHIRE

This Concordat is agreed between the following bodies:

1. Hertfordshire County Council (HCC) which will act through its Health Scrutiny Committee (HSC)
2. Hertfordshire Partnership University NHS Foundation Trust (HPFT)
3. East & North Hertfordshire NHS Trust (ENHT)
4. West Hertfordshire Hospitals NHS Trust (WHHT)
5. East of England Ambulance Service NHS Trust (EEAST)
6. Hertfordshire Community NHS Trust (HCT)
7. Herts Valleys Clinical Commissioning Group (HVCCG)
8. East & North Herts Clinical Commissioning Group (ENHCCG)
9. Cambridge & Peterborough Clinical Commissioning Group (C&PCCG)
10. Princess Alexandra Hospital, Harlow (PAH)
11. Healthwatch Hertfordshire (HWH)

The signatories attached in Appendix 5 reflect the commitment of all partners involved in the Sustainability Transformation Partnership (STP) to follow the Concordat principles for all service changes arising from the STP work plan. This would also include any future developments including the creation of an Accountable Care System or Organisation.

Supporting documents
Appendix 1 Background to NHS consultation & HSC Concordat
Appendix 2 Consultation Principles 2016
Appendix 3 Substantial Variation
Appendix 4 Checklist
Appendix 5 Signatories

26 Oct 2017

HERTFORDSHIRE HEALTH CONCORDAT

Executive Summary

The Concordat applies to relations between the Health Scrutiny Committee (HSC) and the health bodies serving the population of Hertfordshire. It also covers consultations and engagement carried out by any of the NHS Bodies, where HCC is among those formally consulted. The principles outlined below apply not only to extensive formal public consultations of the kind required by legislation, but also to developments which will affect smaller numbers of patients, smaller geographical areas or particular services only. The Concordat covers changes resulting from commissioning decisions or service changes.

The principles that the Concordat are built on underpin the whole relationship between scrutiny and health. The NHS Five Year Froward View states that 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'

Given the financial and service landscape it is accepted that changes will have to be made but that they are done so for the best interest of the population of Hertfordshire and the Hertfordshire and West Essex health and social care system. There is also recognition of the aim to balance timely, well informed decision-making with the use of public monies.

The advent of the Sustainability Transformation Partnership (STP) requires local government and health bodies to work together and that discussions around service changes held in the STP forum will be fed back to HSC.

The Concordat facilitates discussion between HSC and partners so that a culture of 'no surprises' is engendered and maintained through regular contact with Head of Scrutiny and the Chairman of the Committee, to develop engagement into agreed approaches to identify substantial variation and more formally structured consultation.

When consultations take place the Concordat highlights the need to consult the relevant stakeholders in the right way using 'digital by default' as per Central Government consultation principles guidance 2016. While digital contact through social media and webpages should be at the forefront of any consultation, this does not preclude the use of alternative methods to reach all stakeholders. All communications need to have accessible language so that it is clear and allows for responses to be captured resulting in effective reporting, which in turn informs effective decision making.

Ongoing engagement with the population is necessary to create transparency and awareness of the direction of travel for services. To further this goal it is anticipated that engagement will be ongoing; and all consultations should allow everyone to see the use of stakeholder feedback in formulating any final strategy.

26 Oct 2017

PRINCIPLES

1. What is consultation?

1.1 Consultation within the Concordat covers commissioning decisions or service changes with stakeholders to communicate any proposals as well as to gain feedback. All proposed changes require informal liaison with Head of Scrutiny and Chairman of HSC at an early stage and prior to a final decision on consultation being taken by the relevant organisation. At this first meeting the proposals will be shared and agreement sought for the required programme of consultation, which will be dependent on the likely impact of the proposals to residents and/or partner organisations.

2. Consulting the HSC on "substantial variations"

2.1 Legislation requires that scrutiny committees must be consulted in the event of a substantial development or variation. A substantial variation is dependent on local circumstances. **The final definition of what constitutes a substantial variation is determined by the HSC.** The Concordat assumes that a substantial variation is defined as a change or augmentation to a service or provisions that will impact on the health of the local or wider population (see App X). The relevant NHS body must discuss this with the Head of Scrutiny. If it is agreed that the proposed changes are substantial, HSC will require the NHS to undertake a formal consultation process.

2.2 Consultation on substantial variations will extend to an appropriately wide group of stakeholders in addition to the HSC and will conform to the principles outlined in this Concordat. Proposals for substantial variations in NHS services will be the subject of a formal public consultation. It is anticipated that consultation will be undertaken for a proportionate period. This may mean 12 weeks and the Head of Scrutiny must be consulted before any reduction in this timeframe is considered. HSC may decide not to scrutinize the proposal or consultation as detailed at Appendix 3 and agree to a consultation period shorter than 12 weeks.

2.3 It is not the function of HSC to manage the NHS; therefore scrutiny will not consider managerial decisions

2.4 Where there is a national consultation from NHS England, NHS Improvement or other national body, it is agreed that local commissioners and/or providers will share any national consultations that they are aware of with Head of Scrutiny and Chairman when relevant to Hertfordshire. At this time it should be made clear whether the consultation is taking place nationally or locally. If it is nationally there is an understanding that local commissioners and/or providers will share such information with the Committee. This may then mean that local consultation is undertaken in addition to national consultation.

3. No surprises

3.1 **A principle of "no surprises" will operate** i.e. Scrutiny officers and the HSC chairman meet regularly with health bodies providing opportunities for informal discussion of upcoming issues.

3.2 The Government has replaced previous consultation guidance by issuing the Consultation Principles 2016. The key Consultation Principles are:

- departments [*here health bodies*] will follow a proportionate timescale dependent on the expected impact of the decisions or proposals;
- departments [*here health bodies*] will need to give more thought to how they engage with and consult with those who are affected;
- consultation should be 'digital by default', but other forms should be used where these are needed to reach the groups affected by a policy and are seldom heard;
- that the consultation should provide sufficient information to consultees so that they can provide informed responses;
- that consultation should state how responses have been received and how they have informed policy.

3.3 The work of HSC will reflect the Consultation Principles and follow agreed ways of working

- advance notification to HSC of the proposed work programmes
- formal consultation is preceded by meaningful discussions and engagement with a wide range of stakeholders and those likely to be affected
- detailed informal pre consultation activity takes place to develop proposals
- formal proposals in consultation documents should come as no surprise to many of those consulted
- the level of consultation should be effective and proportionate to the change and those affected.

3.4. The NHS should look to provide as much evidence as possible to the extent and effectiveness of its engagement processes and formal consultation. The Chairman, on behalf of the HSC will take this into account when discussing the expected timescales for consultation or to include matters in its work programme for scrutiny. Evidence that NHS bodies have a culture of engagement and consultation embedded in their day-to-day activities will include

- board papers or other strategy and action planning documents indicating a rich and ongoing process of engaging/consulting service users and potential service users
- evidence that this process is part of a circle of dialogue and feedback that influences service planning and delivery
- feedback and updates to HSC from relevant health bodies and HWH over the course of the planning and delivery cycle about the level, extent, inclusiveness and influence of patient and public consultation and involvement.

3.5 Where urgent action is required because of concerns about risks to the safety, or welfare of patients and staff or the viability of a service to

safeguard public safety and the financial stability of a health body HSC would expect to be engaged and informed of any actions as soon as is possible.

3.6 Where the provider or commissioner is operating regionally, information affecting the region is shared with Head of Scrutiny and Chairman, especially when a regional change could affect Hertfordshire.

4. Consulting the right people

4.1 It is anticipated that consultation will be underpinned by the NHS Constitution, principles of good practice accepted nationally and the Secretary of State's 4 Tests (updated 2015)

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from commissioners.

4.2 Consultation processes will attempt to gather the views of a representative cross-section and a geographical spread of the relevant population. The NHS consulting body, including Foundations Trusts, will be able to show how it has encouraged a wide range of people to give their views and how it has enabled the voices of seldom heard people and minorities as well as the majority to be heard.

4.3 Those consulted (key stakeholders, groups and individuals with an interest and those likely to be affected by any proposed changes) will all be given an opportunity to provide an informed view. HCC, the Health & Wellbeing Board, Healthwatch, District/Borough Councils in Hertfordshire and HSC, will be consulted separately as will elected representatives (including MPs) and stakeholders, as appropriate. Consultation with the HSC will not be used as a substitute for consultation with HCC's executive (and vice versa). The organisation will need to consult the executive as HCC's decision-making body and with the executives or other decision-making bodies of the Hertfordshire District/Borough Councils, where appropriate, all of whom may have different perspectives from HSC.

5. Being clear about proposals and options

5.1 It will be clear that it is a **consultation** not a vote or referendum.

5.2 Consultations will have clear stated objectives. It will be made clear to those being consulted what is being proposed. Options will be put forward in good faith, i.e. it will be made clear which options the consulting body considers to be viable ones, what, if any, its current preferences are among these options and what consultees can still change or influence. If certain options have been excluded as being completely unviable, this will be made clear and the constraints spelled out. If the pre consultation engagement has been extensive and the NHS body is able to provide substantial evidence of engagement and how this

activity has shaped proposals, the NHS body may consult on one proposal only. It is anticipated that this will be the exception.

5.3 The consulting body will also make clear that it will give due regard to new alternative options or aspects of options proposed by consultees during the consultation process. Consultees will be specifically asked for their views on options which they do not favour as an understanding of the advantages and disadvantages of all options from the public perspective may be helpful to decision makers.

5.4 Where possible an assessment of the likely effects of proposals on other services and of the groups of people most likely to be affected will be given, including an assessment of the impact of making no change. This should also include the likely impact on other organisations that interact with this service. Short and long-term impacts, knock-on effects, equalities impacts, sustainability and opportunity costs of options will be outlined with an assessment of the likely impact on transport and local site issues.

6. Consulting in the right way

6.1 Consultation will take many forms, both formal and informal, proportionate to the issue and population being effected. Consultation documents will be made available widely and public consultation events will be well publicised using 'digital by default', but also make sure that a range of suitable media communication is used and events are held at times and venues that will suit as many people as possible to be fully inclusive and allow informed decisions to be made. Materials will state clearly how consultees should respond. They will include a contact point for any consultee who wishes to complain about the consultation process. The numbers responding and their submissions to consultation documents or at consultation events will be recorded and reported in a final summary. Questionnaires will be objective, appropriate and fair and the methodology for analysing them will be indicated in the final report of a consultation.

6.2 HSC recognises that public meetings and questionnaires are not always the most appropriate method of consulting people. Where appropriate smaller scale engagement with specific groups can be a more effective means of capturing the views of defined users of particular services and of people whose views are seldom heard, and therefore its use is encouraged.

7. Using accessible language

7.1 The language of consultation documents and at consultation events will be accessible, user-friendly and jargon free. Publicity for consultation events and documents will make clear what the overall implications of proposed changes are likely to be (e.g. a proposal to "reconfigure" services that may result in a closure of a hospital or facility should provide all options that are being considered and **not** simply use vague

terms such as “Come to a meeting about NHS changes” or “new ways of providing health services”).

8. Effective reporting

8.1 Responses to consultations will be analysed using methods that can be shown to be fair and objective and will, where possible, give a demographic breakdown of those responding, including a geographic breakdown.

8.2 NHS boards, HSC, HWB, HWH and the public will have access to full reports of consultations. Access for this purpose may include publication of consultation reports to boards as posted with board papers on health body websites. All signatories to this Concordat shall also comply with their obligations under the Freedom of Information Act 2000 and shall also disclose such information as may be requested under that Act unless they can clearly demonstrate that exemption from disclosure under the Act applies. However, this is likely to be exceptional in the case of information relating to a public consultation exercise.

9. Objective decision-making and feedback

9.1. Decisions made by boards will give due weight and attention to the full range of consultation formats used, including oral and written responses in formal and informal settings. In general, reports of decisions on issues where consultation has taken place will make clear how the pre consultation informal engagement and consultation process has influenced the decision. It is also necessary to include in the report how feedback from stakeholders has been used in the decision making process.

9.2. Health bodies need to ensure that sufficient consideration has been given to any issues raised during the consultation concerning the impact of the proposals on clinical quality and outcomes

9.3. Wherever possible, direct feedback will be given to groups and individuals who have responded to a consultation, indicating where their views have influenced a decision. Where a decision goes against a large body of opinion of those consulted, or against the view of those who will be most affected, reasons will be given for this.

10. Lessons learned

10.1 In their overall consultation strategies, NHS bodies will show how they have evaluated previous consultations and put into practice the lessons they have learned about how to improve consultation.

10.2 This Concordat will be reviewed and its effectiveness tested with both signatories and other stakeholders including HWH, on a four year basis unless other factors suggest an earlier revision is necessary.

11. Implementation of an agreed strategy

26 Oct 2017

11.1. The implementation of a strategy does not require further scrutiny, unless it is a substantial variation to the agreed strategy. This is especially important if implementation of all or part(s) of the strategy will not take place for a considerable period of time. To enable HSC to monitor implementation it has been agreed that health bodies will undertake a full range of activities as requested by HSC in relation to specific strategy implement. This will include

- regular, short, written updates
- assurance that reconfiguration/service changes is in line with the agreed strategy
- reassurance of substantial engagement with users and the community to inform service changes
- hosting site visits for HSC members, where appropriate

The Concordat will be every four years

HERTFORDSHIRE COUNTY COUNCIL (HCC)
HEALTH SCRUTINY COMMITTEE (HSC)

BACKGROUND TO NHS CONSULTATION & HCC CONCORDAT

1. INTRODUCTION

1.1. It is the role of HCC to hold the local NHS to local democratic account. However, the relationship between HCC's Health Scrutiny Committee (HSC) and its health partners is only one of the many that operate at different levels across the two sectors. The Health & Wellbeing Board (HWB) will influence the strategic direction for commissioning services that relate to the health and wellbeing of the population. HCC and health staff work closely together to ensure that their commissioning strategies are aligned and that patients' experience of moving between health and social care services are as seamless as possible.

2. Legislative background

2.1. The law gives powers to local authorities (other than districts in two-tier areas) to consider issues affecting the health of local people and to call the NHS and private providers whose services are funded by the NHS to account on behalf of local communities.[1] The primary aims of health overview and scrutiny is to ensure that:

- health services reflect the views and aspirations of local communities
- all sections of local communities have equal access to services
- all sections of local communities have an equal chance of a successful outcome from services.[2]

2.2. The regulations specifically require NHS bodies to consult on any proposals for "substantial variations or developments" of health services. HSC does not have powers to enforce any of the recommendations it makes to the NHS or private providers, either as a result of carrying out a scrutiny review, or in responding to a consultation. It can only hope to influence decisions by the evidence it brings forward and to ensure that consultation by the NHS has been of a high quality. The final decision on how NHS services are run and developed remains with NHS Boards. In Hertfordshire HSC and NHS bodies have agreed an approach to monitoring the implementation of recommendations through the OSC Review of Recommendations Topic Group.

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[1] Health and Social Care Act 2001, National Health Service Act 2006 (section 244) **as amended by Health and Social Care Act 2012; Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013**
[2] Centre for Public Scrutiny, *Substantial Variations and Developments of Health Services: a Guide*, 2005.

2.3. In addition to the creation of duties relating to local authority scrutiny, legislation requires the NHS to involve and consult the public widely on what it does.[3] Clinical Commissioning Groups (CCGs), NHS Trusts and NHS Foundation Trusts must involve and consult people who receive or who may receive health services on:

- *the planning of the provision of those services,*
- *the development and consideration of proposals for changes in the way those services are provided, and*
- *decisions affecting the operation of those services*

3. Hertfordshire County Council Health Scrutiny Committee (HSC)

3.1 HSC has been carrying out its scrutiny powers since 2002. The statutory health scrutiny powers, following changes made by the Health and Social Care Act 2012, now rest with HCC, but they will continue to be exercised on behalf of HCC by HSC. HSC includes representation from all the districts/boroughs in Hertfordshire. All districts/boroughs, and HCC's executive , continue to provide an executive response to NHS consultation proposals and service developments.

3.2 HSC is aware that the NHS in Hertfordshire has also been developing the ways it involves and consults patients and the public and HSC wishes to encourage these developments, at the same time recognising the finite resources available. HSC aims to ensure that it has a comprehensive overview of NHS developments and an opportunity to contribute to improving the health of the people of Hertfordshire. It wishes to support new developments designed to improve health services, as long as it is assured that good and comprehensive involvement and consultation with patients and the public is happening. HSC believes that the best way for it to scrutinise the activities of the NHS locally is to act as a challenging critical friend.

3.3 HSC expects to be informed of proposed substantial variations in services, as is required by law. However, HSC would not wish – and indeed would not have the capacity - to carry out detailed scrutiny in relation to the content of all new NHS proposals or existing services. This does not preclude HSC from undertaking scrutiny on specific issues it deems necessary. It is very important, therefore, that HSC can be satisfied that adequate, appropriate and effective consultation and involvement of patients and the public has takes place as a matter of course.

3.4 HSC understands that consultations are not referenda and that NHS Boards must weigh up a number of factors in making decisions about changes in services. HSC and the NHS signatories to this Concordat agree that the views of patients and the local population are an important factor which must play and be seen to play a role in those decisions.

4. The Concordat between Health & HCC

[3] National Health Service Act 2006 (section 242) as amended by the Health and Social Care Act 2012.

4.1. HCC, acting through HSC, and the NHS signatories of this Concordat have agreed to develop a Concordat on the way in which patients and the public in Hertfordshire are informed, consulted and involved in decision-making by the NHS. The purpose of this Concordat is:

- to create an explicit consensus between HSC and the NHS in Hertfordshire about the principles that should underlie good consultation of patients and the public
- to enable HSC to prioritise its scrutiny activity and to maintain the role of critical friend referred to above
- to assist patients and the public, including HealthWatch Hertfordshire (HWH), to understand the principles on which consultation with them is carried out by the NHS.

4.2. The guiding assumption is that, only where there is clear evidence that a consultation process has failed to comply with the principles of the Concordat in a way which has materially affected the process or outcome will there be a need for detailed and formal scrutiny review by HSC. Such principles and assessment of compliance with them could never be wholly scientific, since they require a degree of judgement about whether their spirit has been fulfilled, and an understanding of local circumstances. However, it is hoped that they will provide a public benchmark to assist patients, the public, and NHS bodies themselves as well as HSC to plan patient and public involvement and consultation and to evaluate the adequacy and effectiveness of consultations.

4.3. It is accepted that both providers and commissioners have a statutory duty to "involve and consult"; however, the lead organisation in respect of public consultation is the commissioning body. This body is expected to lead the contact with HSC.

4.4. Each signatory shall notify HCC's Scrutiny Officer of the name and contact details for a lead officer within their organisation who shall act as the principle point of contact for all matters in relation to this concordat. Any amendments to the name, role or contact details of a lead officer shall also be notifed accordingly.

5. Status of the Concordat, Amendments, Withdrawal and Successor Bodies

5.1. The Concordat is not a legally binding contract or agreement. However, the signatory organisations voluntarily subscribe to its provisions. Agreeing the Concordat shall be approved by each organisation in accordance with its Constitutional requirements. HCC's Head of Scrutiny shall maintain a definitive current version of the Concordat.

5.2. Significant amendments which impact on the substance of the Concordat or any of its provisions will continue to be revised and agreed by health and HSC. Amendment will only be made with the agreement of all signatories. Minor

amendments (including e.g. changes of organisation name or post titles) shall not require agreement.

5.3. Any signatory may withdraw from the Concordat by giving three months notice in writing to HCC's Head of Scrutiny. Withdrawal from the Concordat does not exempt an organisation from the fulfilment of its statutory duties in respect of consultation.

5.4. An organisation shall automatically cease to be a signatory to this concordat in the event of it ceasing to exist as a statutory body. The Concordat does not bind successor organisations but any successor organisation shall be invited and encouraged to become a signatory. Notification in writing to HCC's Head of Scrutinyl shall constitute an organisation becoming a signatory for this purpose, subject to their having complied with paragraph 12.1 above.

5.5. The establishment of HWH requires inclusion within any Concordat arrangements. Where a member of the public, a representative organisation of the HWH or a member of HSC believes that consultation has not been carried out according to the spirit of the principles in the Concordat they may submit evidence to HSC as to why they consider the Concordat has not been complied with. In such instances HSC will either as a whole, or appoint a sub-group of it members to assess the process of consultation against the principles in the Concordat and decide, on this basis, whether further scrutiny is necessary. Appendix 4 to the Concordat provides a checklist of questions to assist any assessment of whether consultations have followed the principles of the Concordat.

5.6. The Concordat draws on the relevant legislation (referred to in footnotes) and the experience of HSC and the NHS in developing and overseeing good practice on consultation and involvement at a practical level. In addition, the Concordat has drawn on principles outlined in the following documents:

- *Hertfordshire County Council's Have Your Say principles for consultation*
- *Consultation Principles 2016*
- *The Independent Reconfiguration Panel's best practice guidance.*
- *NHS Constitution*
- *Health & Social Care Act 2012*
- *Care Act 2014*

Consultation Principles; Guidance
Cabinet Office

Consultation Principles 2016

A. Consultations should be clear and concise
Use plain English and avoid acronyms. Be clear what questions you are asking and limit the number of questions to those that are necessary. Make them easy to understand and easy to answer. Avoid lengthy documents when possible and consider merging those on related topics.

B. Consultations should have a purpose
Do not consult for the sake of it. Ask departmental lawyers whether you have a legal duty to consult. Take consultation responses into account when taking policy forward. Consult about policies or implementation plans when the development of the policies or plans is at a formative stage. Do not ask questions about issues on which you already have a final view.

C. Consultations should be informative
Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector.

D. Consultations are only part of a process of engagement
Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process.

E. Consultations should last for a proportionate amount of time
Judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long will unnecessarily delay policy development. Consulting too quickly will not give enough time for consideration and will reduce the quality of responses.

F. Consultations should be targeted
Consider the full range of people, business and voluntary bodies affected by the policy, and whether representative groups exist. Consider targeting specific groups if appropriate. Ensure they are aware of the consultation and can access it. Consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

G. Consultations should take account of the groups being consulted
Consult stakeholders in a way that suits them. Charities may need more time to respond than businesses, for example. When the consultation spans all or part of a holiday period, consider how this may affect consultation and take appropriate mitigating action.

H. Consultations should be agreed before publication
Seek collective agreement before publishing a written consultation, particularly when consulting on new policy proposals. Consultations should be published on gov.uk.

I. Consultation should facilitate scrutiny

Publish any response on the same page on gov.uk as the original consultation, and ensure it is clear when the government has responded to the consultation. Explain the responses that have been received from consultees and how these have informed the policy. State how many responses have been received.

J. Government responses to consultations should be published in a timely fashion

Publish responses within 12 weeks of the consultation or provide an explanation why this is not possible. Where consultation concerns a statutory instrument publish responses before or at the same time as the instrument is laid, except in exceptional circumstances. Allow appropriate time between closing the consultation and implementing policy or legislation.

K. Consultation exercises should not generally be launched during local or national election periods.

If exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office.

This document does not have legal force and is subject to statutory and other legal requirements.

https://www.gov.uk/government/publications/consultation-principles-guidance

Appendix 3

HSC Substantial variation guidance

1. Department of Health guidance (2014), good practice as recorded by the Centre for Public Scrutiny (CfPS 2005) and Section 10.6.3 of Local Authority Scrutiny regulations recommend that the following are taken into account when considering whether a development, proposed change or variation is 'substantial':
    - Changes in accessibility of services
    - The impact of the proposal on the wider community and other services (including economic impact, transport and regeneration)
    - The degree to which patients are affected
    - Changes to service models and methods of service delivery NHS e.g. moving a particular service into a community setting from an acute hospital setting

2. Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
    - Planning the provision of services
    - The development and consideration of proposals to change the provision of those services
    - Decisions affecting the operation of services.

To assist in transparency a template for detailing service changes that can be shared with HSC is in Appendix 3a.

Appendix 3a:
Service Changes
[Plan on a page with headline detail, to be accompanied by full EqIA as an attachment]

Organisation	
Lead manager & contact details	
Description of service variation	
Reasons for service variation i.e. Case for Change	
Impact on the Wider Community *(e.g. transport, accessibility)*	
Number of Patients/Carers Affected	
Changes in Methods of Service Delivery	
Impact on other Services (e.g. health, social care, voluntary sector)	
Impact on different communities *(e.g. age, gender, locality)*	
Date due at Health & Wellbeing Board or relevant Commissioner	
Proposed Engagement	

APPENDIX 4

Checklist to ascertain if consultations have followed the Concordat, Consultation Principles, NHS Constitution & best practice

Reflecting the 4 Tests, consultation should provide evidence of

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from commissioners.

1. What efforts has the health body made from an early stage to inform relevant stakeholders that a proposal is being formulated?

2. What evidence is there of patient and public involvement and/or consultation in the development of the proposal?

3. If the proposal is clearly a substantial variation in services and not subject to formal public consultation, how will the health body ensure stakeholder input?

4. If there is doubt about whether the proposal constitutes a substantial variation have the Head of Scrutiny and the Health Scrutiny Committee (HSC) been asked for their views?

5. In the case of proposals that will not lead to substantial variations in services, is the timescale for consultation realistic and acceptable?

6. Have those being consulted been made aware of the objectives of the consultation? Have options been put forward in good faith? Has it been made clear which options are still “on the table” and which have been ruled out and the reasons given in sufficient depth to justify their exclusion?

7. Have the right people been consulted: key stakeholders, user groups and individuals with an interest and those likely to be affected? Has consultation sought to elicit responses from a representative cross-section and a geographical spread (where appropriate) of views? Has the health consulting body encouraged people to give their views and enabled the voices of seldom-heard people and minorities to be heard?

8. Has consultation taken the right forms appropriate to the subject matter and to those being consulted? Have responses to consultation been captured, recorded and reported appropriately? Have consultees been made aware of how they can complain about the consultation process, if they wish?

APPENDIX 4

9. Is the language of any consultation documents and events accessible, user-friendly and jargon free? Has any publicity made clear what the overall implications of any proposed changes will be?

10. Has analysis of consultation responses used fair and objective methods? Has the methodology for analysing consultation responses been recorded in any report of consultation, where appropriate? Where possible, has a demographic and geographic breakdown of responses been provided in any final report? Is any final report available to relevant Boards, HSC and the public and is anonymised raw data from consultation available on request?

11. Have any decisions made after a consultation period given due weight and attention to consultation responses and made it clear how they have influenced the decision(s)? How will feedback be given, where possible, to those consulted? Where a decision goes against a large body of opinion of those consulted, or against the view of those who will be most affected, have reasons been given for this?

APPENDIX 5

Signatories

The signatories below have signed on behalf of their organisation and have done so in agreement with the principles outlined in the Concordat 2017.

1. Signed…… Date…….
   Print Name and Post Title…….....
   (*Hertfordshire County Council which will act through its Health Scrutiny Committee*)

2. Signed…… Date…….
   Print Name and Post Title…….....
   (*Hertfordshire Partnership University NHS Foundation Trust*)

3. Signed…… Date…….
   Print Name and Post Title…….....
   (*East & North Hertfordshire NHS Trust*)

4. Signed…… Date…….
   Print Name and Post Title…….....
   (*West Hertfordshire Hospitals NHS Trust*)

5. Signed…… Date…….
   Print Name and Post Title…….....
   (*East of England Ambulance Service NHS Trust*)

6. Signed…… Date…….
   Print Name and Post Title…….....
   (*Hertfordshire Community NHS Trust*)

7. Signed…… Date…….
   Print Name and Post Title…….....
   (*Herts Valleys Clinical Commissioning Group*)

8. Signed…… Date…….
   Print Name and Post Title…….....
   (*East & North Herts Clinical Commissioning Group*)

9. Signed…… Date…….
   Print Name and Post Title…….....
   (*Cambridge & Peterborough Clinical Commissioning Group*)

10. Signed…… Date…….
    Print Name and Post Title…….....
    (*Princess Alexandra Hospital, Harlow*)

11. Signed…… Date…….
    Print Name and Post Title…….....
    (*Healthwatch Hertfordshire*)

Trust Board Meeting
02 November 2017

Title of the paper	**Summary report on Corporate Risk Register**
Agenda item	**14/53**
Lead Executive	Helen Brown, Deputy Chief Executive
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 19 September 2017. The RRG scheduled for 17th October was cancelled due to business continuity pressures in the Trust. In this report there is 1 new risk, 3 risks for de-escalation and 1 risk that has been closed. Data for this report was extracted from Datix on 20 October 2017.
Where the report has been previously discussed, i.e. Committee/Group	Risk Review Group – 19 September 2017
Action required: • The Board is asked to note the report for information and assurance.	
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	

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West Hertfordshire Hospitals NHS Trust

Trust Board meeting – 02 November 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 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

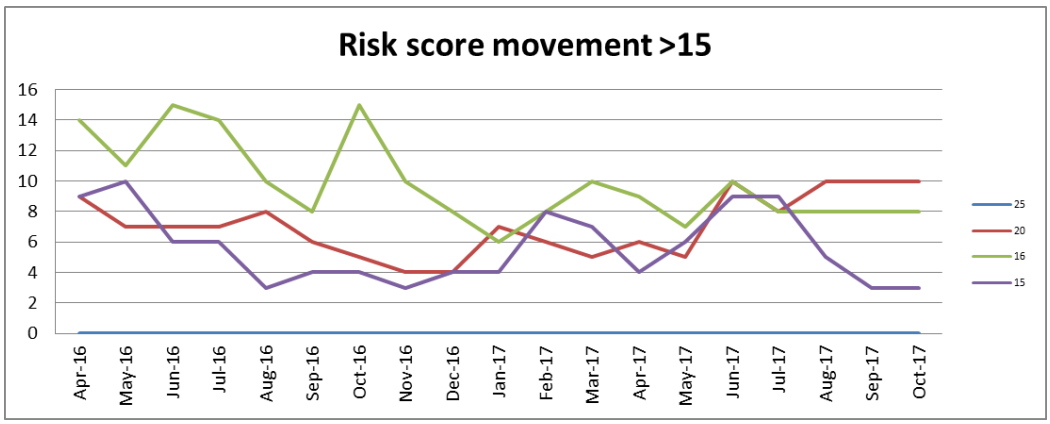
3.1 The risk register is a live document recorded on Datix and risk leads regularly review and update entries.

3.2 Data for this report was extracted from Datix on 20 October 2017. At this date 21 risks were recorded on the corporate risk register with a current score of 15 or more.

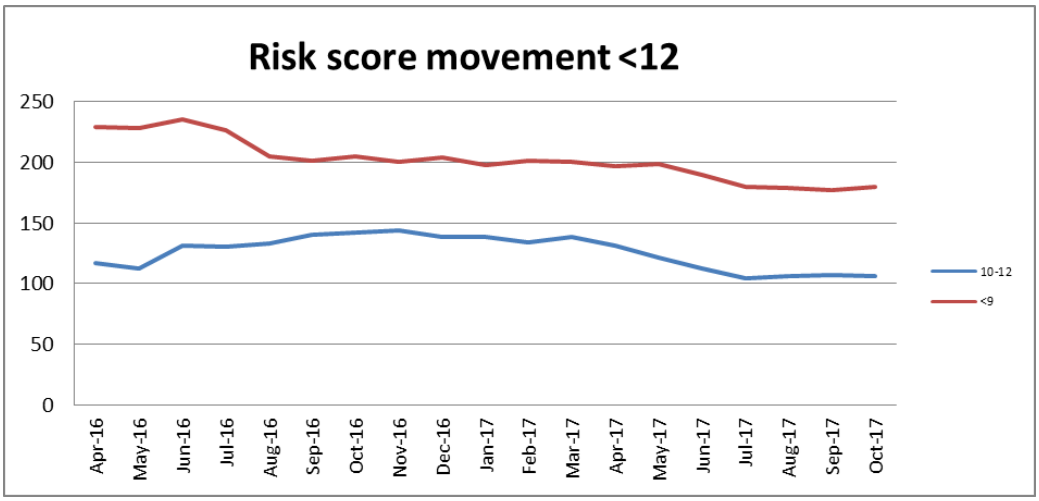
3.3 The chart below demonstrates the risk score movement on the corporate risk register from April 2016. From April 2016 to October 2017 there is an overall decrease of risks on the corporate risk register.

3.4 Work continues both at a corporate level with Board sub-committees and with Divisions to improve the alignment, recording and management of individual risk registers and the corporate risk register (CRR) which contains all risks with a current score of 15 or more.

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 of 2 with a risk score of 15.



This month the graph above shows 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

20 October 2017

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Appendix 1

ID	The Risk	Update	Consequence (current)	Likelihood (current)	Rating (current)	Principal Risk (Primary)	Board Assurance (Primary)	Lead
NEW/ESCALATED RISKS								
3930	Disruption to Endoscopy & Bronchoscopy Services due to decontamination failure	Endoscopy decontamination machines (BES) at both Watford and Hemel sites are running a severely reduced service due to issues procuring replacements for broken/damaged cassettes required to decontaminate scopes after use. Immediate issue with TVC count from Getinge machine now resolved. Ongoing risk that should future counts is out of range, the machine must be taken out of use until count confirmed as within range.	Major	Likely	NEW 16	PR1	Safety and Compliance Committee	KH
CURRENT CORPORATE RISKS								
3781	Unscheduled Care medical workforce - gaps in rota	Potential of offering staff some dividends for those staff who complete their allocated number of shifts as required, in order to reduce the number of late shifts cancellations, being considered.	Major	Likely	16	PR2	Patient & Staff Experience	PdG
3786	Emergency Care Pathway / patient flow	Discussion held at TEC regarding delivery of emergency standards including, additional capacity by having additional beds on Castle Ward. Hourly performance reviews in the ED have commenced.	Major	Certain	20	PR5	Trust Executive Committee	ST

3742	Failure to achieve sufficient efficiencies to support Annual and longer term plans	Targeted SDO & PMO support for CIP schemes (6-8 weeks from October 2017). Use of Model Hospital tool to derive further schemes for use in current and future years' programmes	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.	ITFF application for capital funding completed in July 2017. NHSI review underway.	Major	Likely	16	PR7	Finance & Investment Committee	DR
3503	Hardware Support for McKesson Systems	Meeting 9/10/17 with McKesson to agree schedule for upgrade to commence. Service continues with control measures in place.	Major	Likely	16	PR4	Safety and Compliance Committee	LE
3845	CCG financial situation and consequent impact on WHHT - 2017/18	External advisory support engaged to strengthen contract management arrangements, with report issued and recommendations made. Further CCG engagement underway at Trust level with the support / involvement of STP, NHSI and NHSE colleagues.	Catastrophic	Likely	20	PR7	Finance & Investment Committee	DR
3912	High turnover rate within Band 5 nursing population	Current recruitment pipeline will produce approx. 15 nurses per month as a constant theme moving forward. (since July) Trip to Philippines during Oct 17 to recruit between 70 - 100 nurses with ETA of between 6-8 months. Arrival of new Indian nurses - Feb 18	Major	Certain	20	PR2	Patient and Staff Experience Committee	PdG
3892	ICT Data Centres reduced availability, poor reliability & poor performance	There have been further issues with stability in the data centres. Problems with the Wide Are Network (WAN) have made it difficult to assess the stability of the network.	Major	Likely	16	PR4	Finance & Investment Committee	LE

3894	ICT Applications reduced availability, poor reliability & performance	Oct - Nov 2017 explore options to host services with other Data Centre / Shared Service Providers. Extended Support arrangements in place for Sunquest ICE to reducing the time-to-fix out of hour's outages; lessening the impact to Trust operations. Significant risk of delays to the migration of Sunquest ICE, Theatreman & Infoflex.	Major	Certain	20	PR4	Finance & Investment Committee	LE
3896	ICT Data Networks reduced availability, poor reliability & performance	Remedial action taken with limited success.	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
3899	ICT Trust Bleep System	Despite the various controls in place the bleep system experience a number of outages in September. These outages may have been linked to network problems but a network ASR router has been replaced at WGH and things appear to have stablished. A power fluctuation also appear to trigger a problem with the bleep system.	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.	Further work required to establish reporting governance structures for the Joint Security Forum Supplier unable to patch some of their (iSCSI) server infrastructure waiting Microsoft patching Approx. 32 network switches cannot be patched and discussions are under way about how to deal with these switches	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 – Delivery date estimated as 15th December 2017.	Catastrophic	Possible	15	PR1	Safety & Compliance Committee	KH
3120	Patient Medical Notes missing, Delayed or poor condition.	iFIT: Location based tracking project has been delayed and currently a 'go live' date is scheduled for November. Once in place this will provide efficiency within the department improving availability of notes. Business case for off site medical records solution is having costs finalised. Lengthy delay due to differing options and presentations being discussed. Target date for TEC review: End October 2017 (Board review via FIC date TBC). Visits to warehouses due October 2017 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.	Major	Certain	20	PR4	Finance & Investment Committee	LE

3422	Potential low levels of workforce engagement will negatively impact retention and productivity, which in turn will lead to poor	Ongoing implementation of 2016 national staff survey & local survey results - Mar 18 Trust is joining new NHSI programme to look at improving retention rates, this programme will complete in April 18 New staff engagement programme has commenced in emergency care services to improve staff and patient experience. Oct 18	Major	Likely	16	PR2	Patient & Staff Experience	PdG
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
3741	Risk of failure to achieve financial plan resulting from failing to meet all Sustainability and Transformation Fund conditions.	All reasonable actions are currently being taken. 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 is managing all applicable risks to the best of its abilities. A detailed reforecast exercise was undertaken in October 2017, within formal NHSI processes, acknowledging that the STF conditions for 2017/18 would not be satisfied for Q2-4. This resulted in a current risk rating change to 25 as the financial impact increased to a certain £9.3m. Risk remains in place as work goes on to minimise future risks in 2018/19 and beyond.	Major	Likely	16	PR7	Finance & Investment Committee	DR

3485	Unsafe Chimney Stacks on Boiler House - Hemel Hempstead	120k has been agreed for repairs as part of a capital bid.	Catastrophic	Possible	15	PR3	Safety & Compliance Committee	KH
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
CLOSED/DE-ESCALATED RISKS								
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→12	PR1	Safety & Compliance Committee	TC
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→9	PR4	Finance & Investment Committee	LE
3916	Neonatal consultant staffing shortfalls - risk to safe business continuity and patient safety	Post has been advertised	Major	Possible	20→ 12			

3870	Non Compliance with Regulatory Refore (Fire Safety) Order 2005 (AAU)	All 4 fire doors now replaced.	Catastrophic	Possible	15→ CLOSED	PR1	Safety & Compliance Committee	KH

Trust Board Meeting
02 November 2017

Title of the paper	**Board Assurance Framework 2017/18 update**
Agenda item	**15/53**
Lead Executive	**Helen Brown, Deputy Chief Executive**
Author	**Jean Hickman, Trust Secretary**
Executive summary **(including resource implications)**	The aim of this paper is to assure the Board on the progress being made to mitigate the strategic risks within the Board Assurance Framework (BAF) in 2017/18. The description, gaps in controls and assurance of each principal risk were reviewed by lead executives and lead committees during September and October 2017 and the recommendations and comments are recorded in the report for discussion and approval. An action tracker provides the board with the latest position with regard to the progress of associated actions.
Where the report has been previously discussed, i.e. Committee/Group	All lead committees

Action required:

The board is asked to:

- review and approve the recommended changes made by the lead committees
- monitor the progress made to the associated actions
- note the actions RAG rated as 'red' and the mitigation in place

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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: 15/53

Trust Board meeting – 02 November 2017

Board Assurance Framework 2017/18

Presented by: Helen Brown, Deputy Chief Executive

1. Purpose

1.1 The aim of this paper is to update the board on the key strategic risks to the trust achieving its aims and objectives. The paper provides the board with an overview of the latest position with regards the identified gaps in controls and assurances in the Board Assurance Framework (BAF) for 2017/18 and provides assurance on the status of the actions being taken to mitigate the risks.

2. Background

2.1 The board approved the refreshed 2017/18 BAF in June 2017. It was agreed that the frequency of the board review would be changed from quarterly to termly to align with a new committee structure.

2.2 The next board review of the BAF will be in March 2018.

2.3 The responsibility for each principal risk and associated actions are assigned to a nominated executive with oversight by a designated lead committee. Risks scores are graded from green to red.

3. Analysis/discussion

3.1 Update on principal risks

3.1.1 The description, gaps in controls and assurance of each principal risk have been reviewed and, if required, updated by the lead executive and lead committee during September and October 2017 (appendix 1).

3.1.2 Please see the table below details the recommendations made by lead committees.

Principal Risk	Description	Lead Committee	Committee recommendation/ comment
PR1	Failure to provide safe, effective, high quality care	Safety and compliance	No change to RAG rating
PR2	Failure to recruit to full establishments, retain and engage workforce	Patient and staff experience	No current change to the RAG rating, however the committee recommends a review of the PR to assess whether it accurately reflects the longer term strategic workforce risks. The outcome of the review will be presented to the board in March 2017.

Principal Risk	Description	Lead Committee	Committee recommendation/ comment
PR3	Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care	Safety and compliance	No change to RAG rating
PR4	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care 4A) IM&T 4B) information and information governance	Finance and investment	No change to RAG ratings
PR5	Inability to deliver and maintain performance standards 5A) Emergency Care 5B) Planned Care (including RTT, diagnostics and cancer)	Clinical outcomes and effectiveness	A) No change to RAG rating B) Recommendation that the RAG rating is increased from amber to amber/red to reflect a deteriorating RTT picture
PR7	7A) Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes 7B) Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure	Finance and investment	A) No change to RAG ratings B) To reflect a review and recommendation by the project appraisal unit around capital spend authorisation, the finance and investment committee recommends that the RAG rating should be reduced from red to amber/red.
PR8	Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation	Patient and staff experience	No current change to the RAG rating, however the committee recommends the PR is reviewed to assess that it accurately reflects all the stakeholder engagement risks to the trust. The outcome of the review will be presented to the board in March 2017
PR9	Failure to develop a sustainable long term clinical, financial and estates strategy compromises the organisations' strategic position and reputation	Trust Executive	No change to RAG rating
PR10	System pressures adversely impact on the delivery of the Trust's aims and objectives	Trust Executive	No change to RAG rating

3.2 **Update on actions**

3.2.1 Each associated action is owned by a lead executive and assigned to a lead committee to monitor the progress being made. All actions that have reached their due date have been reviewed and updated and a forward look has been undertaken to escalate any actions with future due dates where there is a risk to delivery (appendix 2).

3.2.2 In response to a recommendation by the care quality commission at a recent inspection, a column has been added to the tracker to demonstrate the date when an action was added to allow more detailed monitoring by the board of progress against timelines.

3.2.3 Action 17 has been deleted as it was a duplication of action 16.

3.2.4 Action 58 has been added relating to the development of a two-year cost improvement plan with clear implementation milestones.

3.2.5 Action 82 relating to the strengthening of a joint Herts Clinical Commissioning Group and trust QIPP board and clinical engagement has been split, a) to develop a board (completed) and b) to develop and implement a work programme (RAG rated amber).

3.2.6 Please see the table below for an overview of the movement of actions.

Actions	Total	Completed	Green	Amber	Red	Not rated
July 2017	85	25	9	14	4	33
November 2017	86	39	8	27	3	9

3.3 **Actions escalated to the board**

3.3.1 Action 16. To develop a metrics for reporting as part of a medical safe staffing assurance report.

This action is RAG rated as red and has a due date of March 2018. The trust does not currently have sophisticated systems in place to be able to proactively collate data to support this type of reporting. This would require some form of e-rostering and significant time and resource to take this forward. The safety and compliance committee will consider whether this action is feasible and achievable or whether it should be removed from the tracker at the next review.

3.3.2 Action 64. To report and implement a benchmarking exercise regarding clinical staffing levels

This action is RAG rated as red and has a due date for completion in November 2017. A benchmarking exercise into clinical department costs was commissioned in October 2017 and the trust is awaiting feedback on an independent review of medical staffing.

3.3.3 Action 77. To secure approval for the acute strategic outcome case (SOC) from HVCCG, Sustainability and Transformation Partnership (STP), NHS Improvement (NHSI), Department of Health and the Treasury.

This action is rated as red and has a due date for completion in November 2017. A SOC has been submitted via the STP process, with the support of the East of England region. A formal review process is underway by NHSI and the trust has asked for a joint meeting with NHS England, NHSI and HVCCG.

4. Recommendation

4.1 The board is asked:

- to review and approve the recommended changes made by the lead committees
- to monitor the progress made to the associated actions
- to note the actions RAG rated as 'red' and the mitigation in place

Helen Brown
Deputy Chief Executive

November 2017

NHS
West Hertfordshire Hospitals
NHS Trust

Board Assurance Framework

Updated in October 2017

Our Aims

Aim One	To deliver the best quality care for our patients
Aim Two	To be a great place to work and learn
Aim Three	To improve our finances
Aim Four	To develop a strategy for the future

Our success will depend on the continued commitment of all of our staff to the delivery of quality care ~ we will support them in every way we can. We will also listen carefully to what our patients and local residents tell us about how we can improve care and learn from our mistakes. We will work in partnership with our commissioners (Herts Valley CCG and NHS England), with local councils and with other local NHS providers to make sure we deliver joined up care for our patients.

2017/18 objectives

AIM	OBJECTIVES	
AIM ONE: To deliver the best quality care for our patients	To sustain our 'expected' or 'better than expected' performance on key mortality indicators (HSMR & SHMI).	CO1
	To meet all national standards.	CO2
	To improve patient experience.	CO3
	To further strengthen and embed quality improvement processes through the development of a quality strategy and delivery of quality priorities set out in the 2017/18 quality account.	CO4
	To agree and implement plans to improve our estate and IM&T . (To bid for additional capital funding to support urgent improvements to our estate.)	CO5
AIM TWO: To be a great place to work and learn	To improve staff satisfaction as measured by the national staff survey and local WHHT temperature checks.	CO6
	To reduce staff turnover rates, vacancies and use of agency staff.	CO7
	To ensure all staff have annual appraisals and personal development plans.	CO8
	To strengthen our clinical and managerial leadership.	CO9
AIM THREE: To improve our finances	To deliver our 2017/18 financial plan.	C10
	To deliver our efficiency savings programme, including opportunities highlighted in the Carter review.	C11
AIM FOUR: To develop a strategy for the future	To identify and implement priorities to support delivery of our strategy and further develop service line strategies.	C12
	To work with regulators to secure approval of our strategic outline case for the redevelopment of our hospitals and progress the development of the outline business case.	C13
	To work with STP partners and local stakeholders to deliver system wide transformation priorities; to agree a partnership strategy to support the long term clinical and financial sustainability of our services, including consideration of the benefits of closer collaboration with the Royal Free Hospital.	C14

Principal Risks

Principal Risk	Description	Executive Lead(s)	Board assurance
PR1	**Failure to provide safe, effective, high quality care**	Chief Nurse / Medical Director	Clinical Outcomes & Effectiveness / Safety & Compliance
PR2	**Failure to recruit to full establishments, retain and engage workforce**	Director of Human Resources and Organisational Development	Patient & Staff Experience
PR3	**Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care**	Director of Environment	Safety & Compliance
PR4	**Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care** **4A) IM&T** **4B) information and information governance**	Chief Information Officer	Finance & Investment
PR5	**Inability to deliver and maintain performance standards** **5A) Emergency Care** **5B) Planned Care (including RTT, diagnostics and cancer)**	Chief Operating Officer	Clinical Outcomes and Effectiveness
** PR6	Failure to maintain business continuity	Chief Operating Officer	N/A
PR7	**7A) Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes** **7B) Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure**	Chief Financial Officer	Finance & Investment
PR8	**Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation**	Deputy Chief Executive / Communications Director	Patient & Staff Experience
PR9	**Failure to deliver a long term strategy for the delivery of high quality, sustainable care**	Deputy Chief Executive	Trust Executive
PR10	**System pressures adversely impact on the delivery of the Trust's aims and objectives**	Chief Executive	Trust Executive

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

Board Assurance Framework – current level of assurance
October 2017

G AG A AR R

	Risk profile deteriorating	Risk profile improving
Trend	↓	↑

Principal Risk	Description	RAG	Trend
PR1	Failure to provide safe, effective, high quality care (insufficiently robust and embedded quality governance and risk management)	A	↔
PR2	Failure to recruit to full establishments, retain and engage workforce	A	↔
PR3	Current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care	AR	↔
PR4	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care	AR	↔
	4A) IM&T 4B) Information and information governance	AG	↔
PR5	Inability to deliver and maintain performance standards	R	↔
	5A) Unscheduled care 5B) Elective care (including RTT, diagnostics and cancer	A	↔
** PR6	Failure to maintain business continuity	G	↔
PR7	7A) Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes	AR	↔
	7B) Failure to secure sufficient capital, delaying needed improvements in the patient care environment, security and safe infrastructure	R	↔
PR8	Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation	AG	↔
PR9	Failure to deliver a sustained long term clinical, financial and estates strategy	AR	↔
PR10	System pressures adversely impact on the delivery of the Trust's aims and objectives	R	↔

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

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Nurse / Medical Director

Risk Description	Controls	Assurance
Principal Risk One: Failure to provide safe, effective, high quality care		
Potential cause: Quality governance (QG) and risk management processes not sufficiently understood or embedded within the organisation. **Potential impact:** Risks to quality and safety of care not identified and controlled leading to harm and / or sub optimal patient experience and outcomes.	**Key controls in place:** • Quality Account and Annual Plan set out priorities. • QG team in place to develop and deliver support and assurance programme • Quality Improvement plan sets out key actions ref. April 2015 CQC visit. • Corporate and divisional risk registers and Risk Review Group • Incident reporting / datix & SI review group • Monthly mortality and clinical harm meetings • M&M and service level governance meetings • Audit and compliance programme • Appriasal and revalidation • QIA of all CIP plans • Clinical Policies & Guidelines – review and ratification process • Whistleblowing policy • Daily review of staffing/escalation • CQC compliance framework • Patient Experience & Carers Strategy **Gaps in controls:** • Gaps in evidence of action completion and embedded / shared learning from SIs and Complaints • Gaps in evidencing implementation of policies • Clinical Guidelines documentation current status not fully established & 50% of guidelines out of date • Complaints response times and inconsistent application of complaints policy. • Adhering to the 'Duty of Candour' policy timeframes and lack of shared understanding of thresholds for moderate and severe incidents. • Patient Experience Strategy performance report in development • Quality Strategy to be developed in 2017/18.	**Key assurance in place:** • IPR quality and safety metrics, including safe staffing • Bi-monthly Safety &Compliance (S&C) and Outcomes & Effectiveness (O&E) sub committee meetings – updates on work plan and cycle of reporting: audit / NICE / Pt Experience Strategy / Quality Account etc. • Safety & Quality IPR for S&C and O&E sub committees • Test Your Care & Ward dashboards & matron quality checks • Monthly QIP plan progress reports to IRGC and Oversight group. • Monthly Quality and Safety Group (QSG) to review work plan • Monthly Risk Review Group reviews all 15+ risks on CRR. • CCG contract and quality meetings • 1/4ly assurance visits with external stakeholders • 15 steps programme **Gaps in assurance:** • Analysis and triangulation of data across different sources needs to be strengthened and made more consistent • Safe staffing data for medical staffing • Adherence to duty of candour for moderate harm incidents. • NICE compliance KPIs

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Director of Human Resources and Organisational Development

Risk Description	Controls	Assurance

Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce

Potential cause:
In some areas it is difficult to recruit to meet the need of increased service demand, which is creating additional pressure on our staff and impacting negatively upon engagement. Basic workforce processes e.g. appraisals are not always being met. This issue is particularly acute within our Band 5 nursing workforce where the current vacancy rate is 23% and turnover is 25%

Potential effect: People feel disengaged and retention may become an issue which results in higher vacancies and increased temporary staff costs and potentially impact the care we are able to offer our patients.

Potential impact: The Trust may fail to provide the highest standards of patient care, increase staff costs and staff morale will be negatively effected

Key controls in place:
- Workforce strategy now in place
- Recruitment and retention strategy in place
- New values in place
- Clinical engagement programme
- Implementation of B&H strategy
- Divisional people engagement plans
- Metrics for key workforce activities in place
- Good development programmes in place for key staff groups
- Health and wellbeing initiatives in place
- Mechanisms for on-going monitoring of engagement in place
- Improved induction processes including training for managers with new joiners
- Improved exit data
- Improved access to e-learning
- Improved management of agency/locum usage
- HR & OD team – business partner model
- PMO support to implementation and tracking of strategy
- Band 5 Nurse retention programme now in place

Gaps in controls:
- Lack of clear development support for our Band 5s e.g. rotational opportunities, transfer opportunities, etc.
- Further embedding of values which drive behaviours
- Good career management structures
- More work required to join up the benefits we offer our staff
- Some leaders still rely upon command and control and this can lead to feelings of bullying
- Lack of clear development pathways for staff
- More work required to grow engagement amongst our medical workforce.
- Staff facilities remain poor

Key assurance in place:
•A work plan to support the implementation of workforce strategy
•Robust exit interviewing data
•Good workforce data available
•Robust Band 5 retention plan now in place

Sources of Assurance:
- Workforce KPIs and delivery against strategy implementation plans reviewed at Patient and Staff Experience sub-committee.

- Workforce Steering Group provides management oversight of the overall workplan.

Gaps in assurance
- Lack of data relating to % of staff with PDPs in place and whether they are being released for development

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Director of Environment

Risk Description	Controls	Assurance

Principal Risk Three: Current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care

Potential cause: The current estate and utilities infrastructure is fit for purpose for the delivery of safe, responsive and efficient patient care

Potential Effect:
Frequent failure of critical infrastructure creating a poor / inadequate / unsafe environment for delivery of healthcare services in beach of CQC Outcome 15

Potential Impact:
Disruption to service delivery (theatres /NICU/MRI all closed in last 12 months)

Patient safety impacted by lack of capacity (space & resources) to meets operational demands and mandated standards

Environment provides poor patient experience and increased infection Risk

Prosecution by statutory bodies

Key controls in place:

- Creation of Environment Division provides structure and staffing levels to deliver effective estates and facilities services
- All identified environment risks entered on Trust Risk Register. Reviewed monthly at Division's Risk & Governance meeting.
- Backlog Maintenance programme based on 6 Facet Condition Survey ensures highest identified risks are addressed first.
- 24/7 reactive maintenance capability across all sites
- Interim Estates Strategy prioritised investment & resources
- Monthly Site Management Meeting .
- Environment Help Desk provides single focal point for all reactive maintenance activity and works requests
- 2016/17 Authorising Engineers (AEs) engaged for all high risk areas (except confined spaces management), as required by HTM 00 for development of a safe system of work across the Trust estate

Gaps in controls :

- Capital funding insufficient to meet minimum requirement for backlog programme thereby increasing likelihood of infrastructure or equipment failure.
- No Authorising Engineer arrangement in place for confined spaces management (due July 2017)
- Process is underway to train / appoint WHHT staff to Authorised Person (AP) positions.
- Programme of audits by Authorising Engineers incomplete – some audits overdue (due to historic gaps in AE workforce now resolved)
- There is no Asset Register for critical infrastructure & major utilities. This limits development and effectiveness of planned maintenance programme and increases safety risk to on-call staff.
- Recruitment & retention challenges together with high sickness in Estates workforce undermine ability to keep controls in place.
- Development Control Plans required for each site to ensure investment is prioritized in accordance with Interim Estates Strategy

Key assurance in place:

- Implementation of Premises Assurance Model (PAM) Dashboard completed. Bi-monthly environment assurance reports through QSG to Safety & Compliance Committee..
- Operation of a Safe System of Work in accordance with HTM 00 including mandated Risk Assessments for high risk areas
- Monthly Divisional Risk & Governance meetings in place reporting to QSG.
- Engagement with HSE to provide external assurance regarding measures taken to manage asbestos containing materials (ACMs) and Legionella
- Mock PLACE visits underway at all sites with representatives from Trust, patients and Healthwatch

Gaps in assurance:

- The Trust's estate management system (ARCHIBUS) cannot currently provide required levels of assurance or 'live' task management / performance reports.
- PAM Action plan to close out highest risk gaps in assurance is underway but not fully complete.
- 6 Facet Survey out of date.
- Given complexity of challenges related to estates infrastructure, capital programme management and strategy, current governance arrangements do not provide sufficient assurance to Board level and need to be further strengthened.

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Information Officer

Risk Description	Controls	Assurance
Principal Risk Four A: Underdeveloped ICT infrastructure compromises ability to deliver safe, responsive and efficient patient care		
Potential cause: Unable to fully deliver improvements in information, communication and technology (ICT) and decision support due to technical issues with supplier solutions, resource, funding, scope and physical estate constraints. Cyber attacks adversely impacts on system resilience. **Potential impact:** Unable to deliver benefits of the 'digital hospital environment' laid out in the IM&T Strategy – to improve patient and staff experience through improved decision support, agile and paperless working, support for integrated models of care	**Key controls in place:** • Five year contract to provide full managed CT service, negotiated with Herts Procurement, IT and Finance • Contract management structure in place for ICT holding supplier to account • Re-baselined programme plan and formal contractual change agreed with supplier • Enhanced resources to support delivery • Weekly exec to exec governance meetings to address issues as they arise • Member of NHSE cyber security programme. Full risk assessment undertaken and requirements placed on supplier to act. • Mitigated future risk of cyber attack by patching to latest NHS E recommended standards. • Membership of NHS CareCERT. • CCIO and CNIO in post to support and promote utilisation of technology. **Gaps in controls:** • High priority issues with network remediation and migration of some applications to the supplier datacentre means that some programme milestones are at risk • Dependency on the ICT infrastructure improvements has adversely affected delivery of other projects including medical records tracking • Risks to IT security as a result of delayed delivery of ICT infrastructure improvements • Clinical and Divisional representation at the ICT Transformation Group needs to be increased • Incomplete asset register • Some key clinical systems reaching end of life • Lack of capital funding to implement strategy	**Sources of Assurance :** • ICT Transformation Group oversight of programme delivery and service management panels • ICT Transformation Group reports through to the Strategy Delivery Board (TEC) monthly • Detailed ICT infrastructure improvement programme update to Finance and Investment Committee monthly, with updates and escalations to Trust Board as required • Robust contract management with Commercial Executive meetings • External (CIO) review of programme governance and supplier management • Lead non –executive with subject matter expertise providing assurance on controls, mitigation and strategy. **Gaps in assurance:** • Insufficient assurance that Trust is adequately protected from future cyber attack.

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Information Officer

Risk Description	Controls	Assurance
Principal Risk Four B: Underdeveloped information/information governance infrastructure compromises ability to deliver safe, responsive and efficient patient care		
Potential cause: Unable to fully deliver improvements in information, communication and technology (ICT) and decision support due to resource, funding, scope and physical estate constraints **Potential impact:** Unable to deliver benefits of the 'digital hospital environment' laid out in the IM&T Strategy – to improve patient and staff experience through improved decision support, agile and paperless working, support for integrated models of care	**Key controls in place:** • Director or Performance and Associate Director of Performance & Information supported by analytics team • Comprehensive suite of reports on iReporter • Comprehensive patient tracking lists and data quality reports developed to prospectively manage patient pathways and support operational management • Regular audits of information Governance compliance being undertaken • Regular audits of data quality being undertaken, DQ indicators including in IPR **Gaps in controls:** • Variable data quality (DQ) • Current Cancer Information System not fit for purpose *(business case approved and OJEU procurement process now underway)* • Variable understanding and utilisation of information available on iReporter.	**Sources of Assurance :** • ICT Transformation Group (including Information) reports through to the Strategy Delivery Board (TEC) monthly • Integrated performance report (IPR), with enhanced exception reporting. • Data Quality reports – oversight by Director of Performance • Annual data quality audits (internal Audit) • CCG CQRM and contract schedules **Gaps in assurance:** • None identified

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Operating Officer

Risk Description	Controls	Assurance

Principal Risk Five A: Inability to deliver and maintain performance standards: unscheduled care.

Potential cause:

- Failure to maintain and improve system flow
- Failure to reduce DTOCs and system waits
- Failure to undertake robust demand & capacity modelling
- Failure of infrastructure/estate resulting in lost capacity
- Financial constraints limit the organisation's ability to respond to risk

Potential effect:

- Failure to meet agreed improvement trajectory

Potential impact:

- Adverse impact upon quality outcomes and patient experience
- Financial impact associated with performance fines and STF funding
- Reputational impact

Key controls in place:

- Bed management policy, escalation policy and surge plan in place and subject to regular review and evaluation
- 24/7 Ops team, senior manager and director on call
- 4 times daily bed meetings to review overall site position
- Bed state reporting on i-reporter
- Daily a.m. system call 365 days per year
- Fortnightly system wide Local ED Delivery Board (Chaired by WHHT CEO) monitors the delivery of system wide improvement
- Partnership wide System Resilience Improvement Plan in place
- Emergency care transformation plan in place with project support via PMO
- Fortnightly ED Transformation task force meeting chaired by Medical Director with strengthened clinical engagement, cross divisional representation
- Continued Emergency Care Improvement Team support
- ED turnaround programme director commissioned to provide intensive improvement support for a defined period (to commence June)

Gaps in controls:

- Insufficiently robust/consistent discharge processes and practice leading to delays and late discharges
- Bed state data not fully 'live' due to delays in entering data out of hours. Short term solution – additional bank admin out of hours pending long term redesign of ward administrative support.
- Workforce gaps/pressures - senior clinical workforce
- External factors outside span of control, e.g. social work capacity, DTOCs, stranded patients, ambulance traffic management
- Weak system wide escalation/responsiveness of partners at times of peak pressure
- ED environment/capacity constraints inhibits service efficiency

Sources of Assurance:

- Monthly integrated performance reports
- System wide urgent care dashboard
- TEC performance meeting & monthly update to part 2 of Trust Board
- Monthly 'day of care' audits
- Daily and weekly performance reports showing demand and performance data
- 4 hour standard breach report
- Monthly Divisional performance meetings

Gaps in assurance:

- None identified (Assurance mapping exercise for safety and quality of care in ED to be undertaken in June).

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Operating Officer

Risk Description	Controls	Assurance
Principal Risk Five B: Inability to deliver and maintain performance standards: Elective care		
Potential cause: •Failure to undertake robust demand & capacity modelling •Failure of infrastructure/estate resulting in lost capacity •Inability to recruit staff to full establishments, and with right skills •Financial constraints limit the organisation's ability to respond to risk •Increased demand (referrals) beyond anticipated growth •Reduced demand as a result of referrers/patients choosing alternative providers •Inability to mitigate patient choice impact •Cancer data system requires upgrade/replacement	**Key controls in place:** • Access policy updated and in use • Weekly referral to treatment (RTT)Access meeting • GOO (patients with no outcome/booked to breach) Patient Tracking List (PTL) meetings • Daily RTT performance update email • Daily, weekly & monthly RTT pathway validation • Suite of iReporter data quality reports developed to safeguard accuracy of PTLs • RTT recovery trajectories by specialty • Director of Performance undertakes regular demand & capacity reviews • Outsourcing programme • Weekly Cancer Access meeting • Manual checks and processes to ensure accuracy and validity of cancer data to mitigate for system constraints • Cancer Improvement Plan • Cancer Action Group – CCG led • Diagnostic Performance meeting • Agreed activity plan with commissioners for 2017/18 **Gaps in controls:** • Variable adherence/application of Access Policy & OPD processes • Risk of loss of capacity associated with e.g. estate & theatre ventilation works • Limited uptake by patients of outsourcing options • Impact of unscheduled care demand / prioritisation of emergencies • Incomplete demand and capacity modelling • Some factors influencing patient choice outside span of control e.g. breast symptomatic 2ww	**Sources of Assurance :** • Monthly integrated performance reports • Comprehensive suite of data quality reports for RTT & Cancer • RTT Programme Board (Chaired by COO) • Divisional Performance meetings • Monthly Performance (RTT/Cancer/Diagnostics) TEC & exceptions reports to Part 2 of Trust Board • Internal audit of compliance with Access Policy and scheduling practices undertaken in August 2016 • Monthly Contract Quality Review Meeting (CQRM) reviews activity against agreed performance plan **Gaps in assurance:** • None identified

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Financial Officer

Risk Description	Controls	Assurance

Principal Risk Seven A: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes

Potential causes:
- Income less than planned due to variance in productivity, capacity restrictions, paid for emergency activity at marginal rate, fines and/or penalties, additional risks from Commissioner financial position.
- STP funding not secured due to not achieving conditions
- Expenditure greater than planned due to spending to respond to emergency patient pressures.
- Expenditure greater than planned due to cost benefit analysis not taking place and options appraised before any decision to overspend
- Failure to achieve required levels of efficiency due to insufficient progress with establishment of internal PMO and project progress limited by competing operational pressures.

Potential effect:
- FY18 plan/target not achieved – reputational damage.
- Insufficient cash to not disrupt services
- Liability to demonstrate financial sustainability.

Potential Impact:
- External intervention
- Deterioration to reputation
- Capital funding delayed/ refused
- Loss of market share
- Financially unviable Trust

Key controls in place:
- Finance team and PMO support to CIP programme
- Budget setting and business planning process
- Budget management process
- Contract negotiation and monitoring process.
- Contracts and other documented agreements
- Standing Financial Instructions
- Annual audit plan and local counter fraud plan
- External audit of annual accounts and value for money assessment
- Monitoring of efficiency programme
- Monthly review with NHSI
- Integrated delivery/ oversight meetings
- Monthly performance divisional review meetings
- NHSI funding application processes.
- Joint QIPP Board and associated processes.

Gaps in controls:
- Limited use of benchmarking and SLR
- Overspending occurs without prior approval and agreed recovery actions
- Variable adherence to controls such as e-rostering
- Need to rapidly identify additional CIP to bridge gap between target and identified schemes.
- Clearer responsibility between health and social care partners for delivery of targets

(See also PR5a / b – significant tranche of STF funding dependent on meeting agreed improvement trajectories for emergency care and RTT standards).

Sources of Assurance:
- Monthly finance report + reconciliations
- Monthly Finance & Performance Committee
- Audit Committee reports
- Internal Audit report on budgetary control
- Internal Audit report on cost improvement programme
- Internal Audit reports on financial controls
- External Audit
- Regular reviews of efficiency programme by Finance & Performance Committee
- Review meetings with commissioners
- Outcomes of monthly accountability meetings
- Monthly cash balances

Gaps in assurance:
- Benefits realisation assessment for approved business cases.

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Financial Officer

Risk Description	Controls	Assurance
Principal Risk Seven B: Failure to secure sufficient capital, delaying needed improvements in the patient care environment securing healthy and safe infrastructure		
Potential causes: • Insufficient funding for critical projects after capital loan repayment and completion of schemes in progress • Inadequate business cases and project management • Failure to access external funding as a sanction for failure to deliver I&E plan **Potential effect:** • Delay of needed improvements in the patient environment • Increased fire-fighting due to not undertaking backlog maintenance or replacement of worn out equipment **Potential impact:** • Failure to make infrastructure changes essential to deliver 2017/18 planned activity • Non compliance with health and safety or other standards • Unsustainable infrastructure	**Key controls in place:** • Capital Planning and Finance Group (CPFG) • Finance and Investment Committee. • Annual planning processes and Budget setting confirm and challenge process • Engagement with the NHSI capital and cash process • Priority one schemes for 2017/18 agreed from internal resources **Gaps in controls:** • Variable quality of business cases • Project management (spending profile, delivery risks, variance control) • Business case development process • ITFF application being developed – risk of delay to approval and / or not fully approved.	**Sources of Assurance:** • Monthly Board reporting • Progress updates to Finance and Investment Committee • Executive sign-off of CPFG recommendations • Monthly reporting to NHSI • Strong pipeline of Strategic Outline cases and Outline Business cases • NHSI review of capital programme provided assurance of robustness of 2017/18 process **Gaps in assurance:** • Lack of assurance that approvals for spending are always within delegated limit / cost overruns on capital projects. • Internal audit of capital controls being undertaken (to report in 2017).

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Deputy Chief Executive / Director of Communications

Risk Description	Controls	Assurance
Principal Risk Eight: Failure to communicate and engage effectively both internally and externally compromises the organisation's strategic position and reputation		
Potential causes: • Competing priorities for the communications team (Smokefree, staff survey, flu etc…) • Lack of clarity as to impact of STP • Lack of clarity as to impact of RFH model • Planned programme of engagement is still being built (and will be ongoing) • Insufficient visibility of Board members and senior leadership team • The intranet and website are unappealing and in need of an overhaul **Potential effect:** • WHHT position not well understood or misrepresented, opportunities for positive messaging missed **Potential impact:** • Reduced confidence of stakeholders and local residents in quality and safety of services	**Key controls in place:** • Weekly meetings to discuss which issues have the highest strategic priority and to discuss workload • Communications team working with divisional structures to source and disseminate positive news stories • 24/7 communications support to respond to media enquiries and monitor media • Quarterly Herts & Minds newsletters • CEO briefings monthly on all 3 sites • Close working with STP and HVCCG communications teams on STP and YCYF communications • The MoU between RFH and WHHT has agreements re dissemination of key messages. This covers timings as well as content of key messages. • Meetings with external stakeholders are regularly taking place (i.e. Communications colleagues at the CCG, Watford BC, RFH etc.) • Communications plan devised for increased internal and external messaging re acute redevelopment strategic outline case. • Regular meetings in place with Watford Borough Council to work on messaging and open meeting planned for late June to address this issue and to promote the benefits of having a shared approach to the site **Gaps in controls:** • Visible Leadership programme needs to be re-invigorated and particular focus on HHGH and SACH sites • Website and intranet are based on old technology and content needs full refresh – this is subject to funding for the business case being secured • Communications resource means that large scale projects like the SOC(s) and planning campaigns to counter local opposition will be a challenge • Stakeholder strategy and action plan to be finalised – stakeholder engagement strategy scheduled for approval at October Patient and Staff Experience Cttee	**Sources of Assurance :** • Delivery against team's own action plan – monitored by the Deputy CEO • Feedback from staff during engagement events in spring and summer of 2017 and the free text that is part of the new pulse check • Media monitoring in help assess effectiveness of messaging • Broadening our stakeholder base enables more feedback into planned external communications and an assurance that our messaging is clear • Metrics on print and social media reported to Board in monthly CEO update • Annual staff survey • Focused work to review the effectiveness of internal communications channels to be concluded by end Q3 • Focused work to review the effectiveness of internal communications channels to be concluded by end Q3 **Gaps in assurance:** • Trend analysis of metrics needed to show progress in both media and staff communications

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Deputy Chief Executive

Risk Description	Controls	Assurance
Principal Risk Principal Risk Nine: Failure to deliver sustainable long term strategy for WHHT – clinical, financial, estates and digital		
Potential cause: Internal operational issues and capacity / capability constraints compromise ability to focus on progressing medium to long term strategic plans. System alignment via Strategy and Transformation Partnership. Note commissioner £ position increasingly challenging. **Potential effect:** Delays to strategy implementation, key sustainability issues not addressed, **Potential impact:** Reduced confidence of stakeholders and regulators in the leadership of the trust. Continued adverse impact on quality, safety and efficiency of services due to sub optimal clinical configuration and poor infrastructure	**Key controls in place:** • CEO, Deputy CEO, CFO and CMO all actively engaged in STP governance and delivery processes. CEO leading Urgent and Emergency Care and IM&T work streams, Deputy CEO leading estates and capital work stream. • Deputy CEO has lead responsibility for development and delivery of Trust strategies, linking with other Executive Directors as applicable. • Director of Integrated Care in place to support delivery of strategy and system wide pathway transformation. • Director of Environment lead responsibility for interim estate strategy and expert advice to development of redevelopment OBC. Strategy and Compliance function within Environment team strengthened to provide capacity to deliver strategy. • Associate Director IM&T leading updating and delivery of IM&T / digital strategy. • Regular dialogue with NHS I finance team to progress business case approvals for SOC & OBC. NHS I have recognised the need for substantial funding to take forward the development of the acute transformation OBC (contingent on SOC approvals) • Agreement in principle to explore closer working with RFL via the group model. Lead executives scoping opportunities. Programme Board established. • Long Term Financial Model **Gaps in controls:** • Limited internal strategic planning / health planning capacity currently in place to support the detailed work required to progress acute transformation OBC. • Availability of capital severely constrained. This is likely to impact on delivery of IM&T and Estates strategies and potentially delay OBC development if funding not secured. • Strategy implementation plans to be developed – overarching Trust strategy, interim estate strategy and IM&T strategy (following refresh) – via PMO / QIP process. • Detailed work plan with RFH to be developed	**Sources of Assurance :** • Strategy / STP & Your Care, Your Future updates to Trust Board • Board strategy development sessions • Long Term Financial model quarterly updates to FIC Committee • IM&T strategy progress updates to ICT transformation group / TEC / FIC. • External review of CGI contract undertaken. **Gaps in assurance**: • Key elements of programme to be incorporated into PMO model and reporting arrangements. • Acute Transformation Programme Board to be established to provide assurance re delivery of the outline business case (OBC) and associated transformation work • Estates governance to be strengthened with establishment of Estates Steering Group (Strategy and Capital)

Current Status	October 2017	G	AG	A	AR	R	⟷	OWNER: Chief Executive Officer

Risk Description	Controls	Assurance
Principal Risk Ten: System pressures adversely impact on the delivery of the Trust's aims and objectives		
Potential Cause Insufficient alignment of demand, capacity and financial plans across the system; service gaps; insufficiently robust system plans to address key pressures and / or plans not delivered and / or plans do not have the anticipated impact on performance **Potential Effect**: Demand exceeds capacity – planned & emergency care pathways including delays discharging medically stable patients to alternative care settings **Potential Impact**: Significant adverse impact on quality, safety, responsiveness and efficiency of services including delivery of national standards and financial plans	**Key controls in place:** • STP / Your Care Your Future programme •Monthly clinical partnership meeting – WHHT & HVCCG clinical commissioning leads •Provider collaborative established , principles for collaboration agreed, shared work programme in place. "One Herts" GP federation established and providing mechanisms for increased work with GPs are providers. •A&E Local delivery Board (LDB)– WHHT CEO chair and EDs active participation •System support being provided by the National Emergency Care Improvement Programme (ECIP) / Emergency Care Improvement plan in place •EoE Ambulance Handover pilot site •System wide discharge improvement plan developed and submitted to NHS E. (HVCCG led) •WHHT COO meets weekly with system partners •Director of Integrated Care appointed – key role in building collaborative relationships , developing and implementing solutions. •Annual contractual negotiation and contract management mechanisms – joint QIPP Board •CEO / representative attends Hertfordshire Chief Executive's Forum **Gaps in controls:** •Significant gap between HVCCG and WHHT contract values. Joint QIPP Board not functioning optimally – needs review, increased clinical engagement & jointly agreed work programme to be developed. •HVCCG and HCC financial positions leading to the decommissioning of community and social care capacity to support people at home as alternative to admission / following admission. Persistent issues in relation to high levels of delayed transfers - system not meeting trajectory to reduce •Continuing care / End of Life care pathways not operating effectively – joint improvement plan to be developed. •Clinical relationships WHHT / primary care under developed in some specialities	**Sources of Assurance:** • Daily / weekly /monthly monitoring of KPIs and escalation to NHS E, NHS I and partners. CEO to CEO / system escalation as required • Fortnightly LDB meeting – reviews LDB dashboard and progress against system improvement plan • Monthly integrated Performance Report (IPR) reports key metrics and remedial actions • Monthly reports to TEC setting out performance, remedial actions and risks / issues. Monthly updates to Trust Board. • Monthly regional escalation meetings. • Finance reports. **Gaps in assurance:** • Insufficient assurance that all LDB resource (readmissions and marginal rate emergency tariff (MRET)) is delivering the maximum impact – particularly ref reducing acute pressures

BOARD ASSURANCE FRAMEWORK ACTION TRACKER 2017/18

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
1	1	Improve complaints performance	CNO		S&C	Review & update KPI's for Board IPR	Jun-17	Jul-17	Narrative updated on the IPR to show divisional overview and performance. Charts also updated, main KPI's not changed. Updated for September Board.	complete	Sep-17	Sep-17
2	1	Improve complaints performance	CNO		S&C	Set trajectory for performance at Trust and divisional level and embed	Jun-17	Jul-17	Trajectory work completed and improved performance seen. Further work to embed and sustain improvement and review again in December 17.	amber	Dec-17	
3	1	Improve complaints performance	CNO		S&C	Review complaints team management capacity and roles and responsibilities	Jun-17	Jul-17	Completed	complete		Jul-17
4	1	Improve complaints performance	CNO		S&C	Implement recommendations from review of complaints team	Jun-17	Oct-17	We have changed our processes to comply with responding to all complaints within the required 25 working days. The policy is being reviewed to consider this strict deadline and negotiating with complainants. The Datix system is being updated to make the above mandatory. This will be completed at the end of October.	complete		Oct-17
5	1	Improve complaints performance	CNO		S&C	Joint audit of quality of complaint responses with Hertfordshire Healthwatch.	Jun-17	Nov-17	~	not rated		
6	1	Implementation of actions to address 'must and should' CQC recommendations (Sept 16 inspection).	CNO	CIO	S&C	Finalise QIP update to reflect all new actions following receipt of CQC report for Sept 15	Jun-17	May-17	All new actions and change forms completed and approved by TEC. Divisional reviews of all musts and should with a full QIP refresh.	complete		Jun-17
7	1	Implementation of actions to address 'must and should' CQC recommendations (Sept 16 inspection).	CNO		S&C	Updated programme reporting format via safety and compliance sub committee to Board and Oversight committee	Jun-17	Jun-17	New reporting via PM3 in place.	complete		Jun-17
8	1	Embedding the learning from SI's	CMO	CNO	S&C	Develop process to track actions from SIs via divisional performance review meetings	Jun-17	Jun-17	Scheduled commenced in July 2017	complete	Jul-17	Jul-17
9	1	Embedding the learning from SI's	CMO	CNO	S&C	Audit effectiveness of SI Review group to provide assurance that all SI action plans are implemented and embedded. (Report to Safety & Compliance Committee)	Jun-17	Feb-18	Report established and presented at each SI Review Group meeting. This provides a RAG rated overview of all open SI action plans to indicate their current status and whether additional action is required in respect of reviewing and closing the action plans.	amber		
10	1	Duty of candour understanding and thresholds for moderate and severe harms	CNO	CMO	S&C	Implement Datix tracking mechanism for moderate harm incidents	Jun-17	Jul-17	Completed	complete		Jul-17
11	1	To meet clinical guidelines in-date trajectory of 90%	CMO	CNO	O&E	Trajectory to deliver improvement from May baseline (54%) to be developed.	Jun-17	Jun-18	Trajectory developed and signed off by the Policy Review group in July 2017	completed	Jul-17	Jul-17

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
12	1	To meet clinical guidelines in-date trajectory of 90%	CMO	CNO	O&E	90% clinical guidelines in date	Jun-17	Mar-18	As at 07/07/17 the percentage of clinical guidelines registered with the Assurance Team and in date is 64%.	green	Sep-18	
13	1	To determine effectiveness of clinical guidelines	CMO	CNO	O&E	Audit a sample of guidelines and practice	Jun-17	Dec-17	~	not rated	Feb-18	
14	1	To set up a Trust wide consent framework linking MCA/Best Interests	CMO	DD Surgery	S&C	MCA / Best Interests training programme and schedule to be finalised	Jun-17	Jun-17	Consent policy approved. Trust wide consent audit framework currently being implemented.	amber	Dec 17	
15	1	To set up a Trust wide consent framework linking MCA/Best Interests	CMO	DD Surgery	S&C	MCA / Best Interests training programme delivered (six month progress report)	Jun-17	Jan-18	~	not rated		
16	1	Establish medical safe staffing assurance report	DWF	CMO	S&C	Develop metrics for reporting	Jun-17	Jun-17	The systems for proactively managing medical workforce allowing this to happen are not in place. This would require some form of e-rostering and whilst the Trust has started down this path, it will require significant time and resource to make this work for this purpose.	red	Mar-18	
18	1	Learning from deaths and implementation of NQB guidance	CMO		O&E	New policy finalised and adopted. *(dependent on national guidance being finalised)*	Jun-17	Dec-17	Trust policy ratified and published. SJR training for clinicians has started with 2 further dates scheduled. Trust Mortality dashboard as regular board agenda item to start Feb 2018	amber	Dec-17	
19	1	Learning from deaths and implementation of NQB guidance *(dependent on national guidance being finalised*	CMO		O&E	Action Plan to address requirements - report via outcomes & effectiveness committee. *(dependent on national guidance being finalised)*	Jun-17	Jun-17	Action plan in respect of the national guidance submitted and approved at June 2017 Mortality Review Group.	complete		Jun-17
20	2	Divisional staff survey action plans in place to drive continued improvement in engagement	DWF		PSE	Divisional staff survey action plans in place to drive continued improvement in engagement	Jun-17	Jun-17	Plans are now in place for all divisions and being managed via Divisional Performance Reviews.	complete		Jun-17
21	2	Review internal targets for appraisal and mandatory training - benchmark with organisations rated 'outstanding' by CQC	DWF		PSE	Review & agree (revised) internal targets for appraisal and mandatory training - benchmark with organisations rated 'outstanding' by CQC	Jun-17	Jun-17	Completed and as a result targets have been adjusted.	complete		Jun-17
22	2	Funding for CPD activity agreed and programmes being implemented	DWF		PSE	Funding for CPD activity agreed and programmes being implemented.	Jun-17	Sep-17	Transformation commissioned to benchmark clinical staffing levels.	complete		Sep-17
23	2	Continued improvement in equality and diversity - address findings from staff survey	DWF		PSE	E&D action plan approved viapatient and staff experience committee	Jun-17	Sep-17	Action plan approved by patient and staff experience committee	complete		Sep-17
24	2	Plan in place to address high level of agency use within surgery and in particular anaesthetics	DWF		PSE	Plan in place to address high level of agency use within surgery and in particular anaesthetics.	Jun-17	Aug-17	• There is an action plan now in place in relation to theatre staffing including apprenticeships, recruitment events, clinical supervision, induction, 'rescue' interviews. • The anaesthetic Consultant business case for recruitment of an additional 12 consultants was approved by TEC on 16th August.	complete		Aug-17

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
25	2	Plan in place to address high level of agency use within surgery and in particular anaesthetics	DWF		PSE	Progress review against plan via Pt & Staff experience committee	Jun-17	Feb-18	On track to meet the deadline in February 2018	amber		
26	2	Maximise opportunities from apprenticeship levy *(with STP partners)*	DWF		PSE	Strategy / implementation plan developed for approval via Pt & Staff experience committee	Jun-17	Oct-17	On going work being undertaken, but more work required before this can be completed.	amber	Feb-18	
27	2	Relaunch of B&H advisors to challenge inappropriate behaviour	DWF		PSE	Relaunch of B&H advisors to challenge inappropriate behaviour	Jun-17	Oct-17	This is being undertaken as part of a wider plan to tackle B&H and is due to launch later this year.	amber	Dec 17	
28	2	Suite of management programmes in place to assist development of our leaders	DWF		PSE	Agreed programme of management development in place	Jun-17	Oct-17	Programme in place	complete		Oct-17
29	2	Launch of 'shared' bank with STP partners *(part of agency reduction strategy)*	DWF		PSE	Launch of 'shared' bank with STP partners	Jun-17	Dec-17	Shared bank has been launched	complete		Oct-17
30	3	Agree and deliver prioritised capital programme for 2017/18	Dir Env		TEC	Finalise priority one capital programme (funded internally)	Jun-17	May-17	Capital programme finalised	complete		May-17
31	3	Agree and deliver prioritised capital programme for 2017/18	Dir Env		TEC	Develop implementation plan with milestones for tracking via Estates Steering Group	Jun-17	Jul-17	Implementation plan finalised	complete		Jul-17
32	3	Agree and deliver prioritised capital programme for 2017/18	DCEO		TEC	Agree priority 2 schemes for inclusion in ITFF application	Jun-17	Jul-17	A list of Priority 2 schemes was put forward for inclusion within ITFF.	complete		Jul-17
33	3	Ensure Authorising Engineers in place for all high risk activities	Dir Env		S&C	Technical Advisor to be confirmed for management of confined spaces.	Jun-17	Jul-17	Technical Advisor was confirmed for management of confined spaces.	complete	Sep 17	Sep-17
34	3	Ensure Authorised Person in place for all high risk activities	Dir Env		S&C	Ensure Authorised & Competent persons in place for all high risk activities (substantive appointments made to all posts / incorporated into existing job roles)	Jun-17	Aug-17	All posts filled by Trust staff	complete		Jul-17
35	3	Establish Estates Transformation Group with agreed set of deliverables for 2017/18, including development of estates and facilities KPI dashboard	Dir Env		S&C	First Estates Steering Group held & monthly forward plan in place (reports to Safety & Compliance Committee)	Jun-17	Jun-17	Regular ETG meetings established, with agreed term of reference and work plan	complete		Jun-17
36	3	Establish Estates Transformation Group with agreed set of deliverables for 2017/18, including development of estates and facilities KPI dashboard	Dir Env		S&C	Dashboard finalised with bi-monthly reporting against agreed metrics (first draft to be issued July 17 after June ESG). System to be fully implemented by Dec 17	Jun-17	Dec-17	Revised date. Populated dashboard to be available for Nov ESG	amber	Nov-17	
37	3	Provide assurance across spectrum of Environment Division activities through operation of the Premises Assurance Model	Dir Env		S&C	All actions from 2016/17 PAM review completed.	Jun-17	Aug-17	5 of 44 activity areas remain Inadequate. Prioritised Action Plan underway. All but one to be upgraded by end Dec 17. No direct patient safety implications requiring immediate action	amber	Dec 17	
38	3	Provide assurance across spectrum of Environment Division activities through operation of the Premises Assurance Model	Dir Env		S&C	Update self-assessment and develop new action plan to further strengthen assurance.	Jun-17	Dec-17	PAM interim review complete. The findings were presented to safety and compliance committee on 9 Aug I7. Continuous improvement action plan in place.	green	Mar-18	
39	3	Provide assurance that estate is 'fit for purpose'	Dir Env		S&C	Updated 6 facet survey and summary report	Jun-17	Sep-17	Draft 'report' being quality assured. Reset deadline to January 2018	amber	Jan-18	

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
40	3	Deliver programme to develop and populate ARCHIBUS to provide full functionality	Dir Env		S&C	ARCHIBUS full functionality implemented	Jun-17	Sep-17	Draft 'report' being quality assured. Reset deadline to January 2018	amber	Jan-18	
41	3	Provide development control plans (DCPs) to direct investment in line with Trust and Estates strategy.	Dir Env		S&C	Development Control Plans produced for WGH, SACH and HHGH	Jun-17	Mar-18	Programme underway with clinical teams to determine 'As Is' and 'To Be' models for each site. DCP programme delayed 3 months.	amber		
42	3	Provide assurance that estate is 'fit for purpose'	Dir Env		S&C	Develop action plan to address highest risk areas - identify priorities for 2018/19 capital programme based on 2017 ^ Facet & Life Cycle exercise	Jun-17	Feb-18	Action dependent upon the production of 6 Facet Survey.	amber	Dec 17	
43	3	Complete estate asset database and roll out full PPM programme for 2017/18	Dir Env		S&C	Asset Database fully populated.	Jun-17	Sep-17	Data being uploaded. Revised completion date January 2018	amber	Jan-18	
44	3	Complete estate asset database and roll out full PPM programme for 2017/18	Dir Env		S&C	PPM programme completed - assurance update report to Safety & compliance	Jun-17	Mar-18	Action dependent upon the completion of an Asset Survey.	amber		
45	4a	Implement formal chief nursing information officer (CNIO) role	CIO	CNO	FIC	Implement formal chief nursing information officer (CNIO) role	Jun-17	May-17	CNIO appointed and in post.	complete		Apr-17
46	4a	Updated digital strategy (implementation dependent on securing funding - to include in ITFF and other bidding opportunities to be pursued).	CIO		FIC	Board development session	Jun-17	Jun-17	Updated Board on digital strategy at Board Development Session in June 2017	complete		Jun-17
47	4a	Updated digital strategy (implementation dependent on securing funding - to include in ITFF and other bidding opportunities to be pursued).	CIO		FIC	Formal Board approval of updated digital strategy	Jun-17	Sep-17	Discussed with Chair and CEO. Agreed to revise timetline to December 2017, to ensure focus on completion of the ICT infrastructure improvement programme.	amber	Dec 17	
48	4a	Completion of ICT infrastructure improvement programme	CIO		FIC	Completion of ICT infrastructure improvement programme	Jun-17	Jul-17	Plans in place with robust programme management and monthly Exec level review. The timeline was been moved to reflect delays due to the trust's response to cyber risks and high priority incidents. 90% EUD rollout completed by the end Sep 2017	amber	Network remediation ongoing (now expected end Oct 2017) All applications migrated to data centres - Dec 2017	
49	4a	Procurement and implementation of new cancer information system	CIO		FIC	CIS capital funding secured	Jun-17	May-17	Complete	complete		May-17

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
50	4a	Procurement and implementation of new cancer information system	CIO		FIC	CIS implementation plan approved by TEC	Jun-17	Jul-17	The business case was approved by TEC and the project established. OJEU procurement process is underway per national framework and associated timeframes	green		
51	5a	Develop and deliver ED workforce transformation plan	DD USC	CMO	PSE	Plan/business case for TEC review.	Jun-17	Jul-17	Business case for 3 new Acute physicians, 2 ANPs approved by TEC June 2017 .	complete		Jun-17
52	5a	Develop and deliver ED workforce transformation plan	DD USC	CMO	PSE	Recruitment timeline for new posts - target for appointments to be made by Oct-17 and staff in post by Jan-18.	Jun-17	Jan-18		not rated		
53	5a	ED infrastructure improvements	DCEO	CFO	O&E	Submit bid for GP streaming capital	Jun-17	Apr-17	Bid submitted but not successful; other funding routes to be explored.	complete		Apr-17
54	5a	ED infrastructure improvements	DCEO	DD USC	O&E	Develop bid for phase one 'do minimum' improvement works for ED	Jun-17	May-17	Bid submitted as a variant bid to wave 2 national ED transformation programme. £1m capital funding confirmed.	complete		May-17
55	5a	ED infrastructure improvements	DCEO	CFO	O&E	National funding contingent on delivery by end Oct 17. Plan in place to deliver this.	Jun-17	Oct-17	Contract awarded and works commenced. Weekly meetings to review progress.	green		
56	5b	Develop an RTT delivery work plan to address gaps in controls and assurance and embed new processes implemented in 16/17 (including actions from audit recommendations)	Dir Perf	COO	O&E	Develop an RTT delivery work plan to address gaps in controls and assurance and embed new processes implemented in 16/17 (including actions from audit recommendations)	Jun-17	Jun-17	The audit has been completed and was provided to RSM on 14/9. A response is awaited from RSM prior to review by the Audit Committee. Performance of RTT continues to be reviewed by TEC	green		
57	5b	Delivery of improved performance against Breast Symptomatic 2 week wait standard, develop a joint action plan with HVCCG	Dir Perf	COO	O&E	Delivery of improved performance against Breast Symptomatic 2 week wait standard, develop a joint action plan with HVCCG	Jun-17	Jun-17	Draft plan developed for review by Beds and Herts Cancer Action Group. WHHT sign off by the TEC in June 2017.	complete		Jun-17

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
58	7a	Ensure the Trust has a robust two year CIP programme (to include retender of soft FM, back office, DTOC reduction and agency cost reduction).	CFO	CIO	FIC	Develop 2 year CIP plan with clear implementation milestones.	Jun-17	Oct-17	[1] CIP strategy meetings between CFO, CIO, Assistant FD, Head of Programme Delivery Support designing methodology for further developing the 2 year CIP plan. Key to the development is the identification of financial benefits from strategic change projects. [2] Use of pipeline ideas to flow into evaluation process, assigned suitable time slots; delayed projects to flow into following year; abandoned projects reassessed for viability (i.e. what would it take to have made them a success, would this occur at a future point etc). [3] Benchmark Trust performance against NHS and external peers using a range of sources such as the Model Hospital, resulting in, e.g. establish best practice processes and organisation, collaborative efforts across institutions, contract renegotiations dependent on current terms and expiries. [4] Demand management programmes in conjunction with HVCCG and appropriate other institutions. Key to the success of such ventures is recognition of genuine changes in demand. [5] Improvements to CIP progress contained within Recovery Plan (see below). Action plan in place to produce detailed delivery programme for all identified CIP activities, including Model Hospital, existing and pipeline transformation projects, demand management, agency spend reduction and acceleration of Trust's private patient management capability. Action plan shared with NHSI as part of overall Financial Recovery Plan. Plan will be iterated further by November 2017. Strategy Delivery and PMO resources directed to prioritise support to CIP-yielding schemes.	amber	Mar-18	
59	7a	Commission independent review of cost of back office function metrics (e.g. IT) to support more targeted interventions.	CFO		FIC	External report commissioned.	Jun-17	May-17	Review commissioned and initial report provided.	complete		May-17

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
60	7a	Commission independent review of cost of back office function metrics (e.g. IT) to support more targeted interventions.	CFO		FIC	Action plans to be agreed with relevant directorates following receipt of report.	Jun-17	Oct-17	Initial report issued March 2017 and follow-up report discussed by the finance and investment committee in October 2017. Next step is for a more detailed analysis of outlying areas following which relevant directorates to develop plans to close gap. . Some benefits already being worked up on basis of initial report, with the majority of targeted interventions expected to have an impact from 2018/19.	amber	Dec-17	
61	7a & 7b	Develop applications for loan finance to cover revenue deficit and capital expenditure plans	CFO		FIC	ITFF application submitted.	Jun-17	Jul-17	ITFF application submitted July 2017. Next steps likely to be an NHSI review of business cases. 2016/17 ITFF funding not confirmed until M11 - not yet clear whether quicker decision will be made in this year.	complete		Jul-17
62	7a	Develop SLR and cost benchmarking capability to support efficient use of resources and identification of opportunities for CIP.	CFO		FIC	Improve SLR and cost benchmarking and agree pilot projects for deep dive	Jun-17	Jul-17	TOR agreed for working group. The first new project group meeting was held in October 2017. Group work continues to complete deep dives into selected areas.	amber	Nov-17	
63	7a	Review of staffing establishment levels to respond to efficiency challenge and NHSI challenge to Trust's high staff costs.	CFO		FIC	Commission external review of staffing levels	Jun-17	Jun-17	GK Transformation commissioned to benchmark clinical staffing levels.	complete		Jun-17
64	7a	Review of staffing establishment levels to respond to efficiency challenge and NHSI challenge to Trust's high staff costs.	CFO		FIC	Report and implementation milestones TBC	Jun-17	Nov-17	Independent review of nursing endorsed by NHSI expected for October 2017. Benchmarking of clinical department costs commissioned by CFO report in October. Feedback tba on independent review of medical staff establishment.	red		
65	7a	Strengthen contractual risk assessment, mediation and arbitration processes.	CFO		FIC	Commission third party expertise to strengthen contractual risk assessment, mediation and arbitration processes.	Jun-17	Jun-17	PWC reviewed 16/17 contract dispute and drafted mediation statement. Recommendations to strengthen arrangements this year made as part of this process. New mediation cases emerging however.	complete		Jun-17
66	7a	Strengthen contractual risk assessment, mediation and arbitration processes.	CFO		FIC	Action plan / implement recommendations	Jun-17	Jul-17	PWC recommendations implemented by contracts team.	complete		Jul-17
67	7b	Internal audit of costing, tendering and control of estates capital projects	Dir Env		FIC	Actions to be implemented as agreed from audit outcome	Jun-17	Oct-17	Management actions agreed with delivery due dates through to Oct-17	green		

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
68	7b	Strengthen capital programme delivery (environment)	Dir Env		FIC	Recruit capital programme manager & retender call off contract for project support.	Jun-17	Sep-17	Senior Capital PM in post. Review of project management underway. Current contract with GCSI extended to allow deliver of in-year programme. Review of requirement and re-tender process will follow.	green		
69	8	Re-boot 'visible leadership' programme	Dir Comms		TEC	Proposed approach to be presented to TEC for approval.	Jun-17	May-17	Proposed approach agreed at TEC in May-17. new milestone to be added for review in Jan 18	complete		May-17
70	8	Stakeholder strategy and action plan	Dir Comms		PSE	Finalise strategy and action plan for approval by PSE and Trust Board.	Jun-17	Jul-17	Draft presented to PSE in June. Agreed further work required and represented in October with target for board approval in December	amber	Dec-17	
71	8	Stakeholder strategy and action plan	Dir Comms		PSE	Implementation milestones TBC	Jun-17	TBC	~	not rated		
72	8	Comprehensive communications plans for four major strategic issues	Dir Comms		PSE	Comprehensive communications plans for four major strategic issues (STP, SOC, Hemel SOC, RFH partnership)	Jun-17	Jun-17	STP communications team providing monthly briefings with event in September 2017. Hemel SOC clinical engagement workshops held in September 2017. RFH group model presented at clinical event in July 2017. Timelines reset due to priority being given to internal CQC comms.	amber	Nov-17	
73	8	Intranet update	Dir Comms	CIO	PSE	Business case to be reviewed and updated.	Jun-17	Oct-17	There has been a delay due to resource issues	not rated	Jan-18	
74	8	Intranet update	Dir Comms	CIO	PSE	implementation TBC following confirmation of funding	Jun-17	TBC	~	not rated		
75	8	Trend analysis of communications KPIs	Dir Comms		PSE	Bi-annual updates to Trust Board	Jun-17	Oct-17	Delayed due to resource issues. Will be reviewed by Patient and Staff Experience Committee in December, prior to Board in January 2018.	not rated	Jan-18	
76	8	Trend analysis of communications KPIs	Dir Comms		PSE	Bi-annual updates to Trust Board	Jun-17	Apr-18	~	not rated		
77	9	Mobilise Acute Transformation Programme Board & additional internal programme delivery capacity to support development of outline business case and associated service transformation.	DCEO		TEC	Secure approval for acute SOC from HVCCG, STP, NHSI, DH &Treasury	Jun-17	Oct-17	SOC submitted via STP capital process with support of EoE region. Formal NHSI review process underway. WHHT have requested joint meeting with NHS E / NHSI / HVCCG.	red	Nov-17	
78	9	Mobilise Acute Transformation Programme Board & additional internal programme delivery capacity to support development of outline business case and associated service transformation.	DCEO		TEC	Mobilise additional internal programme team capacity & programme management structures	Jun-17	Oct-17	First meeting of Programme Board held 11/10/17 (subset of proposed membership). First full meeting to take place in November 2017. One additional service planning post recruited to – in post early November. Review wider resource commitment to enable progress to commence prior to formal approval scheduled October 17.	amber	Jan-18	

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
79	9	Establish Partnership Board with Royal Free London	DCEO		TEC	Scope potential opportunities and agree work plan	Jun-17	Jul-17	Draft work plan developed – final version for approval to be presented to October Programme Board / WHHT Board in November. On track for revised delivery date.	green	Nov-17	
80	10	Implement new STP governance arrangements with strengthened PMO to support delivery.	CEO	STP CEO	TEC	Implement new STP governance arrangements with strengthened PMO to support delivery.	Jun-17	Jul-17	New STP governance arrangements agreed in principle. Additional programme support recruited into PMO to support workstreams. Recruitment to clinical lead role / clinical advisory group in progress.	complete	Aug-17	Aug-17
81	10	Implement new STP governance arrangements with strengthened PMO to support delivery.	CEO	STP CEO	TEC	Ensure visible leadership contribution from WHHT to STP work streams - agree WHHT nominees.	Jun-17	May-17	WHHT CEO SRO for urgent and emergency care and IM&T, Deputy CEO SRO for estates and capital work stream. WHHT Chair attends STP Oversight Committee. Active input from CMO and CFO and other Execs to relevant work streams. Suggested WHHT representatives have been provided to STP PMO.	complete		May-17
82a	10	Strengthen joint HVCCG and WHHT QIPP Board with clear TOR and increased clinical engagement.	CEO	HVCCG	TEC	Develop joint HVCCG and WHHT QIPP board and increase clinical engagement.	Jun-17	Jul-17	Joint QIPP Board established. Increased clinical engagement in place.	complete		Jul-17
82b	10	Strengthen joint HVCCG and WHHT QIPP Board with clear TOR and increased clinical engagement	CEO	HVCCG	TEC	Develop and implement	Oct-17	Oct-17	Agreed programme of pathway redesign in place with several pathways under active redesign. Ongoing dialogue with HVCCG re contractual / financial arrangements and realistic go live dates for new pathways. Local pricing review underway.	amber	Jan-18 / TBC	
83	10	Implement new 'discharge to assess' pathways *dependent on agreement of all partners*	DIR IC		TEC	Pathway one (discharge home) – pilot started in March. Due for review to inform long term sub contract by July 2017.	Jun-17	Jul-17	• Project Initiation Document developed for the complete Discharge to Assess service - being led by Herts County Council. • Review underway of pathway 1 between WHHT & HCT. • Extension to the block arrangement for July 2017 so that further modelling for a cost per case arrangement can be put into place. Sub contract arrangements now to be in place for August 2017 • Review completed with a decision in principle to develop a cost and volume service. • Service Specification completed • Business case to come to TEC for end of October 2017 which if approved will see a Service Level Agreement in place with HCT by the end of November 2017	amber	Nov-17	

ref	PR	Improvement area / action	owner 1	owner 2	Lead sub-ctte	actions / milestones	Date of entry	due date (original)	update	RAG	due date (revised)	date complete
84	10	Implement new 'discharge to assess' pathways *dependent on agreement of all partners*	DIR IC		TEC	Pathway two (further assessment and / or rehabilitation prior to decision re long term care) – plan to be developed by July 2017. Implementation milestones TBC	Jun-17	Jul-17	• Project Initiation Document developed for the complete Discharge to Assess service - being led by Herts County Council. • Scoping still required by HCC to determine the complete numbers of patients that need to be accommodated through this pathway. • As a starting point, 10 cohorted beds in a care home facility are being commissioned by HCC from 01/11/17. HCC working with HVCCG to identify and secure the appropriate primary care support	amber	Nov-17	
85	10	Implement new 'discharge to assess' pathways *dependent on agreement of all partners*	DIR IC		TEC	Pathway three (patients expected to need a long term placement). Transition hub to be developed / implemented by July 2017.	Jun-17	Jul-17	Project Initiation Document developed for the complete Discharge to Assess service - being led by Herts County Council. • Simpson ward is the identified hub for this pathway. • Joint HCT, HCC & WHHT operational group working through the detail for service transfer to HCT in August 2017 • Standard operating procedure completed for pathway 3 ahead of the transfer of Simpson ward to HCT which was completed on 1st Aug as planned. • Final draft of the specification for pathway 3 service prepared for the Service Level Agreement between WHHT & HCT for the Discharge to Assess provision on Simpson. Service Level Agreement for completion by end of November 2017	Amber	Nov-17	
86	7a	In response to deterioration to plan produce a formal re-forecast for NHSI to be accompanied by a comprehensive Financial Recovery plan for the year.	CFO		FIC	Develop financial recovery plan and covering letter to be signed by CEO and Chair. Secure Board agreement for the plan.	Oct-17	Oct-17	Recovery plan sent on 16 October 2017. Progress with the plan will form part of the trust's next Quarterly Review meeting with NHSI.	complete		Oct-17

Report to:	Finance and Investment Committee
Title of Report:	Finance and Investment Assurance Report to Trust Board
Date of meeting:	2 November 2017
Recommendation:	For information and assurance
Chairperson:	John Brougham, Non Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Investment Committee at its meeting on 24 October 2017
Background	The Committee meets monthly and provides assurance on:

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

Financial Performance

i. I&E Deficit

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

The deficit in September of £4.1m, comprising £27.7m of revenues and costs of £31.2m, was £3.5m worse than budget but marginally better than forecast by £0.3m, with higher revenues of £0.5m partly offset by £0.2m of higher costs. The first half year deficit of £24.7m is £10.2m worse than budget, and £9.7m higher than the £15.0m full year budget.

As reported last month, the Committee concluded that a number of budgeted challenges for the year would not realistically be delivered. These comprise the £8.2m extra CIP stretch target, the shortfall in STF funding of £9.3m, as a result of not achieving the deficit and A&E performance targets, and 3 post budget decisions that have increased the deficit by £2.5m, £2.1m relating to 2016/17 and £0.4m following arbitration on reduced Ambulatory Care tariffs.

The October Board agreed that the realistic, but still very challenging, year end forecast should be £35.0m, which excludes the £20m above, and is in line with the Trust's original plan, pre the extra CIP challenge.

This forecast has now been reviewed with, and submitted to, NHSI and the Committee reviewed the latest status of plans to underpin achieving it and the associated risks and mitigations. The plans include reducing the first half year run rates of both pay and non pay costs, including delivering the original planned full year CIPs of £13.7m, which requires an increase from £4.5m delivered in the first half year, to £9.2m in the second half.

The Committee reviewed the plans to offset agreed QIPP activity revenue reductions with reductions in costs, and CQUIN performance, which is broadly on track.

The Committee was assured of the Trust's focus and commitment to achieve the deficit forecast but recognised the challenges in delivering it, and that in the region of £5m is yet to be underpinned.

The Committee recommends that the plans and risks in achieving the £35m deficit target are reviewed in part 2 of the November Board

ii. Update on Carter Report recommendations and Back Office Savings

The Committee reviewed the development of the Model Hospital Benchmarking Tool by NHSI, which is one of the key recommendations of the Carter Report aimed at improving productivity and performance in NHS acute hospitals, through standardisation of procedures and greater collaboration between Trusts.

The Model Hospital advises Trusts on the most efficient allocation of resources and allows performance comparison against other Trusts.

A presentation was made on the Model Hospital by NHSI to the Trust Executive in September and was well received, and the Committee was assured that these principles would be applied to CIP schemes from October onwards with the aim of driving up savings across the Trust

The Committee reviewed the progress being made to reduce costs in back office and other support areas. The commissioned non clinical benchmarking report has identified significant savings opportunities which are being assessed by the Trust Executive. The Committee was updated on progress in respect to payroll and finance systems and discussed other areas of opportunity.

The Committee recognises that making savings in these areas is an essential part of achieving the required level of CIPs both in this and future years, and will receive monthly updates on progress.

iii. Capital Expenditure/Funding

Capital spend in September of £0.5m resulted in a first half year spend of £2.2m. The Committee was assured that commitment and spend is being carefully prioritised and managed not to exceed the current NHSI authorisation limit of £7.7m.

Following review and recommendation by the Project Appraisal Unit (PAU) of NHSE, a revised ITFF application for £14.5m of funding has been made which, if approved, would authorise capital spend in the year of £22.2m, £0.8m lower than originally planned.

The Committee remain concerned that the timing of approval would not enable all the spend to be made in the year, and supported the Executive working with NHSI to secure early agreement to carry forward unspent approved funds into 2018/19.

iv. Revenue Funding

Funding of revenue spend by NHS is subject to monthly approval and following review the Committee recommends ratification by the Board of a loan of £3.36m for the month of October. NHS loan funding of £1.36m was also received in October for the Q1 STF revenues.

The Trust has applied for an increase in revenue funding of £20m for the year to cover the increase in the forecast deficit from the budgeted £15m to £35m.

Corporate Risk Register

The Committee reviewed the latest assessment of risks and mitigation plans relating to Finance and IM&T. The Committee noted, and agreed, with the transfer of a risk relating to medical records to come under the remit of the Safety and Compliance Committee, and was assured that all but one of the existing 11 risks should remain on the CRR with no changes to the risk rating. The Committee agreed that there should be an increase to one risk relating to achieving all the STF conditions for this year.

Information and Communications Technology

The Committee reviewed the progress of the infrastructure improvement plan.

The Committee was assured by a number of achievements in September, including meeting the 90% target rollout of end user devices, further progress with network remediation, which have yielded significant performance improvements on the primary link to the supplier datacentres and the successful deployment of the new Carestream PACS system, which is now in use by clinicians across all three Trust sites.

BAF Action Tracker

The Committee reviewed the BAF relating to the two Principal Risks under its remit, and agreed that, given the recommendation above by the PAU on capital spend authorisation, the RAG rating on failing to secure sufficient capital, should be improved from Red to Amber Red, when the BAF is reviewed at the November Board. Following review the Committee agreed there should be no other changes to either Principal Risk assessment presented to the Board.

The Committee reviewed the BAF action tracker and asked for a number of changes to be made to the status of actions to bring them fully up to date for presentation to the November Board.

Procurement Contract Management

The Committee reviewed the status of supplier contract control and management.

Hertfordshire NHS Procurement is not an outlier compared with comparators in respect of contract coverage and contract management, but there are significant opportunities for improvement by working with the Trust to improve both.

These should be enabled by ensuring that Procurement have full oversight of all supplier contracts, and by ensuring the Trust has a fit for purpose contract management system, with appropriate training, to improve operational management of the contract, and discussions are taking place with UCL Partners procurement service to help with this.

The Committee was assured by the actions in place to improve in both areas, and by the Executives planned review of supplier contacts to identify and realise further opportunities for savings.

The Committee has asked for an update on progress in January.

Transforming Pathology Services, Strategic Outline Business Case (SOC)

The Committee reviewed the draft SOC taking into account the national drive to achieve more efficiencies in pathology, including increasing consolidation of services across the NHS, the Trust's site development plans which propose using the land occupied by the pathology block at Watford, and the need to take advantage of technological advances in pathology to provide the quality of service required in the future.

The SOC rated 7 options for quality of service, financial return, and value for money, and recommended that 5 options, including centralising services at an existing WHHT site, collaborating with other providers, and outsourcing, should undergo further evaluation..

Following review the Committee agreed that the options should go forward to the next stage, the Outline Business Case (OBC), where each option would be subject to a more thorough evaluation, and recommends that the SOC is presented to Part 2 of the November Board for approval, and submission to NHSI for authorisation to proceed with the OBC.

Risks to refer to risk register See comments above on Corporate Risk Register.

Issues to escalate The Committee recommends the following:

To Part 1 of the November Board for ratification:

i. the NHS revenue support loan of £3.3m to cover funding requirements in October

To Part 2 of the November Board for review:

ii. the plans and risks in achieving the £35m deficit forecast

To Part 2 of the November Board for approval

iii. the Strategic Outline Case to transform pathology services

Attendance record

Attended
John Brougham, Non-Executive Director (Chair)
Don Richards, Chief Financial Officer
Jeremy Livingstone, Divisional Director, Surgery, Anaesthetics & Cancer
Katie Fisher, Chief Executive
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

Apologies
Helen Brown, Deputy Chief Executive
Kevin Howell, Director of Environment
Lesley Headland, Chair of Staffside
Tom Drabble, Patients' representative

Clerk
Clare Ransom, Executive Assistant

Agenda Item: 17/53

Report to:	The Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	02 November 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 17 October 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

Review of Standing Financial Instructions, Scheme of Delegation and Standing Orders.

The committee reviewed the annual update of the standing financial instructions, scheme of delegation and standing orders; incorporating the new committee structure.

RSM agreed to benchmark the documents against other organisations and provide feedback.

The committee approved the documents subject to a number of minor amendments.

Review of Risk management arrangements, including board assurance framework

The committee discussed and reviewed the controls in place to manage risk within the organisation, together with the maintenance and monitoring of the board assurance framework.

Over the past year the Trust's risk management strategy and procedures have been reviewed along with guidance to all staff on how to raise and report any identified risk. The committee was advised that a divisional peer review programme of risk is included in the risk review group work plan.

An internal audit in April 2017 concluded that the Trust's management of risk was suitably designed and consistently applied.

Conflicts of Interest Policy

The committee reviewed the policy incorporating the new national guidance from NHSE.

The guidance introduces common principles and rules for managing conflicts of interest and provides advice to staff and organisations.

The committee discussed the inclusion of:-

- Guidance on bequests, not currently in the national guidance.
- Ensure strengthening of wording on encouraging staff to give consent to payments received from the pharmaceutical industry to be disclosed.

The committee approved the policy and recommended the additions be agreed by the Trust Executive Committee before adoption.

Internal Audit Progress Report

The committee reviewed the up to date internal audit progress report. Concern was expressed that there were still a number of outstanding actions not being completed by the lead executives and it was agreed that this must improve. It was agreed that RSM would continue to work with individuals to ensure actions were progressed on time.

Risks to refer to risk register

None

Issues to escalate

- Update of standing financial instructions, scheme of delegation and standing orders were approved subject to a final update to ensure references to the most recent regulations etc.
- Conflict of interest policy was approved subject to inclusion of bequests and strengthening policy on pharmaceutical company payments.
- Review of Risk management arrangements, including board assurance framework
- Internal Audit Progress report – outstanding actions still not being completed/reviewed in agreed timescales.

Agenda item: 18/53

Report to:	Trust Board
Title of Report:	Safety & Compliance Committee Assurance Report to Trust Board
Date of board meeting:	2 November 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 12 October 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 August data in the September 2017 performance report and noted the areas of good performance and areas requiring performance improvement. **Corporate Risk Register and Risks aligned to Safety and Compliance Committee** The Committee received a report on the risks scoring 15 or more on the corporate risk register and the risks aligned to the committee with progress against the action plan. It was noted that since the last report there had been 2 new risks added to the corporate risk register aligned to the Safety and Compliance Committee. On reviewing the risks aligned to the committee, it was noted that *Risk 3120 - Patient Notes missing, delayed or poor condition* had been on the register since July 2014 without resolution but that an off-site business case would be finalised soon by TEC and FIC to finally mitigate it.

Board Assurance Framework action tracker

The Committee reviewed the status and progress of actions in the Board Assurance Framework, designated to the committee.

PLACE update

The Committee noted the update on the 2017 PLACE audit.

Fire Safety Update

The Committee received an update with regards to Fire Safety measures and management procedures throughout the Trust.

The Fire Safety update highlighted the continued challenge of the recruitment of a Fire Safety Officer but that there was an alternative solution to ensure duties and responsibilities were maintained. It was further noted that two local Trusts had received enforcement notices and that it would be proactive to understand the criteria for such notices.

Theatre Ventilation Update

The Committee was updated on the status of theatre ventilation on the Watford and St Albans sites which highlighted the operational impact on patient care, access and income. The Committee also heard that, although a detailed delivery plan for improvement exists, the Chief Operating Officer had to deal hourly with the implications.

Premises Assurance Model (PAM)

The Committee was updated on the implementation of the Premises Assurance Model (PAM) and noted the progress to address the five areas currently graded ‘inadequate’.

Endoscopy Decontamination Update

The Committee noted the business case submitted to TEC outlining the issues currently being experienced with the decontamination of Endoscopy scopes.

Medical Devices Update

The Committee received an update on the management of Medical Devices throughout the Trust and the most significant areas of concern. The update highlighted just how poor the use and maintenance of the process had been but that there was a corrective action plan which would be held under additional scrutiny in the Committee.

Maternity Services Security

The Committee received a report of the outcome of the Baby snatching exercise which was undertaken in August 2017, in partnership with Hertfordshire Police, and noted the associated action plan, with the main focus on training and awareness.

Review of themes identified during Investigation of Two Never Events between 2015 and 2016 in the Maternity Department

The Committee was assured by the report on the two Never Events which occurred in the Maternity department which showed that processes had since been strengthened and that the department will continue to closely monitor compliance.

Consent Framework Update

The Committee noted the paper reviewing the present position of the Trust in connection with its framework around Regulation 11 of the Health and Social Care Act 2008 ensuring that consent is obtained from patients correctly and within the law and noted that the Trust had a rolling programme of consent audits.

RSM Internal Audit Report on Divisional Governance, Women's and Children's

The committee received the RSM Internal Audit Report on Governance, Women's and Children's, which had been rated as 'reasonable assurance'.

Hertfordshire Safeguarding Adults Board (HSAB), Annual report, 2016-2017

The Committee received the Hertfordshire Safeguarding Adults Board Annual report for 2016-2017.

Quality Improvement Plan

The Committee was assured by the progress on the delivery of the Quality Improvement Plan (QIP).

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 and noted the progress updates and indicators contained in the report reflecting September data.

Risks to refer to risk register	There are 5 risks on the corporate risk register aligned to the Safety and Compliance Committee (scored at 15 and over).
Key decisions taken	None

Issues to escalate	1. Corporate Risks 2. Fire Safety Update 3. Theatre Ventilation 4. Medical Devices Update
Challenges and exceptions	None
Future exceptional items	None

Attendance record
Phil Townsend, Non-Executive Director Jonathan Rennison, Non-Executive Director Katie Fisher, Chief Executive Helen Brown, Deputy Chief Executive Sally Tucker, Chief Operating Officer 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 Rachael Corser, Deputy Director of Governance and Assistant Chief Nurse Maxine McVey, Deputy Chief Nurse Paddy Hennessey, Associate Director of Environment Mary Bhatti, Divisional Manager, Women's and Children's Services Danielle Boyd, Governance Assurance Lead, Women's and Children's Services Jo Fearn, Head of Nursing Children's Services Marissa Ruppersburg, Lead Nurse Medicine Phil Downing, Head of Nursing Unscheduled Care Lisa Morris, Executive Assistant (minute taker) *For individual items:* Tim Duggleby, Director of Environment (Premises Assurance Model)

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

TRUST BOARD MEETING IN PUBLIC
AGENDA

07 December 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
01/54	**Opening and welcome**	To note	N/A	Chair	Verbal
02/54	**Patient experience presentation**	To receive	N/A	Chief Nurse	Presentation
OPENING					
03/54	**Apologies for absence**	To note	N/A	Chair	Verbal
04/54	**Conflict of interests**	To note	N/A	Chair	Paper
05/54	**Minutes of the meeting held on 02 November 2017**	For approval	N/A	Chair	Paper
06/54	**Board action log from 02 November 2017 and previous meetings and decision log**	To note	N/A	Chair	Paper
07/54	**Chair's report**	To note	N/A	Chair	Paper
08/54	**Chief Executive's report**	To note	N/A	Chief Executive	Paper
PERFORMANCE					
09/54	**Integrated performance report – month 7**	To note	Trust Executive Committee	Chief Operating Officer	Paper
SAFE EFFECTIVE CARE (BAF RISK 1)					
10/54	**Quality improvement plan update**	For information and assurance	Trust Executive Committee	Chief Nurse	Paper
11/54	**Annual paediatric and neonatal establishment review**	For information and assurance	Safety and Compliance	Chief Nurse	Paper
12/54	**Bi-annual update on patient experience strategy**	For information and assurance	Safety and Compliance	Chief Nurse	Paper

14/54	**Nursing, midwifery and allied health professional strategy update**	For information and assurance	Safety and Compliance	Chief Nurse	Paper
UNDERDEVELOPED INFORMATICS INFRASTRUCTURE (BAF RISK 4)					
15/54	**Digital strategy refresh**	For information	Finance and Investment Committee	Chief Information Officer	Paper
DELIVER A LONG TERM STRATEGY (BAF RISK 9)					
16/54	**Strategy update – month 8**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
17/54	**Sustainability and Transformation plan update**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
GOVERNANCE					
18/54	**Review of risk management strategy**	For information/ assurance	Trust Executive Committee	Deputy Chief Executive	Paper
COMMITTEE REPORTS					
19/54	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
20/54	**Assurance report from the Patient and Staff Experience Committee**	For information and assurance	Patient and Staff Experience Committee	Committee Chair/Director of Human Resources	Paper
21/54	**Assurance report from Clinical Outcomes and Effectiveness Committee**	For information and assurance	Clinical outcomes and effectiveness committee	Committee Chair/Chief Nurse	Verbal
REPORT TO CORPORATE TRUSTEE					
22/54	**Assurance report from the Charitable Funds Committee**	For information and assurance	Patient & staff experience committee	Committee Chair/Director of Human Resources	Verbal
ANY OTHER BUSINESS					
23/54	**Any other business previously notified to the Chairman**	N/A	N/A	Chair	Verbal
QUESTION TIME					
24/54	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
25/54	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
26/54	**Draft agenda for next board meeting**	To approve	N/A	Chair	Paper

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27/54	**Date of the next board meeting in public:**11 January 2018, Terrace Executive Meeting Room, Watford Hospital	To note	N/A	Chair	Verbal

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