TRUST BOARD MEETING IN PUBLIC
AGENDA

01 November 2018 at 9.30am – 12.00noon

Executive Meeting Room, The 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
01/64	**Opening and welcome**	To note	N/A	Chair	Verbal
02/64	**Schwartz rounds** Presented by David Gaunt and Sue Whiterod	To receive	N/A	Chief Nurse	Presentation
03/64	**Briefing on black history month** Presented by Marsha Jones	To receive	N/A	Chief Nurse	Presentation
OPENING					
04/64	**Apologies for absence**	To note	N/A	Chair	Verbal
05/64	**Declarations of interest**	To note	N/A	Chair	Paper
06/64	**Minutes of the meeting held on 04 October 2018**	For approval	N/A	Chair	Paper
07/64	**Board action log from 04 October 2018 and previous meetings and decision log**	To note	N/A	Chair	Paper
08/64	**Chair's report**	For information	N/A	Chair	Paper
09/64	**Chief Executive's report**	For information	N/A	Chief Executive	Paper
PERFORMANCE					
10/64	**Integrated performance report – month 6**	For information and assurance	Trust Executive Committee	Chief Operating Officer	Paper
11/64	**Emergency department and referral to treatment performance update**	For information	Trust Executive Committee	Director of Performance	Paper

AIM 1: BEST QUALITY CARE (OBJECTIVES 1 – 5)					
12/64	**Infection prevention and control annual report**	For information and assurance	Clinical Outcomes and Effectiveness Committee	Chief Nurse	Paper
13/64	**End of life care annual report**	For information and assurance	Clinical Outcomes and Effectiveness Committee	Chief Nurse	Paper
14/64	**Preparations for a 'no deal' Brexit scenario**	To approve	Trust Executive Committee	Chief Operating Officer	Paper
AIM 4: A STRATEGY FOR THE FUTURE (OBJECTIVE 10-12)					
15/64	**Strategy update** **15.01 Monthly STP update**	For information and assurance	Trust Executive Committee	Interim Director of Strategy	Paper Verbal
GOVERNANCE					
16/64	**Outcome of well-led framework review**	For approval	Trust Executive Committee	Chair and Chief Executive	Paper
17/64	**2019/20 corporate meetings schedule**	For approval	N/A	Trust Secretary	Paper
COMMITTEE REPORTS					
18/64	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
19/64	**Assurance report from Clinical Outcomes and Effectiveness Committee**	For information and assurance	Clinical Outcomes and Effectiveness Committee	Committee Chair/Chief Nurse	Paper
20/64	**Assurance report from Safety and Compliance Committee**	For information and assurance	Safety and Compliance Committee	Committee Chair/Medical Director	Paper
21/64	**Assurance report from Audit Committee**	For information and assurance	Audit Committee	Committee Chair/Chief Financial Officer	Paper
REPORT TO CORPORATE TRUSTEE					
22/64	**Assurance report from West Herts Charity Committee**	For information and assurance	Charity Committee	Committee Chair/ Director of Communications	Paper
ANY OTHER BUSINESS					
23/64	**Any other business previously notified to the chair**	N/A	N/A	Chair	Verbal

QUESTION TIME					
24/64	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
25/64	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
26/64	**Draft agenda for next meeting**	To approve	N/A	Chair	Paper
27/64	**Date of the next board meeting in public:** 06 December 2018	To note	N/A	Chair	Verbal

NHS
West Hertfordshire Hospitals
NHS Trust

Acronyms and abbreviations

A

AAA	Abdominal Aortic Aneurysm
ACS	Accountable Care System
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
AGM	Annual General Meeting
AGS	Annual Governance Statement
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner

B

BAF	Board Assurance Framework
BAMM	British Association of Medical Managers
BAU	Business as usual
BBE	Bare Below Elbow
BC	Business Continuity
BCP	Business Continuity Plan
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
CDI	Clostridium Difficile Infection
C.Diff	Clostridium Difficile
CEO	Chief Executive Officer
CfH/CFH	Connecting for Health
CFO	Chief Financial Officer
CHC	Continuing Health Care
CHD	Coronary heart disease
CIO	Chief Information Officer
CIP	Cost improvement programme
CIS	Care Information Systems
CMO	Chief Medical 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	Commissioning Support Unit
CT	Computerised Tomography

D

DBS	Disclosure Barring Service
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
EHR	Electronic Health Record
EHRC	Equality and Human Rights Commission
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
FTE	Full Time Equivalent
FYE	Full Year End

G

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

H

H&S	Health and Safety
HAI	Hospital Acquired Infection
HAPU	Hospital Acquired Pressure Ulcer
HCA	Health Care Assistant
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
ICS	Integrated Care System
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
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
LD	Learning Disability
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

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

N

NBOCAP	National Bowel Cancer Audit Programme
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
NICU	Neonatal Intensive Care Unit
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
SOP	Standard Operating Procedure
SQ	Safety and Quality
SPA	Supporting Professional Activity
SRG	System Resilience Group
STEIS	Strategic Executive Information System
ST & M	Statutory and Mandatory
STF	Sustainability and Transformation Funding
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
TNA	Training Needs Analysis
T&O	Trauma and Orthopaedic
TOP	Termination of Pregnancy
TOR	Terms of Reference
TPC	Transformation Programme Committee
TSSU	Theatre Sterile Service Unit
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
TVT	Tissue Viability Team

U

UCC	Urgent Care Centre
UTI	Urinary Tract Infection

V

VFM	Value For Money
VSM	Very Senior Manager
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

OUR VALUES
Commitment
Care Quality

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70 YEARS OF THE NHS 1948 - 2018

Schwartz Rounds at WHHT

the very best care for every patient, every day

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70 YEARS OF THE NHS 1948 - 2018

Schwartz Rounds at WHHT

Some Statistics

- 29 Rounds since January 2016
- 1 Round at Hemel Hempstead
- Average of 52 participants per Round
- Maximum number participants – 122
- 493 staff members have been to one or more Rounds

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70 YEARS OF THE NHS 1948 - 2018

Experience

- Notable Rounds
  - Child Protection
  - Death and Dogs
  - Maternity Death
  - Hear My Voice
  - It's Tough at the Top
- Awards
  - Most Powerful Round, 2017
  - Shining Stars, 2018

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70 YEARS OF THE NHS 1948 - 2018

New Developments

- Team Time
  - Children's Services
  - Bluebell Ward
  - Emergency Medicine

- Training the next generation of facilitators

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70 YEARS OF THE NHS 1948 - 2018

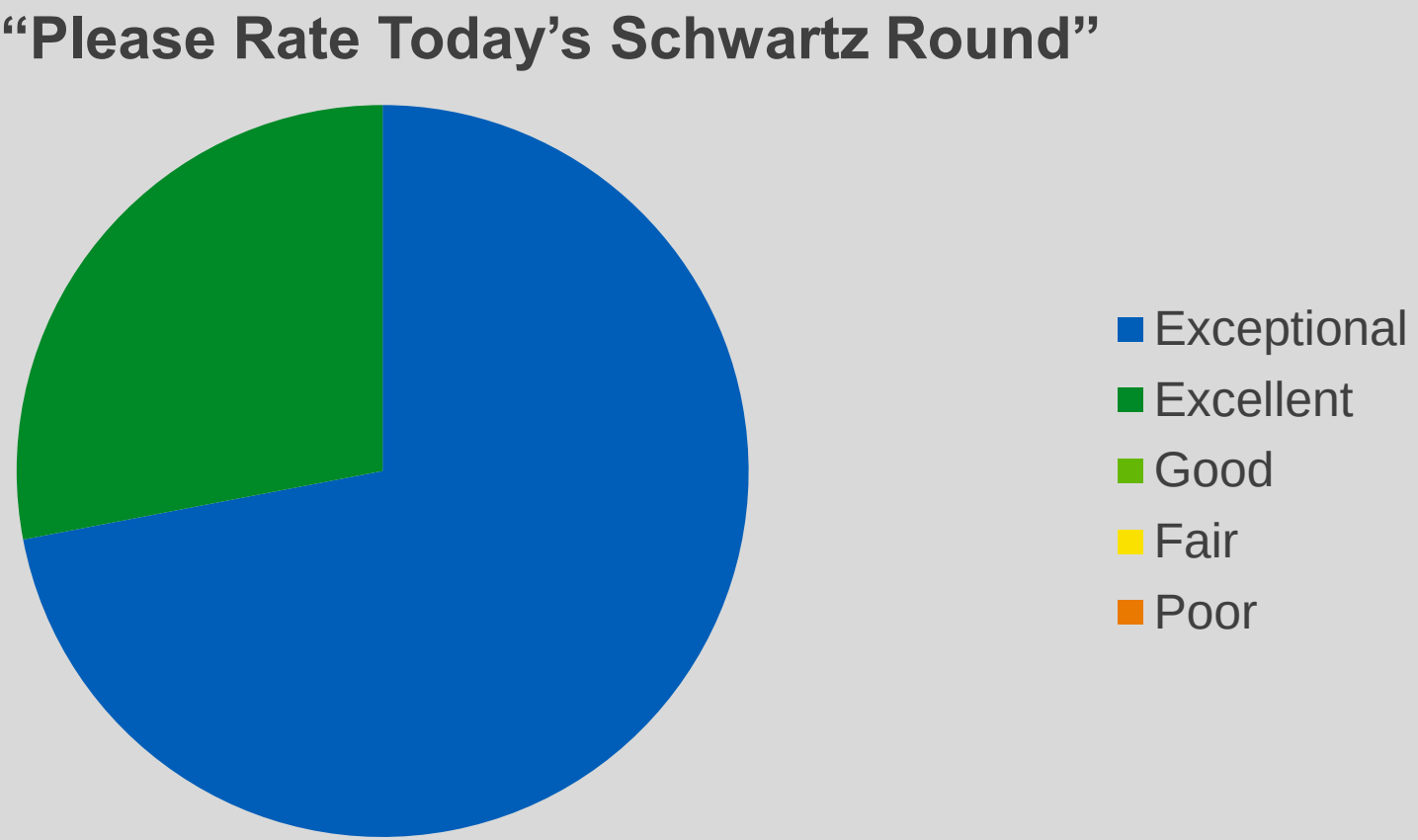
Research

- A Longitudinal National Evaluation of Schwartz Centre Rounds®: an intervention to enhance compassion in relationships between staff and patients through providing support for staff and promoting their wellbeing.

"We found that psychological wellbeing scores reduced significantly in regular Rounds attenders, dropping from 25% to 12%" (lower is better).

Maben, J, 2017, Kings College London

Evaluation from 17th October, 2018 Round



the very best care for every patient, every day

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70 YEARS OF THE NHS 1948 - 2018

Feedback

"The most important thing we do for our staff"

"Fantastic and wonderful to hear stories from colleagues"

the very best care for every patient, every day

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70 YEARS OF THE NHS 1948 - 2018

Thank you

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OUR VALUES

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West Hertfordshire Hospitals NHS Trust

Black History Month at WHHT Past and Present

Marsha Jones, Associate Chief Nurse for Quality

November 1, 2018

WHHT-One Trust
Many Nationalities

West Hertfordshire Hospitals NHS Trust

70 YEARS OF THE NHS 1948 - 2018

'A people without the knowledge of their past history, origin and culture is like a tree without roots'

Marcus Garvey

Black History
Windrush 70

West Hertfordshire Hospitals NHS Trust

- During WW2-Caribbean men women served in the armed forces
- Empire Windrush-Caribbean Tilbury 22nd June 1948
- 1948- Britain beginning to recover from the war
- Challenges with racism
- Staff from BAME background makes up almost a quarter of the NHS

WHHT Nurses
Windrush Era

Black History
NHS 70

West Hertfordshire Hospitals NHS Trust

- 70th Anniversary of Windrush generation of 1948
- South Asians arrival in the 1960's and 70's
- 202 nationalities represented in the NHS
- BAME leaders acknowledged and recognised
- Celebrations-Downing Street, Westminster Abbey, Great British Menu, York Minister Ceremony, BBC NHS 70 Season
- National Windrush Day 22nd June 2018

Black History Month
When did it start?

West Hertfordshire Hospitals NHS Trust

- First proposed in the U.S.A by Black Educators in 1969
- First celebration of Black History Month in Feb 1970
- First celebrated in the UK, in October 1987
- UK Black History was organised by Akyaaba Addai-Sebo whilst working for the Greater London Council.

Black History Month
WWHT Way

West Hertfordshire Hospitals NHS Trust

- RCN Black History Month Event- 6 BME staff attended.
- Maternity hosted event-Jacqueline Dunkley-Bent
- Connect-Multcultural Staff Network- Windrush era nurses
- Tea with Mayoress Sanchia Alisa (absent - illness)
- Jamaican High Commissioner Seth Ramocan

RCN Black History Event
Wednesday 17th October 2018

Black History Event
Tuesday 23rd October 2018

Black History Event
Thursday 25th October 2018

Black History Event
Monday 29th October 2018

Black History Month
Wednesday 31st October 2018

The Jamaica High Commissioner, Seth Ramocan visits WGH

NHS Workforce Race Equality Standard

- Equality and Diversity Council, 2014 agreed action for all staff from BME backgrounds have equal access to career opportunities
- Requirement for NHS Commissioners and Providers through the NHS Contract in 2015/2016
- WRES-supporting the system in understanding the challenges and it is leaders responsibility to make a difference
- WRES Phase 2- enabling people to work comfortably with race equality

WHHT WRES data

West Hertfordshire Hospitals NHS Trust

- Presented to Trust Board in September 2018
- Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce.
- Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.
- Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
- Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff

WHHT WRES Data
Through my lens

West Hertfordshire Hospitals NHS Trust

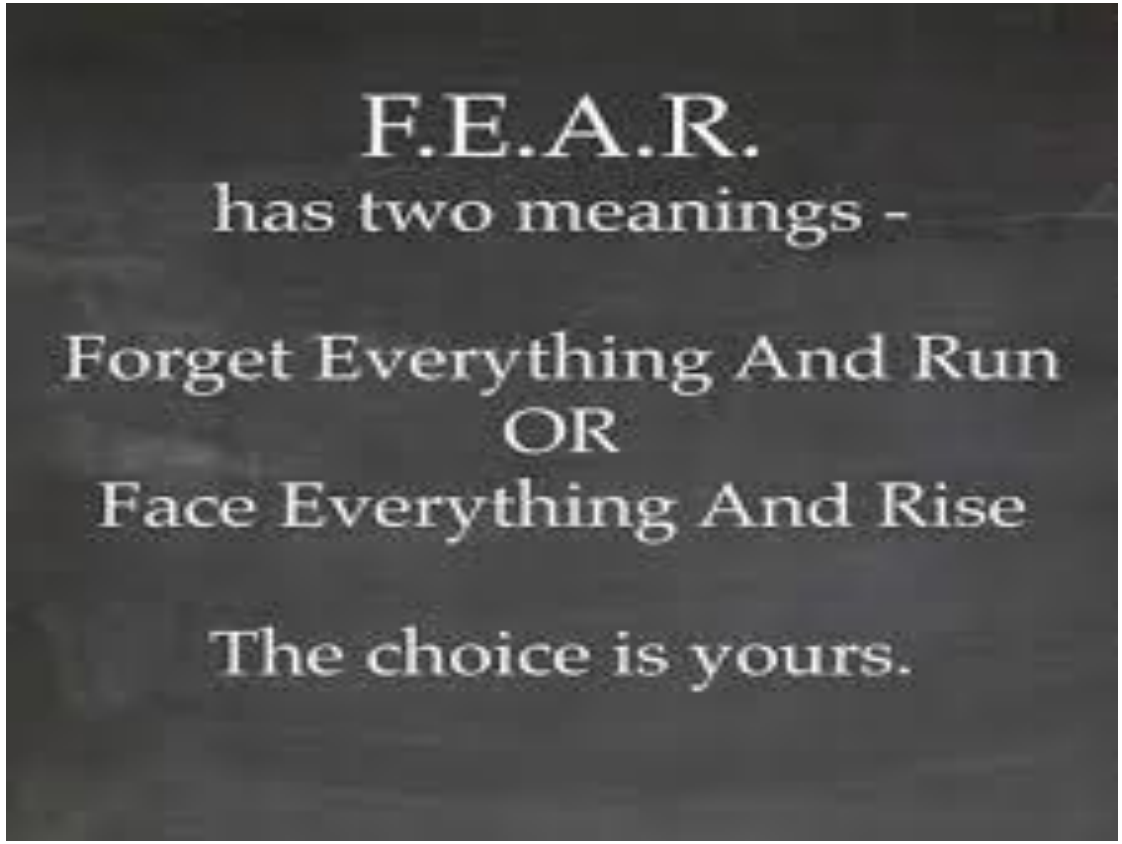
- Equality vs Justice
- ‘Seek first to understand, then to be understood’ Steven Covey
- ‘No decision about me, without me’ Andrew Landsley. Is your action plan co-produced?
- Challenge the nuances of ‘Unconscious Bias’
- Cultural Competency in Leadership
- Safe space
- Reverse mentoring

WHHT WRES Data
Through my lens

West Hertfordshire Hospitals NHS Trust

- Talent management including mentoring of BME staff
- Senior BME staff to be mentored by board members
- Executive lead for BME network- board member
- Accountability- how do BME staff hold Senior Leader and the Board to account?
- **'Accountability is the glue that ties commitment to the result'** Bob Proctor

WRES Data-Options Appraisal
Through my lens



Thank you

OUR VALUES
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Care Quality

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Declaration of board members and attendees interests
01 November 2018

Agenda item: 05/64

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 • Visiting Professor University of West London Business School. • Honorary Visiting Professor Cranfield University School of Management • Wife is CEO of Rotherham NHS Foundation Trust		Present June 2018 Present Present Present Present
Andy Barlow	Divisional Director, Women's and Children's Services	• Barlow Medical Services Ltd	April 2011	Present
John Brougham	Non-Executive Director	• Non-Executive Director and Chair of the Audit Committee of Technetix Ltd	2010	Present
Helen Brown	Acting Chief Executive	• None		
Professor Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	• None		

Last updated : October 2018

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
Paul da Gama	Director of Human Resources and Organisational Development	• None		
Virginia Edwards	Non-Executive Director	• Trustee Peace Hospice Care • Global Action Plan; providing support to their programme called Operation TLC • Director of Edwards Consulting Ltd * Coaching on East of England Accelerated Director development programme * Health Education England, self carer and carer workstream programme support • Husband is CEO of Nuffield Trust • Husband is Director of Edwards Consulting Ltd • Husband is a non-remunerated member of the Strategy Committee of Guy's and St Thomas's Charitable Trust • Charitable Funds for West Hertfordshire Hospitals NHS Trust	2011 2016 2011 2011 2011 2011 2014	Present Present Present Present Present Present

Last updated : October 2018

Sean Gilchrist	Chief Information Officer	• None		
Nick Kennell	Director of Strategy	• Financial interest – employee of Gate One Ltd	May 2017	Present
Jeremy Livingstone	Divisional Director of Surgery , Anaesthetics and Cancer	• Jeremy Livingstone Ltd		Present
Arla Ogilvie	Divisional Director for Medicine	• Private practice • UK Associate Chair of medicine St Georges International school of medicine	 2012	Present Ongoing
Jonathan Rennison	Non-Executive Director	• Trustee of Rising Tides Ltd • Change Management and strategy support with Kings College London • Director of Yellow Chair Ltd • Edgecumbe Consulting - Consultancy • Association of NHS Charities • The Teapot Trust - Coaching • BNET - Consultancy	May 2015 March 2017 Aug 2012 April 2015 Sept 2016 June 2016 Oct 2016	Present Present Present Present Present Present Present
Don Richards	Chief Financial Officer	• None		
Jane Shentall	Director of Performance	• None		
Phil Townsend	Non-Executive Director	• Son works on an agency basis for third party that Atos use to supply staff to the BBC contract	Oct 2018	
Sally Tucker	Chief Operating Officer	• None		
Dr Mike van der Watt	Medical Director	• Owner and Director Heart Consultants Ltd • Wife is Director of Hearts Consultants Ltd		Present

Last updated : October 2018

TRUST BOARD MEETING IN PUBLIC

04 October 2018

Terrace executive meeting room, The Kitchen Restaurant, Watford Hospital

Chair	Title	Attendance
Professor Steve Barnett	Chair	Yes
Voting members		
John Brougham	Non-Executive Director	Yes
Helen Brown	Deputy Chief Executive	Yes
Professor Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	Yes
Ginny Edwards	Non-Executive Director	Yes
Jonathan Rennison	Non-Executive Director	No
Don Richards	Chief Financial Officer	Yes
Sally Tucker	Chief Operating Officer	Yes
Phil Townsend	Non-Executive Director	Yes
Dr Mike van der Watt	Medical Director	Yes
Non-voting members		
Dr Andy Barlow	Divisional Director, Women's and Children's	No
Paul da Gama	Director of Human Resources	Yes
Sean Gilchrist	Acting Chief Information Officer	Yes
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	No
Dr Arla Ogilvie	Divisional Director, Medicine	No
Jane Shentall	Director of Performance	No
In attendance		
Dr Sundeept Bhalara	Consultant Rheumatologist	Yes
Sarah Cerys	Bowel cancer screening manager	Yes
Sahil Gul	Graduate trainee (observing)	Yes
Louise Halfpenny	Director of Communications	Yes
Jean Hickman	Trust Secretary (notes)	Yes
Sundera Kumara-Moorthy	Representative, Healthwatch Hertfordshire	Yes
Emma Purkis	Endoscopy Nurse	Yes

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/63	**Opening and welcome**		
01.01	The chairman opened the meeting and welcomed the board and members of the public.		
02/63	**Endoscopy JAG accreditation**		
02.01	The chair introduced Dr Alistair King, Emma Purkis and Sarah Cerys to the meeting and invited them to update the Board on a successful joint advisory group assessment of the endoscopy service. The senior leadership team described the history of the service with regard to JAG accreditation and explained the elements of the review process. It was reported that the Trust had invested in a new endoscopy unit in 2017 together with new decontamination equipment and the recruitment and development of nurse endoscopists, which, together with positive team engagement, had led to the service achieving re-accreditation in 2018. It was noted that the Trust was one of only two thirds of endoscopy units in country that had achieved JAG accreditation. The senior management team reported that the accreditation had resulted in the positive recruitment and retention of staff.		
02.02	Paul Cartwright thanked the team for the interesting presentation and enquired how the service ensured that it remained effective between inspections. Dr King responded that a good team culture and proactive steps to becoming a centre of excellence were key to the service continuing to offer excellent patient care.		
02.03	Ginny Edwards congratulated the team on achieving JAG accreditation and asked how the service planned to promote its reputation so that patients and the wider population were aware of the great service it provided. Dr King replied that, as well as a press release to announce the approval, the reputation of the service was spread actively through patient feedback.		
02.04	The director of workforce asked for clarity on the strategy employed to recruit staff. Emma Purkis responded that both an internal and external strategy was used and added that the service was considered to offer good development opportunities. The chief nurse enquired on the changes that had led to the improvement in recruitment and retention and Emma Purkis confirmed that the new unit had been instrumental, supported by a good induction programme and development pack. The medical director reported that patients were being repatriated back to the Trust which attracted good consultants and nurses. Furthermore, Dr King informed the committee that a multi-disciplinary approach was used to ensure all staff felt part of the team and decision-making.		
02.05	John Brougham asked whether the successful actions taken by the service had been extended across other areas. The chief operating officer advised that the trust executive committee had recently received a presentation on the work of the endoscopy and bowel cancer screening service which had led to discussions between the divisions. The medical director praised the service as being an excellent example of a clinical service working together and reported that the respiratory service was following their examples.		
02.06	The chair congratulated and thanked the team for its presentation and for delivering the excellent service.		
02.07	Resolution: The Board received the presentation for information.		

Agenda item	Discussion	Lead	Dead-line
OPENING			
03/63	**Apologies for absence**		
03.01	Apologies were received from non-executive director, Jonathan Rennison; the director of performance and divisional director of women's and children's services as they were attending a national seminar. The divisional director for surgery, anaesthetics and cancer and the divisional director of medicine were also absent.		
04/63	**Declarations of interests**		
04.01	No additional declarations of interest were received from those circulated prior to the meeting.		
05/63	**Minutes of the meeting held on 06 September 2018**		
05.01	Minute 09.04. The medical director advised that the reported improvement measures had not commenced by the time of the Board meeting in September; however since then a trial had begun on Elizabeth ward.		
05.02	Minute 10.04. Ginny Edwards asked for the word 'surprised' to be replaced with 'shocked'.		
05.03	Minute 11.01. The chief operating officer confirmed that the annual assurance paper on emergency preparedness, resilience and response had been submitted to NHS England within the required timeframe and it had been reviewed and approved by the safety and compliance committee.		
05.04	Subject to the changes reported above, the minutes were agreed to be a true record on the meeting.		
06/63	**Board action log from previous meetings and decision log**		
06.01	The actions were either completed or on track for the completion date.		
07/63	**Chair's report**		
07.01	The chair presented his report and highlighted an item relating to a national review into the management of a surge in demand over the winter period. It was reported that, to date, the Trust had not received a request for the Board to sign off a winter plan and the chief operating officer advised that NHS Improvement (NHSI) would be undertaking a winter assurance visit on 30 October 2018. The acting chief executive confirmed that the Board would receive an update in November 2018 which outlined the system-wide winter plan and the chair welcomed this and asked for regular updates to assure the Board that the plan was having the expected impact.		
07.02	The Board was updated on a partnership board meeting with the Royal Free London NHS Foundation Trust (RFL), at which the clinical partnership agreement was discussed. The chair advised that all points that the Trust had required had been reflected in the final draft agreement and confirmed that the agreement would go the RFL Board for approval later in October 2018.		
07.03	Paul Cartwright asked for clarity on the impact on the Trust of an agreed five year contract as part of a new NHS supply chain. The chief financial officer advised that the impact was not known at that time and assured the Board that the new contract would be closely monitored by the finance and investment committee.		
07.04	Resolution: The Board received the report for information.		

Agenda item	Discussion	Lead	Dead-line
08/63	**Chief Executive's report**		
08.01	The Board received a report from the chief executive which provided an overview of key decisions taken by the trust executive committee since the last meeting. She reported that the Trust had been notified that the care quality commission (CQC) would be making unannounced visits over the forthcoming months, followed by a well-led framework inspection at the end of November 2018. The acting chief executive reported that plans were progressing to expand the emergency department, as part of the Trust's winter planning programme. This would be funded from £1.2m awarded to the Trust from the government's winter funding programme. The Board was informed that Herts Valleys clinical commissioning group (HVCCG) had agreed to commission the equivalent of 40 beds and clinical leads would be working closely with community trust colleagues to manage patient flow.		
08.02	The Board discussed the merits of having the performance headlines in the report. Paul Cartwright raised the question of why the Board did not receive a report which currently went to the private session on the recovery of performance relating to ER, referral to treatment and cancer performance in the public session of the Board. The chief executive supported the principle of transparency and agreed for the report to be reviewed to ensure it contained no sensitive or confidential information. The representative for Herts Healthwatch agreed to review the report to confirm it was suitable for public viewing	ST	11/18
08.03	Resolution: The Board received the report for information.		
PERFORMANCE			
09/63	**Integrated performance report- month 5**		
09.01	The chief operating officer presented the integrated performance report (IPR) and summarised the areas of good performance and those which needed improvement.		
09.02	Phil Townsend noted that the IPR had positively evolved over a period of time and raised a question of whether the executive summary clearly articulated how the Trust was performing and helped to drive the Board debate. The Board discussed how the IPR could be improved; in particular to measure performance against expected outcomes and whether action plans were on target to achieve. It was agreed that a clear dashboard which focused on key performance indicators would be beneficial to guiding the Board discussion. Although the acting chief executive agreed that this would be a positive improvement, she cautioned that due to the complexity and fluctuation of performance, only a small number of key indicators that required Board monitoring and tracking would be able to be included in the dashboard.	ST/JS	11/18
09.03	The chief financial officer updated the Board on the latest financial position. He reported a £4.2m deficit in August, which was £0.8m worse than budget due to lower than expected pay and non-pay costs. The chief financial officer advised that the year to date deficit of £25.9m was £1.0m worse than budget and stressed that to deliver the budgeted full year deficit of no more than £52.9m for the year would require the monthly deficit to reduce to an average of £3.9m for the remaining months of the 2018/19. The chief financial officer reported an improvement in the cost improvement programme (CIP); with £2.3m being generated in the month, bringing the year to date total to £5.0m, which left a further £1.8m of CIPs to be identified. The chief financial officer assured the Board that the cash flow position had improved and		

Agenda item	Discussion	Lead	Dead-line
	that loans were being paid in a timely manner. It was reported that capital spend in the month had been £0.3m bringing the spend year to date to £1.2m from a budget of £18m. £13.2 m of the spend had been authorised by NHSI, with the remained yet to be authorised. John Brougham stressed the significant challenges to the Trust achieving the £52.9m deficit, particularly with the forthcoming winter pressures and reminded the Board of the importance of identifying the full cost improvement programme and underpinning the CQUINs.		
09.04	Resolution: The Board received the report for information and assurance.		
10/63	**Freedom to speak up**		
10.01	Ginny Edwards, in her role as freedom to speak up (FTSU) guardian, presented a paper which provided assurance on the Trust's position to meeting the recommendations from the Francis review together with other planned actions. She advised that most of the FTSU cases had been managed by supporting the member of staff through their concern. The Board noted a diagram which had been developed to signpost staff to the correct HR process. Ginny Edwards advised the Board that there would be a session on FTSU as part of the Board development programme in October 2018; this would align with the national FTSU month.		
10.02	The chair thanked Ginny Edwards and the HR team for their hard work and diligence in managing this important area.		
10.03	Resolution: The Board received the report for information and assurance that the Trust was meeting its FTSU mandatory requirements.		
11/63	**Hertfordshire and West Essex STP Estates plan**		
11.01	The acting chief executive re-presented a paper on the Hertfordshire and west Essex sustainability and transformation partnership's (STP) estates plan. The Board was reminded that the same paper had been reviewed in September 2018 and the acting chief executive confirmed that the plan contained all the STP priority areas of strategic work. She informed the Board that the STP would not be able to submit any wave four applications or business cases without an approved estates plan. The chair directed the Board to take the recommendation of the acting chief executive that the plan was appropriate as she had been working closely with STP colleagues on its development.		
11.02	The Board received a monthly STP update from the acting chief executive. The chair welcomed the update and asked for future editions to be overlaid with implications for the Trust. The acting chief executive advised that she would attempt to do this if possible and provided a brief overview with regard to early discussions on integrated care pathways and the development of the STP plan. She reported that the director of finance for the STP would be attending the private session of the meeting to discuss progress on the development of an STP medium term financial plan. Phil Townsend reported that he had been involved in the appointment of a new STP chair.		
11.03	Resolution: The Board approved the Hertfordshire and west Essex STP estates plan.		
12/63	**Assurance report from the Finance and Investment Committee**		
12.01	The Board received an assurance report on the work of the finance and		

Agenda item	Discussion	Lead	Dead-line
	investment committee from John Brougham. He advised that the committee had recommended that the Board ratify an NHS revenue support loan for September 2018.		
12.02	Resolution: The Board received the report for assurance and ratified an NHS revenue support loan for £5m for September 2018.		
13/63	**Assurance report from the Clinical Outcomes and Effectiveness Committee**		
13.01	In the absence of Jonathan Rennison, Ginny Edwards provided a verbal update on the work of the clinical outcomes and effectiveness committee. She advised that there were no key items of escalation from the last committee meeting and outlined some points of assurance for information. She advised that the date of the committee meeting had been close to the Board meeting and therefore a formal written report would be received by the Board at the November meeting.		
13.02	Resolution: The Board received the verbal report for assurance.		
14/63	**Assurance report from the Patient and Staff Experience Committee**		
14.01	Ginny Edward presented a report on the work of the patient and staff experience committee. She noted that a number of the items discussed by the committee were on the Board agenda. She advised that the committee had reviewed the annual NHS workforce race equality standard report 2018 which the Board had approved for publication in September 2018 due to the timing of the committee meeting. She offered assurance that the actions and demonstrable impact of the report would be monitored by the committee.		
14.02	Resolution: The Board received the report for assurance.		
15/63	**Assurance report from Charity Committee**		
15.01	In the absence of Jonathan Rennison, Ginny Edwards provided a verbal update on the work of the charity committee. She reported that the committee had been assured that the charity's annual report and annual accounts were correct and had been satisfied that the charity fulfilled it conditions and requirements set out in a letter of representation. The committee recommended both of these things for approval. In addition, following a consultation and staff vote on the charity's name and brand identity, the committee recommended that the name 'Raise' be adopted by the charity.		
15.02	Resolution: The Corporate Trustee approved the annual report and accounts, letter of representation and for the charity and brand identity to be known as 'Raise'.		
16/63	**Any other business**		
16.01	The chief operating officer advised that the Trust had received verbal confirmed that it had achieved full compliance status for emergency preparedness, resilience and response for the second year. Formal confirmation was expected to be received in November 2018.		
16.02	The Board was advised that flu vaccinations would be available following the meeting.		
16.03	Ginny Edwards was thanked for her work to facilitate a Board to Board meeting with HVCCG.		
17/63	**Questions from Healthwatch**		
17.01	There were no questions raised by the Healthwatch representative.		
18/63	**Questions from patients and the public**		
18.01	There were no questions raised by patients or the public.		

Agenda item	Discussion	Lead	Dead-line
19/63	**Draft agenda for the next meeting**		
19.01	The draft agenda for the meeting on 01 November 2018 was approved, subject to possible changes.		
20/63	**Date of the next Board meeting in public**		
20.01	The next meeting will be held on 01 November 2018 in the executive meeting room, Watford.		

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire
Hospitals
NHS Trust

Agenda item 07a/63

Action log Part 1 – 01 November 2018

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	16.01/61	Actions resulting from observations by NHS Improvement of committee meetings to be considered and reported back to the Board.	JH	~~10/18~~ Deferred to 12/18	Due to a change to the date of the patient and staff experience committee, the final observation will take place on 05 November 2018, following which the Board will receive an overview report on any themes resulting from the findings.
2	15.01/62 & 05.01/62	Future strategy reports to include timelines/indicators to provide assurance that key change projects are on track, both for time and budget	NK	11/18	
3	08.02/63	A report on ED, RTT, diagnostics and cancer performance to be reviewed by the Healthwatch representative to confirm it is suitable for public reviewing	ST	11/18	Report sent to Sundera Kumara-Moorthy to review. Report on meeting agenda.
4	09.02/63	A dashboard to be developed and included to future the integrated performance reports	ST/JS	11/18	A mock-up of a potential dashboard/summary sheet is in development and will be circulated for discussion at the meeting.

Agenda item: 07/64

BOARD AND CORPORATE TRUSTEE
DECISION LOG 2018/19 PART 1

Board meeting/decision date	Decision reference (from minutes)	Item presented to Board for action	Comments/outcome
04/10/2018	15.02/63	Assurance report from Charity Committee	The Corporate Trustee approved the annual report and accounts, letter of representation and for the charity and brand identity to be known as 'Raise'.
04/10/2018	12.05/63	Assurance report from Finance and Investment Committee	Approved a NHS revenue support loan for £5m for September 2018.
04/10/2018	11.03/63	The Hertfordshire and west Essex STP estates plan.	Approved
06/09/2018	19.02/62	2018/19 terms of reference and work plan for Clinical Outcomes and Effectiveness Committee	Approved.
06/09/2018	22.02/62	2018/19 terms of reference and work plan for Audit Committee	Approved
06/09/2018	18.02/62	Assurance report from Finance and Investment Committee	Approved an NHS revenue support loan of £8.6m for July 2018 and £3.39m for August 2018
06/09/2018	17.04/62	Report on corporate risk register and board assurance framework	Approved the board assurnce framework
06/09/2018	13.03/62	Annual NHS workforce race equality standard report 2018	Approved for publication
06/09/2018	11.03/62	Emergency prepardness, resilience and response annual assurance report	Approved for submission to NHS England
06/09/2018	10.06/62	Safeguarding annual report	Approved for publication
05/07/2018	19.05/61	Assurance report from West Herts Charity Committee	Approved funding of £8,200 to support a staff appreciation scheme.
05/07/2018	15.02/61	Assurance report from Finance and Investment Committee	Approved an NHS revenue support loan of £7.8m
05/07/2018	14.02/61	2018/19 terms of reference and work plan for Clinical Outcomes and Effectiveness Committee	Approved the terms of reference and work plan
05/07/2018	10.03/61	Report on the quality account	Ratified the quality account for publication
07/06/2018	20.02/60	Assurance report from Finance and Investment Committee	Approved a revenue support loan for £4.0m.
07/06/2018	19.02/60	Work plans and terms of reference.	Approved the terms of reference and work plan for the Board and the terms of reference for the Trust Executive Committee.
07/06/2018	18.02/60	Proposal to undertake a leadership and governance review (well-led framework)	Proposal approved
07/06/2018	17.04/60	The board assurance framework	The BAF was approved, subject to further defining work.
07/06/2018	11.03/60	Maternity safety strategy actions and CNST incentive scheme	Approved the submission to NHS Resolution.
07/06/2018	10.02/60	Business case for additional workforce in emergency medicine for winter inpatient surge cover	Approved option 4 of the business case.
03/05/2018	17.02/59	Assurance report from the Audit Committee	Approved a recommendation to delegate authority to the audit committee to sign off the accounts, annual report and quality accounts.
03/05/2018	15.02/59	Assurance report from Safety and Compliance committee	Approved the self-certification of condition G6(3) and FT4(8).
03/05/2018	14.02/59	Assurance report from Finance and Investment Committee	Approved a revenue support loan for £6.1m.
03/05/2018	13.02/59	Modern slavery and human trafficking statement 2017/18.	Approved.
03/05/2018	12.03/59	Work plans and terms of reference.	Approved for remuneration, finance and investment, clinical outcomes and effectiveness, patient and staff experience and safety and compliance committees
12/04/2018	13.02/58	Assurance report from Finance and Investment Committee	Ratified an interim revenue support loan of £13.7m
12/04/2018	11.04/58	Aims and objectives 2018-2020	Approved.

BOARD AND CORPORATE TRUSTEE DECISION LOG PART 1 2017/18			
01/03/2018	15.01/57	Assurance report from Finance and Investment Committee	Ratified an interim revenue support loan of £11.4m
01/03/2018	13.04/57	Gender pay gap report 2017	Approved for publication
01/03/2018	12.04/57	Quarterly learning from deaths report	Approved for publication
01/03/2018	11.04/57	Quality commitment	Approved
01/02/2018	13.05/56	Review of corporate governance structure	Approval of the current corporate governance structure to continue for 2018/19, subject to the proposed refinements
07/12/2017	17.01/54	Corporate governance meeting schedule	Approval of 2018/19 corporate governance meeting schedule.
07/12/2017	18.03/54	Assurance report from the Charitable Funds Committee	The corporate trustee approved a recommendation to appoint Kingston Smith to undertake a review.
02/11/2017	13.03/53	Hertfordshire health concordat	Approved
02/11/2017	15.04/53	Board assurance framework	Approved
05/10/2017	13.03/52	Assurance report from Finance and Investment Committee	Ratified a £1.4 interim revenue support loan
05/10/2017	13.03/52	Assurance report from Finance and Investment Committee	Approved £1m capital expenditure funding for the redevelopment of the A&E department
07/09/2017	10.02/51	NHS England emergency preparedness, resilience and response annual assurance.	Approved
07/09/2017	13.02/51	Infection prevention and control annual report 2016/17 for publication on the Trust website	Approved
06/07/2017	16.04/50	The terms of reference and work plans for the board and committees	Approved
06/07/2017	22.05/50	Recommended way forward to the future management of the charity	Approved
06/07/2017	18.02/50	Annual accounts, annual report, governance statement and quality account 2016/17	Approved
01/06/2017	15.03/49	Proposed monitoring arrangements for aims and objectives	Approved the approach
01/06/2017	14.04/49	Outline business case for theatre reconfiguration	Approved option E
01/06/2017	17.01/49	NHS self-certification 2017/18	Approved condition G6 (3)
01/06/2017	18.02/49	Assurance report from Finance and Investment Committee	Ratified the terms and conditions of a £42m interim revenue support loan
04/05/2017	20a.03/48	West Herts charity strategy	Approved
04/05/2017	20b.02/48	Discretionary resources policy	Approved
04/05/2017	15.02/48	Assurance report from Finance and Investment Committee	Ratified an interim revenue support loan of £1.964k
06/04/2017	16.02/47	Assurance report from Finance and Investment Committee	Ratified an interim capital support facility agreement £7.5m
06/04/2017	11.04/47	Hospital Pharmacy Transformation Plan	Approved as direction of travel for pharmacy service.
06/04/2017	16.02/47	Assurnce report from Finance and Investment Committee	Approved a deficit control total for 2017/18 of £15.4m
06/04/2017	14.02/47	Aims, objectives and principle risks.	Approved

BOARD AND CORPORATE TRUSTEE DECISION LOG PART 1 2016/17			
06/03/2017	15.02/46	Assurance report from Finance and Investment Committee	Approved the conversion of an IRWCF loan of £26.8m to an ISLF loan.
06/03/2017	18.02/46	The 2017/18 Board and Committee structure and meeting schedule	Approved
06/03/2017	17.02/46	Assuance report from Audit Committee	Approved a recommendation to delegate responsibility to the Audit Committee to sign off the Annual Accounts, Annual Report and Annual Governance Statement.
06/03/2017	15.02/46	Assurance report from Finance and Investment Committee	Approved an interim loan of £4m to cover cash flow requirements in February and March 2017 Approved
06/03/2017	13.07/46	Assurance report from Patient and Staff Experience committee	ApprovedA graded approach to workforce metrics for future reporting.
02/02/2017	12.01/45	The transfer of 0.29 hectares (0.72 of an acre), to Watford Borough Council in line with the Trust's obligations under the Health Campus agreement	Approved
02/02/2017	02.13/45	Recommendation that the Watford site continue to be the location for emergency and specialised care and the St Albans site continue to be the location for planned care as recommended in the SOC	Approved
02/02/2017	12.01/45	An interim revenue support loan of £2.3m to cover February 2017 revenue cash requirements	Approved
12/01/2017	15.2/44	Counter fraud policy	Approved
01/12/2016	10/43	Nursing, midwifery and allied health professions strategy	Approved
03/11/2016	19/42c	Update to terms of reference for the Board	Approved
03/11/2016	18/42	The gifts, hospitality and sponsorship policy	Approved
03/11/2016	13/42	Statutory annual public sector equality duty report 2015	Approved
03/11/2016	19/42a	Recommendation to reduce the frequency of Integrated Risk and Governance Committee meetings	Approved
03/11/2016	12/42	Patient experience and carer strategy	Approved
03/11/2016	19/42b	Draft Board and Committee meeting schedule 2017/18	Approved
07/10/2016	14/41	Board assurance framework	Approved recommended changes
07/10/2016	07/41	Recommendation to increase the number of scheduled Board meetings to eleven per annum.	Approved
01/09/2016	23/40	Terms of reference for the Trust Executive Committee	Approved
01/09/2016	21/40	Charitable Funds annual report and annual accounts 2015/16 , £12,000 of funds of funds to support a holistic service for patients and their carers	Approved
07/07/2016	21/39	Updated Board Assurance Framework	Approved
07/07/2016	.09/39	The quality account 2015/16	Approved
07/07/2016	18/39	The end of life care strategy	Approved
07/07/2016	19/39	Updated terms of reference and work plans for the Safety and Quality Committee and the Trust Board	Approved
07/07/2016	17/39	Infection prevention and control annual report 2015/16	Approved for publication
07/07/2016	16/39	Funding for external advisory support to develop a strategy outline case (SOC) for the configuration of acute hospital service	Approved
05/05/2016	17/37	Terms of reference and work plans for 2016/17 for the Audit, Remuneration, Workforce, Finance and Performance, Charitable Funds and Integrated Risk and Governance Committees	Approved
07/04/2016	16/36	Corporate aims and objectives 2016/17	Approved, subject to inclusion of comments from Board
07/04/2016	17/36	Board Assurance Framework 2016/17	Approved

Trust Board Meeting
01 November 2018

Title of the paper	Chair's report
Agenda Item	08/64
Presenter	Professor Steve Barnett, Chair
Author(s)	Jean Hickman, Trust Secretary
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: *X*
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care – *Objectives 1-5*: X Aim 2 Great place to work – *Objectives 6-8*: X Aim 3 Improve our finances – *Objective 9*: X Aim 4 Strategy for the future – *Objective 10-12*: X
Links to well-led key lines of enquiry	X Is there the leadership capacity and capability to deliver high quality, sustainable care? X Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? X Is there a culture of high quality, sustainable care? X Are there clear responsibilities, roles and systems of accountability to support good governance and management? X Are there clear and effective processes for managing risks, issues and performance? X Is appropriate and accurate information being effectively processed, challenged and acted on? X Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? X Are there robust systems and processes for learning, continuous improvement and innovation? X How well is the trust using its resources?
Previously considered by	Committee/Group: N/A — Date:
Action required	The Board is asked to receive the report for information.

8

Agenda Item: 08/64

Trust Board Meeting – 01 November 2018

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

State of care assessment

2.1. The Care Quality Committee (CQC) published its annual state of care assessment of health and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve.

2.2. This year's report found that most people in England receive a good quality of care. The ratings show that quality overall has been largely maintained from last year, and in some cases improved, despite the continuing challenges that providers face.

2.3. Five key factors were highlighted from the assessment as affecting the sustainability of good care; access, quality, workforce, demand and capacity and funding and commissioning.

2.4. The full report can be accessed on the CQC's website (www.cqc.org.uk).

Review into operational productivity in ambulance trusts

2.5. NHS improvement (NHSI) has published a review into operational productivity in ambulance trusts. Lord Carter conducted the review which concluded with nine recommendations to improve patient care, efficiency and support for frontline staff who have responded to a significant rise in demand for ambulance services in recent years.

2.6. The report found that if more patients were treated at the scene by paramedics or were better assessed over the phone when dialling 999, thereby avoiding the need for an ambulance when it is safe to do so, the NHS could treat patients closer to home and reduce unnecessary pressure on emergency departments and hospital beds.

2.7. It was reported that offering safe and quicker care could save the NHS £300m a year by 2021, with a further £200m of savings through improvements in ambulance trusts infrastructure and staff productivity.

Measures to stop fraud against the NHS

2.8. The health and social care secretary, Matt Hancock announced new plans in October 2018 on how it will take tougher action on fraud and save hundreds of millions of pounds for the NHS over the next five years.

2.9. The new approach will start with a commitment to halve prescription fraud, which costs the NHS £256 million a year. This will be achieved by digitising prescriptions and allowing pharmacies to check whether the patient does not have to pay charges before their medication is dispensed. This will be piloted next year, before being rolled out across the NHS.

2.10. The focus on prescriptions is one aspect of a wider crackdown on NHS fraud, which aims to prevent up to £300 million being lost to fraud by April 2020. This is part of the government's commitment to ensuring public finances are managed responsibly and that every penny invested goes towards improving care.

2.11. Further measures being introduced to stop fraud include:

- a new partnership between the NHS counter fraud authority (NHSCFA) and the fraud prevention service Cifas, allowing NHS counter fraud professionals to access Cifas data
- more collaboration and data sharing between the NHS Business Services Authority and NHSCFA to identify the small number of pharmacists and dentists claiming payments for services they have not carried out
- the introduction of a new counter fraud profession in central government, bringing together around 10,000 counter fraud specialists, including 400 focused on fraud in the NHS

2.12. NHSCFA will take forward these measures by working with its data-sharing partners to analyse large amounts of information and identify anomalies, unusual activity and inconsistencies in the NHS, referring to NHS investigators for further action.

2.13. The Trust commissions RSM to provide a full counter fraud service and the audit committee regularly monitors this work and considers all cases of fraud against the Trust.

The New UK Code of Governance

2.14. The new UK corporate governance code will come into force on 01 January 2019 and will be of interest to Board members as a benchmark of good corporate governance.

2.15. The key changes to the updated code include:

- the promotion of greater Board engagement with the workforce so the Board can describe how it has considered stakeholder interests when it is promoting the success of the organisation
- a greater emphasis on the need for Boards to align an organisation's values with its strategy so the Board can assess how it leads in generating and preserving value over the long-term rather than the short-term
- an emphasis on Boards having the right combined experience to ensure constructive challenge and promotion of diversity. The requirement for robust succession-planning and consideration to the length of term that chairs remain in post
- a strengthening of the role of the remuneration committee
- an emphasis on the importance of external Board evaluation
- a requirement for remuneration committees to take into account workforce remuneration when setting director remuneration.

2.16. The chair and the trust secretary will discuss the relevance of these changes on the Trust's current corporate governance arrangements and agree any amendments as necessary.

GPs to refer patients to social activities and support

2.17. The Government has announced that it will invest nearly £4.5 million in programmes to refer patients to local voluntary and community services such as walking clubs, gardening or arts activities. The practice, known as 'social prescribing', aims to improve patients' quality of life and health and wellbeing by recognising that health is affected by a range of social, economic and environmental factors.

2.18. Evidence shows that this approach can reduce demand on NHS services: a UK study found that after three to four months, 80% of patients referred to a social prescribing scheme had reduced their use of A&E, outpatient appointments and inpatient admissions.

2.19. A total of 23 social prescribing projects in England will receive a share of the funding to extend existing social prescribing schemes or establish new ones. The schemes include a focus on:

- reaching out to people who may be socially isolated, for example because of mental health problems or learning difficulties
- providing support for those impacted by health inequalities, such as transgender people or people from black, Asian and minority ethnic (BAME) backgrounds
- helping people with particularly complex needs who regularly access health services

2.20. The funding will come from the health and wellbeing fund, part of a programme of Government investment in the voluntary sector. The projects will be fully funded through the scheme in their first year. Additional joint funding from local commissioners will be agreed for the subsequent two years.

Switching to better value medicines

2.21. It is reported that the NHS saved £324m during the last financial year (surpassing its target of £250m) by switching from ten expensive medicines to better value medicines that are equally effective. NHSI is working with NHS trusts to continue to identify further savings of around £200m this financial year. Around £100 million of the further savings are expected to come from savings generated through using new biosimilar medicines as two original biological medicines come off patent.

2.22. The top ten medicines continue to form part of the Trust's efficiency programme. To date, this work has delivered around £390k of savings, with an increased uptake of biosimilars accounting for a large part of the savings.

National moving to good meeting

2.23. A number of the senior leaders attended a national 'moving to good and beyond' meeting on 04 October 2018 aimed at supporting organisations in their preparation for CQC inspections, with a key emphasis on the well-led domain.

2.24. The event, hosted by NHSI, encouraged best practice and shared learning across the system and was attended by the CQC, organisations that previously had either special measures or required improvement ratings and had not achieved an overall outstanding rating.

2.25. The learning from this event has been discussed by the trust executive committee and any relevant measures will be taken forward.

Investment to ease winter pressures

2.26. In October 2018, the secretary of state for health and social care announced £240 million in social care investment to help local authorities reduce pressures on the NHS by getting patients home quicker and freeing up hospital beds across England.

2.27. The extra funding is aimed at reducing delayed transfers of care and could pay for home care and reablement packages and home adaptations. Funding has been distributed to councils using the 'adult social care relative needs formula' and Hertfordshire council has been awarded £4,134,415.

2.28. The Trust has been working closely with Herts Valleys Clinical Commissioning Group (HVCCG), Hertfordshire Community Trust (HCT) and Hertfordshire County Council to put plans in place to reduce pressure on the hospital over the winter period.

Developing the long term plan

2.29. In June 2018, the prime minister set out a funding settlement for the NHS in England for the next five years. In return, the NHS was asked to set out a long term plan for its future, setting out ambitions for improvement over the next decade and plans to meet them over the five years of the funding settlement.

2.30. Over the summer, scoping of the plan has been taking place, and working groups have been established, comprising local and national NHS leaders, clinical experts and patient representatives. These working groups have been engaging with relevant stakeholders to develop proposals. During September the groups attended over 150 meetings with stakeholders and received hundreds of submissions, which have helped them draw up draft policy proposals for inclusion in the plan.

2.31. The work done by these groups will help to refine policy proposal, which will be brought together over the course of October and November 2018. Other engagement will continue during this time, meaning that stakeholders will continue to have the opportunity to influence the final plan up to its publication, expected in November 2018.

2.32. Engagement will continue after publication and between December 2018 to March 2019, staff, patients, the public and other stakeholders will have the opportunity to help local health and care organisations determine what the plan means for their area, and how best the ambitions can be met.

2.33. As part of this work, our chief executive attended events in late October 2018, which had a key focus on workforce, the development of a national tariff payment system and signalled a requirement for one year and five year sustainability and transformation partnership (STP) plans to be developed by mid-January 2019 and July 2019 respectively.

2.34. The Hertfordshire and west Essex STP plans will build on the current work on the STP strategy and medium term financial plan.

Sustainability and transformation partnership update

2.35. NHS England and NHS Improvement have asked STPs and integrated care systems to develop and agree plans by mid-January on how they will run the local NHS system in 2019/20 using the resources available.

2.36. Before finalising their strategic plans, STPs will consider the outputs of the NHS long term plan, which is due to be published in November 2018 and the spending review 2019 capital settlement , which is due to be published in the spring 2019, as well as engaging with patients, the public and local stakeholders.

2.37. The Trust is working with its Hertfordshire and west Essex STP colleagues to develop and submit a robust and credible system-wide clinical strategy and a medium term financial plan by mid-January 2019. This plan will address the challenges faced in caring for the local population over the next five years.

Transforming NHS technology

2.38. In October 2018, the secretary of state for health and social care launched his vision to transform NHS technology to allow appropriate access to real-time data. This will be underpinned by the digital services and data innovations needed.

2.39. The vision outlines plans to introduce minimum technical standards that digital services and IT systems in the NHS will have to meet. Having these open standards in place means systems will be able to talk to each other securely and ensure they are upgradable. Any system that fails to meet these standards will be phased out.

2.40. The Government will look to end contracts with providers who do not understand these principles for the health and care sector. Outside those standards, all trusts and clinical commissioning groups will have freedom to buy what they need. This should encourage competition on user experience and better tools for everyone.

2.41. As mentioned previously, the Trust's contract with its current ICT service provider will end on 29 March 2019. Work is continuing to consider the provision of services after that date, some of which could come back into the Trust, whilst others will transition to other suppliers. The ICT infrastructure transition committee is monitoring this work closely to ensure the transition is managed as smoothly as possible and the new solution fits with the technology vision and is cost effective.

Preparations for a 'no deal' Brexit scenario

2.42. In September 2018, the department for exiting the European union published a further set of technical notices, which set out the preparations the government is undertaking to plan for a possible 'no-deal scenario'.

2.43. As a result of triggering Article 50 the UK is scheduled to leave the EU on Friday 29 March 2019 at 11pm. Any requirements for business continuity arrangements as a result of the UK's departure will be coordinated by the Trust's emergency preparedness, resilience and response department.

2.44. Developments in the UK's plan to withdraw from the EU are monitored by the trust executive committee with the key areas of focus being pharmaceuticals, blood products, organs, tissues and cells, clinical consumables and medical devices, workforce and procurement.

2.45. The Board will receive a report under item 14 on today's meeting agenda to provide assurance on the plans in place for continued monitoring and contingency planning to minimise any risk in relation to a 'no deal' Brexit scenario.

3. LOCAL NEWS AND DEVELOPMENTS

Chief executive recruitment

3.1. A recruitment campaign to appoint a substantive chief executive is continuing. There has been significant interest from some excellent candidates and a stakeholder event and formal interviews will be held on 06 November 2018.

Care Quality Commission inspection

3.2. Since the last Board meeting, the CQC, the independent regulator of health and social care services in England, has conducted an unannounced inspection. This is part of the new framework introduced last year to check standards of quality and to make sure hospitals are providing safe, caring, effective and responsive care, and that they are well-led.

3.3. The inspection team arrived on 16 October 2018 and focused their visit on the emergency department, surgery and maternity services during a two and a half day inspection at Watford.

3.4. During the visit, the inspection team noted that the Trust had built on the improvements seen in the 2017 inspection. In particular, the team commented on a collaborative and positive culture, an understanding of risk and effective use of governance data to make improvements; good medicine management practice and good compliance with infection prevention and control measures. There were no safety issues escalated, however, as expected, the inspectors have asked for additional information in a number of areas and highlighted a small number of concerns/areas for improvement.

3.5. The final stage of the inspection is for the CQC to lead an assessment on the Trust's use of resources on 22 November 2018. This will be followed by a well-led framework review on 28 to 30 November, which will involve inspectors talking to members of the Board and senior divisional leadership teams. In addition, there will be a further unannounced inspection of services before the end of November 2018.

3.6. In line with national requirements, an externally facilitated well-led framework assessment was undertaken during September and early October 2018. The overall outcome was positive and the Board will receive the final report under item 16 on today's meeting agenda.

Local campaign to reduce emergency patients

3.7. In an effort to reduce inappropriate accident and emergency department attendances, local clinical commissioning groups ran a Hertfordshire NHS campaign throughout October to urge people to call NHS 111 for urgent medical help NHS 111 is the single telephone number to get urgent help from a variety of healthcare services. It's free to call and is open 24 hours a day, 7 days a week.

3.8. It has been reported that last year, NHS 111 Hertfordshire prevented 20,271 unnecessary ambulance call-outs by diverting patients to a service more appropriate for their requirements. This happens through the NHS 111 team of doctors, nurses, palliative nurses, dental nurses and pharmacists assessing people's symptoms over the phone and helping people access more appropriate support. This support could be advice, arranging to speak to a qualified professional or signposting the patient to the right health service, including booking an appointment to see a GP in the evenings and at weekends.

3.9. It is too early to identify if this initiative has had an impact on the number of patient attendances received by the Trust, however this will be kept under review.

Clinical partnership with Royal Free London

3.10. Following months of close collaboration, the Trust and the Royal Free London NHS Foundation Trust (RFL) approved a new clinical partnership.

3.11. RFL is one of four trusts across the NHS to be chosen to develop a group model, enabling the trust to share services and resources more effectively across hospitals in order to improve the experience of patients and staff. Individual trusts are able to join the group under a range of membership options, from full membership to arrangements such as clinical partnerships and buddying.

3.12. Ahead of the partnership being formalised, clinicians at both trusts were working on a wide range of projects to improve patient care by sharing best practice. As a starting point, staff have been collaborating on ways to treat pneumonia, urgent gall bladder problems, induction of labour, early pregnancy, prostate conditions, anaemia and symptoms of wheeziness in children.

3.13. Becoming clinical partners does not change the status of either trust. The Trust will continue to be a standalone organisation with its own Board and leadership team.

New chief executive of Hertfordshire community NHS trust

3.14. Clare Hawkins has been appointed as the chief executive of Hertfordshire Community NHS Trust (HCT). Clare has been acting into the chief executive role since September 2017 and has brought strong leadership and direction to HCT, as well as making a significant contribution to supporting the wider health and social care system.

Closure of west Herts medical centre

3.15. The west Herts medical centre based at Hemel Hempstead hospital closed at the end of October 2018. Herts Valleys Clinical Commissioning Group (HVCCG) managed the closure and 2,500 patients have been re-registered around with other practices within Hemel Hempstead and the wider Dacorum and Herts Valleys area.

Supporting national healthcare campaigns

3.16. Thank you to all staff for supporting the following national healthcare campaigns in October 2018:

- Ginny Edwards, non-executive director and freedom to speak up guardian, visited the three hospitals to raise awareness during national freedom to speak up month
- Marsha Jones, associate chief nurse for quality governance arranged a series of events in support of black history month. She will also be presenting to the Board under item 3 of today's meeting agenda
- Staff from St Albans theatres raised awareness of international infection prevention and control week by dressing up in halloween costumes for the corridor damp dusting process
- The Macmillan information and support centre hosted an information table to mark breast care awareness month
- The resuscitation team supported a restart a heart day and teaching CPR and basic life support skills to members of the public in the Watford shopping centre
- The infection prevention and control team arranged a host of activities to raise awareness during infection prevention and control week
- The health and wellbeing team ran mental wellbeing sessions as part of world mental health day

Recognising and celebrating staff

3.17. Congratulations and well done to the following staff and teams for their outstanding work since the last board meeting:

- The maternity and special care baby team for being shortlisted for a health service journal award for an 'I see U baby' innovation. The winner will be announced at a ceremony on 21 November 2018
- Respiratory physician Dr Kay Roy for speaking on local radio on the point of care viral infection test which has been developed by the respiratory, microbiology and acute care teams at Watford
- Dr Ratna Makker for achieving an accreditation from the association for simulated practice in healthcare
- The children's carer support team for being shortlisted in the helpforce champions national awards for health volunteers 2018. The winners will be announced at a ceremony on 08 November 2018
- The SCBU runners, namely Avinash Jinadatha, Sankara Narayanan, Samantha Sharratt and Eve Sherratt-Cross, for raising £1,968 for a paediatric cardio scanner by taking part in the hercules festival of sport
- Renton L'Hevreau for raising money for the carer support team by running in the hercules festival of sport
- Kevin Swaby, Joel Kent and Kelly Oliver along with other members of staff in theatres for raising compliance with fit mask testing

4. BOARD UPDATE

4.1. The Board held a development workshop on 11 October 2018. The agenda included an update on FTSU guidance, a report and development of an action plan from an externally facilitated well led framework assessment and a session on the financial recovery plan.

4.2. Also on 11 October 2018, the Board met with HVCCG's Board. The meeting was facilitated by Ginny Edwards, non-executive director for the Trust and Alison Green, lay-member for

HVCCG and the two organisations considered clinical service redesign and how to achieve a sustainable financial position across the health economy.

5. KEY MEETINGS

5.1. Since the last Board meeting, I have undertaken the following business:

- Chaired an interview panel to appoint a consultant radiologist
- Met with prospective candidates for the chief executive post
- Presented a staff award
- Attended Hertfordshire chairs meeting
- Co-chaired a board to board meeting with HVCCG
- Attended a joint Trust and HVCCG chair and chief executive meeting
- Attended the Hertfordshire community NHS trust's celebrating community health services and 2018 annual general meeting

6. RECOMMENDATION

6.1. The Board is asked to receive the report for information.

Professor Steve Barnett
Chair

November 2018

Trust Board Meeting
01 November 2018

Title of the paper	Chief Executive's report
Agenda Item	09/64
Presenter	Helen Brown, Acting Chief Executive
Author(s)	Jean Hickman, Trust Secretary
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: *X*
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care – *Objectives 1-5*: X Aim 2 Great place to work – *Objectives 6-8*: X Aim 3 Improve our finances – *Objective 9*: X Aim 4 Strategy for the future – *Objective 10-12*: X
Links to well-led key lines of enquiry	X Is there the leadership capacity and capability to deliver high quality, sustainable care? X Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? X Is there a culture of high quality, sustainable care? X Are there clear responsibilities, roles and systems of accountability to support good governance and management? X Are there clear and effective processes for managing risks, issues and performance? X Is appropriate and accurate information being effectively processed, challenged and acted on? X Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? X Are there robust systems and processes for learning, continuous improvement and innovation? X How well is the trust using its resources?
Previously considered by	Committee/Group: N/A; Date:
Action required	The Board is asked to receive the report for information.

Agenda Item: 09/64

Trust Board meeting – 01 November 2018

Chief Executive's report

Presented by: Helen Brown, Acting Chief Executive Officer

1. PURPOSE

1.1. 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.

2. LEADERSHIP AND GOVERNANCE

Quality improvement

2.1. Since the approval of the quality commitment by the Board in March 2018, there have been a number of developments. The Trust has secured £100k in special measures funding to support quality improvement and has furthered its clinical partnership with the Royal Free London Foundation NHS Trust. This will include the launch of a clinical partnership group (CPG) programme aimed at driving quality improvement across seven priority pathways.

2.2. This quality improvement work is important to help break the cycle of operational and financial pressure, however it also means the Trust must implement its quality strategy in a way that is sympathetic to the organisational needs and pressures. Therefore in 2018/19 the Trust will use £100k of special measures funding to provide quality improvement resources to support the CPG programme and use the seven CPG pathways to implement quality improvement capability. Best practice will also be identified and shared across the other CPGs and more widely and, as part of a contract with the Institute of Healthcare Improvement, training will be provided for staff working on priority improvement projects.

2.3. This important work will continue in 2019/20 with the expansion of the CPG programme to cover more pathways and investment in greater support for quality improvement.

Improving committee governance

2.4. The trust executive committee was joined by divisional managers and heads of nursing in October for a session on effective committee meetings. The group discussed the roles and responsibilities of individuals who attend committee meetings, committee etiquette, report writing and presentation and the sources that help the committee gain assurance.

Oversight meeting

2.5. The Trust met with NHS Improvement (NHSI) and other external colleagues as part of a regular oversight meeting in October 2018. The agenda included deep dives into the medicine and surgery divisions and a review of the quality improvement programme.

3. SERVICES

Winter planning

3.1. System partners have been working collaboratively to formulate plans to support patient flow throughout the winter period. This has enabled the formation of a joint surge, escalation and capacity plan. In addition to this and following the movement to a single Hertfordshire and west Essex sustainability and transformation partnership (STP) A&E local delivery Board, the STP has coordinated the completion of a system winter assurance template required by NHS England. This document is available on the resource section of diligent and will form the basis of a winter assurance visit by NHSI which took place on 30 October 2018.

3.2. Internal actions, in addition to completion of the winter assurance template, have also included a review and refresh of the Trust's surge plan which was ratified by the trust executive committee on 31 October 2018 and the formation of a surge business case for winter resources which was also considered by the trust executive committee on 31October 2018.

3.3. Over the last few weeks, the trust executive committee has also considered and approved several business cases to support the winter plan. These related to additional space to be created within the emergency department at Watford and, in order to achieve this, a suitable environment to be created to relocate orthopaedic services. The day surgery and surgical admissions lounge will also be expanded to provide a better environment for patients and, at times of peak demand on inpatient bed capacity, to ensure that assessment services can continue to function. A further business case is currently being finalised around the re-provision of ambulatory care services.

3.4. Achieving discharges as early in the day as possible is vital to the patient experience and to support a good flow throughout the hospitals. With this in mind, a simple, practical tool has been developed to prompt and encourage staff involved in patient care and discharge planning to work together with the aim of discharging as many patients as possible before midday.

Electronic referral system

3.5. Towards the end of 2016, NHS England, in partnership with NHS Digital and NHSI, initiated a national paper switch-off programme to provide individual, project-based support to NHS providers to prepare trusts and clinical commissioning groups to establish local projects to achieve an electronic booking referral system for outpatient services.

3.6. The NHS e-Referral Service (e-RS) is a national digital platform used to refer patients from primary care into elective care services. e-RS allows patients to choose their first outpatient hospital or clinic appointment and book it in the GP surgery, online or on the phone. For the past few years the use of e-RS between primary and secondary care in England has maintained a steady position at approximately 50% of such referrals.

3.7. In line with NHS England's guidance, as from 01 October 2018, the majority of the Trust's services now only accept referrals from GPs who use the NHS e-RS for consultant-led outpatient services.

Home for walking aids

3.8. In October 2018, the minister of state for health, Steve Barclay urged NHS staff to accept patients' unwanted medical equipment and reuse it, where it safe to do so. The move is part of plans to reduce the NHS carbon footprint and put a stop to equipment being thrown away or left unused in homes, rather than reused or recycled.

3.9. To this end, a walking aid drop off point is now available for patients and families to return walking aids they no longer need outside the inpatient therapy unit at Watford. This will allow patients to be able to return equipment and know that it will be put to good use helping others. It will also help ensure equipment is used in an environmentally friendly way and that taxpayers' money is spent wisely.

Emergency preparedness

3.10. The Trust has received verbal confirmation that, for the second year running, it has achieved full compliance status for its emergency preparedness, resilience and response arrangements. This is clearly positive news for the safety of patients and staff and for the continuity of services.

3.11. As part of emergency preparedness, staff took part in a chemical, biological, radiological and nuclear major incident training exercise in October 2018 with partners from Hertfordshire fire and rescue service, the police, the Herts Valleys Clinical Commissioning Group, the Lister Hospital Trust and the ambulance service.

Overview of gastroenterology services

3.12. Dr Mohammed Shariff, clinical lead for the gastroenterology, attended a trust executive committee meeting in October 2018 to present an overview of the gastroenterology service. The presentation included departmental achievements, teaching and training and the current JAG accreditation status.

Cancer services

3.13. Due to the timing of the Board meeting, it is not possible for the integrated performance report to contain the latest confirmed position for cancer performance. Therefore, the table below provides the validated performance across all cancer indicators for August 2018 which was reported in draft in the IPR in October 2018.

Standard	Target	August 2018
2ww	93.0%	94.5%
2ww breast	93.0%	94.2%
31 day 1st	96.0%	95.8%
31 day surgery	94.0%	100%
31 day drug	98.0%	100%
31 day palliative	94.0%	100%
31 day other	94.0%	100%
62 day	85.0%	85.1%
62 day screening	90%	100%

4. ESTATES INFRASTRUCTURE

Acute redevelopment plan

4.1. Regulators continue to be supportive of the need for investment in the Trust's estate, particularly at Watford. However, as there is strong competition for public money for hospital redevelopment, the Trust is refreshing its strategic outline case at the request of NHSI to make it as affordable as possible. The refresh will consider a phased redevelopment based on retaining emergency and critical care services at Watford. The Trust considers this to be the most affordable and deliverable option and also the least likely to affect patient attendances at neighbouring hospitals.

4.2. The redevelopment of Watford and St Albans hospitals remain the Trust's agreed proposal, with a complementary range of services in Hemel Hempstead. The refresh of the strategic outline case will revisit plans for these services and will also consider the potential to develop a new facility that would offer a range of planned and urgent care services similar to those currently provided at St Albans and Hemel Hempstead hospitals. This option would result in the closure of those hospitals. More work is required to determine whether this is a viable option and has merit over the currently agreed option.

4.3. A public engagement programme started in October 2018 to update stakeholders on the progress with the strategic outline case. A presentation has been prepared and as well as outlining the above, the presentation made it clear that any options will need to take into account these factors:

- Affordability; limited public capital, competition for that capital from other hospital trusts, and an indication that funding must be phased
- Sustainability; the need to consider the impact of plans on neighbouring A&E hospitals so that it doesn't destabilise them
- Deliverability; any new sites must be the right size and have capacity to expand to meet future demand, and must have support from local authorities and to have or be able to accommodate the required infrastructure (utilities, access routes and public transport).

Changes to the restaurant at Watford

4.4. The Trust's catering provider, Mitie is embarking on a project to refurbish and re-launch the restaurant at Watford. The refurbishment will bring a completely new look and feel to the space with key features including a dedicated staff only area, a separate coffee shop and a new look servery, as well as enhancements to the outside eating area. The number of seats in the restaurant area will increase from 140 to around 230.

4.5. The project will be completed in two phases and patient catering will not be affected by the work. However, there may be some disruption whilst the work is underway and Mitie will endeavour to minimise this as much as possible.

Fire at St Albans

4.6. A small fire broke out in Gloucester wing at St Albans in October 2018. As a safety precaution, around 100 patients and staff were evacuated, however, the fire was dealt with quickly and there were no injuries.

5. WORKFORCE

Keeping staff healthy

5.1. October was a busy month for the staff health wellbeing team, with a number of activities to support world mental health day and back care awareness week. A staff health and wellbeing roadshow has also been out and about across the organisation during the month offering staff cholesterol and blood pressure testing.

5.2. Emotional wellbeing is just as an important consideration as a person's physical health and wellbeing, even if it is not a visible concern. The implications of decreased emotional wellbeing are detrimental as it can contribute to mental health and stress concerns; therefore it is important to ensure good staff wellbeing by encouraging discussions.

5.3. With this in mind, a new initiative called 'team-time' has been established that will enable staff to reflect on the emotional impact that their role brings. The concept uses Schwartz Round methodology on a much smaller scale and brings benefits to teams who work together regularly in wards and departments. Team-team is currently regularly held in children's services and will be introduced in other wards and departments.

Flu vaccination programme

5.4. The Trust's flu campaign has been launched and over 1,000 members of staff had their flu vaccination in the first three days of the campaign. As of 24 October 2018, over 40% of staff have received the vaccination. This is a huge step in keeping staff healthy and protecting patients and their families.

5.5. The vaccination programme includes offering flexible flu clinics and multiple drop-in immunisation sessions in clinical areas and open spaces including staff restaurants. There are a cohort of dedicated flu champions, who are trained and have allocated areas to administer vaccinations. A programme manager oversees the campaign, coordinates vaccinator champions and measures performance against targets on a weekly basis.

5.6. The programme is underpinned by a communications plan and the chief nurse and medical director are leading communications across the Trust. The trust executive committee and the patients and staff experience committee is closely monitoring the progress of the programme.

Nurse recruitment

5.7. Although the Trust continues to actively undertake local recruitment campaigns; national shortages means this is not achieving the level of recruitment required to maintain safe staffing levels on wards and departments. Therefore, the Board agreed in October 2018 to invest in the continuation of overseas nurse recruitment in order to reduce high levels of band 5 nurse vacancies and support patient safety.

Apprenticeships

5.8. As part of the national talent for care framework, the Trust is committed to developing opportunities for offering apprenticeships. The purpose of an apprenticeship is to help staff develop new skills that suit both their individual needs and that of the organisation.

5.9. In a change to previous rules, the Trust can now offer apprenticeships at any level, higher, equal or lower, to a qualification the person already holds, if it allows them to acquire substantial new skills and the training is materially different. There is an obligation to make sure that at least 2.3% of the workforce starts an apprenticeship every year, which equates to 110 staff for the Trust. Therefore, going forwards, the Trust will be linking all relevant vacancies at band two and three (both clinical and non-clinical) to an apprenticeship.

5.10. This commitment will support the Trust to become an employer of choice locally, which could lead to a reduction in staff turnover rates. In addition, linking existing vacancies to apprenticeship programmes will provide an opportunity to play an active role in moulding the Trust's future workforce and addressing the critical skills gaps.

Staff survey

5.11. The national staff survey is underway and a number of measures are being taken to encourage staff to complete the survey and give their views on working at the Trust. Staff can complete the survey online, on paper or by phone. It can be completed in other languages if English is not the first language and computers are available at all three hospital sites for staff to complete the survey electronically if they wish.

6. RECOMMENDATION

6.1. The Board is asked to receive the report for information and assurance that the trust executive committee is effectively managing the business of the trust.

Helen Brown
Acting Chief Executive

November 2018

Trust Board Meeting
01 November 2018

Title of the paper	**Integrated Performance Report**
Agenda Item	**10/64**
Presenter	**Sally Tucker** **Chief Operating Officer**
Author(s)	**Jane Shentall** **Director of Performance**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	The integrated performance report covers the October reporting period (September data). For this reporting period, the Board is asked to note the following: **Safe, Effective, Caring:** • HSMR remains within the "as expected" range at 98.2 • Patients with a LOS>14 days rose from 338 to 342 • At 92.7%, overall harm free care is below target (95%) although new harm, at 97.7%, is in line with the national average (97.9%) • No cases of Clostridium difficile reported (ytd 9 against ceiling target of 22) • Inpatient & day case FFT positive scores are better than target (95%) but A&E and Maternity scores are below target. • Complaints response times is above internal trajectory at 72.7% • VTE risk assessments are below target at 92.6% • Combined C-section rates have increased to 31.6% (ceiling target 28%), the growth being in emergency sections which are up from 16.2% to 19.4% • Stroke indicator performance is better than target (80%) with 90.3% of patients spending 90% of their stay on the stroke unit • 64.9% of patients were admitted to the unit within 4 hours (target 90%) **Responsive:** • RTT (incomplete) performance has deteriorated slightly at 83.2% (from 83.8%) • Fewer 52 week breaches were reported – down 12 to 111 (last month 123) • Diagnostic waiting time performance is just below standard at 98.9% • ED 4 hour wait performance fell to 79.8% from 83% • Ambulance turnaround delays between 30-60 minutes rose from 225 to 255 and delays over 60 minutes increased from 30 to 50 • All cancer waiting time standards have been achieved with the exception of 31 day subsequent surgery where there were 3 breaches • DToCs have increased to 4.4% from 3.7% (34.4 beds/1033 bed days) **Well Led:** • Staff turnover (rolling 12 months) is unchanged at 16.7% • % Bank pay remains within the target range (8-12%) at 11% • Agency pay has reduced and is better than target (6.4%) at 4.7% • Appraisal rates have improved, at 84.1% (now including medical staff) • Mandatory training has improved to 82.4% from 80.3% • Inpatient and Maternity FFT response rates are better than target but the A&E rate has fallen to 4% against a target of 10%

10

Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care *Objectives 1-5*	Aim 2 Great place to work *Objectives 6-8*	Aim 3 Improve our finances *Objective 9*	Aim 4 Strategy for the future *Objective 10-12*
	✓	✓	✓	
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?			
Previously considered by	Committee/Group: TEC – Executive Performance Review Date: 24 October 2018			
Action required	The Board is asked to receive this report for information, assurance and discussion.			

10

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

October 2018

(September data)

Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Effective Caring

Reporting sub committees – COE and S&C

Areas of good performance

- HSMR mortality was in the expected range *(pages 3 & 17)*
- Day case FFT % positive indicator was better than the standard *(pages 3 & 40)*
- There were no medication errors causing serious harm *(pages 4 & 23)*
- Clostridium difficile was better than the monthly (2 v 3 cases) and better than the YTD (9 v 16 cases) thresholds. *(pages 3 & 20)*
- Patients spending 90% of their time on the stroke unit was better than the performance standard *(pages 4 & 18)*
- Complaints responded to within agreed timescales is meeting the internal improvement trajectory, though was worse than the 85% external performance (*and therefore counted as not meeting standard*) *(pages 3 & 19)*
- There were no never events reported *(pages 4 & 21)*
- There were no cases of MRSA bacteraemia *(pages 3 & 20)*
- The inpatient FFT % positive indicator was better than the standard *(pages 3 & 40)*

New to category this month:

None

Achieving	
Sep-18	12
Aug-18	14
Jul-18	10

Better than national average	
Sep-18	9
Aug-18	9
Jul-18	9

Areas requiring performance improvement

- VTE risk assessment was worse than the performance standard *(pages 4 & 23)*
- Admissions to stroke ward within 4 hours was worse than the performance standard and the national average *(pages 4 & 18)*
- There were 2 mixed sex accommodation breach *(pages 3 & 28)*
- Harm free care (all harms), as measured through the Safety Thermometer was worse than the performance standard and worse than the national average. New harm free care was worse than the national average *(pages 4 & 24)*
- Complaints responded to within agreed timescales was worse than the 85% external performance threshold but meeting the internal improvement trajectory *(pages 3 & 19)*
- The percentage of patients receiving a caesarean section was worse than the performance threshold (pages 4 & 28)

New to category this month:

- The maternity and A&E FFT % positive indicator was worse than the standard *(pages 3 & 40)*

Not achieving	
Sep-18	9
Aug-18	7
Jul-18	11

Worse than national average	
Sep-18	8
Aug-18	8
Jul-18	8

Responsive

Reporting sub committee – TEC

Areas of good performance

- Hospital initiated outpatient cancellations under 6 weeks performed better than the performance standard *(pages 6 & 30)*
- The 2WW cancer and breast symptomatic indicators achieved the performance standard (provisional) *(pages 5 & 31)*
- The cancer 62 day GP and 62 day screening indicators achieved the performance standard (provisional) *(pages 5 & 33)*
- The cancer 31 day subsequent drug indicator achieved the performance standard (provisional) *(pages 5 & 32).*

New to category this month:

- The cancer 31 day first indicator achieved the performance standard (provisional) *(pages 5 & 32- 33)*

Achieving	
Sep-18	8
Aug-18	9
Jul-18	10

Better than national average	
Sep-18	8
Aug-18	7
Jul-18	8

Areas requiring performance improvement

- A&E 4 hour wait performance was below standard *(pages 5 & 34)*
- Ambulance turnaround times' performance was worse than standard *(pages 5 & 34)*
- The RTT incomplete indicator was worse than the standard *(pages 5 & 29)*
- Patients not treated within 28 days of their last minute cancellation was below standard *(pages 6 & 30)*
- The Trust recorded 111 52-week RTT breaches *(page 5)*
- Formal DToCs were worse than standard *(pages 6 & 35)*

New to category this month:

- The cancer 31 day subsequent surgery indicator did not achieve the performance standards (provisional) *(pages 5 & 32)*
- Diagnostic wait times did not achieve the performance standard *(pages 5 & 30)*

Not achieving	
Sep-18	13
Aug-18	12
Jul-18	11

Worse than national average	
Sep-18	6
Aug-18	7
Jul-18	6

Well led

Reporting sub committee – PSE

Areas of good performance

- The sickness rate was better than target *(pages 7 & 36)*
- Temporary costs and overtime as % of total pay bill was better than target *(pages 7 & 36), including and excluding unfunded beds (two indicators)*
- Bank pay was better than the target range of 8 %– 12% *(pages 7 & 36)*
- Maternity Friends and Family response rate was better than target *(pages 7 & 40)*

New to category this month:

- Agency pay was better than target (*pages 7 & 35)*
- Inpatient FFT response rate was better than the target *(pages 7 & 39)*

Achieving	
Sep-18	8
Aug-18	6
Jul-18	6

Better than national average	
Sep-18	5
Aug-18	5
Jul-18	5

Areas requiring performance improvement

- The staff turnover rate (rolling 12 months) was below the performance standard *(pages 7 & 36)*
- Staff turnover (rolling 3 months) was worse than target *(pages 7 & 36)*
- The vacancy rate was worse than the performance standard *(pages 7 & 36)*
- Appraisals were worse than target *(pages 7 & 37)*
- Mandatory training was worse than target *(pages 7 & 37)*
- Friends and Family response rate for A&E was below threshold *(pages 7 & 39)*
- Staff FFT response rate was worse than the performance standard *(pages 7 & 39)*
- Staff FFT % recommend was worse than the performance standard *(pages 7 & 39)*

New to category this month:

None

Not achieving	
Sep-18	10
Aug-18	12
Jul-18	10

Worse than national average	
Sep-18	5
Aug-18	5
Jul-18	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-18	Aug-18	Sep-18	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/ or as expected	✓ 95.7	✓ 98.0	✓ 96.5			MD	May-18	Y	National	100	May-18		G	
	HSMR - Total (Rolling three months)	100/ or as expected	✓ 98.1	✓ 101.0	✓ 98.2			MD	Jun-18	Y	National	100	Jun-18		G	
	Crude Mortality Rate (Non elective ordinary)**	3.5%	✓ 2.5%	✓ 2.6%	✓ 2.5%	✓ 2.5%	3.5%	MD	Sep-18	Y	National	3.0%	Jun-18		G	
	30 Day Emergency Readmissions - Combined *	tbc	7.7%	7.07%	7.05%	7.2%	4.0%	MD	Sep-18	Y	National	11.4%	2011-12		G	£ National contract: Marginal tariff reimbursement, possible penalties
	30 Day Emergency Readmissions - Elective *	n/a	3.4%	2.8%	3.1%	3.0%	n/a	MD	Sep-18	Y	National	n/a			G	£ National contract: Marginal tariff reimbursement, possible penalties
	30 Day Emergency Readmissions - Emerg *	n/a	11.7%	11.0%	10.6%	11.1%	n/a	MD	Sep-18	Y	National	n/a			G	£ National contract: Marginal tariff reimbursement, possible penalties^
	Number of patients with a length of stay > 14 days *	tbc	317	338	342	2034	tbc	MD	Sep-18		Local	n/a			G	£ Reduction in reimbursement vs largely fixed costs. No penalty levied.
	Staff FFT % recommended care	tbd NHSI^	N/Av	58.0%	56.9%	56.9%	tbd NHSI^	DoW	Jun-18	Y	National	n/a			G	
	Inpatient Scores FFT % positive	95%	✗ 94.7%	✓ 95.7%	✓ 95.5%	✓ 95.3%	95%	CN	Sep-18	Y	National	95.7%	Aug-18		G	
	A&E FFT % positive	95%	✗ 93.8%	✓ 95.5%	✗ 92.8%	✗ 93.5%	95%	CN	Sep-18	Y	National	87.7%	Aug-18		G	
	Daycase FFT % positive	95%	✓ 98.8%	✓ 98.9%	✓ 97.7%	✓ 98.6%	95%	CN	Sep-18	Y	National	n/a			G	
	Maternity FFT % positive	95%	✗ 91.9%	✓ 97.1%	✗ 94.3%	✗ 94.9%	95%	CN	Sep-18	N	National	96.9%	Aug-18		G	
	● % Complaints responded to within one month or agreed timescales with complainant	85%	✗ 69.0%	✗ 72.7%	✗ 72.2%	✗ 66.7%	85%	CN	Sep-18	N	Local	n/a			R	
	Complaints - rate per 10,000 bed days	tbd NHSI^	21.9	13.4	14.7	22.6	tbd NHSI^	CN	Sep-18	N	National	n/a			R	
	Reactivated complaints		4	6	2	41	n/a	CN	Sep-18	N	Local	n/a			R	
	Proportion of complaints with verbal communication at the beginning of the process	100%	✗ 95.5%	✗ 92.6%	✗ 93.1%	✗ 89.3%		CN	Sep-18	N	Local				R	
	● Mixed sex accommodation breaches	0	✗ 1	✗ 4	✗ 2	✗ 19	0	CN	Sep-18	N	National	49 Trusts breaching	Aug-18		G	£ National contract: Penalties from CCG. £250 per day per service user.
	Clostridium Difficile	2	! 3	! 2	✓ 0	✓ 9	16	CN	Sep-18	Y	National	2.9 average	Aug-18		G	£ National contract: Penalties from CCG, fines from other statutory authorities. £10,000 per case above threshold.
	C.diff per 100,000 beddays		15.0	10.0	0.0	7.7		CN	Sep-18	Y	Local					
	MRSA bacteraemias	0	✗ 1	✓ 0	✓ 0	✗ 2	0	CN	Sep-18	Y	National	n/a			G	£ National contract: Penalties from CCG, fines from other statutory authorities. £10,000 in respect of each incidence in the relevant month.
	MSSA bacteraemias	tbc	0	1	2	12	0	CN	Sep-18	Y	Local					
	E. Coli Bacteraemia	tbc	3	5	2	16	tbc	CN	Sep-18	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). Benchmark East of England
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
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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-18	Aug-18	Sep-18	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Safe, Effective, Caring	Never events	0	✓ 0	✓ 0	✓ 0	✗ 1	0	MD	Sep-18	Y	National	n/a			G	£ National contract: Penalties from CCG, fines from other statutory authorities, prosecution^
	Serious incidents - number*	tbd NHSI^	7	5	5	35	tbd NHSI^	MD	Sep-18	Y	National	n/a			G	
	% of patients safety incidents which are harmful*	n/a	10.6%	9.7%	11.9%	10.4%	n/a	MD	Sep-18	Y	National	n/a			G	
	Medication errors causing serious harm *	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Sep-18	Y	National	n/a			G	
●	CAS Alerts: Number issued each month	n/a	11	3	6	6	n/a	CN	Sep-18	Y	National	n/a			G	
	CAS alerts not acknowledged within 48 hours	0	✓ 0	✓ 0	✓ 0	✓ 0	0	CN	Sep-18		National	n/a			G	
	Number of falls*		91	93	102	564		CN	Sep-18	Y	Local				G	
	Number of falls with harm*		17	21	22	118		CN	Sep-18	Y	Local				G	
	Number of G3 pressure ulcers (Hospital acquired)	0	1	3	10	30	0	CN	Sep-18	Y	Local				G	
	Number of G4 pressure ulcers (Hospital acquired)	0	0	0	0	1	0	CN	Sep-18	Y	Local				G	
●	Safety Thermometer Harm Free Care (acquired within and outside of Trust)*/**	95.0%	✗ 88.3%	✗ 92.9%	✗ 92.7%	✗ 91.4%	95.0%	CN	Sep-18	Y	National	94.3%	Sep-18		G	
	Safety Thermometer % New Harm Free Care (acquired within Trust)*/**	tbd NHSI^	97.6%	98.9%	97.7%	98.1%	tbd NHSI^	CN	Sep-18	Y	National	97.9%	Sep-18		G	
	Safety Thermometer New Harm Free Care: Catheter & UTI New Harms*/**	tbd NHSI^	1	0	1	6	tbd NHSI^	CN	Sep-18	Y	National	0.17 WHHT vs 0.28	Sep-18		G	
●	VTE risk assessment*	95.0%	✗ 94.8%	✗ 93.3%	✗ 92.6%	✗ 93.5%	95.0%	MD	Sep-18	Y	National	95.6%	Q1 18/19		A	£ National contract: Penalties from CCG
●	Caesarean Section rate - Combined*	28.0%	✗ 32.6%	✗ 28.4%	✗ 31.6%	✗ 32.1%	28.0%	MD	Sep-18	Y	Local	26.7%	Apr15-Aug15		A	
	Caesarean Section rate - Emergency*	15.0%	19.2%	16.2%	19.4%	18.9%	15.0%	MD	Sep-18	Y	Local	15.3%	Apr15-Aug15		A	
	Caesarean Section rate - Elective*	11.0%	13.4%	12.2%	12.2%	13.2%	11.0%	MD	Sep-18	Y	Local	11.4%	Apr15-Aug15		A	
	Maternal deaths	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Sep-18	N	National	n/a			G	
●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 75.0%	✗ 57.7%	✗ 64.9%	✗ 63.5%	90.0%	COO	Sep-18	Y	National	52.8%	Mar-18		G	
	Stroke patients spending 90% of their time on stroke unit *	80.0%	✓ 84.6%	✓ 86.0%	✓ 90.3%	✓ 85.2%	80.0%	COO	Sep-18	Y	National	83.4%	Mar-18		A	

* Performance may change for the current month due to data entered after the production of this report. Performance has been aligned to SSNAP report from April 2018

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

NB Exception reports not provided for FFT scores

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

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

Exception indicators key

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◆ Red for the latest data point

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NHS West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	Jul-18	Aug-18	Sep-18	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%	✗ 68.1%	✗ 72.4%	✗ 67.2%	✗ 67.9%	90.0%	COO	Sep-18	Y	Local	74.8%	Aug-18		G	
	●	Referral to Treatment - Non Admitted*	95.0%	✗ 89.2%	✗ 89.8%	✗ 88.1%	✗ 88.9%	95.0%	COO	Sep-18	Y	Local	89.0%	Aug-18		G	
	●	Referral to Treatment - Incomplete*	92.0%	✗ 84.8%	✗ 83.8%	✗ 83.2%	✗ 84.3%	92.0%	COO	Sep-18	Y	National	87.2%	Aug-18		G	£ National contract: CCG penalty of £100 in respect of each excess breach above the threshold
	●	Referral to Treatment - 52 week waits - Incompletes	0	✗ 124	✗ 123	✗ 111	✗ 605	0	COO	Sep-18		National	3407 (all Trusts)	Aug-18		G	
	◆	Diagnostic wait times	99.0%	✓ 99.9%	✓ 99.9%	✗ 98.9%	✓ 99.7%	99.0%	COO	Sep-18	Y	National	96.9%	Aug-18		G	£ National contract: CCG penalty of £200 in respect of each excess breach above the threshold
	●	ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 83.9%	✗ 83.0%	✗ 79.8%	✗ 84.4%	95.0%	COO	Sep-18	Y	National	88.9%	Sep-18		G	£ National contract: 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-18	Y	National	153 (all Trusts)	Sep-18		G	£ National contract: CCG penalty £1,000 per incidence
	●	Ambulance turnaround time between 30 and 60 mins	0	✗ 185	✗ 225	✗ 255	✗ 1,165	0	COO	Sep-18	Y	National	n/a			R	£ National contract: CCG penalty £200 per service user waiting over 30 mins
	●	Ambulance turnaround time > 60 mins	0	✗ 23	✗ 30	✗ 50	✗ 157	0	COO	Sep-18	Y	National	n/a			R	£ National contract: CCG penalty £1,000 per service user waiting over 60 mins
		Cancer - Two week wait *	93.0%	✗ 93.0%	✓ 94.5%	✓ 94.5%	✓ 93.2%	93.0%	COO	Sep-18	Y	National	91.4%	Q1 18/19		G	£ National contract: CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
		Cancer - Breast Symptomatic two week wait *	93.0%	✓ 95.7%	✓ 94.2%	✓ 95.7%	✗ 89.8%	93.0%	COO	Sep-18	Y	National	83.8%	Q1 18/19		G	£ National contract: CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
		Cancer - 31 day *	96.0%	✓ 98.5%	✗ 95.8%	✓ 96.5%	✓ 96.3%	96.0%	COO	Sep-18	Y	National	97.5%	Q1 18/19		G	£ National contract: 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-18	Y	National	99.4%	Q1 18/19		G	£ National contract: CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	◆	Cancer - 31 day subsequent surgery *	94.0%	✗ 90.0%	✓ 100.0%	✗ 82.4%	✗ 91.0%	94.0%	COO	Sep-18	Y	National	94.4%	Q1 18/19		G	£ National contract: CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
		Cancer - 62 day *	85.0%	✗ 82.4%	✓ 85.3%	✓ 89.8%	✗ 84.9%	85.0%	COO	Sep-18	Y	National	80.8%	Q1 18/19		G	£ National contract: CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
		Cancer - 62 day screening *	90.0%	✓ 92.0%	✓ 100.0%	✓ 94.7%	✗ 85.4%	90.0%	COO	Sep-18	Y	National	88.6%	Q1 18/19		G	£ National contract: 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

10

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Indicator	Target	Jul-18	Aug-18	Sep-18	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-18	Y	National	n/a			G	
	●	Number of patients not treated within 28 days of last minute cancellation	0	✗ 4	✗ 9	✗ 11	✗ 57	0	COO	Sep-18	Y	National	13 (avg. all Trusts)	Q1 18/19		G	
	●	Delayed Transfers of Care (DToC)*	3.5%	✗ 4.4%	✗ 3.7%	✗ 4.4%	✗ 4.2%	3.5%	COO	Sep-18	Y	National	6.0%	Feb-16		G	£ National contract: Penalties from CCG
		Delayed Tranfers of Care (DToC) beddays used in month		909	855	1,033	5,510		COO	Sep-18	Y	National	n/a			G	£ National contract: Penalties from CCG
		Delayed Tranfers of Care (DToC) beds used in month		29.3	27.6	34.4	30.1		COO	Sep-18	Y	National	n/a			G	
	●	Outpatient cancellation rate	8.0%	✗ 12.0%	✗ 12.4%	✗ 11.3%	✗ 11.8%	8.0%	COO	Sep-18	Y	Local	n/a			G	
		Outpatient cancellation rate within 6 weeks^	5.0%	✓ 4.4%	✓ 4.1%	✓ 3.7%	✓ 4.2%	5.0%	COO	Sep-18	Y	Local	n/a			G	
	●	Patient initiated cancellations (all)		12.8%	12.9%	13.0%	12.7%		COO	Sep-18	Y	Local				G	
		Hospital + Patient initiated cancellations (all)		24.8%	25.4%	24.2%	24.4%		COO	Sep-18	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*

Exception indicators key

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NHS West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Indicator	Target	Jul-18	Aug-18	Sep-18	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%	✗ 17.0%	✗ 16.7%	✗ 16.7%	✗ 16.9%	12.0%	DoW	Sep-18	Y	National	15.4% (Beds and Herts orgs)	Q1 18/19		G	
		Staff turnover rate (rolling 3 months)	12.0%	✗ 13.4%	✗ 13.9%	✗ 16.6%	✗ 15.3%	12.0%	DoW	Sep-18	Y	National	15.4% (Beds and Herts orgs)	Q1 18/19		G	
		Nurse Band 5 Turnover Rate		✗ 24.2%	✗ 23.0%	✗ 21.7%	✗ 23.3%		DoW	Sep-18	Y	Local	n/a			G	
		% staffleaving within first year (excluding medics and fixed term contracts)		22.1%	22.0%	22.3%	21.9%		DoW	Sep-18	Y	National	n/a			G	
		Sickness rate	3.5%	✓ 3.2%	✓ 3.3%	✓ 3.2%	✓ 3.1%	3.5%	DoW	Sep-18	Y	National	3.8% (EoE orgs)	Q1 18/19		A	£ Payments made to staff for nil productivity
	●	Vacancy rate	9.0%	✗ 11.9%	✗ 12.5%	✗ 12.1%	✗ 11.5%	9.0%	DoW	Sep-18	Y	National	13.5% (local survey)	Q1 18/19		G	£ Costs saved in short term for nil productivity
	●	Appraisal rate (non-medical staff only)	90.0%	✗ 78.6%	✗ 82.2%	✗ 83.7%	✗ 79.9%	90.0%	DoW	Sep-18	Y	National	82.0% (local survey)	Q1 18/19		G	
		Appraisal rate (medical staff)	90.0%	✗ 0.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	90.0%	MD	Sep-18	N	National				A	
		Appraisal rate (Total)	90.0%	✗ 78.6%	✗ 82.2%	✗ 84.1%	✗ 79.9%	90.0%	MD	Sep-18	N	National					
	●	Mandatory Training	90.0%	✗ 82.0%	✗ 80.3%	✗ 82.4%	✗ 83.6%	90.0%	DoW	Sep-18	Y	Local	88.0% (local survey)	Q1 18/19		A	
		Essential Training		70.5%	65.5%	67.5%	68.2%		DoW	Sep-18	Y	Local					
		% Bank Pay**	8% - 12%	✓ 10.0%	✓ 10.0%	✓ 11.4%	✓ 10.8%	8% - 12%	DoW	Sep-18	Y	Local	n/a			G	£ Costs at established rates rather than premium
		% Agency Pay**	6.4%	✗ 6.4%	✗ 7.4%	✓ 4.7%	✓ 6.1%	6.4%	DoW	Sep-18	Y	Local	7.5% (local survey)	Q1 18/19		G	£ Costs at premium rates rather than established
		Temporary costs and overtime as % of total paybill** (Inc. unfunded beds)	22.6%	✓ 16.8%	✓ 17.8%	✓ 16.4%	✓ 17.3%	22.6%	DoW	Sep-18	Y	National	n/a			G	£ Premium payments of various types vs established rates
		*Temporary costs and overtime as % of total paybill** (Excl. unfunded beds)*		✓ 6.4%	✓ 7.3%	✓ 4.6%	✓ 5.9%		DoW	Sep-18	Y	National	n/a			G	£ Premium payments of various types vs established rates
		Inpatient FFT response rate	35.0%	✗ 29.2%	✗ 34.3%	✓ 35.1%	✗ 31.4%	35.0%	CN	Sep-18	Y	National	25.0%	Aug-18		G	
	●	A&E FFT response rate	10%	✗ 3.5%	✗ 5.2%	✗ 4.0%	✗ 3.8%	10.0%	CN	Sep-18	Y	National	12.9%	Aug-18		G	
		Daycases FFT response rate	tbd NHSI^	42.6%	37.6%	38.8%	35.2%	tbd NHSI^	CN	Sep-18	Y	National	n/a			G	
	◆	Staff FFT response rate+	50%	N/Av	✗ 14.2%	✗ 13.3%	✗ 13.3%	50%	DoW	Jun-18	Y	National	n/a			G	
		Staff FFT % recommended work	66%	N/Av	✗ 53.4%	✗ 52.6%	✗ 52.6%	66%	DoW	Jun-18	Y	National	n/a			G	
		Maternity FFT response rate	25%	✓ 41.8%	✓ 28.2%	✓ 43.3%	✓ 34.2%	25%	CN	Sep-18	N	National	20.3%	Aug-18		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
+ Staff FFT reports latest quarterly positions in monthly columns (eg. Q1, Q2 and Q3 = month 1, 2, and 3)

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

Detailed reports

September 2018 – Summary of Results

NHS West Hertfordshire Hospitals NHS Trust

70 YEARS OF THE NHS 1948-2018

Trust Definition	Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance		YTD Budget	Actual	Variance	
Income	Divisional Income	(32,096)	(4,250)	(2,905)	(1,344)	Bii	(15,902)	(15,775)	(127)	Fii
	NHS Revenue	(304,342)	(24,290)	(23,805)	(485)	Bi	(151,717)	(148,923)	(2,795)	Fi
	Income Unallocated CIPs	(1)	(13)		(13)		25		25	
Income Total		**(336,440)**	**(28,554)**	**(26,711)**	**(1,843)**	**B**	**(167,594)**	**(164,697)**	**(2,897)**	**F**
Pay	Medical Pay	68,951	5,693	6,225	(532)		34,719	36,444	(1,725)	
	Non-Clinical Pay	53,684	4,766	3,886	881		26,037	22,639	3,398	
	Nursing Pay	74,786	6,572	6,103	470		37,353	36,938	416	
	Other Clinical Pay	25,094	2,508	2,244	264		12,570	13,671	(1,100)	
	Scientific, Technical & Profes	24,578	2,217	2,004	213		12,387	12,691	(303)	
	Pay Unallocated CIPs	(1,943)	(199)		(199)		(54)		(54)	
Pay Total		**245,151**	**21,658**	**20,461**	**1,096**	**C**	**123,013**	**122,382**	**631**	**G**
Non Pay	Clin Supp Serv	30,888	2,403	2,395	8		15,442	15,109	333	
	Drugs	22,017	1,902	1,955	(53)		10,957	11,729	(772)	
	OTHER (NON CLIN)	81,741	6,944	5,377	1,567		41,643	40,750	893	
	Non Pay Unallocated CIPS	(843)	(118)		(118)		1,218		1,218	
Non Pay Total		**133,803**	**11,131**	**9,726**	**1,406**	**D**	**69,260**	**67,588**	**1,672**	**H**
Recharges	Recharges	0	0	0	0		0	0	0	
Recharges Total		**0**	**0**	**0**	**0**		**0**	**0**	**0**	
Financing Charges	Depreciation	8,022	668	661	8		4,011	3,828	183	
	Trust Debt Redemption	2,313	193	180	12		1,157	1,097	60	
	Unwinding Discount	50	4	5	(1)		25	30	(5)	
Financing Charges Total		**10,386**	**865**	**846**	**19**	**E**	**5,193**	**4,955**	**238**	**I**
Total		**62,900**	**5,000**	**4,323**	**677**	**A**	**29,872**	**30,228**	**(355)**	**J**

A – The trust reported an in month favourable variance of £677k by delivering an actual deficit of £4,323k against a plan of £5,000k. This takes the YTD position to an overspend of £355k(J). **In addition to the favorable variance against plan, the position was £0.4m better than the last base forecast. This was all driven by a a £1.6m YTD benefit recognised against financial penalties.**

B- The income position showed an underperformance against plan of £1,843k taking the YTD underachievement to £2,897k (F).
Bi – Divisional income showed an underperformance of £1,344k against plan in month. This is mainly due to a retrospective budgetary adjustment to reflect the impact of the pay award (offset by the pay position -C). The YTD underperformance of £127k (Fii) represents a normalized position and is driven by reductions in Health Education England funding and lower private patients.
Bii- NHS Revenue was £485k away from plan. The underperformance is directly linked to two divisions; Surgery and WACS (£0.9m & £0.15m respectively). The performance of these divisions also underpins the Trusts' YTD £2,795k underperformance against NHS revenue (Fi). This underperformance is explained further on the NHS revenue slide (pages 6 & 7)

C – The overall pay bill for the month was £20,461k which was £1,096k better to plan. After taking into account the budgetary impact of the pay award, the position was in line with trend and forecast expectations. The YTD position is now £631k underspent.. Despite this, the medical and other clinical pay positions are the key areas of concern. Premium cover for high levels of vacancies and sickness across divisions represent the main problems within medical staff. The cost of 1:1 nursing care sits within other clinical pay. This has a YTD overspend of £841k.

D – The non pay position reported an underspend of £1,405k in month.. The expenditure showed a large decrease in month which was driven by the year to date, £1.6m benefit on penalties. Excluding the benefit against penalties, the YTD position would be breakeven and shows an overspend on pass through drugs (offset by income) and underspends against clinical supplies and other non pay.

E – Financing charges were underspent against plan by £19k. This is driven by lower capital interest payments and lower depreciation charges. The YTD position shows an underspend of £238k (I).

NHS West Hertfordshire Hospitals NHS Trust

Overview Dashboard

NHS West Hertfordshire Hospitals NHS Trust

70 YEARS OF THE NHS 1948-2018

Financial Overview as at 30 September 2018

Month 6 FY19 Income & Expenditure

£m	Plan	Actual	Var
Surplus / (Deficit)	(5.0)	(4.3)	0.7

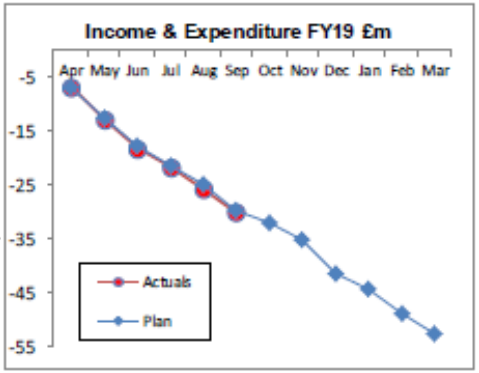
£m	YTD FY19		
Surplus / (Deficit)	(29.9)	(30.2)	(0.4)

Statutory / Regulatory Duties

Breakeven	The Trust has a deficit plan of £52.9m for FY19.	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 30/09/18 equated to 6 days' spend	R
BPPC	Month 6 performance - 84% on number, 80% on value (95% target)	A

Financial Risk Rating	FY19	3

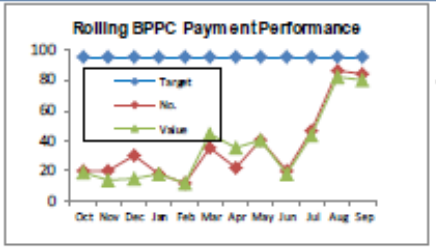
Income & Expenditure FY19 £m



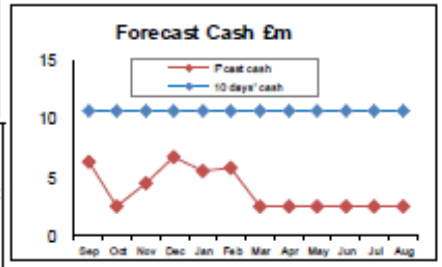
YTD Variance by Division

	£m	% Budget
Medicine	0.6	16
Unscheduled Care	0.6	11
Surgery	(3.3)	(94)
Women's	(1.0)	(10)
Clinical Support	0.3	9
Estates & Facilities	0.9	7
Corporate	0.3	1
Other	1.4	
Total	(0.4)	

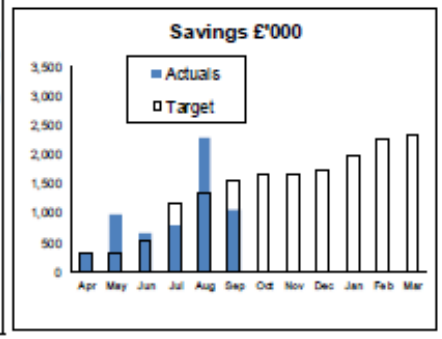
Rolling BPPC Payment Performance



Forecast Cash £m



Savings £'000



Commentary

- See earlier pages for I&E detail.
- A financial risk rating of 3. Two Trust divisions: Surgery and Women's and Children's are adverse to budget.
- The Better Practice Payment statistics show a generally improving trend. In September 84% of bills were paid within 30 days.
- The cash balance at the end of September was £6.3m.
- Savings were £1.0m in September, £6.0m ytd, forecast to reach £13.7m by year end.

September 2018 – Trust Income Performance

West Hertfordshire Hospitals NHS Trust

In Month Performance (£s)

Expense Type	POD	Annual Budget	In Month (£000's) Budget	Actual	Variance
NHS Revenue	A&E	(16,374)	(1,295)	(1,443)	148
	Critical Care	(12,757)	(1,008)	(896)	(109)
	Elective	(54,553)	(4,344)	(3,955)	(426)
	Non elective	(107,110)	(8,705)	(8,679)	(26)
	Other SLA	(42,429)	(3,402)	(3,090)	(312)
	Outpatient	(89,644)	(5,529)	(5,736)	207
	NHS Rev Unallocated CIPs	(1,474)	33		33
NHS Revenue Total	Total	(364,342)	(24,290)	(23,909)	(408)

In Month Performance (spells)

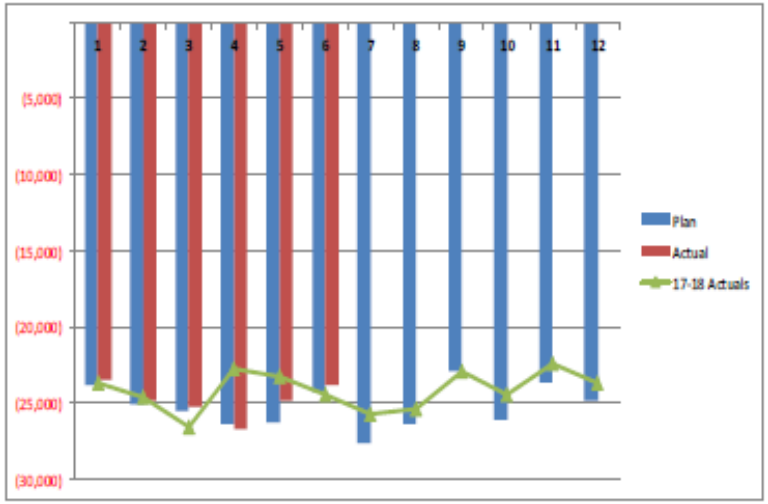
Expense Type	POD	Annual Budget	In Month (Activity) Budget	Actual	Variance
NHS Revenue	A&E	119,981	9,576	10,798	1,222
	Critical Care	21,100	1,691	1,644	-47
	Elective	43,720	3,508	3,371	-136
	Non elective	48,948	3,908	3,785	-123
	Other SLA	3,454,853	276,026	289,557	13,531
	Outpatient	450,425	36,092	36,845	753
NHS Revenue Total	Total	4,139,113	330,786	346,000	15,200

Divisional Income

Overall Divisional Income for the Trust shows a £1.3m underperformance against a plan of £4.25m.

This was driven by a retrospective budgetary adjustment to account for the 18/19 pay award. This is offset by the pay position.

NHS Revenue: Performance by Month (£s)

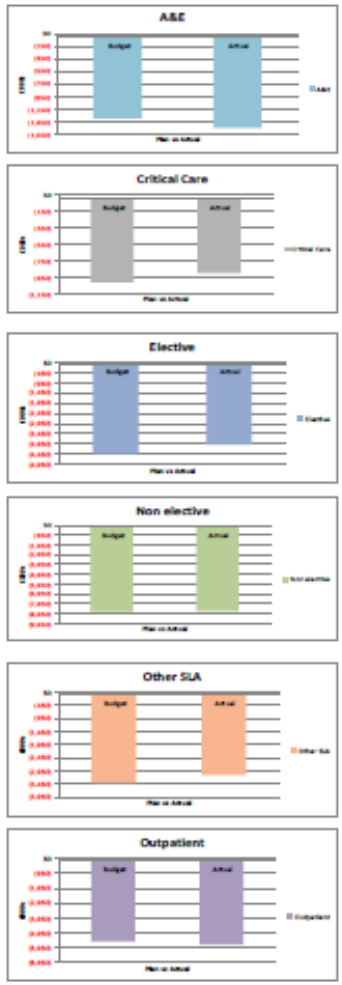


NHS Revenue in Month 6 delivered £23.81m against a plan of £24.29m resulting in an under performance of £0.48m.

Most points of delivery had a decrease from previous months.

- Critical care was £109k adrift from plan and had an all time low occupancy rate of 65%.
- Elective performance, mainly within surgery, was £426k away from plan. General surgery and orthopaedics had the highest level of underperformance.
- The £26k underperformance represented an improvement against last month despite a trend of low maternity birth numbers.
- Outpatient performance across the Trust improved between Months 5 & 6 and delivered an over performance of £207k. However it should be noted that this over performance was still lower than the average over performance generated in Q1.
- Finally other SLA, £312k adverse to plan, includes a provision held for prior year challenges.

The under performance demonstrated above can be summarised by division with Surgery underperforming by £0.9m and Women's and Children's underperforming by £0.2m



6

West Hertfordshire Hospitals NHS Trust

September 2018 – Trust Pay Performance

Trust Pay Performance

Expense Type	Annual Budget	In Month (£000's)			WTE		
		Budget	Actual	Variance	Budget	Actual	Variance
Medical Pay	68,951	5,693	6,225	(532)	653.54	700.90	-47.36
Non-Clinical Pay	53,684	4,766	3,886	881	1,224.95	1,168.10	56.85
Nursing Pay	74,786	6,572	6,103	470	1,660.77	1,610.84	49.93
Other Clinical Pay	25,094	2,508	2,244	264	928.57	983.52	-54.95
Scientific, Technical & Profes	24,578	2,217	2,004	213	506.18	508.82	-2.64
Pay Unidentified CIPs	(1,943)	(199)		(199)	0.00	0.00	0.00
	245,151	21,558	20,461	1,096	4,974.01	4,972.18	1.83

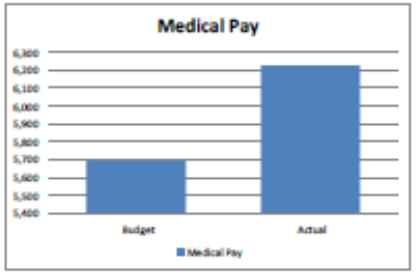
The Trust reported an in month underspend against the pay budget of £1,096k. However this included an element of the pay award which is offset by divisional income. This amounted to £1,656k in month, Therefore allowing for the impact the in month position would have shown a £560k overspend.

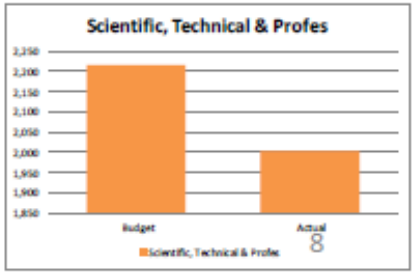
The main drivers were;

1. The medical pay position was overspent by £532k. This was driven by retrospective input across Emergency Medicine. The total Medical overspend for the division amounted to £421k. In addition to this, there continues to be high levels of junior doctor vacancies across the Trust.

2. Within other clinical pay the spend for enhanced care nursing (1:1 care) remains an issue. The in month spend was approximately £125k.

3. The phasing of the CIP target treated a shortfall with the pay lines of £199k.





8

September – 2018 Trust Bank & Agency Spend

NHS West Hertfordshire Hospitals NHS Trust

70 YEARS OF THE NHS 1948-2018

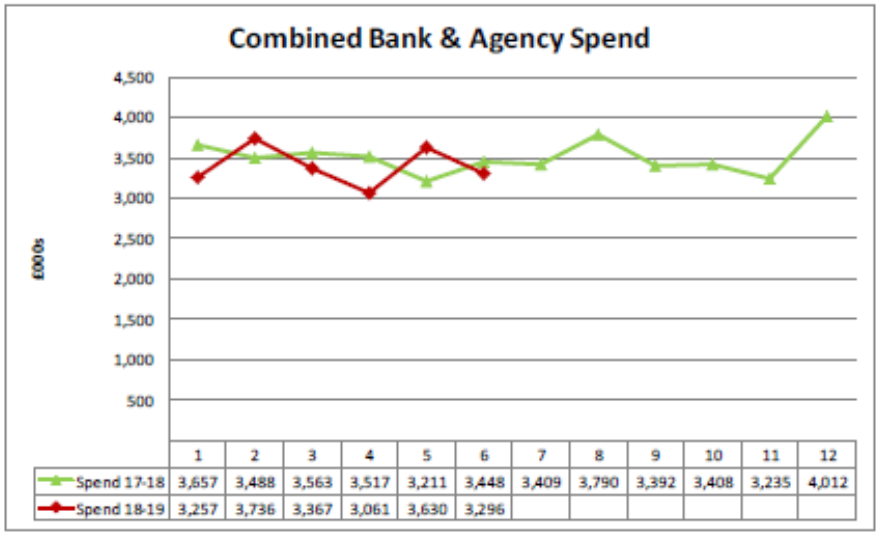
Commentary

Agency

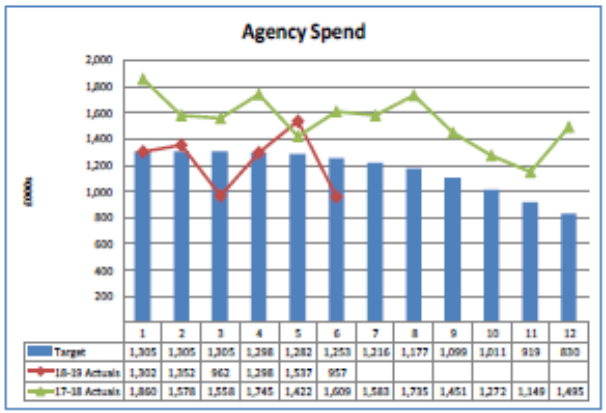
Agency expenditure in the month totalled £1.0m. This represented a decrease from previous months. This was due to the non recurrent release of medical shifts relating to 17-18 and cancelled shifts booked but not worked in April 18. The YTD agency spend stands at £7.4m - further improvements will need to be made in order to meet the internal £14m trajectory. The Trust is currently within its NHSI ceiling.

Bank

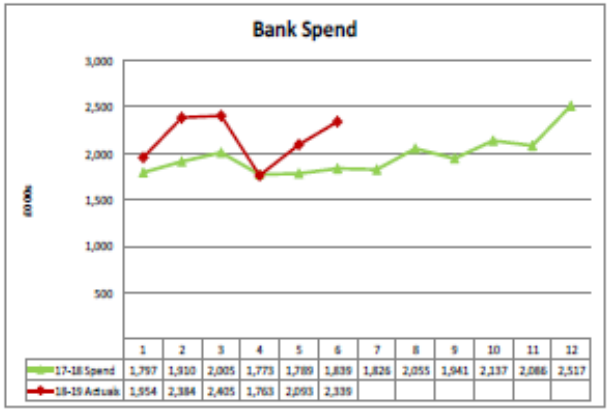
Bank spend saw a continued increase in the month of September. Again this is not expected to be recurrent and is attributed to seasonal factors. Despite the increase, the Trust has spent £0.5m less on bank & agency when compared to the same period last year.



	1	2	3	4	5	6	7	8	9	10	11	12
Spend 17-18	3,657	3,488	3,563	3,517	3,211	3,448	3,409	3,790	3,392	3,408	3,235	4,012
Spend 18-19	3,257	3,736	3,367	3,061	3,630	3,296						



	1	2	3	4	5	6	7	8	9	10	11	12
Target	1,305	1,305	1,305	1,298	1,282	1,253	1,216	1,177	1,099	1,011	919	830
18-19 Actuals	1,302	1,352	962	1,298	1,537	957						
17-18 Actuals	1,860	1,578	1,558	1,745	1,422	1,609	1,583	1,735	1,451	1,272	1,149	1,495



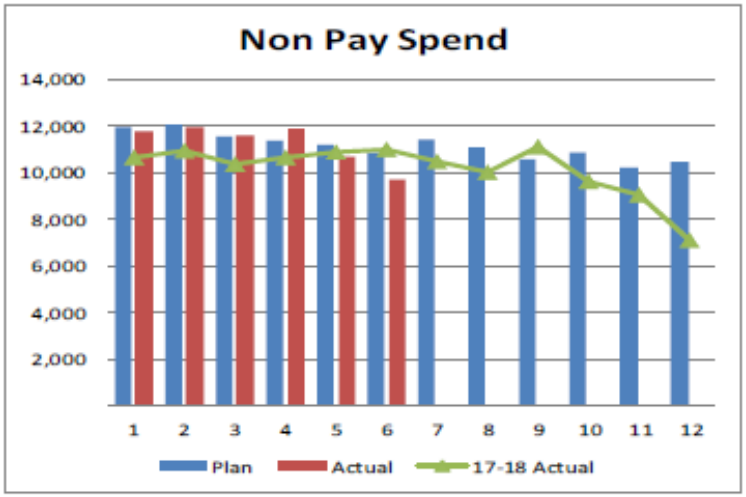
	1	2	3	4	5	6	7	8	9	10	11	12
17-18 Spend	1,797	1,910	2,005	1,773	1,789	1,839	1,826	2,055	1,941	2,137	2,086	2,517
18-19 Actuals	1,954	2,384	2,405	1,763	2,093	2,339						

September 2018 – Trust Non Pay Performance

West Hertfordshire Hospitals NHS Trust

Non Pay Performance

Expence Type	Annual Budget	In Month (£000's) Budget	In Month (£000's) Actual	In Month (£000's) Variance	YTD Budget	YTD Actual	YTD Variance
Clin Supp Serv	30,888	2,403	2,395	8	15,442	15,109	333
Drugs	22,017	1,902	1,955	(53)	10,957	11,729	(772)
OTHER (NON CLIN)	81,741	6,944	5,377	1,567	41,643	40,750	893
Non Pay Unallocated CIPS	(843)	(118)		(118)	1,218		1,218
Total	**133,803**	**11,131**	**8,726**	**1,406**	**69,260**	**67,588**	**1,672**



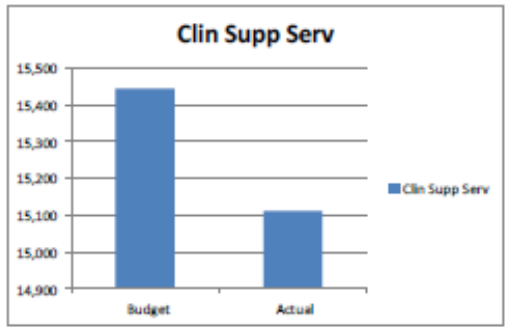
The in month non pay position reported an underspend of £1,405k. This takes the YTD position to £1.672k favourable against budget.

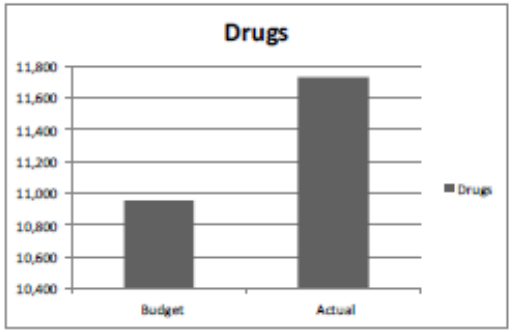
The main drivers of the YTD position include:

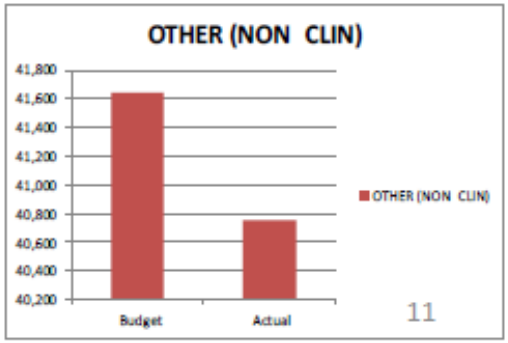
1. A £1.6m YTD benefit against financial penalties shown in month.
2. Also within the YTD position there is a £756k rebate in relation to a prior year rates.

3. The two above items are offset by higher drugs expenditure, of which some is pass-through and offset by the income position and overspends within other non clinical lines.

YTD Performance







11

FY19 CIP Performance by Category – QPID FOT Month 6 (September)

NHS West Hertfordshire Hospitals NHS Trust

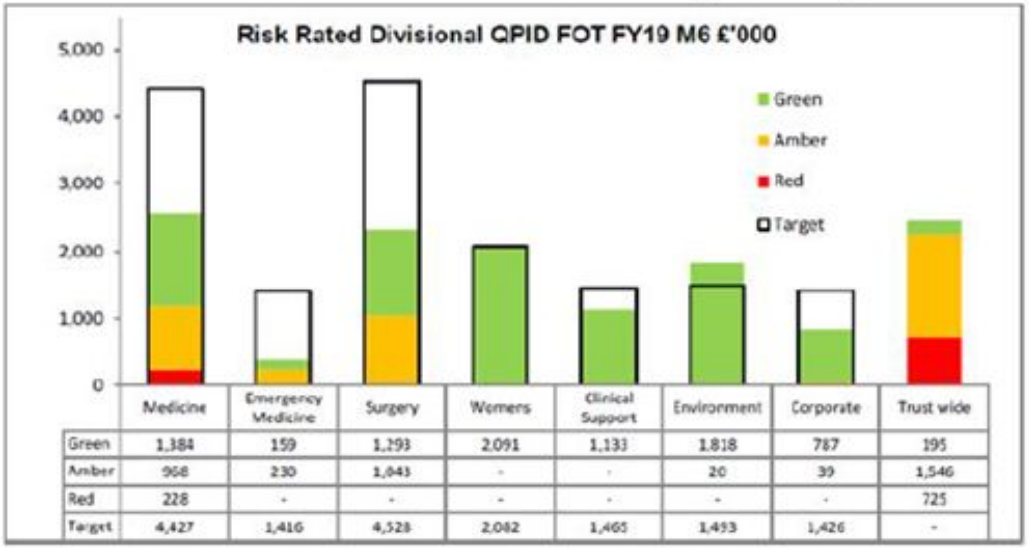
70 YEARS OF NHS

FY19 Forecast Divisional Delivery by Efficiency Category

All Values £000

FY19 QPID Reporting FOT Division	Non-Pay	Non-SLA Income	Service Development	Workforce	Grand Total	FY19 Divisional CIP Target £000	Variance to Target £000
Clinical Support	601	153		379	1,133	1,465	(332)
Corporate	195	5		626	826	1,426	(600)
Environment	1,636	129		73	1,838	1,493	345
Medicine	493	623	1,051	412	2,580	4,427	(1,847)
Surg, Anaesth, Cancer	729	230	600	778	2,336	4,528	(2,192)
Women's & Children's	177	273	814	827	2,091	2,082	9
Emergency Medicine	159	0	230	0	389	1,416	(1,027)
Trustwide	1,106	125		1,235	2,466	0	2,466
Grand Total	**5,095**	**1,538**	**2,695**	**4,331**	**13,659**	**16,837**	**(3,178)**

- The above table details £13.7m FY19 FOT by Division & Efficiency Category.
- In percentage terms the £13.7m FOT is comprised of 37% Non-Pay, 11% Non SLA Income, 20% Service Development and 32% Workforce.
- The chart to the right details FY19 FOT by the indicative QPID risk ratings of the respective Divisional schemes.



	Medicine	Emergency Medicine	Surgery	Womens	Clinical Support	Environment	Corporate	Trust wide
Green	1,384	159	1,293	2,091	1,133	1,818	787	195
Amber	968	230	1,043	-	-	20	39	1,546
Red	228	-	-	-	-	-	-	725
Target	4,427	1,416	4,528	2,082	1,465	1,493	1,426	-

Note: QPID contains schemes that have been through a form of validation and approval before 'qualifying' for inclusion. While it cannot be said that comprehensive plans are in place for all schemes, formal PID / QIA are in progression.

NHS West Hertfordshire Hospitals NHS Trust

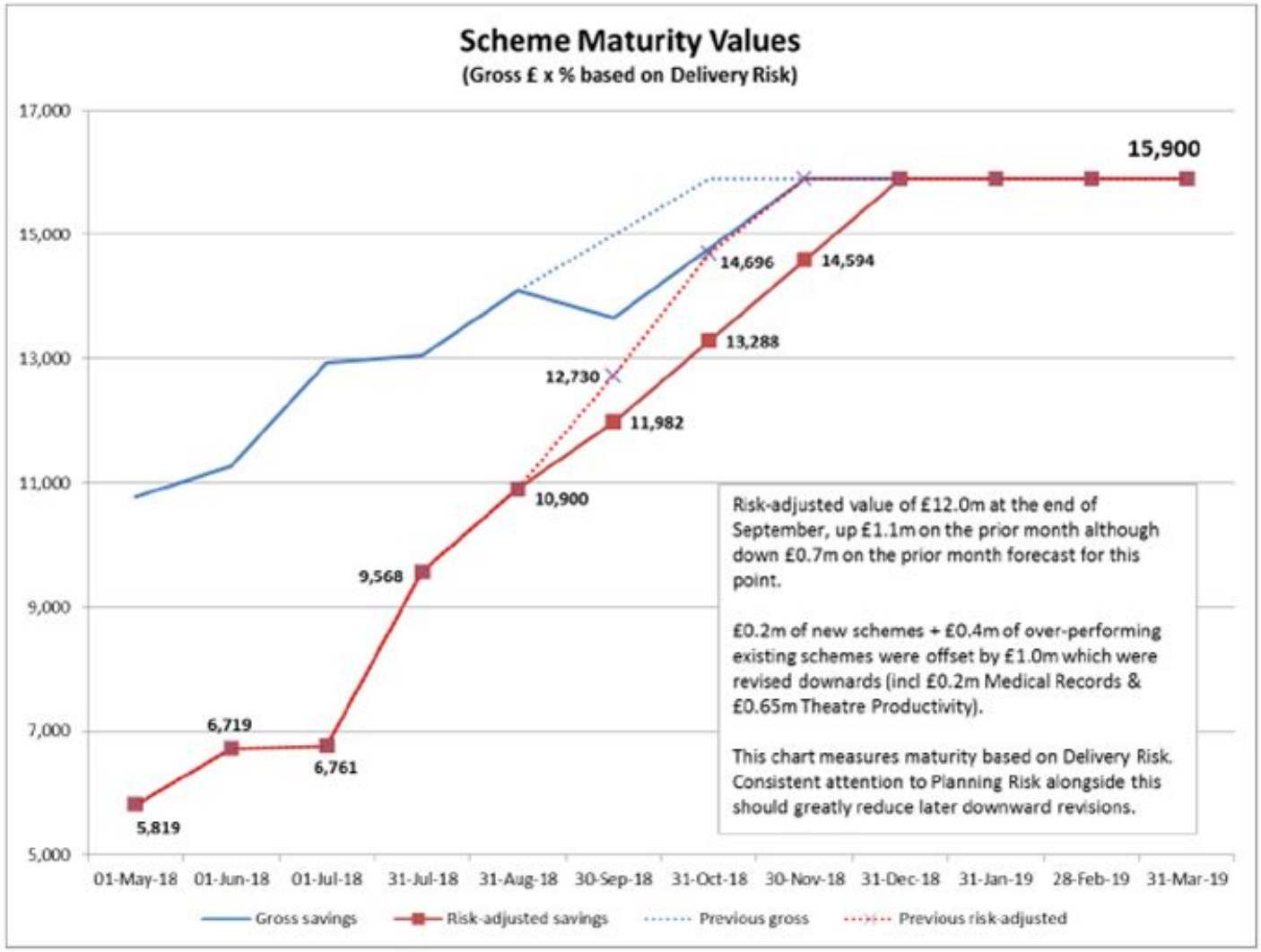
CIP Maturity Assessment

NHS West Hertfordshire Hospitals NHS Trust

70 YEARS

Scheme Maturity Values

(Gross £ x % based on Delivery Risk)



Risk-adjusted value of £12.0m at the end of September, up £1.1m on the prior month although down £0.7m on the prior month forecast for this point.

£0.2m of new schemes + £0.4m of over-performing existing schemes were offset by £1.0m which were revised downards (incl £0.2m Medical Records & £0.65m Theatre Productivity).

This chart measures maturity based on Delivery Risk. Consistent attention to Planning Risk alongside this should greatly reduce later downward revisions.

Safe, effective, caring

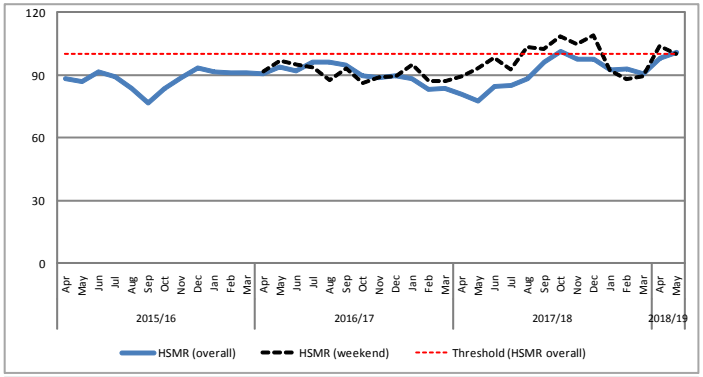
Reporting sub committee - S&C & COEC

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

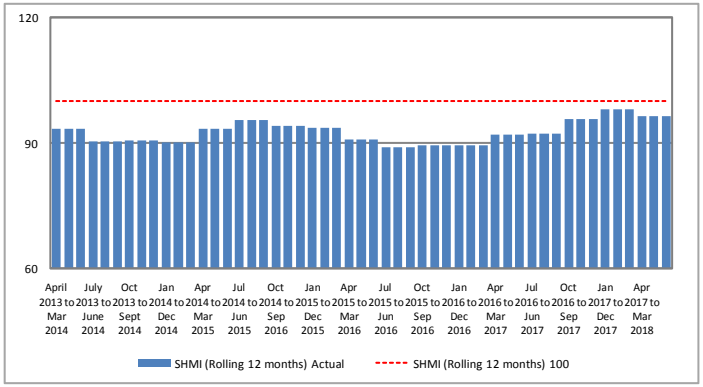
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Sep-18	4	4
Aug-18	3	5
Jul-18	4	4

NHS West Hertfordshire Hospitals NHS Trust

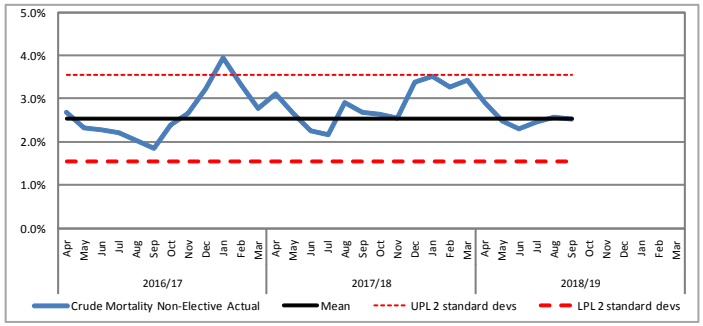
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



Hospital mortality

Dr Foster benchmarks the Trust against the Shelford group. WHHT is 1 of 7 out of a peer group of 16 that sit within the 'as expected' range.

The Summary Hospital Mortality Indicator's (SHMI) latest performance (for April 17 to March 18) was 96.45 and 'as expected' (band 2).

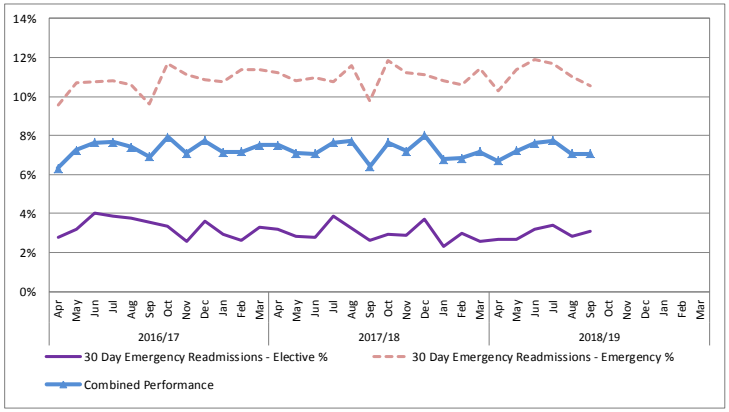
For the 12 month period (July 2017 to June 2018), the Trust's overall HSMR of 100.9 was in the 'as expected' range. As the trust has previously maintained a 'lower than expected' rating for a sustained period, each 'outlying' primary diagnostic SMR group has a 'deep dive' by case note review with a speciality or senior trust consultant and the coding manager.

On each occasion, there have been no lapses of care identified and in a substantial proportion, the clinical coding was deemed to be incorrect . The Trust is working on a strategy to improve the accuracy of primary diagnostic coding and the case note reviews will continue with any subsequent outliers.

Monthly specialty/departmental Mortality Review meetings continue, cases from which are then referred for Structured Judgement Review according to criteria described in the trust 'Learning From Deaths' policy.

Earlier referrals for SJR may occur now that the Medical Examiners are in post.

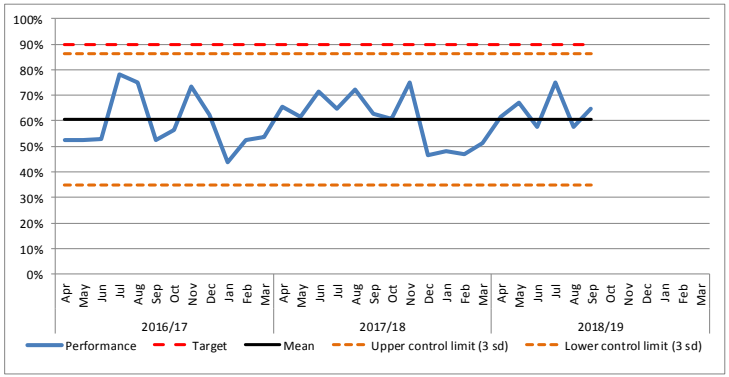
% Emergency re-admissions within 30 days following an elective or emergency spell*



Emergency Readmissions
Combined readmission rates (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.

The readmission rate remains unchanged at 7.1% this month.

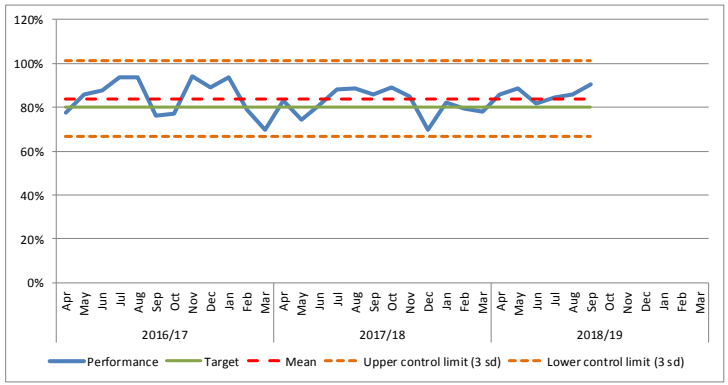
Patients admitted directly to stroke unit within 4 hours of hospital arrival*



Stroke
September's performance against the 4 hour admission target to the stroke unit is 63%, an improvement from the previous month. This is the second consecutive month in which there has been an increase in the number of medical patients bedded on the unit. The stroke specialist team continue to provide care and support to patients whilst they await transfer to the stroke unit.

90% stay
In this reporting month 87% of patients spent 90% of their stay on the stroke unit, better than the 80% target .

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



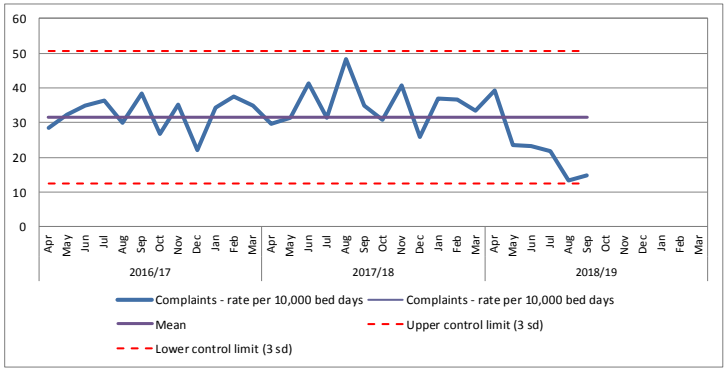
Stroke 60 mins, stroke care and STeMI 150 mins* (to follow)

Thrombolysis within 1 hour
A total of six patients were thrombolysed and 50% compliance on this target was achieved in September.

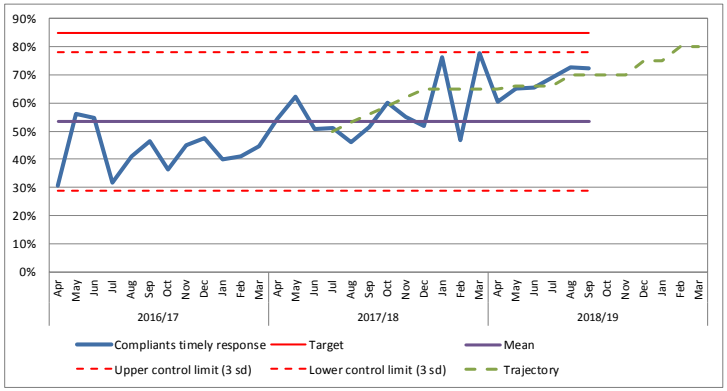
Safe, effective, caring (continued)

West Hertfordshire Hospitals NHS
NHS Trust

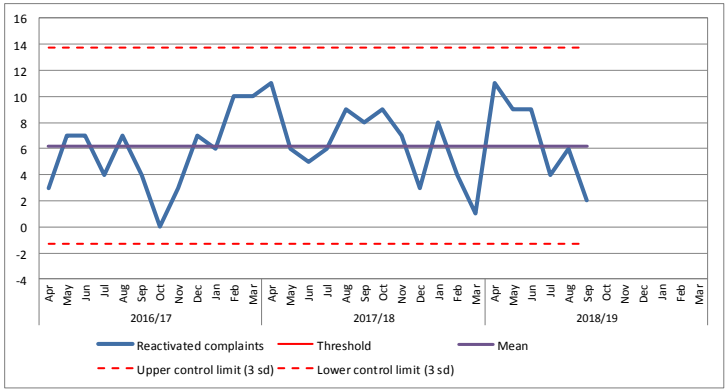
Complaints - rate per 10,000 bed days



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



Number of reactivated complaints



29 new complaints were received in September 2018, 33 fewer than the same month last year.
41% (12) were Surgery, Anaesthetics and Cancer (SAC), Women's and Children's (WACS) 25% (7), Medicine 14% (4), Emergency Medicine 11% (3) and Environment, Corporate and Clinical Support Services (CSS) each had 3% (1).
In 62% (18) the patient was unhappy with their clinical treatment (of which WACS had 7, 4 were in Surgery, 3 Medicine, 3 Emergency Medicine and 1 Clinical Support. Issues ranged from returns to theatre and dissatisfaction with the care given.

Lessons Learned: As a result of a complaint a leaflet is in development in the Critical Care Unit, explaining sepsis , how/why sepsis develops and the treatment for it.

Performance is better than the Trust's internal improvement trajectory plan for September (70% responded to within agreed timescales). The complaints team continue to meet weekly with the divisions to review all outstanding complaints. The table below shows the percentage of complaints responded to on time by each Division. In September 43 responses were sent in total.

	Jun 18	July 18	Aug 18	Sept 18
Trust wide	66%	69%	73%	72%
Medicine	83%	86%	80%	100%
Emergency Medicine	62%	69%	70%	50%
SAC	46%	39%	57%	59%
WACS	92%	100%	86%	100%
Environment	67%	N/A	100%	100%
CSS	100%	N/A	N/A	N/A
Corporate	100%	N/A	N/A	N/A

	Target	YTD
% of complainants with verbal communication at the beginning of process (called within 3 working days of receipt of complaint)	95%	95%
% of complaints responded to within the agreed timescale	70%	68%
% of complaints taken longer than 6 months to investigate	<5%	<2%
% of complaints acknowledged within 3 working days	100%	100%

2 complaints were re-activated in September, 4 less than the previous month (1 SAC, 1 Medicine) with both complainants unhappy with the response. A local resolution meeting has been arranged for one complainant and for the second a further investigation and response will be provided.

There are 2 outstanding complaints, both over 6 months old, one for the Emergency Medicine and one for Surgery, Anaesthetics and Cancer.

Safe, effective, caring

Reporting sub committee - S&C & COEC

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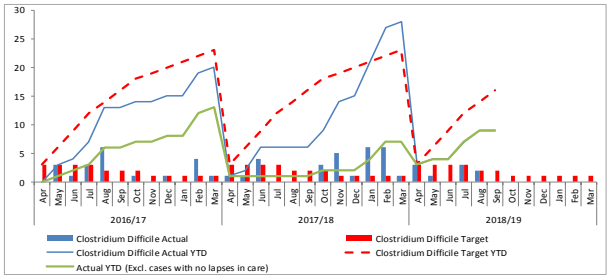
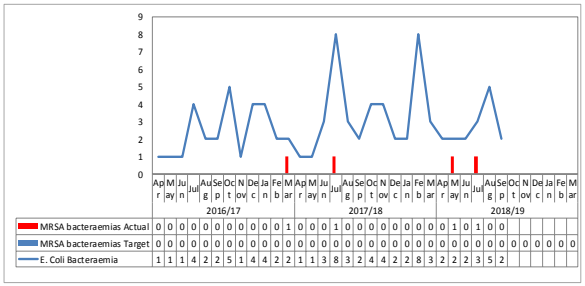
NHS West Hertfordshire Hospitals NHS Trust

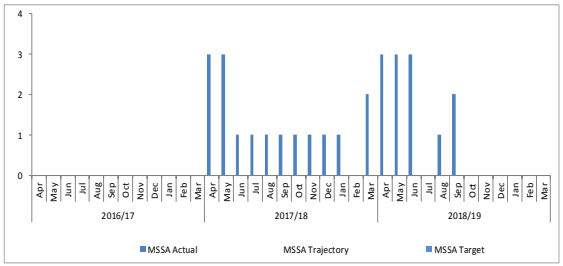
Clostridium difficile Infection (CDI)



MRSA and E.Coli



MSSA



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

There were no WHHT apportioned case reported in September. The full year target ceiling for WHHT apportioned CDI is 22, with a year to date total of 9. Action plans for all RCAs undertaken are being followed up. The IPCT alnd the divisions continue to embed learning from CDI, mainly correct sampling and isolation of patients with diarrhoea on admission. There is continued generally good management of CDI positive patients once the results are known.

During October various C.difficile training and awareness will be delivered throughout the Trust, and included as part of international Infection prevention and control week. This will include C.difficile training sessions as part of the infection and control study day, C.diffile trolley dash on the wards, decontamination training and a C.difficile display board in the Kitchen restaurant. We also have planned hand hygiene training during C.difficile ward rounds, drop in sessions in PMOK, audit of personal protective technique (PPE). There is a continued focus on power training on the wards which had the 9 cases of C.difficile.

Following divisional sign-off of CDI RCAs, a selected number of CDI cases are sent to Herts Valley CCG for appeal. The divisions have been reminded to complete their action plans with evidence and submit them to the IPCT. The IPC audit programme continues to ensure both the environment and equipment are clean and safe for patients to use.

MRSA bacteraemia (MRSAb)

The full year target for MRSAb is 0 avoidable cases. The trust is no longer under national trajectory monitoring due to on-going good performance. There were no MRSAb case in September. General areas of focus relating to MRSA compliance include effective screening of all patients on admission including wounds and invasive lines, blood culture on admission for patients who meet the sepsis screening criteria and commencing the appropriate antibiotic for patients with known or suspected MRSA infection. This is embedded at face to face infection prevention and control training sessions.

E. Coli bacteraemia (E colib)

There were 2 cases of post 48hrs (trust apportioned cases) and 22 cases of pre-48 hour (non-trust cases) E.coli reported in September. The number of post-48 hour trust cases year to date is 16. The CCG's target is to have 50% reduction by 2021 and there is no target for WHHT. The E.coli action plan is included in the IPC overarching improvement programme and includes data collection and review, RCA completion, addressing risk factors, to dip or not to dip, review of the need for a catheter restriction programme and display of E.coli figures on the ward IPC board.

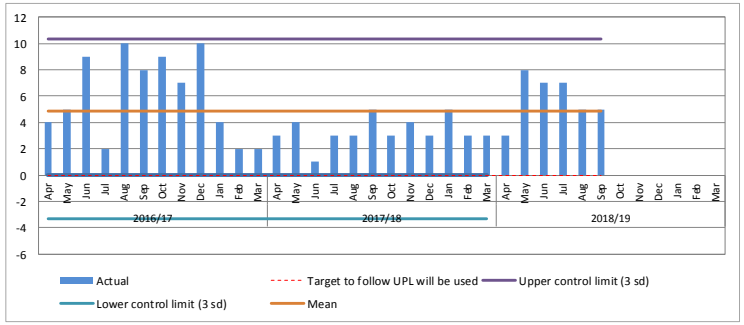
Methicillin-sensitive Staphylococcus aureus (MSSAb)

There were 2 post-48 hour (trust apportioned cases) and 3 pre 48 hour (non-trust cases) cases of MSSAb reported in September. The number of post-48hr trust cases year to date is 12. Each case is reviewed by a microbiologist using an RCA tool to identify and share learning. The rate of MSSAb cases has been reviewed with Herts Valley CCG, the majority of which are non-trust apportioned and risk factors are mainly associated with intravenous (IV) devices. The possibility of screening specific patient groups for MSSAb to ensure more informed and timely management is under review. There will be continued focus on line care to ensure compliance.

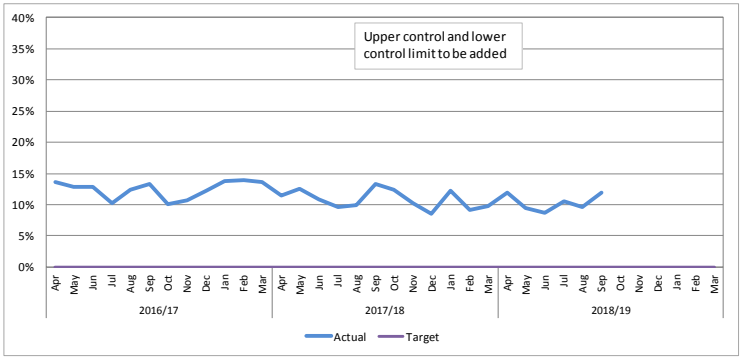
IPC Progress Update

During October the Carbapenemase Producing Enterobacteriaceae (CPE) campaign will be launched in the Trust as part of IPC week, where the IPCT is leading on awareness and management of CPE. Staff are reminded at the operational bed meetings and at ward levels around the need to complete the IPC risk assessment on admission to screen and isolate the relevant CPE positive patients. CPE awareness resources have been distributed during September Trust-wide hand hygiene compliance for September was 99%, and at ward level staff are reminded of the need for compliance with bare below the elbow (BBE). The IPC Code of Practice (CoP) audits continue and action plans completed to ensure improvement. Infection prevention and control training compliance is 84% for clinical staff and 91% for non-clinical staff in September. This is an improvement on the previous month. Sessions are provided by IPC team and staff are encouraged to undertake online sessions.

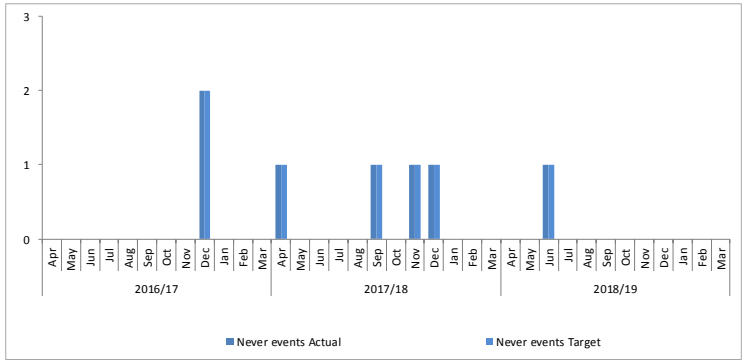
Serious incidents



% of reported patient safety incidents that are harmful



Never events*



At the end of September 2018 the Trust had 52 open SIs, of which 37 had been completed and were with commissioners pending formal closure on StEIS. There were 15 ongoing SI investigations.

Division	Number
Women's and Children's	1
Surgery, Cancer & Anaesthetics	1
Emergency Medicine	1

Learning from Serious Incidents

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. There was 1, 45-day meeting in September 2018. 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 Deputy Medical Director, reviews all SI action plans where senior divisional representation provides assurance and evidence that actions have been implemented before the SI is formally closed internally. The last SIRG meeting took place in July 2018. Six action plans were reviewed and four 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 two action plans were closed in the SIRG action log – these are action plans which had been discussed at SIRG before but not closed at the time due to outstanding evidence. The next SIRG meeting is scheduled to take place on 3 October 2018.

% of patient safety incidents which are harmful

11.9% of incidents reported in September 2018 were recorded as having caused harm to the patient; the previous month the level of harm was 9.7%. 27 incidents were reported with a level of harm moderate or above during September. 19 of these incidents are still awaiting harm validation. Two incidents were reported with a harm level of Death/Catastrophic in September, 3 less than in August.

Never event

There were no never events recorded in September 2018.

Safe, effective, caring

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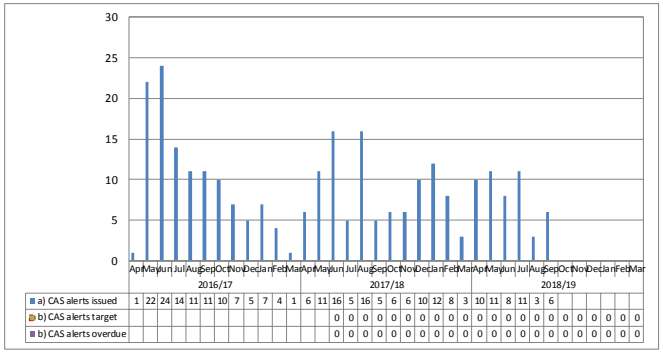
West Hertfordshire Hospitals NHS Trust

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)



CAS Status September 2018

Issued by CAS	**3**
Breached in month	0
Currently overdue	0
CAS alerts not acknowledged within 28 hours	0

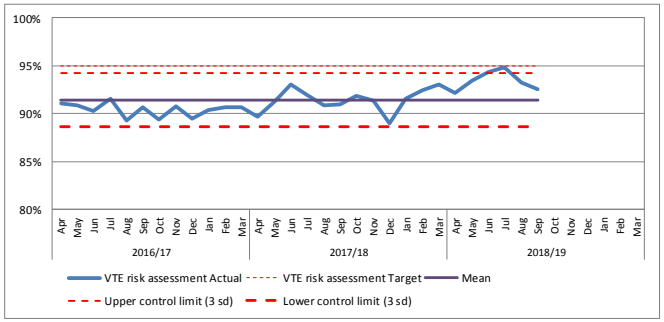
All alerts issued by CAS in September 2018 were acknowledged within the 48hr deadline.
6 alerts were issued in September 2018:
4 Medical Device Alerts
1 Estate & Facilities Alert
1 Supply Disruption Alert

The 4 Medical Device alerts were circulated and are awaiting confirmation of whether they are applicable to the trust.

The Environment division is assessing the Estates and Facilities alert to ascertain whether actions are required.

The supply disruption alert has been circulated to all clinical areas as well as to Pharmacy to ensure all appropriate staff are made aware.

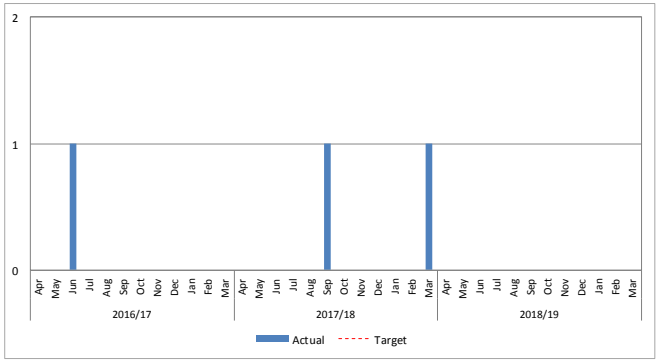
VTE risk assessment*



Medication incidents causing serious harm
There were no medication incidents reported during September with a harm level of serious or above.

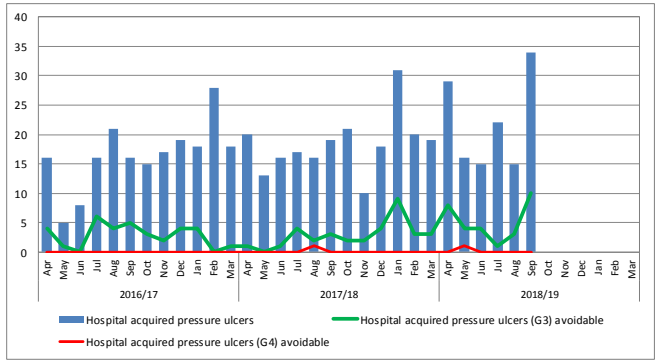
VTE
Further measures are being introduced to improve performance, with a pilot scheme to commence shortly in AAU which will involve having the VTE assessment attached to the prescription chart, which it is hoped will improve compliance.

Medication errors causing serious harm*

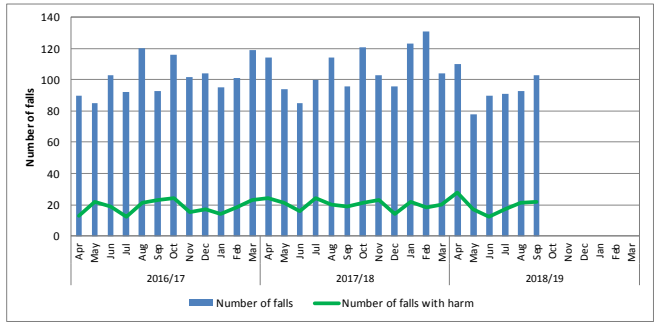


NHS West Hertfordshire Hospitals

Hospital acquired pressure ulcers



Falls and falls with harm



Hospital acquired pressure ulcers

37 new pressure ulcers were recorded, affecting 32 patients:

- 24 x category (grade) 2
- 10 x category 3
- 3 x category 1 (not shown in chart but is a barometer for deteriorating skin damage)

The category 3 pressure ulcers are subject to an RCA

The category 2 pressure ulcers are validated by the Matrons for the clinical areas

The themes from the Grade 3 PU are heels – the TVN Team with the clinical areas will be conducting a Heel campaign to raise awareness of preventative strategies.

Next Steps

1. Targeted training completed on Sarratt, Heronsgate/ Gade and AAUBY3 on the Best Shot care plan.
2. Harm Free Care team to further support Divisions and key clinical areas identified by the Quality Improvement Forum- sarratt and Heronsgate/ Gade
3. Bi-weekly harm free panels (Wed & Fri) incorporated within the SI panels to strengthen and drive improved analysis and learning.
4. Gap analysis against the Band 5 tissue viability competencies being undertaken on Sarratt and Heronsgate/Gade – to establish learning requirements.
5. Targeted education around Waterlow assessment and repositioning continues with Sarratt, Heronsgate/ Gade and AAUBY3

Falls and falls with harm

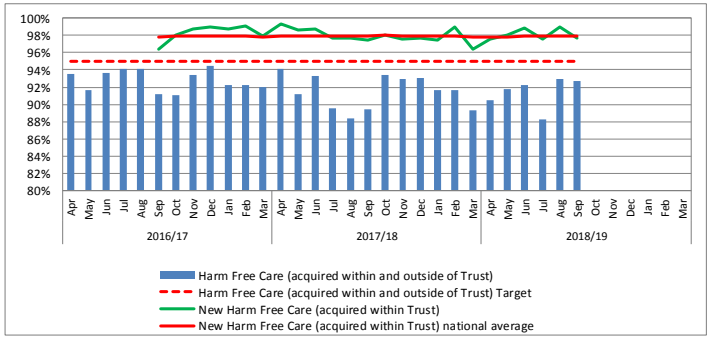
In September there were 102 inpatient falls, across 31 clinical areas, 30 resulting in harm. 29 were low harm, and 1 severe. Falls with harm remain low in comparison to the number of falls. September's total is an increase from August.

Next Steps

1. Deep dive in progress around September falls on Tudor and Flaunden
2. Fall Champions role being reviewed together with the Falls CNS and the Manual handling team
3. Continued joint working with Community teams, Falls Frailty Stakeholders Group and the Herts Valley Partnership Working Group. Feedback is noted in the Falls Group meetings.
4. Falls resource folder for staff in development launch end of November
5. Trust NHSI Falls improvement work, collaborative completed results will be shared across the organisation and rolled out to other clinical areas within medicine.
6. NHSI Falls collaborative to be presented to Medicine Governance meeting date to be agreed.
7. Falls taken to SI panels and Quality Improvement forums for discussion and learning.
8. Harm Free education undertaken on preceptorship programme.

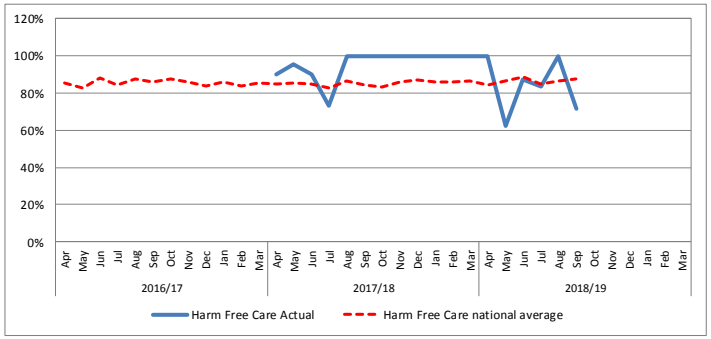
NHS West Hertfordshire Hospitals

Adult Safety Thermometer: Harm Free Care and New Harms



Indicator	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18
Number of patients with two harms	-	-	-	-	-	-	1	1	-	1	1	2	1
New pressure ulcers	5	8	6	5	6	4	11	9	5	2	7	3	11
Old pressure ulcers	50	25	26	25	30	35	41	40	34	36	51	33	30
Number of falls	14	10	12	13	8	16	7	5	6	8	6	6	8
Number of falls with harm	4	1	-	3	1	1	3	2	2	3	2	1	2
Catheters	99	110	107	80	85	86	92	88	111	102	102	82	97
Catheter & New UTI	3	-	2	2	1	-	2	1	1	2	1	-	1
New VTE	4	2	7	3	5	1	5	-	3	-	4	2	1

Children's Safety Thermometer: Harm Free Care



NB. Indicator reported at WHHT from April 2017

Adult Safety Thermometer

The Adult Safety Thermometer focuses on four commonly occurring harms in healthcare: pressure ulcers, falls, UTI in patients with a catheter and VTEs. This is a point prevalence survey with a national target of 95%.

New Harm Free Care acquired in the Trust for September 2018 was 97.7%.

In September one patient received 2 harms which was a low harm fall and a hospital acquired cat 2 pressure ulcer., 11 new pressure ulcers were reported.

8 Falls have been reported. Falls with harm increased to 2 (low harm) There was 1 new VTE and 1 new UTI in a patient with a catheter.

Next Steps

1. Triangulation of information relating to Harm Free Care , staffing fill rates, sickness , turnover and patient acuity is being analysed to understand increase in pressure ulcers and falls.
2. In November we will add E.coli data into the ward scorecard to enable scrutiny and focus.
3. Skin Champion Study day took place 12th October 2018 with good attendance
4. NHSI Falls collaborative improvement work to be rolled out to other medical areas mid November
6. Teaching for staff to commence regarding new NHSI Pressure Ulcer Measurement & Definitions, 1st November
7. Working group formed to drive actions and an implementation program relating to the NHSI Pressure Ulcer Measurement & Definitions.
8. Harm Free Care conference planned for November 13th full day 2018
9. Continued Education of Band 6 staff comprising of Safety Thermometer , Test Your Care , accountability and national care standards.
10. All falls and Pressure ulcers are taken to the SI panel for discussion – learning to be taken back to the Pressure Ulcer Review Group and The Falls Group.
11. Divisions continue to concentrate on the learning from Pressure Ulcers and Falls to enable a drive and focus on improvement.

To note: Data is also captured within the safety thermometer survey for harms acquired both inside and outside of the Trust. September performance, at 92.7% is below the national average (94.2%).

Children and Young People's Services Safety Thermometer

The Children and Young People's Services Safety Thermometer focuses on patient observations (PEWS completed) that are triggered but not escalated, extravasation (leakage of a fluid out of its container), patients in pain at the time of survey and any pressure ulcer or any moisture lesion. Harm free care was 71.4% in September for Acute Children's Services compared to the national average of 87.7% in August. This related to 3/14 patients with pain at the point of the survey. All patients concerned were on regular analgesics and reviewed for analgesia. The safety thermometer does not have a section for reassessment but analgesia was given with good effect. There was 1/14 patients who had an extravasation but VIP scoring and appropriate action was taken.

NHS West Hertfordshire Hospitals NHS Trust

Ward scorecard & Themes– based on the adult inpatient scorecard

Analysis

Safety Alerts: An increase in the number of alerts in September at 43 (August 40). Safety alerts are mainly due to the number of falls, falls with harms and pressure ulcers. The areas with high numbers of falls are Tudor (14), Flaunden (8) , CCUPG3 and Heronsgate/ Gade (7).Areas with high falls with harm are Tudor, CCUPG3 and Langley (3) . Areas with the highest Pressure Ulcers for September are AAUBY3 (7) Sarratt (6) DLM and Ridge (5).

September has seen a rise in pressure ulcers across the clinical areas – 22 pressure ulcers have occurred on heels, sacrum and buttocks , high pressure loading areas suggesting prolonged positioning. Analysis of previous years data has seen a seasonal increase in Pressure ulcers over the summer months July, August September. Initial analysis of Octobers data has seen an improvement.

Process Alerts: An increase in the number of alerts in September at 85 (August 82). The majority of process alerts are due to the percentage of supervisory filled hours and low FFT response rates. There appears to be a direct link between process – risk assessment and care planning, with an increase in safety outcomes such as pressure ulcers.

Summary:

- Paediatrics – no Safety alerts
- Maternity – no Safety alerts
- Thirteen clinical areas are demonstrating a higher trend of alerts in September

Next Steps

1. Increased ward based training with focus on understanding and completion of Pressure ulcer risk assessments- Band 5 recruited undertaking ward based and 1:1 training on Sarratt, Heronsgate AAUBY3
2. Education on heel protection and offloading equipment with Sarratt, Heronsgate AAUBY3
3. Additional Mirrors ordered to aid heel inspection- all nursing staff to be given a mirror within the identified wards above.
4. Tissue Viability team have undertaken a heel protection resource audit across all in patient areas – to address any equipment issues- findings include all wards have some form of heel protection equipment.
5. Tissue Viability completing observational walk rounds with senior ward staff identifying best practice and areas of improvement- Croxley ward completed ,Sarratt ward in November.
6. Focus on education- Skin Champion Day held October 12th 2018- Good attendance and the Champions tasked with taking the learning back to their clinical areas.
7. Skin Champions with the Tissue Viability team are devising a heel awareness campaign to commence November
8. To maintain focus we have organised a Trust day of continued awareness to coincide with the World Stop the Pressure day November 15th
9. Task and finish group assembled with clear plan around the new NHSI guidance – planned teaching drop in sessions for staff 1st November.
10. Continue Harm Free Care promotion using newsletters, Mr B Harmfree etc – key messages, trolley dashes and use of simulation.
11. Harm Free Conference (full day) organised for 13th November 2018 for all staff
12. Trust has completed the NHSI Falls Collaborative involving AAUBY3 and Letchmore, the plan is to roll this out across other medical areas after analysis mid November
13. Deep dive into areas with high falls – to establish root causes

Evaluation

- For September the clinical areas are demonstrating a rise in both the safety and process measures with a rise in pressure ulcers and falls, Harm Free Care team supporting clinical areas with improvements.
- Continued focus is required regarding the completion of the patient experience questions being undertaken monthly by the clinical areas.

West Hertfordshire Hospitals NHS Trust

Ward Scorecard September 2018

Alert Trigger Point		<90%	<90%	<90%	<90%	>0	>4	>0	<90%	<90%	>0	>0	<90%	<54%	>0	>1	<90%	<95%	n/a	Number of Alerts	
Number of Alerts	Process	9 / 25	1 / 30	9 / 32	8 / 29				9 / 26	3 / 26				16 / 27		1 / 29	23 / 29	6 / 29	n/a		
	Safety					14 / 30	6 / 26	14 / 26			0 / 26	3 / 26	6 / 28		0 / 29						
Division	Ward	Patient Experience	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	Hospital acquired MRSA isolate	% Extremely Likely>90	FFT Response >54%	Red Flag Number of shifts less than 2 RN's on shift	Red Flag Number of shifts more than 8 hours less than planned	% of Supervisory filled Hours	Overall Fill Rate	Care hours per patient	Safety	Process
Emergency Medicine	AAU B1	✓ 98%	✓ 100%	✓ 91%	✗ 67%	✓ 0	✓ 0	✓ 0	✗ 70%	✓ 100%	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	! 76%	✓ 97%	8.35	0	3
	AAU G1	! 90%	✓ 100%	✓ 99%	✓ 100%	✓ 0	! 1	✓ 0	✗ 70%	✗ 0%	✓ 0	✓ 0	✓ 100%	✗ 2%	✓ 0	✓ 0	✗ 52%	✓ 98%	8.23	0	5
	AAU P1	✓ 100%	✓ 100%	✓ 95%	✓ 100%	✓ 0	✗ 5	✗ 2	✗ 70%	✓ 95%	✓ 0	✓ 0	✓ 100%	✗ 16%	✓ 0	✓ 0	✗ 52%	! 94%	7.93	2	4
	AAU Y1	✓ 100%	✓ 100%	✓ 96%	✓ 100%	✗ 1	! 4	✓ 0	✗ 70%	✗ 0%	✓ 0	✓ 0	! 80%	✗ 8%	✓ 0	✓ 0	✓ 100%	✓ 99%	8.00	2	3
Medicine	AAU B/Y 3	Not Done	✓ 91%	✓ 94%	✓ 92%	✗ 7	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 97%	✓ 70%	✓ 0	✓ 0	! 76%	✓ 113%	9.04	2	1
	Frailty	✓ 100%	✓ 95%	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✗ 0%	✓ 100%	✓ 0	✓ 0	✓ 100%	! 57%	NA	NA	NA	NA	NA	0	1
	CCU/ P/G 3	Not Done	✓ 99%	✓ 98%	✓ 100%	✓ 0	✗ 7	✗ 3	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	! 57%	✓ 0	✓ 0	✗ 67%	✓ 113%	8.28	2	1
	Aldenham	Not Done	✓ 98%	✓ 97%	✓ 93%	✗ 1	! 2	✓ 0	✓ 100%	✓ 96%	✓ 0	✓ 0	✓ 96%	✓ 84%	✓ 0	✓ 0	✗ 71%	! 94%	6.26	1	2
	Bluebell	✓ 99%	✓ 94%	! 79%	✗ 68%	✓ 0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✗ 1	✓ 100%	✗ 22%	✓ 0	✓ 0	✗ 41%	✓ 96%	11.53	2	4
	Cassio	Not Done	✓ 100%	! 88%	✗ 71%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 93%	✓ 100%	✓ 0	✓ 0	✗ 24%	✓ 115%	6.47	0	3
	Croxley	Not Done	✓ 100%	! 86%	! 85%	✓ 0	! 2	✗ 2	✓ 100%	✓ 97%	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✗ 57%	✓ 122%	7.84	1	3
	Heronsgate & Gade	! 85%	✓ 95%	✗ 72%	! 80%	✗ 1	✗ 7	✗ 1	✓ 100%	✓ 95%	✓ 0	✓ 0	✓ 97%	✗ 37%	✓ 0	✓ 0	! 86%	✓ 106%	6.45	3	5
	Oxhey	✓ 96%	✓ 100%	✓ 94%	✓ 94%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 27%	✓ 0	✓ 0	✗ 57%	✓ 110%	7.38	0	2
	Red	! 75%	✓ 96%	✓ 100%	✓ 100%	✓ 0	! 1	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 93%	✓ 84%	✓ 0	✓ 0	✗ 48%	✓ 102%	6.43	1	2
	Sarratt	! 76%	✓ 97%	! 86%	! 85%	✗ 6	! 4	✗ 1	✗ 71%	✓ 100%	✓ 0	✓ 0	! 88%	✓ 111%	✓ 0	✓ 0	✗ 47%	✓ 124%	8.57	3	5
	Stroke	! 89%	✓ 97%	✓ 91%	✓ 100%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 32%	✓ 0	✗ 2	! 81%	✓ 111%	8.82	0	4
	Tudor	! 78%	✓ 95%	✓ 92%	! 89%	✗ 2	✗ 14	✗ 3	✓ 100%	✗ 0%	✓ 0	✓ 0	✓ 100%	✗ 3%	✓ 0	✓ 0	! 77%	✓ 106%	11.23	3	5
	Winyard	✓ 98%	✓ 94%	! 83%	✗ 73%	✗ 3	! 2	✗ 2	! 83%	✓ 100%	✓ 0	✓ 0	! 84%	✓ 76%	✓ 0	✓ 0	✗ 59%	✓ 131%	8.00	3	4
Surgery	Cleves	✓ 94%	✓ 97%	✓ 97%	✓ 94%	✗ 1	! 1	✓ 0	✓ 100%	✓ 90%	✓ 0	✗ 1	✓ 99%	✓ 65%	✓ 0	✓ 0	! 84%	✓ 107%	7.03	2	1
	DLM	✓ 100%	✓ 97%	✓ 99%	✓ 100%	✗ 5	! 3	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 47%	✓ 0	✓ 0	✓ 100%	✗ 71%	8.17	2	2
	Flaunden	! 79%	✓ 93%	✓ 91%	✓ 94%	✗ 1	✗ 8	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 86%	✓ 65%	✓ 0	✓ 0	✓ 95%	✓ 96%	6.08	4	1
	ICU	✓ 98%	✓ 97%	✓ 98%	✓ 100%	✗ 1	✓ 0	✓ 0	✗ 0%	✓ 100%	✓ 0	✗ 1	NA	NA	✓ 0	✓ 0	✓ 100%	✓ 102%	26.88	2	1
	Langley	! 78%	✓ 92%	✓ 100%	✓ 100%	✗ 1	! 4	✗ 3	✓ 100%	✓ 96%	✓ 0	✓ 0	! 85%	✓ 61%	✓ 0	✓ 0	! 79%	✓ 120%	6.78	3	2
	Letchmore	! 90%	! 90%	! 88%	✓ 92%	✗ 2	✗ 5	✗ 2	✗ 60%	✓ 90%	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✗ 47%	✓ 109%	6.73	3	5
	Ridge	✓ 93%	✓ 98%	✓ 98%	✓ 100%	✗ 5	! 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 94%	✗ 40%	✓ 0	✓ 0	! 90%	✓ 116%	7.54	1	2
	Elizabeth	✓ 91%	✓ 93%	✓ 98%	✓ 94%	✓ 0	! 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	✗ 24%	✓ 0	✓ 0	✗ 52%	✓ 126%	6.52	1	2
Paeds	SCBU	✓ 92%	✓ 94%	✓ 96%	✓ 100%	✓ 0	NA	NA	NA	NA	NA	NA	✓ 95%	✗ 36%	✓ 0	✓ 0	✓ 100%	✓ 116%	13.45	0	1
	Starfish	✓ 100%	✓ 100%	✓ 95%	✓ 100%	✓ 0	NA	NA	NA	NA	NA	NA	✓ 94%	✗ 19%	✓ 0	✓ 0	✓ 100%	! 92%	8.38	0	2
	CED	✓ 96%	✓ 100%	✓ 98%	NA	✓ 0	NA	NA	NA	NA	NA	NA	✓ 93%	✗ 3%	✓ 0	✓ 0	✗ 62%	NA	NA	0	2
	Safari	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 0	NA	NA	NA	NA	NA	NA	✓ 96%	✗ 25%	✓ 0	✓ 0	✗ 24%	NA	NA	0	2
Maternity	Delivery Suite	NA	NA	! 83%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 94%	✗ 43%	NA	NA	NA	! 94%	20.50	0	3
	Katherine	NA	NA	! 85%	NA	NA	NA	NA	NA	NA	NA	NA	✓ 92%	NA	NA	NA	NA	✗ 90%	4.75	0	2
Green		>=90	>=90	>=90	>=90	0	0	0	>=90	>=90	0	0	>=90	>=54	0	0	>=90	>=95	n/a		
Amber		80-89	80-89	80-89	80-89	n/a	1-4	n/a	80-89	80-89	n/a	n/a	80-89	50-53	1	n/a	75-89	90-94	n/a		
Red		<=79	<=79	<=79	<=79	>=1	>=5	>=1	<=79	<=79	>=1	>=1	<=79	<=49	>=2	>=1	<=74	<=89	n/a		

West Hertfordshire Hospitals NHS Trust

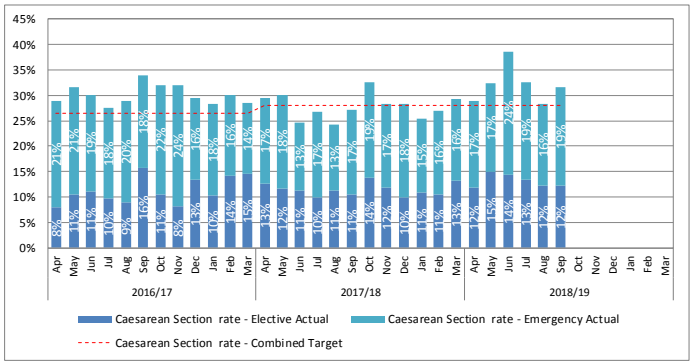
Ward Scorecard (Other/ Non Adult Inpatient) September 18

Alert Trigger Point		<90%	<90%	<95%	>8%	<95%	<95%	N/A	N/A	>0	<95%	>9%	<95%	<90%	<54%	Number of Alerts (WIP)	
				<92%													
Number of Alerts	Process	4 / 27	0 / 9	7 / 19	9 / 14	0 / 4	2 / 10	TBC	TBC	1 / 31	23 / 25	12 / 25	11 / 25		12 / 12		
	Safety													4 / 26			
Division	Ward	TYC Overall	Hand Hygiene Audit	Waiting Times (A&E/RTT)	DNAs	Cleaning Scores	COP Audit	Datix Incidents	Complaints	Datix SIs reported (TBC)	Mandatory Training	Vacancies	Appraisals	% Extremely Likely>90	FFT Response >54%	Safety	Process
Unscheduled Care	A&E	✓ 97%	✓ 100%	✗ 69.6%	NA	NA	✓ 97%	94	3	✗ 1	✗ 83%	✗ 29%	✗ 73%	✓ 96%	✗ 5%	0	6
	MIU	! 84%	NA	✓ 99.6%	NA	NA	NA	4	0	✓ 0	✗ 75%	✗ 12%	✗ 27%	✓ 93%	✗ 1%	0	5
	UCC	! 88%	NA	✓ 100.0%	NA	NA	NA	4	0	✓ 0	✗ 88%	✓ 8%	✗ 55%	! 89%	✗ 5%	1	4
Paeds	SCBU	✓ 96%	✓ 100%	NA	NA	! 98%	✓ 100%	51	0	✓ 0	! 93%	✓ 7%	✓ 96%	✓ 95%	✗ 36%	0	2
	Starfish	✓ 95%	✓ 100%	NA	NA	✓ 99%	✗ 94%	6	0	✓ 0	✗ 86%	✗ 11%	✓ 100%	✓ 94%	✗ 19%	0	4
	CED	✓ 98%	NA	NA	NA	✓ 99%	✓ 100%	15	1	✓ 0	✗ 89%	✗ 10%	✗ 78%	✓ 93%	✗ 3%	0	4
	Safari	✓ 100%	✓ 100%	NA	NA	✓ 99%	✓ 100%	2	0	✓ 0	! 93%	✗ 16%	✓ 100%	✓ 96%	✗ 25%	0	3
Maternity	Community	✗ 76%	NA	NA	NA	NA	NA	0	0	✓ 0	✗ 88%	✓ -4%	✓ 97%	✓ 100%	NA	0	2
clinical support	Radiology WGH	✓ 96%	✓ 100%	✓ 100%	✓ 5%	NA	NA	28	0	✓ 0	✗ 85%	✓ 9%	✓ 98%	✓ 93%	NA	0	1
	Radiology HHGH	✓ 99%	NA	✓ 100%	✓ 4%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 100%	NA	0	0
	Radiology SACH	✓ 96%	NA	✓ 100%	✓ 3%	NA	NA	0	0	✓ 0	✗ 87%	✗ 25%	✗ 0%	NA	NA	0	3
	Radiology AAU	NA	NA	NA	NA	NA	NA	0	0	✓ 0	NA	NA	NA	NA	NA	0	0
Medicine	Outpatient WGH	✓ 95%	✓ 100%	✗ 91%	✗ 10%	NA	✓ 100%	43	3	✓ 0	! 93%	✗ 13%	! 95%	✓ 93%	NA	0	5
	Outpatient HHGH	✓ 100%	✓ 100%	✓ 94%	✗ 9%	NA	✓ 100%	0	0	✓ 0	✗ 88%	✓ -5%	✓ 100%	✓ 91%	NA	0	2
	Outpatient SACH	✓ 100%	NA	✗ 91%	✗ 9%	NA	✗ 91%	0	0	✓ 0	! 94%	✗ 11%	✓ 100%	✓ 90%	NA	0	5
	Endoscopy HHGH	✓ 96%	NA	✓ 97%	NA	NA	NA	0	0	✓ 0	! 93%	✓ -12%	✗ 85%	✓ 99%	✗ 33%	0	3
	Endoscopy WGH	✓ 96%	NA	✗ 92%	NA	NA	NA	4	0	✓ 0	! 95%	✗ 15%	✓ 97%	✓ 96%	✗ 37%	0	4
	Cath lab WGH	✓ 100%	✓ 100%	NA	NA	NA	NA	11	0	✓ 0	✗ 70%	✗ 81%	✗ 0%	✓ 100%	✗ 27%	0	4
	Dermatology WGH	✓ 100%	NA	✓ 96%	✗ 12%	NA	NA	0	0	✓ 0	✗ 87%	✓ 6%	✓ 96%	✓ 93%	NA	0	2
	Dermatology SACH	NA	NA	✓ 97%	✗ 9%	NA	NA	0	0	✓ 0	NA	NA	NA	! 87%	NA	1	1
	Dermatology HHGH	✓ 100%	NA	✓ 95%	✗ 8%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 94%	NA	0	1
	Helen Donald WGH	✓ 98%	NA	NA	NA	NA	NA	0	0	✓ 0	✗ 70%	✓ 2%	✓ 100%	✓ 100%	✗ 3%	0	2
Surgery	Day surgery SACH	NA	✓ 100%	NA	NA	NA	NA	40	0	✓ 0	✓ 95%	✓ 8%	✓ 100%	✓ 98%	✗ 44%	0	1
	Opthalmology WGH	✓ 100%	NA	✓ 92%	✗ 10%	NA	NA	0	0	✓ 0	✗ 88%	✓ -1%	! 90%	✓ 100%	NA	0	3
	Pre Op WGH	✓ 100%	NA	✓ 96%	✗ 10%	NA	NA	2	0	✓ 0	✗ 63%	✓ 4%	✓ 100%	! 89%	NA	1	2
	Pre Op HHGH	NA	NA	✓ 100%	✓ 7%	NA	NA	0	0	✓ 0	✓ 99%	✓ -16%	✓ 95%	✓ 100%	NA	0	0
	Pre Op SACH	✓ 94%	NA	✗ 75%	✓ 6%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 94%	NA	0	1
	Theatres WGH	✓ 93%	NA	NA	NA	NA	✓ 100%	21	0	✓ 0	✗ 85%	✗ 25%	✗ 80%	NA	NA	0	3
	Theatres SACH	✓ 93%	NA	NA	NA	NA	✓ 96%	0	0	✓ 0	✗ 89%	✗ 27%	! 91%	NA	NA	0	3
	Theatres Delivery WGH	! 85%	NA	NA	NA	NA	NA	9	0	✓ 0	NA	NA	NA	NA	NA	0	1
	Pre Op WGH	✓ 100%	NA	✓ 96%	✗ 10%	NA	NA	2	0	✓ 0	✗ 63%	✓ 4%	✓ 100%	! 89%	NA	1	2
Green		>=90	>=90	>=95	<=8	>=95	>=95			0	>=95	<=9	>=95	>=90	>=54		
Amber		80-89	80-89	85-94	TBC	85-94	85-94	TBC	TBC		85-94	TBC	85-94	80-89	50-53		
Red		<=79	<=79	<=84	>8	<=84	<=84			>0	<=84	>9	<=84	<=79	<=49		

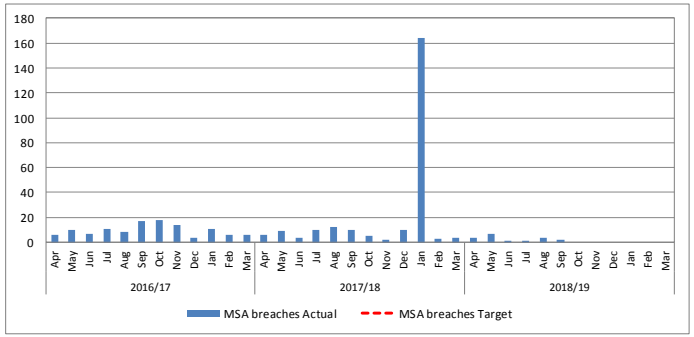
NHS West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS Trust

C-section rate



Mixed sex accommodation



C-section rate

The recent audit of 150 emergency LSCS performed May - July showed that 89.4% (n=134) were necessary with a further 6% (n=10) avoidable. Following this two key work streams were identified:

- To expand CTG training to include interactive, human factors training to increase situational awareness at monthly PROMPT training day.
- To provide training and support on the effective use of drugs which induce labour.

These will be the key areas that the Division will concentrate on over the next couple of months.

Additional key enablers to progress the ongoing work stream are the updating of the Caesarean Section guideline, due in October 2018 and the Normal Birth Strategy which will include Better Births (2015) the national maternity strategy.

Mixed sex accommodation (MSA)

There were two breaches reported in September.

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, 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.

A thematic review of the breaches in ITU has been completed and the MSA Policy is under review with the addition of SOP's being included.

Next Steps

- Continued focus within operational management meetings
- Working with Deputy Chief Nurse for HVCCG
- Site visits to monitor and review progress

Responsive

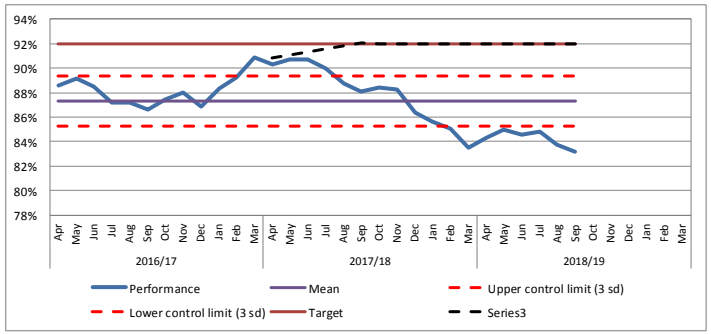
Reporting sub committee - TEC

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

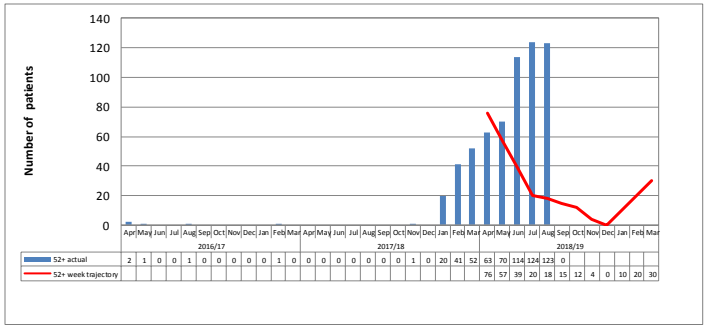
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Divisional Managers

West Hertfordshire Hospitals NHS Trust

Incomplete pathways within 18 weeks



Long waiters (52 weeks+)



Reporting specialty	Number of 52+ week waiters September
General Surgery	48
Orthopaedic Surgery	40
Urology	10
Spinal Surgery Service	1
Colorectal Surgery	4
Ophthalmology	2
Ear Nose And Throat	4
Vascular Surgery	2
Total	**111**

RTT

There was a slight deterioration in the incomplete pathways within 18 weeks, decreasing to 83.2%. The most recent national data available (August) shows that WHHT performance that month was below the national average (87.2%). Performance at L&D (91.1%) and RFH (78.0%) was also below the national standard of 92%.

The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was worse than the national position (8.0 vs 7.6 weeks) and worse than the 92nd percentile wait time (25.7 vs 22.1 weeks).

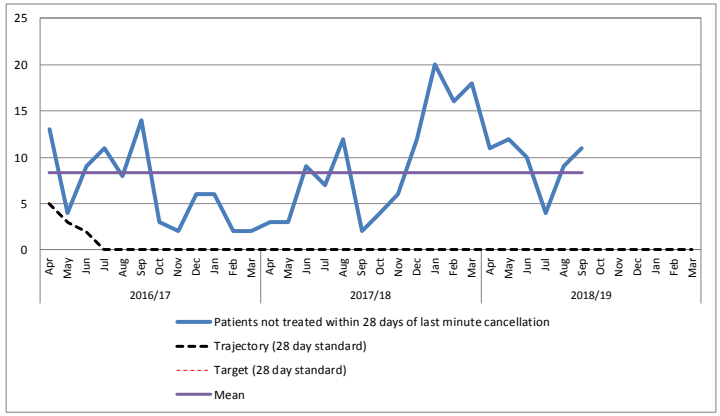
There has been a reduction in the number of 52 week breaches, 111 at month end (from 124 the previous month). Of these, 78% have a date for admission. 48% of these breaches are in General Surgery and 36% are in Orthopaedics. 57 x 52 week wait patients were treated in month and 45 patients tipped in to this category, an improvement on August when 57 patients entered this category. The majority of 52 week breaches are WGH only cases which limits the options for improvement, as the challenge of increasing elective capacity on the acute site has to be balanced with maintaining non-elective patient flow and ED performance.

Service	18 Weeks Plus	% Under 18 Weeks
GENERAL MEDICINE	0	100.00%
ANAESTHETICS	0	100.00%
PAED CLINICAL HAEMATOLOGY	0	100.00%
PAED CYSTIC FIBROSIS	0	100.00%
STROKE MEDICINE	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
CLINICAL NEUROPHYSIOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
WELL BABIES	0	100.00%
OBSTETRICS	0	100.00%
GYNAECOLOGICAL ONCOLOGY	0	100.00%
ORTHOPTICS	0	100.00%
OTHER	3	99.10%
ENDOCRINOLOGY	9	97.55%
PAED CARDIOLOGY	3	97.52%
BREAST SURGERY	9	97.40%
GERIATRIC MEDICINE	3	97.35%
CLINICAL HAEMATOLOGY	8	97.08%
PAED DERMATOLOGY	2	96.77%
ORTHOTICS	4	96.75%
GYNAECOLOGY	25	96.47%
CLINICAL ONCOLOGY	1	96.43%
PAED OPHTHALMOLOGY	8	96.04%
DERMATOLOGY	102	95.99%
GASTROENTEROLOGY	77	94.93%

Service	18 Weeks Plus	% Under 18 Weeks
HEPATOLOGY	2	94.74%
NEPHROLOGY	4	94.52%
RESPIRATORY MEDICINE	34	94.50%
RHEUMATOLOGY	28	94.26%
CARDIOLOGY	87	93.56%
DIABETIC MEDICINE	4	92.86%
PAED GASTROENTEROLOGY	7	92.39%
PAEDIATRICS	45	92.09%
PAED UROLOGY	13	91.67%
NEUROLOGY	97	89.81%
UPPER GI SURGERY	7	88.52%
PAED ENDOCRINOLOGY	7	87.27%
COLORECTAL SURGERY	47	86.69%
PAED EPILEPSY	7	85.11%
ENT	578	77.22%
ORAL SURGERY	222	76.97%
UROLOGY	359	76.29%
ORTHODONTICS	31	75.20%
VASCULAR SURGERY	30	74.36%
TRAUMA & ORTHOPAEDICS	682	73.32%
GENERAL SURGERY	555	73.19%
OPHTHALMOLOGY	725	70.10%
PAIN MANAGEMENT	352	53.50%
CRITICAL CARE MEDICINE	4	33.33%
Total	**4181**	**83.20%**

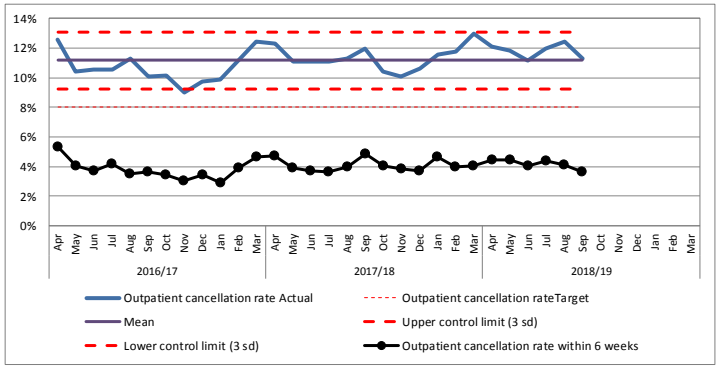
West Hertfordshire Hospitals NHS Trust

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

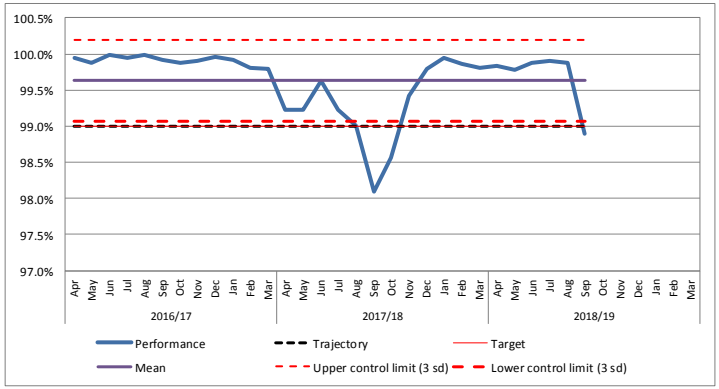


Hospital outpatient cancellations all and % cancelled* within 6 weeks

*Excluding 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



Diagnostics



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

There has been an increase to 11 breaches of the 28 day rebooking standard this month:

- 2 General Surgery – 1 due to priority of an emergency and 1 because the new date offered was not within 28 days
- 5 Orthopaedic – 1 because equipment was not available and 4 because the new date offered was not within 28 days
- 2 Urology – 1 prioritisation of emergency and 1 cancelled for a second time due to theatre estate/infrastructure issues
- 1 Gynaecology – new date offered was not within 28 days
- 1 Oral Surgery – new date offered was within 28 days but the patient declined. This is still a breach because less than 3 weeks' notice of the new date was given.

Hospital cancellations – patients cancelled within 6 weeks and overall

Short notice, hospital initiated cancellation remains below the Trust tolerance (5%) at 3.7% (excluding valid cancellations and patient initiated cancellations) and is lower than in previous months.

Total cancellations: 24.2%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
11.3%	3.7%	13.0%	9.9%

NB: Total cancellation rate does not equate to unfilled capacity as vacated appointment slots are often re-filled.

Diagnostic wait times

Performance against the 6 week waiting time standard is below standard at 98.9%. This is as a result of failure to follow established booking processes for DEXA scans.

Responsive

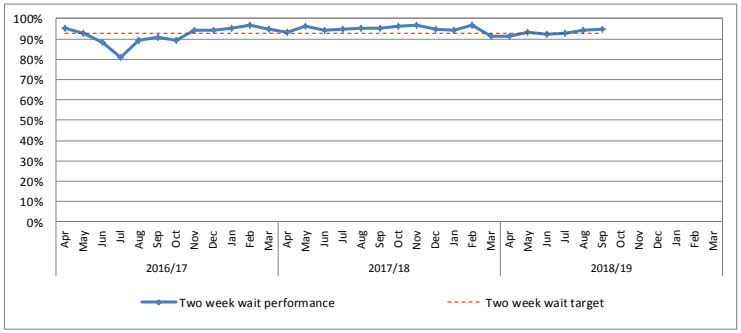
Reporting sub committee - TEC

CWTs

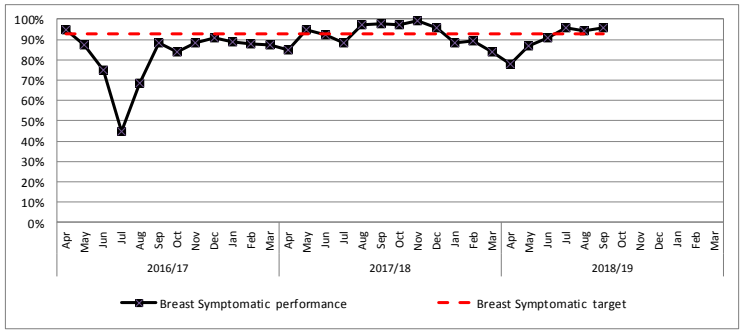
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Divisional managers

West Hertfordshire Hospitals NHS Trust

Two week standard



Breast symptom two week standard



2ww

The provisional position for September is compliant at 94.9%.

The majority of breaches are within skin with 29 of the 74 breaches. LGI had 22. Improved performance is noted in Gynae and breast .

There is still improvements to be made in LGI service as the TAS service requires further attention at the beginning of the pathway.

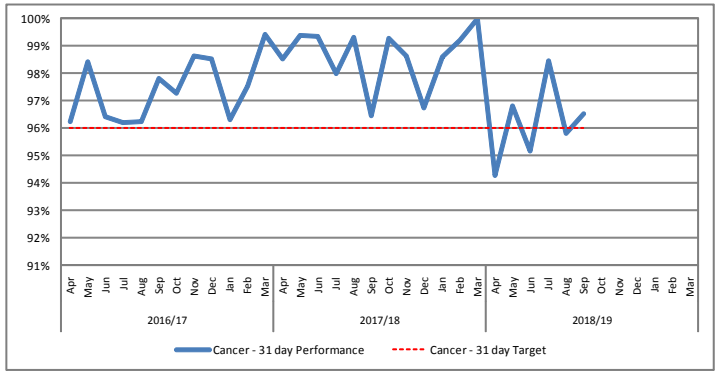
The skin service is reporting significantly higher referral rates which has been a theme for several months now. Work is being undertaken by the service to review capacity and demand.

Breast symptomatic

The provisional position for September is compliant at 95.7%.

Reducing appointment polling time and monitoring clinic capacity have been the main factors in sustaining improved performance.

31 day standard

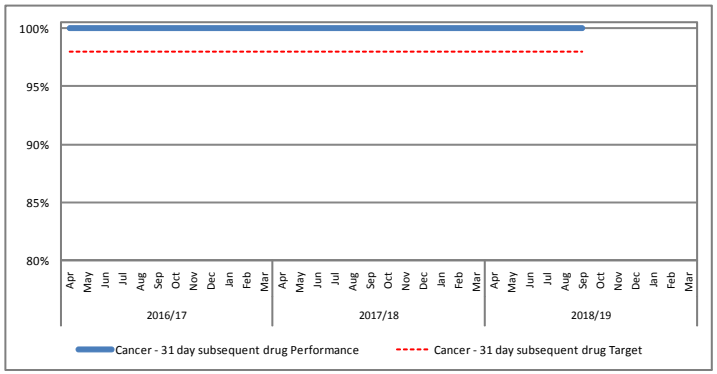


31 day first definitive treatment
The position is provisionally compliant at 96.5%
A total of 144 patients were treated and there were 5 breaches in total. Breast x 2, urology x 2 and skin x 1.

Validation is underway and breach reasons include poor escalation, clinical delays.

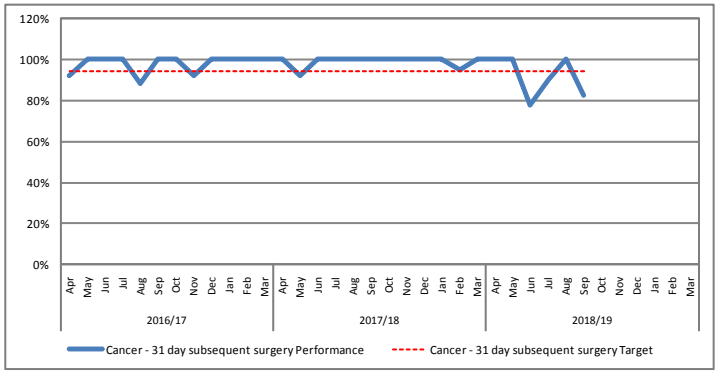
Escalations within urology had improved, but they are still sub-optimal. Further improvements have been made which should improve the position next month.

31 day subsequent drug standard



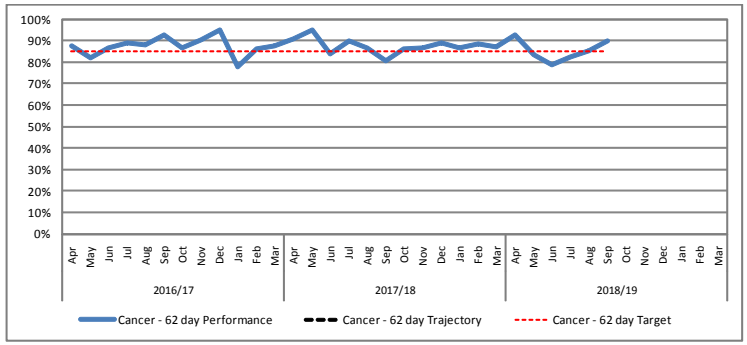
31 Day subsequent – Drug
The provisional position for September is compliant at 100%

31 day subsequent surgery standard

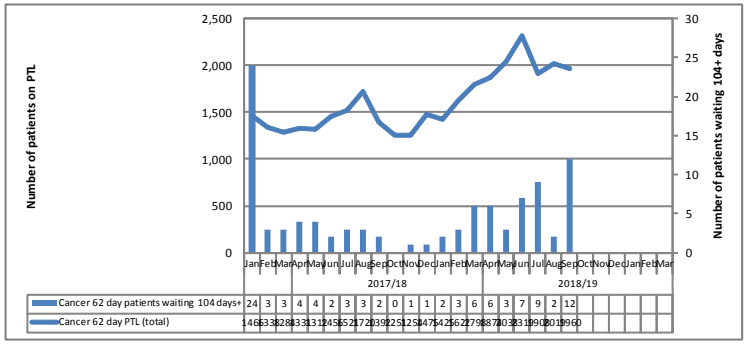


31 day subsequent – Surgery
The provisional position is currently non-compliant at 82.4%, with 17 treatments and 3 breaches (urology x 2 and UGI x1).

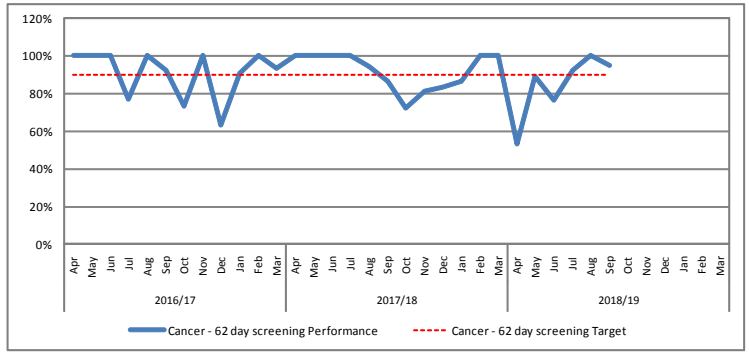
62 day standard



62 day standard number of 104+ day waiters



62 day screening standard



62 day GP – urgent
The provisional position for September is compliant at 89.8%.
Although the position is subject to change before submission on 31.10.18, it is expected to remain compliant.

Currently there are 68.5 treatments with 7 breaches (13 patients).

Urology tracking is improving and escalation processes have required further attention this month. Urology account for 6 of the 13 breaches, with lung x 1, skin x 1, LGI x 2, H&N x 1 and gynae x 2

Tumour site performance is as below:

Tumour type	July	August	September	Q2 (provisional)
Breast	95.9	85.7	100	94.6
Gynaecological	81.3	77.8	83.3	80.4
Haematological	69.2	100	100	81
Head and Neck	44.4	60	66.7	52.9
Lower Gastrointestinal	85.7	76.9	33.3	71.8
Lung	16.7	85.7	87.5	66.7
Other	0	0	100	66.7
Sarcoma	0	0	0	0
Skin	100	97.7	96.6	98.2
Upper Gastrointestinal	70	100	100	88
Urological	77.4	80.6	80.8	79.1
Testicular	100	100	0	100
Total	82.4	85.3	89.8	85.3

104 day waits
Open: There were 12 open >104 day pathways in September's submission .

Delay reasons include: complex pathways, >1 primary cancer, patients requiring discussion as different MDTs, administrative delays and patient cancelling diagnostics.

Closed: Provisionally, 7 x >104 day pathways were closed. These have not yet been validated.

62 day screening
Performance is provisionally compliant at 94.7%.

Responsive

Reporting sub committee - TEC

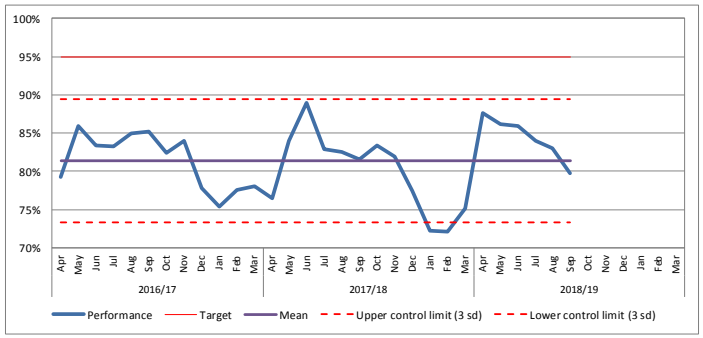
Emergency flow indicators - A&E, ambulance turnaround and DToC

Executive lead	Clinical lead	Operational lead
Sally Tucker	Dr Rachel Hoey	Divisional managers

Performance relative to targets/ thresholds		
	Achieving	Not achieving
Sep-18	1	4
Aug-18	1	4
Jul-18	1	4

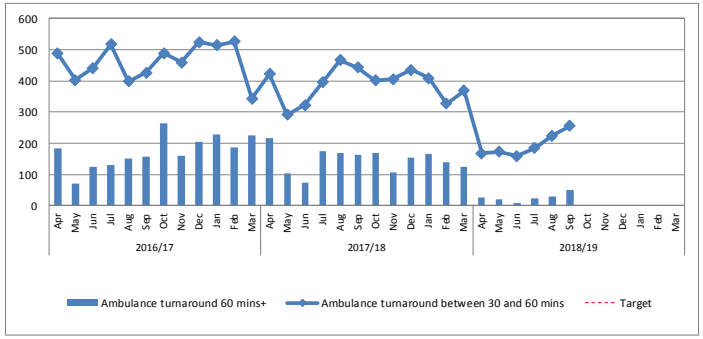
West Hertfordshire Hospitals NHS Trust

A&E



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

Ambulance turnaround time



A&E performance, at 79% was lower than in the previous month (83.%). Minors performance also deteriorated from 90.2% to 89%. Recruitment of Emergency Nurse Practitioners (ENPs) continues, in order to increase resilience in the Minors service across all sites. A new lead for minors at Watford is now in post. CED performance dropped from 95% to 89.2% .

The ED Performance Manager is now in post. This role will focus on performance and flow throughout ED and the post holder will work closely with the minors lead to drive performance improvement.

The Lead Nurse (EM) and Minors Lead have developed an action plan which will focus on the achievement of the 4 hour standard in Minors.

GP streaming is due to resume form 1st October, subject to shift fill.

The role of the senior site manager is to be re framed so that more focus and support is given to the ED team overnight and at weekends. Certain objectives will be linked to those of the ED Performance Manager.

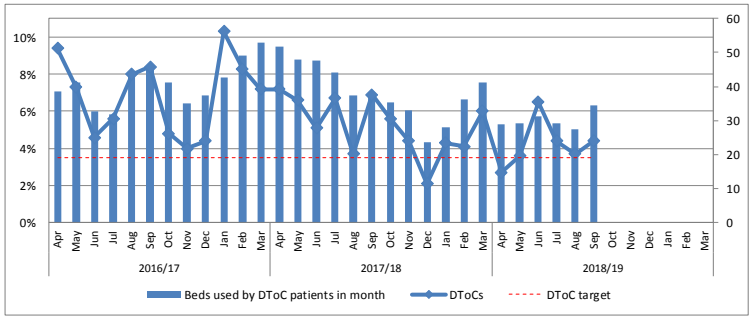
Work on pathways continues with a view to improving compliance with the 30 minute target for Internal Professional Standards (review of A&E patients by specialty teams). Streaming of patients is occurring much earlier in the patient pathway although activity is limited when assessment areas are used for bedded patients at times of peak pressure. Focus on ensuring full use of the Emergency Surgical Assessment Unit (ESAU), Medical Assessment Area (MAU), Ambulatory Care (ACU) and Frailty continues. Plans are being developed to re provide assessment services should they become bedded over winter.

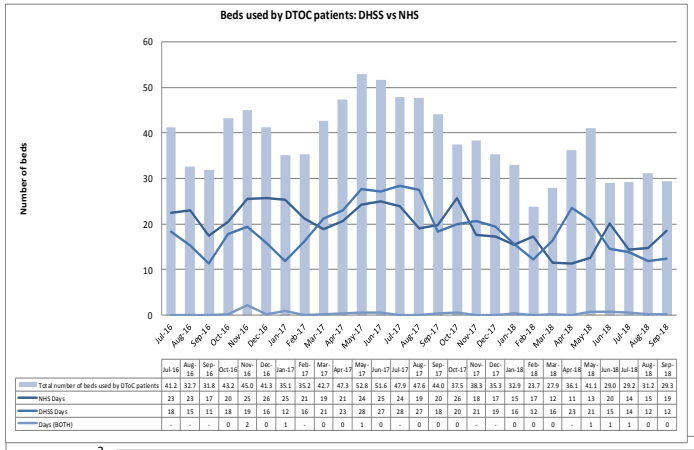
The ambulance response times project has continued to impact positively on hand over times and regular meetings with EEAST and new ways of working have been implemented.

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

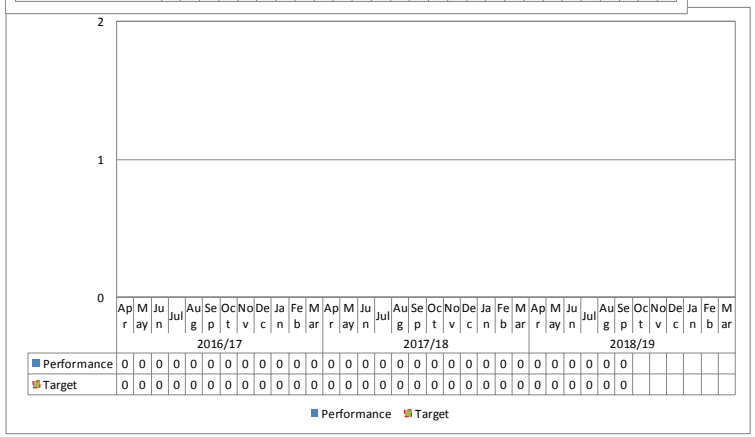
- Type 1 attendances are up by 5.2%.
- Ambulance arrivals down by 0.3%
- Admission rate from A&E (excluding ambulatory and frailty) is up by 0.1%.

Delayed Transfers of Care (DTOC)





12 hour trolley waits



Delayed Transfers of Care

DToC patients represented 4.4% of occupied beds in September, up from 3.7 % in August, 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 impact because it includes all patients waiting in the month. In September, DToC patients consumed 1033 bed days, the equivalent of 34.4 beds.

Weekly LOS MDT meetings continue, twice a week, with participation from therapies, IDT, surgery, clinicians and s CCG representative.

Good progress is being made on the longest LOS patients. Due to some exceptional work by the IDT team, especially the head of IDT, the two longest waiters have now been discharged meaning there are now no patients waiting over 100 days

Lack of capacity is the main reason for moving patients from hospital. Many patients are waiting for packages of care, dementia beds and Discharge Home to Assess capacity

Early identification of very complex patients has helped prevent them becoming 100 day + LOS

There is a national requirement to achieve a reduction of long stay patients by 25% by December, from a baseline of 133 patients, the target being 99 patients. This is a system wide requirement and the Trust is expected to achieve 50% of the overall reduction which equates to a target of 117 patients with a LOS of 21 days or more. The current position is in line with plan.

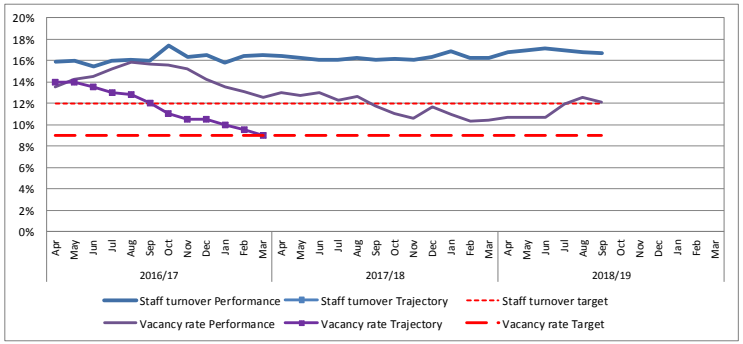
Well led

Reporting sub committee - PSE

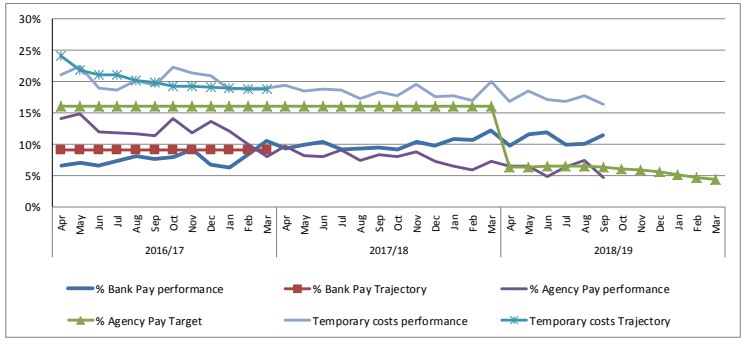
Workforce indicators - staff turnover, sickness, bank & agency, vacancy, appraisal, and mandatory training

Executive lead	Clinical lead	Operational lead
Paul da Gama		

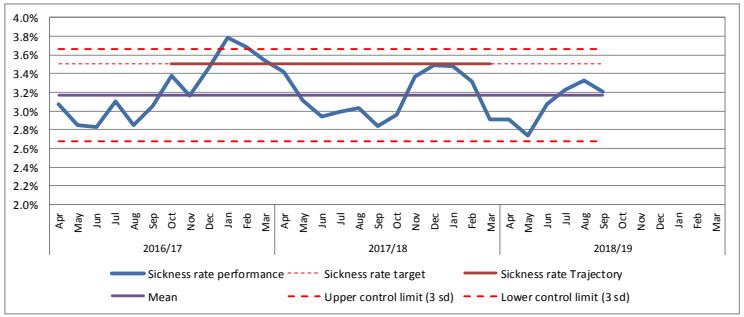
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate



Turnover and Vacancies

The number of staff in post increased slightly by 20wte to 4,354wte during September. The funded establishment remained constant although in the previous two months it increased by over 125 wte) due to approval of business cases for Emergency Medicine and Theatres.

As a result of the recent increase in establishment, vacancies increased from 515wte in July to 620wte in August although they decreased in September by 20wte to 600wte due to the increase in staff in post. This equates to 12.1% of establishment, up from 10.7% in July. Looking at longer term trends, the overall Trust vacancy rate fell from 13.0% to 10.4% over the 17/18 financial year.

Turnover based on a rolling 12-months, increased from 16.3% in March to 17.0% in July, but decreased to 16.7% in August and September. This is higher than the same period last year (16.0%). The 3 monthly turnover rates helps identify more immediate changes in trends. The rate is currently 16.6%,which indicates that turnover will maintain its current rate in the near future.

% Bank and Agency Expenditure

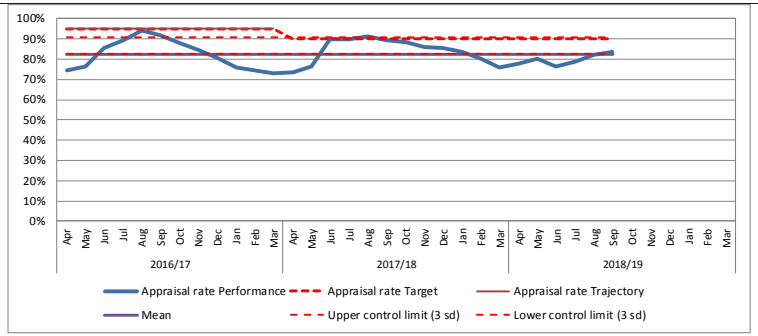
Agency spend as % of the pay-bill decreased from 8.7% in November 2017 to 7.3% in March 2018 and 4.7% in September. The internally-set target for 2018/19 is £14.0m with an NHSI cap of c£18m. Expenditure to date is £7.41m.

Bank expenditure is currently at 11.4% compared to a year ago when it was 9.5%, and reflects the investment in promoting bank working and the downward pressure on agency costs.

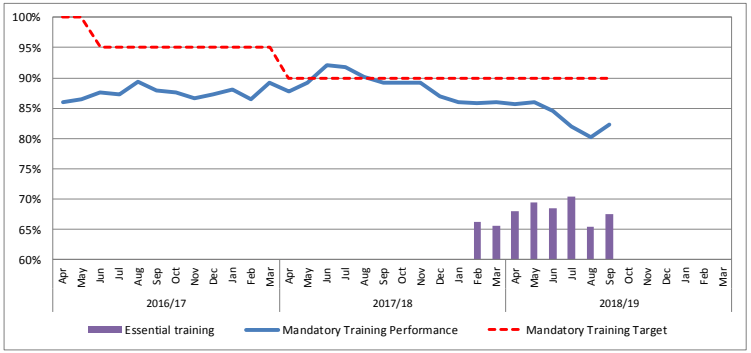
Sickness rate

Sickness absence is currently 3.2%. This is well below the Herts and Beds average (3.8% at end of Q1 18/19), and still below the target of 3.5%. Sickness management continues to be closely monitored by managers and the employee relations team. It should be noted that there are currently just under 500 live sickness absence cases being managed within the Trust. Over the last 2 years, sickness absence has fluctuated between 3.8% and 2.8%.

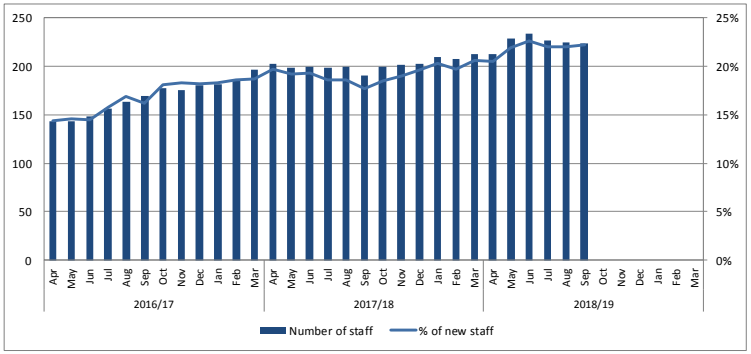
Appraisal rate (non medical staff only)



Mandatory training



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



Appraisal – non medical staff

The appraisal rate at the end of August was 84.3% compared with 73% at the beginning of the year. Divisional HR Business Partners are continuing to work closely with Divisions to improve appraisal rates. Going forward, there will be increasing attention on ensuring a link between appraisal and incremental progression. Historically the Trust has not included medical appraisal numbers in the headline rates.

At the end of Q1, the average for the Herts and Beds area (ten Trusts) was 82%. The Trust is ranked 10 out of 12 currently. 30% of staff who have had an appraisal have had this within 3 months of their incremental date.

Mandatory training

Mandatory training rate at the time of reporting was 82%. Releasing staff appears to be the challenge and to this extent a director-lead publicity campaign is now underway.

The new ACORN system is now working well in the production of accurate reports and data at both Trust and local levels and staff are completing their training on it.

Number of staff leaving within first year

The overall rate in September was 22.3% (22.0% last month) and continues to represent a challenge to retention following successful recruitment. A year ago the figure was 17.7%, and this has progressively increased since then. Divisional rates are over 20% for all apart from Surgery and Emergency Medicine where figures are 18% and 19% respectively.

HCAs represent the highest number and % by job role, with 60 / 26.2% of leavers leaving with under 1 year of service. Band 2 staff comprised 36.7% of all leavers with under a year's service, and Band 5 staff represented 20.1 % of all leavers. It should be noted that the Trust has taken significant steps to reduce the vacancy rate for this group of employees which now stands at 1.8%.

Reasons for leaving with the most growth are lack of opportunities, dismissals, work-life balance and relocation from the area.

Approximately two thirds of known leavers are to other NHS providers.

A Project Lead has been appointed to review and improve the on-boarding experience for new staff to help address this issue.

Workforce BAF scorecard

Workforce Indictors - Progress Table
Progress against target - Sep 2018

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	13.5%	11.8%	10.7%	12.1%	9.0%	3.1%	↗	34%
Band 5 Nurse Vacancy			16.0%	18.9%	9.0%	9.9%	↗	110%
Turnover	15.4%	16.0%	17.1%	16.7%	12.0%	4.7%	↘	39%
Band 5 Turnover			24.4%	21.7%	16.0%	5.7%	↘	36%
Total Sickness	3.8%	2.8%	3.1%	3.20%	3.5%	-0.3%	↗	-9%
Non-Medical Appraisal	82%	90.0%	77.0%	84.0%	90.0%	-6.0%	↗	7%
Medical Appraisal		99.0%	99.0%	100.0%	99.0%	1.0%	↗	-1%
Core Skills Framework	88%	89.0%	85.0%	82.0%	90.0%	-8.0%	↘	9%
Agency as a % of Paybill	7.5%	8.3%	4.8%	4.7%	6.5%	-1.8%	↘	-28%
Friends and Family Test (Work)	60%	53.9%	52.6%	51.4%	66.0%	-14.6%	↘	22%
Overall Summary								

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 Q1 18/19 - Local Survey
Turnover	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 18/19 - Local Survey
Sickness	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 18/19 - Local Survey
Appraisal	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 18/19 - Local Survey
Core Skills Framework	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 18/19 - Local Survey
Friends and Family Test	Based on FFT Survey

Vacancy % is obtained by taking current vacancy wte as a % of the workforce planning establishment return.
NB - Sickness is broken down into 3 separate targets (overall, short term and long term) - However only the total sickness contributes to the overall score.
Benchmark data taken from Herts & West Essex and BLMK STP workforce

The Board Assurance Framework shows key workforce indicators in the context of current performance, performance 12 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.

The BAF performance indicators reflect core areas of the workforce that need monitoring, including B5 nurse vacancies and turnover, reflecting the focus on recruitment and retention in conjunction with NHSI. These areas are identified as the Trust's highest workforce risk factors. Turnover rates for Band 5 nurses improved over the last 8 months, from over 27% to 22% to March and are currently 21.7% currently. The Trust is slightly above the trajectory to achieve the 16% target by December 2018.

Overall vacancy rates have increased recently to 12.1%. This is due entirely to the increase in establishment wte in Emergency Medicine and Surgery recently approved by the Trust. There has been a consequent increase in vacancy rates for qualified Nursing & Midwifery posts due to this increase, and Band 5 nursing vacancy rates are now 18.5%. There are around 250 nurses in the recruitment pipeline, many of which are overseas nurses and approval of a business case will lead to the recruitment of a further 59. . Monthly skype interviews and discussion are taking place and feed in to the recruitment pipeline..

Appraisals are below target at 84% although this reflects an increase from 79% two months ago. Mandatory training compliance at the time of reporting was 82%. The most recent weekly figures show that this has since increased to 85%. The accurate mapping of training needs onto the new ACORN training system should also be noted.

The Trust has achieved its target of a sickness rate less than 3.5% at 3.2%.

The current agency pay bill percentage is 4.7%. The target rate for 2017/18 was 8% and in 2018/19 it is 5.9%, reflecting the reduced agency cost target envelope. This will vary each month to reflect changing demand over the year. The target for September was 6.4%

The 12 month turnover rate is 16.7%, a decrease compared to 17.1% 3 months ago. It is above the target of 12%. It is also slightly above the benchmark average.

The latest Q2 FFT score (51.4%) shows a slight decrease compared to 3 months ago. The target is 60% and the current score is now at 22% outside the target.

West Hertfordshire Hospitals NHS Trust

Safe, effective, caring

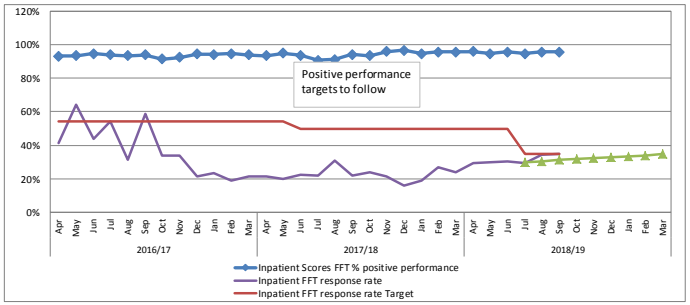
Well led

Reporting sub committees - PSQ and PSE

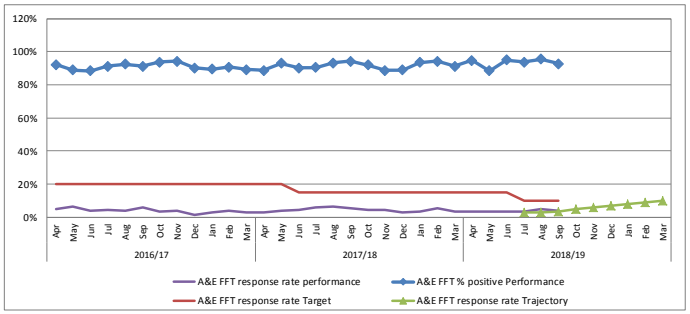
Friends and family

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

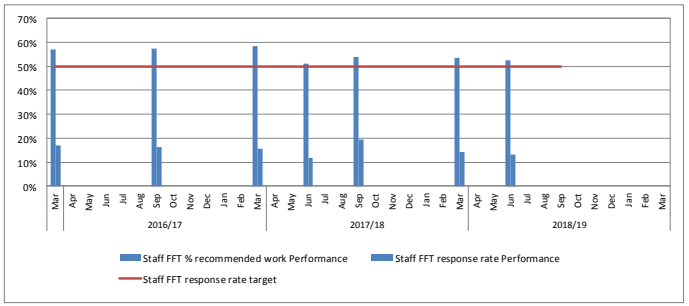
Inpatient scores (% positive and negative) and response rate



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



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



The overall FFT response rate for September was 17.4% and the recommendation rate was 93.1%.

Inpatients

The response rate target for in patients is 35% (A&E 10%) with a 95% recommendation rate. Divisional rates were: Surgery 39.9% / 94.5%, Medicine 37.9% / 96.2%, Emergency Medicine 5.3% / 95.9%, Women & Children 51.6% / 94.3%

1202 positive and 13 negative comments were received, a number of which referred to noise at night and quality/availability of food. Positive comments focused on the care and kindness of staff.

"Great care from every single member of staff. Very confident professional team. All investigations were done promptly" Stroke Unit,

"Lovely team, very helpful, very busy and run off their feet but still kind and compassionate. Thank you for looking after me !" Flaunden ward

A&E

Response and recommendation rates decreased but with a reduction in the not recommending rate. UTC at HHGH had the most responses. Of 254 patient responses including free text comments, 11 were critical of long waiting times and staff attitude. Positive comments included:

"*Everyone was kind and professional and treated me with respect. " (*ED)

*"What an amazing lady. Last week my son refused any Dr/Nurse to look at him at C W hospital and today Sian made my son feel so at ease and laugh. What a great asset to the hospital. She has made my day ! :) Happy Mummy x" (*CED*) , "Have been seen quickly by the nursing team and treated well" (MIU, SACH)*

Staff Survey

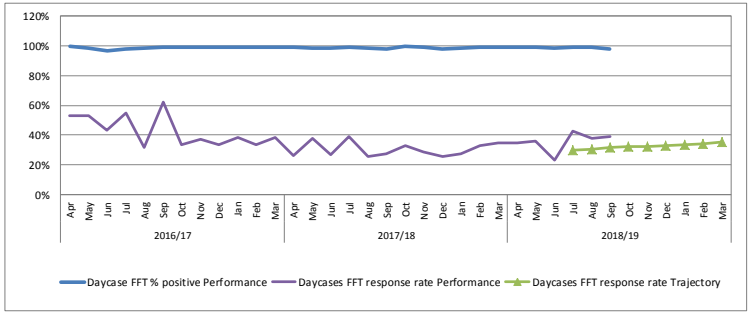
19% of staff have completed the survey to date. A communication campaign is being launched to encourage staff to complete their surveys. The survey closes on 30 November. The Q2 results for staff FFT show a very small increase in the overall engagement score at 3.49 from 3.48 in Q1, largely due to the increase in staff who would recommend the Trust to friends and family as a place to receive treatment, at 3.51 in Q2 from 3.41 in Q1. There was a decrease in staff who would recommend the Trust as a place to work from 3.28 in Q1 to 3.25 in Q2. Results are broken down by division and used to inform action and implementation of the Big 5.

Trust Totals - Staff Friends and Family Q2 18/19

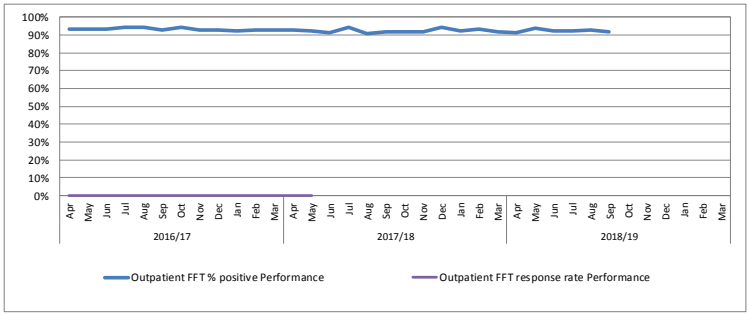
Question	Engagement Score Q4 16/17	Engagement Score Q1 17/18	Engagement Score Q2 17/18	Engagement Score Q4 17/18	Engagement Score Q1 18/19	Engagement Score Q2 18/19	Change on Last Quarter
Q1. How likely are you to recommend this Trust to friends and family if they needed care or treatment?	3.7	3.59	3.62	3.47	3.41	3.51	↗
Q3. How likely are you to recommend this Trust to friends and family as a place to work?	3.49	3.32	3.34	3.3	3.28	3.25	↘
Q5. I am able to do my job to a standard I am personally pleased with?	3.75	3.73	3.67	3.58	3.57	3.63	↗
Q6. My manager asked for my opinion before making decisions which affect my work?	3.56	3.55	3.48	3.47	3.51	3.49	↘
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?	3.15	2.97	3	2.93	3.01	3.01	↘
Q8. I generally feel well informed about what's going on within the Trust	3.52	3.61	3.64	3.53	3.53	3.57	↗
Q9. I generally feel well informed about what's going on in my local place of work	3.63	3.61	3.64	3.55	3.56	3.51	↘
Q10. I feel proud to work for WHHT	3.79	3.73	3.71	3.6	3.61	3.62	↗
Q11. I feel proud to work within my local place of work	3.94	3.88	3.88	3.83	3.83	3.84	↗
Overall Engagement Score	**3.62**	**3.55**	**3.55**	**3.47**	**3.48**	**3.49**	↗

NHS West Hertfordshire Hospitals NHS Trust

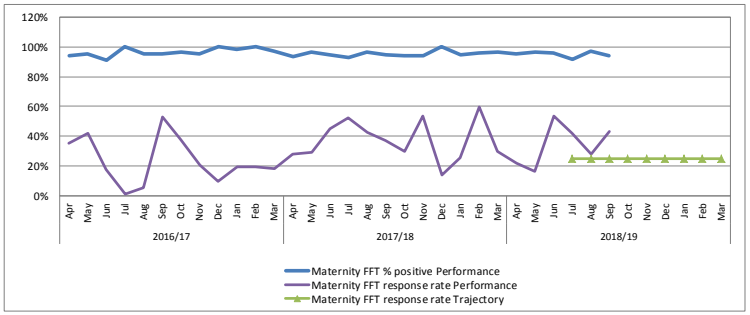
Daycases scores (% positive and negative) and response rate



Outpatient scores (% positive and negative) and response rate



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



Day Case

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

Outpatients

Response rates have reduced this month but the recommendation rate has improved and those not recommending is unchanged. There were 1607 positive comments, including:

"The student nurse was calm and polite and explained the process well. Floenca was great helpful and helped me very supportive." (Pre Op Assessment, WGH)

"Everyone who was involved put me at ease explained everything and spoke to me through the procedure. Lovely ladies (and registrar) " Hysteroscopy, SACH

The minimum response rate for OP is 1900 per month.

Maternity Question 2

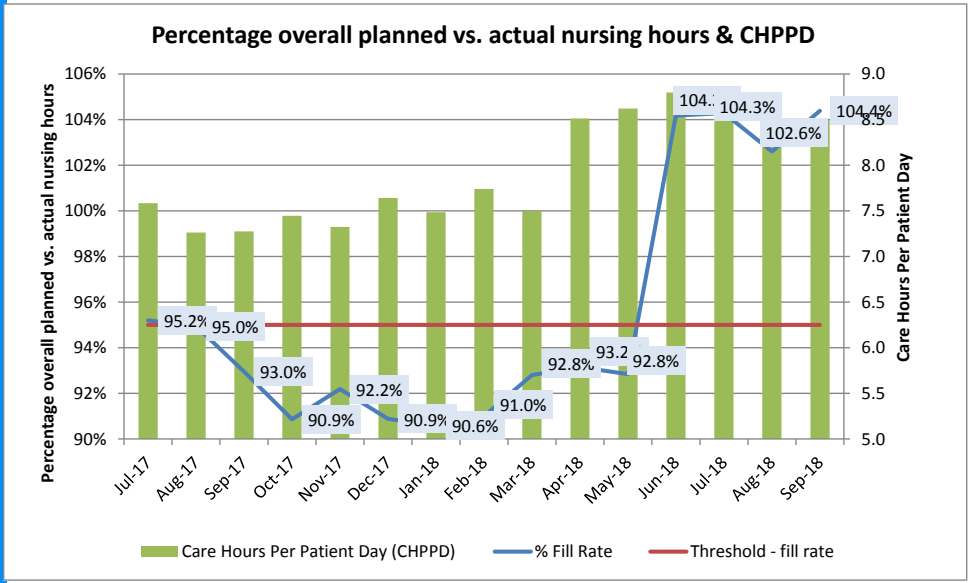
The response rate overall has significantly improved this month and is back in the region of the June & July rates that were above the trajectory of 35% and recommendation is close to 95%. An increase in those not recommending overall has been investigated but no themes identified from the 7 negative comments submitted. 123 of the 131 comments received were positive, including:

"Friendly relaxed environment, with midwives that support and encouraged along labour to help my experience be as easy as possible, very well looked after from start to finish." (Alexander, Delivery)

"Both the student midwife and midwife were very supportive throughout the labour process. " Delivery suite

Safer staffing

Indicator	Performance (September)	Threshold	Trend	Forecast next month
% Nursing hours versus planned	104.4%	>95%	Up	>95%
Care hours per patient day	8.5	n/a	Stable	8.2



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	89.9%	122.4%
	Night	96.1%	126.6%
Care hours per patient day	All	4.8	3.7

Next Steps

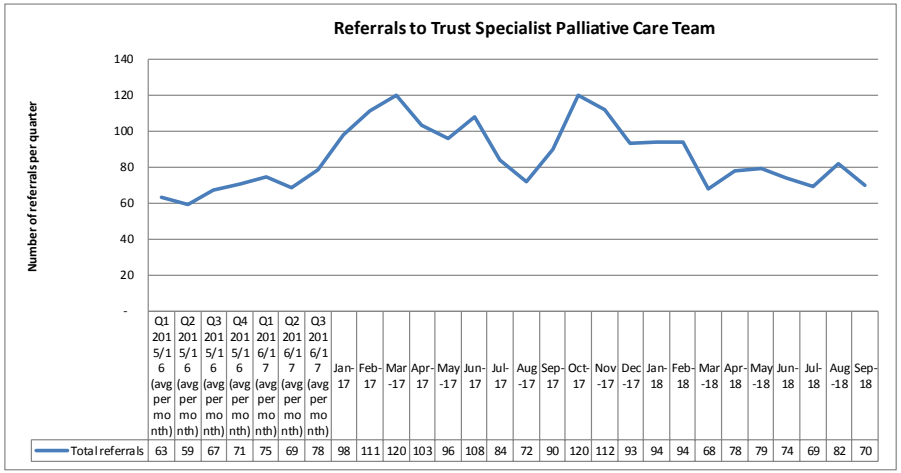
- From September the Trust will be reporting externally on CHPPD, on My NHS and NHS Choices
- NHSI visited Trust on 10 September to join workforce meeting report to follow.
- Continue to work with 10 wards as part of the phase 2 NHSI Deep Dive to improve productivity. A follow up call has been scheduled to take place on the 1st November.
- Nursing Workforce to continue to support divisions in producing efficient rosters
- Enhanced Care review undertaken - Band 6 and Band 4 to be appointed
- Currently 2 clinical areas, Sarratt and AAU Blue are part of the NHSI staff engagement initiative
- Continue to embed Safe Care in the Trust, plan to introduce to Theatres, OPD
- Adult Establishment paper went to TEC and Safety and Compliance in October, to go to board next month.
- Reporting of fill rates to continue to provide breakdown of registered and unregistered
- New Paediatric Shelford multipliers are used on safe care.
- Ryalto app launched

Analysis

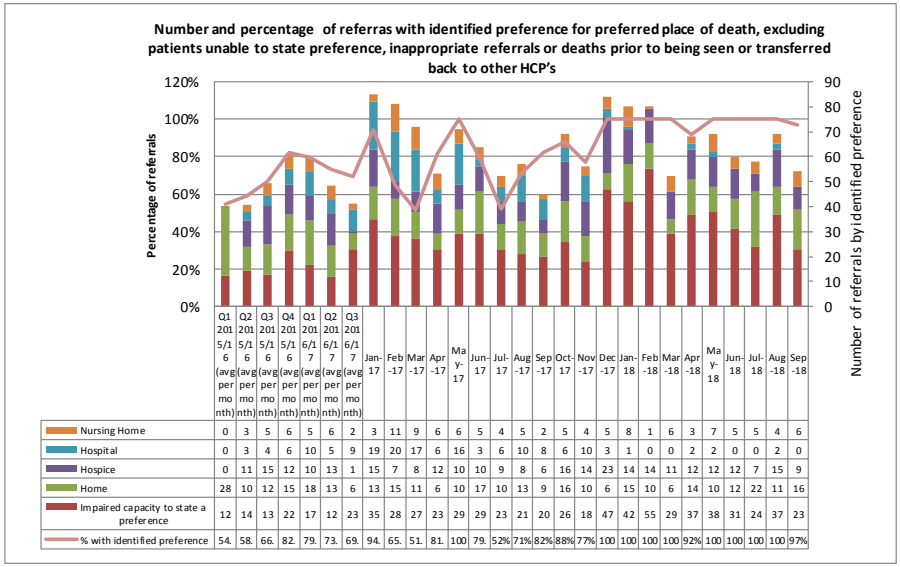
The Trust % overall fill rate in September was 104.4%, an increase of 1.8% on last month and above the national threshold of 95%. On further analysis this equates to 96.2% registered and 109.4% unregistered. The fill rate within Medicine was 108.3%, an increase of 3.8% from last month (89.7%% registered and 133.9% unregistered). In Surgery the fill rate was 101.8%, a decrease of 1.6% from last month (94.6% % registered and 116.1% unregistered). Overall the fill rate in WACS was 96%, a decrease of 0.6% from last month. On further analysis, maternity fill rates were 91.1%, down 0.5% from last month (92.6% registered and 87.4 unregistered), paediatric services fill rates were 106.8%, an increase of 3% from last month (108.1% registered and 100.3% unregistered). The high % of unregistered in medicine and surgery will include enhanced care workers deployed to clinical areas. The number of shifts rag rated green were 65.5% a decrease of 5.7% from last month. Shifts rag rated amber were 34.4% an increase of 5.8% from last month and the number of shifts rag rated red were 0.1% a decrease 0.2% from last month. No shifts was red flagged showing less than a minimum of 2 RNs on shift (compared to 1 last month). There were 2 shifts red flagged for registered nurses more than 8 hours less than planned, same as last month. No harm to patients was reported and mitigations were put in place. **In Safe Care % utilisation** There were four areas with overall fill rates at 90% or below – ABC, Katherine, Victoria and De La Mare & Beckett. Staff continue to be redeployed through safe care to address acuity and staffing. In September a total of 1195 shifts were redeployed (591 day and 604 night). **Bank analysis -** Enhanced care needs continue to be provided by the Trust enhanced care team and bank/agency. Additional CSWs have been added to the pool. In September 84,549 bank and agency hours were requested. The overall fill rate was 85% an increase of 1% from last month (57.6% were filled by NHSP and 27.4% by agency). Overall Trust supervisory hours lost was 31.5 % a decrease of 5.9% from last month. **Care Hours Per Patient Day -** The Trust's CHPPD has shown an increase since April 2018 from 7.5 to a range over last six months 8.5-8.8. Prior to April the enhanced care team were not being reported on as part of CHPPD. With the implementation of safe care across all inpatient areas, the enhanced care workers are now redeployed to each of the clinical areas and are now reported on CHPPD. From looking at Model hospital we are currently 0.5 above national figures but as part of the collaborative, NHSI are aware of this and have advised they recognise the number of small wards in the Trust so this is not a concern in reporting, also redeployment of our support staff and our increase in fill rates for registered and unregistered nurses. In addition from hospital reconfiguration work reassignment of the ward profile in model hospital is being currently being managed and will allow us to compare like for like with our peers .

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	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total referrals	63	59	67	71	75	69	78	98	111	120	103	96	108	84	72	90	120	112	93	94	94	68	78	79	74	69	82	70



	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	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Nursing Home	0	3	5	6	5	6	2	3	11	9	6	6	5	4	5	2	5	4	5	8	1	6	3	7	5	5	4	6
Hospital	0	3	4	6	10	5	9	19	20	17	6	16	3	6	10	8	6	10	3	1	0	0	2	2	0	0	2	0
Hospice	0	11	15	12	10	13	1	15	7	8	12	10	10	9	8	6	16	14	23	14	14	11	12	12	12	7	15	9
Home	28	10	12	15	18	13	6	13	15	11	6	10	17	10	13	9	16	10	6	15	10	6	14	10	12	22	11	16
Impaired capacity to state a preference	12	14	13	22	17	12	23	35	28	27	23	29	29	23	21	20	26	18	47	42	55	29	37	38	31	24	37	23
% with identified preference	54.	58.	66.	82.	79.	73.	69.	94.	65.	51.	81.	100	79.	52%	71%	82%	88%	77%	100	100	100	100	92%	100	100	100	100	97%

In 2008 the End of Life Care Strategy 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 70 referrals were made to the Trust Specialist Palliative Care Team.

Of the patients with capacity to make decisions about PPD, 97% had an identified PPD.

There were three patients who died in hospital with a preferred place of death of home. In all cases, this was because the patients' physical symptoms did not permit remaining at home.

Trust data quality, by exception

Data Quality RAG key

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

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

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

Domain	Indicator	Data Quality RAG	Description of issues	Improvement action plan	Target date for 'Green' rating
Safe, Effective, Caring	Discharges between 8am and 12pm* (main adult wards excl AAU)	A			
Safe, Effective, Caring	% Complaints responded to within one month or agreed timescales with complainant	R	Operational and clinical pressures has meant it has been challenging to find the time for clinical and operational staff to respond to concerns on time.	The Unscheduled Care Division are recruiting a 0.5 WTE position to assist clearing the backlog. The team are recruiting a new complaints manager and have approach NHSP and agencies to fill the vacancy. The Surgery Division has held a complaints workshop to address backlog. The same will be done in Unscheduled Care. The Women and Children's Division are recruiting a post to deal with complaints. The Environment and Medicines Division have improved their response times considerably.	Recruitment expected to be completed by end of Summer. Improvements are hoped to be seen by end of 2017.
Safe, Effective, Caring	Complaints - rate per 10,000 bed days	R	Capturing complaints across the Trust.	All complaints are captured and triaged daily. All complaints are logged daily and there are systems in place to capture all complaints received through the CEO, executive assistants, through NHS net and on social media. Reminders are sent to all staff about forwarding complaints received in clinical areas. There is a system for auditing all new complaints taken through triage on the following day.	This risk is being minimised as much as possible.
Safe, Effective, Caring	Reactivated complaints	R	Increase in reactivated complaints	We telephone every reactivated complaint to talk through concerns. We consider if someone independent needs to investigate. We send reactivated complaints to external investigators in complex cases. We invite complainants to meetings to discuss their concerns. We now record the reason for reactivated complaints and will audit this. We have asked Healthwath Hertfordshire to review a pool of complaints and provide feedback. We will ask that they include a small pool of reactivated complaints also.	This risk is being minimised as much as possible.
Safe, Effective, Caring	Hospital Acquired Pressure Ulcers - Grade 3	A			
Safe, Effective, Caring	Number of Falls*	A			
Safe, Effective, Caring	VTE risk assessment*	A	Paper based VTE forms used for assessing compliance by clinical coding team. Evidence elsewhere within notes demonstrating compliance not on form not previously identified.	Clinical Advisory Group has approved new process for coding team to assess VTE compliance. Electronic system required to improve compliance to green.	July 2017 (Amber). Electronic system date of implementation TBC (for Green)
Safe, Effective, Caring	Caesarean Section rate - Combined*	A	Perception that there is a difference between caesarean section rate on CMiS compared to what has been clinically coded	Review of clinically coded notes and comparison to CMiS to review discrepancies	July 2017
Safe, Effective, Caring	Caesarean Section rate - Emergency*	A	As above	As above	As above
Safe, Effective, Caring	Caesarean Section rate - Elective*	A	As above	As above	As above
Safe, Effective, Caring	Stroke patients spending 90% of their time on stroke unit *	A			
Responsive	Ambulance turnaround time between 30 and 60 mins	R	Identified inaccuracies in timing of Ambulance Service data	Ongoing work with ambulance service	TBA
Responsive	Ambulance turnaround time > 60 mins	R	As above	Ongoing work with ambulance service	TBA
Well Led	Sickness rate	A	1. Potential for under reporting 2. There can be issues with data recorded on ESR but this will be fixed with the implementation of the new ESR 2 system.	1. HR undertook a number of audits to look into areas who were reporting 0% sickness throughout 2016 and have implemented learning from those audits, including a new process for capturing absences if medical staff. 2. implementation of the new ESR 2 system.	September 2017 (linked to the ESR implementation). There will also be ongoing audits to ensure that absence data is still being accurately recorded
Well Led	Mandatory Training	A	1. Potential for reporting inconsistencies on ESR in certain staff groups	A project group has been set up to investigate and correct reporting issues	Feb-18

Trust Board Meeting
01 November 2018

Title of the paper	ED, RTT & Diagnostics Performance Update (September 2018 reporting period)
Agenda Item	**11/64**
Presenter	Jane Shentall, Director of Performance
Author(s)	Jane Shentall, Director of Performance
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	This paper provides an update on performance against the national standards for Accident & Emergency, Diagnostics, Referral to Treatment and Cancer waiting times. ED performance fell from 83% to 79.8% this month. There were over 700 more attendances (of which 500 were at WGH) in September compared with August. Inpatient flow was slow throughout the month, with only 97 discharges more than admissions from ED and the DToC position worsened, from 3.7% to 4.4%. RTT performance, at 83.2%, was also down on the previous month (83.8%). The Trust is on track to ensure the PTL size in March 2019 is no bigger than in March 2018, with 24889 open pathways in September (March 25288). The number of patients waiting 40 weeks or more decreased, from 522 to 482 and the number of 52 week breaches continues to fall, from 123 to 111. The number of patients who tipped (45) in was lower than the number of patients already at or exceeding 52 weeks (57). A revised trajectory has been shared with NHSE, NHSI and HVCCG mapping the expected reduction of 52 week breaches to 0 by March 2019. The cancer waiting times standard has not yet been achieved for 31 day subsequent surgery (where there are 3 breaches in a total of 16 pathways) Performance against all other standards is compliant. All 31 day subsequent performance and 62 day performance is provisional until the closure of the reporting period. The standard for diagnostic waiting times was not achieved in September due to failure to follow established booking processes for DEXA scans. Despite increasing the volume of scans outsourced, a significant number of breaches were incurred. At 98.9%, 6 fewer breaches would have resulted in achievement of the standard. Actions have been implemented to address the issue and the position is improving.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care – *Objectives 1-5*: ✓ Aim 2 Great place to work – *Objectives 6-8*: Aim 3 Improve our finances – *Objective 9*: Aim 4 Strategy for the future – *Objective 10-12*:

<table>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>TEC – Executive Performance Review</td><td>24 October 2018</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for information and to note the impact of actions to improve performance against nationally mandated waiting times.</td></tr>
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11

Agenda Item: 11/64

Trust Board Meeting – 01 November 2018

ED, RTT & Diagnostics Performance Update (September 2018 reporting period)

Presented by: Jane Shentall, Director of Performance

1. Purpose

1.1 The purpose of this report is to provide a summary of the Trust's performance against the nationally mandated standards for Accident & Emergency, Diagnostics, Referral to Treatment and Cancer waiting times standards.

2. Background

2.1 Trusts are expected as a minimum to achieve the following operational performance standards:

- 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- Less than 1% of patients should wait 6 weeks or more for a diagnostic test, measured against 15 key diagnostic tests (see Appendix 1).
- More than 92% of patients on incomplete (open) pathways should have been waiting no more than 18 weeks from referral.
- A maximum of 2 weeks
  - from urgent GP referral for suspected cancer to first outpatient appointment – 93% operational standard
  - from referral or any patient with breast symptoms (where cancer is not suspected) to first hospital assessment – 93% operational standard
- Maximum one month (31 days)
  - from decision to treat to first definitive treatment – operational standard of 96%
  - decision to treat/earliest clinically appropriate date to start second/subsequent treatment where the treatment is surgery (operational standard 94%), drug treatment (operational standard 98%), radiotherapy (operational standard 94%)
- Maximum two months (62 days) from
  - urgent GP referral for suspected cancer to first treatment – 85% operational standard
  - urgent referral from NHS Cancer Screening Programme (breast, cervical, bowel) for suspected cancer to first treatment – 90% operational standard

3. Analysis/Discussion

3.1 **Non-elective Care Pathway**
Please see appendix 2 for performance against trajectory.

3.2 Overall performance was lower than the previous month (83%) at 79.8%. The 95% standard was achieved at MIU and UTC but not in Minors (88.4%) or CED (89.2%)

3.3 The key factors influencing performance were higher attendances and slower inpatient flow. Average daily A&E attendances rose significantly in September. Across all 3 sites there was an average of 406 attendances per day versus 368 in August. At Watford there was an increase from 244 in August to 269 in September.

3.4 Inpatient flow was slower in comparison to the previous month, with a daily average of 70 admissions and 73 discharges (August averages – 72 admissions and 79 discharges) and the number of patients with a LOS of 14 days or more rose from 338 to 342. The DToC position also deteriorated at 4.4% (was 3.7%) or 34.4 beds/1033 bed days used (was 27.6 beds/855 bed days).

3.5 Ambulance handover delays worsened, with 255 reported between 30 and 60 minutes and 50 delays recorded over 60 minutes.

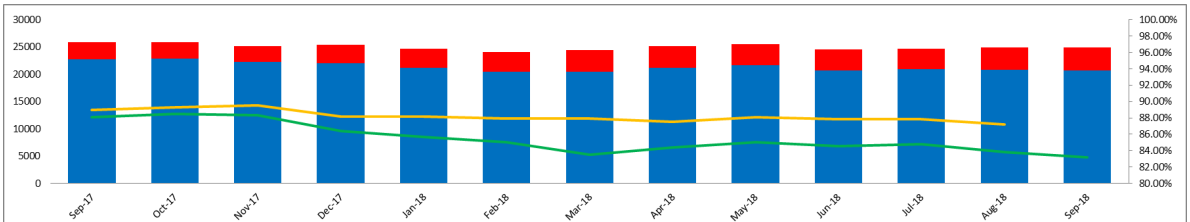
3.6 A number of work streams are in progress – GP streaming in ED, extension of the Ambulatory Care Unit (ACU) hours, development of the Minor Injuries Unit and Urgent Treatment Centre. The streaming model aims to build on previous primary care streaming pilots and is expected to start at the beginning of October. The plan for ACU is to extend the service until 20.00 every evening, maximising the opportunities for ambulatory care and avoiding admission. Plans are underway to expand the range of complaints currently managed by Minor Injuries Unit to include minor illness. At UTC plans include increasing booked appointment slots and widening the range of blood testing to avoid the need for attendance at WGH for further investigation.

3.7 Maintaining inpatient flow is a significant focus in the organisation, with Fresh Eyes ward rounds, two MDT LOS review meetings each week where barriers and blocks to discharge are explored and removed where possible. There is a system wide requirement to achieve a 25% reduction in the number of patients with a stay of 21 days or more by the end of December and the trust is on track to deliver the target allocated to the hospital stay. As noted above, the DToC reduction plan is key and progress in line with the trajectory is variable. The ambition is to achieve no more than 3.5%.

3.8 Recruitment to the posts included in the ED Business case which was approved by the Board in June 2018, is ongoing. A summary of progress is attached (appendix 3).

3.9 Referral to Treatment Pathway

At 83.2% September's performance was lower than that submitted for August (83.8%). The most recent benchmarking data shows that the Trust's position remains below the national average which has also deteriorated (latest available 87.2%). Service level performance, backlog and 52 week breach trends are included (appendix 4) for information.



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Pathways > 18	3076	2949	2953	3390	3540	3597	4034	3928	3837	3822	3749	4039	4181
Pathways < 18	22749	22898	22243	22016	21131	20476	20426	21176	21707	20721	20912	20844	20708
Submitted performance against 92% target	88.10%	88.45%	88.30%	86.40%	85.65%	85.06%	83.51%	84.40%	85.00%	84.50%	84.80%	83.80%	83.20%
National Average	89.0%	89.30%	89.50%	88.2%	88.20%	87.90%	87.90%	87.50%	88.10%	87.80%	87.80%	87.20%	

3.10 The Trust is on track to meet the 2018/19 Planning Guidance requirement to ensure the PTL size in March 2019 is no bigger than in March 2018, with 24889 open pathways in September (March 25288).

3.11 The total number of RTT clock stops for September was 8203, slightly higher than in the previous month (8130). However, there was a more substantial increase (15%) in the number of pathways closed over 18 weeks, at 1325, in comparison with 1152 in August.

3.12 35 on the day, non-clinical hospital initiated cancellations occurred in September (August 46). The main cancellation reasons were list overruns and bed capacity, particularly for Orthopaedics.

3.13 There were 11 patients who were not treated within 28 days of cancellation this month. These were in General Surgery (2), Orthopaedics (5), Urology (2), Oral Surgery (1) and Gynaecology (1). The main reason for breaches was failure to offer a new date within the required period.

3.14 A detailed breakdown of the RTT PTL (rolling 12 months) is shown below.

Month end position	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total pathways	25825	25847	25196	25406	24671	24073	25288	25104	25544	25453	25387	24883	24889
Pathways <18 weeks	22749	22580	22243	21487	21131	20476	20383	21176	21707	20721	20912	20844	20708
Total backlog	3076	2949	2953	3390	3540	3597	4018	3928	3837	3822	3749	4039	4181
Non-admitted pathways	20178	19770	19343	19028	18731	18089	18498	18997	19291	18396	18481	18756	18696
Non-admitted backlog	1370	1246	1230	1427	1425	1387	1605	1534	1425	1403	1313	1484	1488
Admitted pathways	5647	5759	5853	5849	5940	5984	5903	6107	6253	6147	6180	6127	6193
Admitted backlog	1706	1703	1723	1963	2115	2210	2413	2394	2412	2419	2436	2555	2693
52 week waits	0	0	1	0	20	41	59	64	70	114	124	123	111
Long waits (40+ weeks)	64	46	75	114	154	212	289	343	371	426	451	522	482
Clock stops <18 weeks	7348	7885	8002	6092	7871	7030	7063	7233	7774	7638	7746	6978	6878
Clock stops >18 weeks	1558	1553	1590	1130	1566	1400	1316	1408	1435	1460	1396	1152	1325
Submitted performance against 92% target	88.1%	88.4%	88.3%	86.4%	85.7%	85.1%	83.5%	84.4%	85.0%	84.5%	84.8%	83.8%	83.2%
RTT Incomplete pathway standard	92.0%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Surgery	83.0%	83.1%	83.4%	80.9%	79.9%	78.8%	76.3%	7734.0%	77.8%	77.0%	76.9%	75.4%	75.5%
Elective Medicine	94.6%	95.3%	94.7%	94.0%	94.0%	94.1%	94.1%	9418.0%	94.9%	95.1%	95.4%	94.7%	94.6%
Clinical Support	97.6%	97.4%	97.0%	95.8%	95.9%	95.4%	94.6%	9744.0%	97.6%	98.8%	97.9%	97.9%	96.7%
WACS	96.1%	97.2%	97.8%	95.7%	95.4%	94.9%	94.7%	9496.0%	96.2%	96.0%	95.6%	95.0%	94.4%

3.15 52 week breaches

The number of patients whose waiting time exceeded 52 weeks in September was 111 (123 in August). At month end 57 of these patients had been treated and there were 45 tip ins to 52 weeks. Service level trends can be viewed in appendix 5. Just over 78% have planned admission dates (through to December 2018).

3.16 A trajectory for 52 week breach reduction has been refreshed and shared with NHSE, NHSI and HVCCG (appendix 5). This shows performance is in line with plan for the month and the weekly snapshots are ahead of plan.

3.17 Services continue to undertake clinical reviews of all long wait (48 weeks plus) patients to ensure re-prioritisation where appropriate and to identify patients at risk of clinical deterioration. Appendix 6 details the current position with regard to such reviews within the Surgical division, where the majority of long waits occur.

3.18 Additional capacity for elective admissions to the WGH has been achieved through the opening of Castle ward. In addition a 4 week pilot of admission of some ASAIII patients at SACH commenced in mid-September. Outsourcing for General Surgery, Urology, Pain, ENT and Ophthalmology has been agreed and contracts with Spire and One Hatfield signed, with an expectation of a September start. Weekend operating lists at Watford will also be reintroduced, but not until October. Discussions with HVCCG have resulted in agreement to undertake additional outsourcing to further support performance improvement.

3.19 **Cancer Waiting Times Performance**

Performance against cancer waiting times standards is provisional, pending validation and closure of the relevant reporting periods for the 31 day subsequent and 62 day standards.

3.20 The national standard has been achieved for all standards except 31 day surgery, where 3 breaches have resulted in provisional non-compliance with the standard. Breach themes include clinical complications, delays at tertiary centres and surgical capacity. A breakdown of performance against each of the cancer operational standards can be found in appendix 7.

3.21 **104 day breaches**
There were 12 open pathways over 104 days this month. Delays have occurred due to complexity, patient choice delays and some clinical and administrative delays.

3.22 7 pathways over 104 days were closed in the month.

3.23 **Diagnostics**
Performance against the diagnostic standard, which requires 99% of patients to wait less than 6 weeks for their investigation, is non-compliant in September as a result of DEXA scan breaches. These have been incurred as a result of failure to follow established booking processes and record appointment offers. The staff member with responsibility for the day to day booking of these scans has now left the organisation and some re-education and training put in place. Outsourcing has also been increased to ensure a return to compliance at the earliest opportunity.

4 Risks

4.1 Risks to achievement of the urgent care standards include:
- Failure of system wide demand management schemes resulting in
- Increases in demand, above plan
- Reduced flow of inpatients from the hospital in to community capacity

4.2 Risks to achievement of the elective care standards include:
- Estate (theatre) infrastructure.
- Insufficient capacity to meet demand.
- Urgent care admissions to the elective care bed base at WGH

5 Recommendation

5.1 The Board is asked to receive this report for information and to note the impact of actions to improve performance against nationally mandated waiting times.

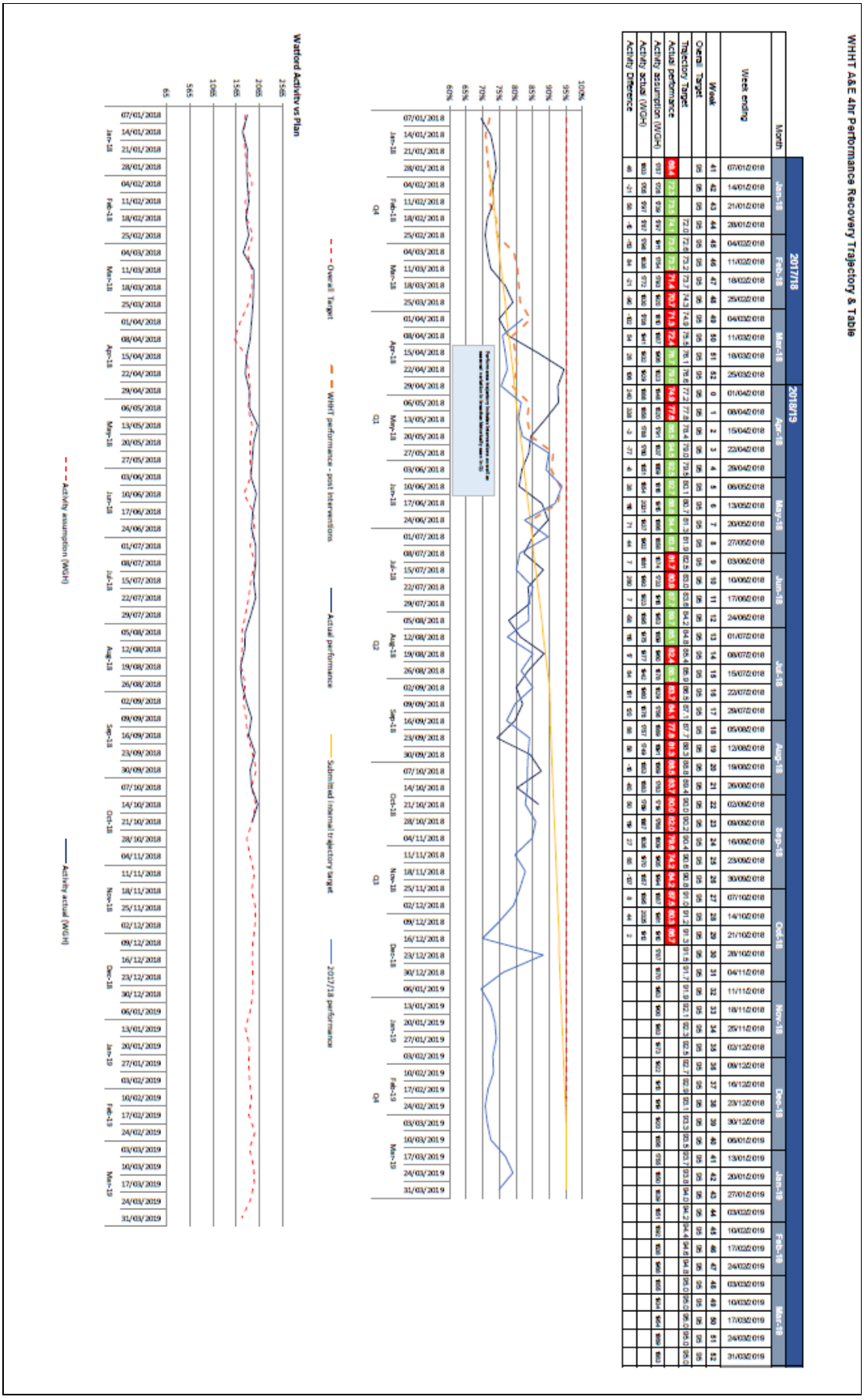
Jane Shentall
Director of Performance
23 October 2018

Appendix 1
The 15 key diagnostic tests

1. Imaging - Magnetic Resonance Imaging
2. Imaging - Computed Tomography
3. Imaging - Non-obstetric ultrasound
4. Imaging - Barium Enema
5. Imaging - DEXA Scan
6. Physiological Measurement - Audiology – Audiology Assessments
7. Physiological Measurement - Cardiology - echocardiography
8. Physiological Measurement - Cardiology - electrophysiology
9. Physiological Measurement - Neurophysiology - peripheral neurophysiology
10. Physiological Measurement - Respiratory physiology - sleep studies
11. Physiological Measurement - Urodynamics - pressures & flows
12. Endoscopy - Colonoscopy
13. Endoscopy - Flexi sigmoidoscopy
14. Endoscopy - Cystoscopy
15. Endoscopy – Gastroscopy

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf

Appendix 2
ED Performance trajectory



Appendix 3
ED Business case recruitment tracker

Emergency Medicine workforce Update								
Post Type	**Establishment Total Inc BC(WTE)**	**BC WTE**	**In post (WTE)**	**Pipeline (WTE)**	**Gap in overall establishement**	**BC Post Recruited WTE**	**BC Post Cost**	**Comment**
Middle Grade Doctors	9.00	0.70	6.00	1.00	2.00	0.00	-	Only 0.7 wte is a newly funded post. It has been difficult to recruit to existing posts. We have had an increase in ST3 trainees – 1st year of specialist training, however these are very junior middle grades and cannot take responsibility for the department overnight. Overseas recruitment on-going.
Junior Doctors	24.00	0.80	20.00	0.00	4.00	0.00	-	Overseas recruitment on-going by Skype – posts offered, but not taken up. Using locum to back fill.
Band 5 Nursing	75.40	23.46	50.28	13.00	8.00	20.00	740,161	Rolling recruitment – considering bus advertisements and radio advertising, being mindful of turnover. Currently using bank to backk fill.
Band 2/3 CSW	46.80	28.76	20.95	10.00	4.76	14.00	234,858	More had been recruited however due to sickness/ OH reasons offers have been retracted / they are placed elsewhere.
Band 7	9.80	2.60	9.80	0.00	0.60	2.00	16,000	Fully established
Band 5 (MAU)	10.44	10.44	7.44	2.00	1.00	7.44	314,343	Using bank to back fill
UTC Band 5	6.66	1.20	5.40	1.20	0.00	1.20	39,898	Recruited starting in January
ANP	14.80	1.50	3.60	3.00	1.20	0.00	-	For context the Directorate has an ANP establishment of 14.8 this is the only vacancy.
Consultants	12.00	1.00	12.00	0.00	0.00	1.00	120,000	Fully established (11 Consultant + 1 Associated Specialist)
Consultant Cover CED	0.00	0.30	0.30	0.00	0.00	0.30	22,500	Backfilling with additional sessions
Admin – Board Administration	2.66	2.66		1.66	1.00	0.00	-	Currently being covered by bank, whilst waiting for appointees to start. Will re advertise for remaining post.
ED Performance Manager B8a	1.00	1.00	1.00	0.00	0.00	1.00	63,182	This was a difficult post to recruit to (out to advert 3 times) at various points it has been covered with bank however, now internal seconded appointee in post.
Total	**212.56**	**74.42**	**136.77**	**31.86**	**22.56**	**46.94**	**1,550,942**	

Headlines - recruitment has progressed well. Acknowledging pipeline posts and post recruited to we have recruited 65 wte . The general ED establishment currently has a turnover of 13.9% , this explains number of posts in column D , namely that the 'gap ' is the gap in overall establishment. Please note that we are backfilling most unfilled posts with locum or bank staff when able to fill

Appendix 4
Specialty level RTT performance against 92% open pathway standard – September 2018

Service	18 Weeks Plus	% Under 18 Weeks
GENERAL MEDICINE	0	100.00%
ANAESTHETICS	0	100.00%
PAED CLINICAL HAEMATOLOGY	0	100.00%
PAED CYSTIC FIBROSIS	0	100.00%
STROKE MEDICINE	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
CLINICAL NEUROPHYSIOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
WELL BABIES	0	100.00%
OBSTETRICS	0	100.00%
GYNAECOLOGICAL ONCOLOGY	0	100.00%
ORTHOPTICS	0	100.00%
OTHER	3	99.10%
ENDOCRINOLOGY	9	97.55%
PAED CARDIOLOGY	3	97.52%
BREAST SURGERY	9	97.40%
GERIATRIC MEDICINE	3	97.35%
CLINICAL HAEMATOLOGY	8	97.08%
PAED DERMATOLOGY	2	96.77%
ORTHOTICS	4	96.75%
GYNAECOLOGY	25	96.47%
CLINICAL ONCOLOGY	1	96.43%
PAED OPHTHALMOLOGY	8	96.04%
DERMATOLOGY	102	95.99%
GASTROENTEROLOGY	77	94.93%

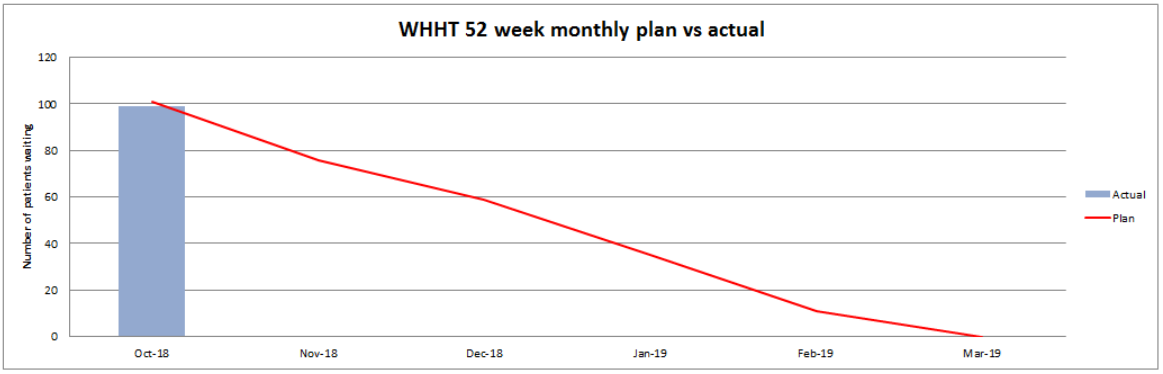
Service	18 Weeks Plus	% Under 18 Weeks
HEPATOLOGY	2	94.74%
NEPHROLOGY	4	94.52%
RESPIRATORY MEDICINE	34	94.50%
RHEUMATOLOGY	28	94.26%
CARDIOLOGY	87	93.56%
DIABETIC MEDICINE	4	92.86%
PAED GASTROENTEROLOGY	7	92.39%
PAEDIATRICS	45	92.09%
PAED UROLOGY	13	91.67%
NEUROLOGY	97	89.81%
UPPER GI SURGERY	7	88.52%
PAED ENDOCRINOLOGY	7	87.27%
COLORECTAL SURGERY	47	86.69%
PAED EPILEPSY	7	85.11%
ENT	578	77.22%
ORAL SURGERY	222	76.97%
UROLOGY	359	76.29%
ORTHODONTICS	31	75.20%
VASCULAR SURGERY	30	74.36%
TRAUMA & ORTHOPAEDICS	682	73.32%
GENERAL SURGERY	555	73.19%
OPHTHALMOLOGY	725	70.10%
PAIN MANAGEMENT	352	53.50%
CRITICAL CARE MEDICINE	4	33.33%
Total	**4181**	**83.20%**

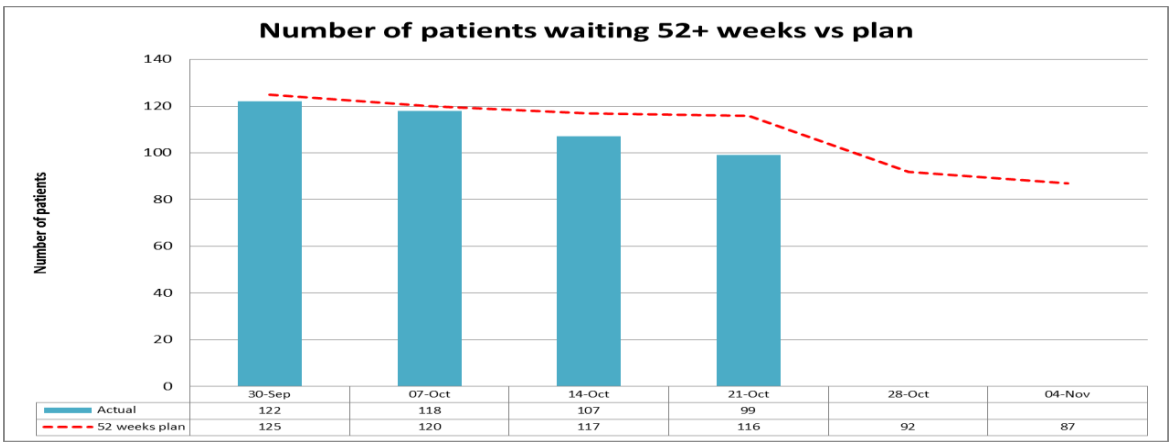
Appendix 5
52 week breach position – September 2018

SERVICE	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	August	Sept	Trends: Total 52 week breaches
(100) GENERAL SURGERY	0	0	2	5	9	12	21	36	50	51	48	
(101) UROLOGY	0	1	1	0	4	2	3	5	9	9	10	
(110) TRAUMA & ORTHOPAEDICS	1	0	15	32	40	39	38	60	51	48	40	
(120) ENT	0	0	0	4	4	4	3	3	1	3	4	
(130) OPHTHALMOLOGY	0	0	1	1	2	1	1	1	3	4	2	
GENERAL MEDICINE	0	0	0	0	0	0	0	0	1	0	0	
(X01_Other_104) COLORECTAL SURGERY	0	0	0	0	1	0	1	6	6	6	4	
(X01_Other_106) UPPER GASTROINTESTINAL SURGERY	0	0	1	1	1	0	0	0	0	0	0	
(X01_Other_107) VASCULAR SURGERY	0	0	0	0	0	0	1	1	2	2	2	
(X01_Other_191) PAIN MANAGEMENT	0	0	0	0	0	0	1	0	0	0	1	
ORTHOTICS	0	0	0	0	0	0	0	0	1	0	0	
Total	2	2	21	44	62	61	70	114	124	123	111	

11

Appendix 6
52 week breach reduction trajectory





Appendix 7
Cancer waiting times performance – September 2018

Standard	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
2ww	93.0%	95.2%	96.5%	96.9%	94.7%	94.1%	96.3%	91.4%	91.2%	93.4%	92.2%	93.1%	94.5%	94.5%
2ww breast	93.0%	97.6%	97.4%	99.3%	95.9%	88.4%	89.2%	84.0%	78.1%	86.8%	91.0%	94.2%	94.2%	95.7%
31 day 1st	96.0%	96.5%	99.3%	98.6%	96.7%	98.6%	99.2%	100.0%	95.4%	96.7%	95.2%	97.3%	95.8%	96.5%
31 day surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	77.8%	94.7%	100.0%	82.4%
31 day drug	98.0%	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%
31 day palliative	94.0%	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%
31 day other	94.0%	100.0%	100.0%	-	100.0%	-	-	-	100.0%	-	100.0%	100.0%	100.0%	100.0%
62 day	85.0%	83.7%	86.2%	86.8%	89.0%	86.3%	88.6%	87.3%	90.7%	83.4%	78.8%	81.2%	85.1%	89.8%
62 day screening	90%	86.4%	72.2%	81.0%	83.3%	84.6%	100.0%	100.0%	53.3%	88.9%	76.5%	95.5%	100.0%	94.7%

Performance in grey indicates the latest position in an incomplete reporting period

11

TRUST BOARD MEETING
01 November 2018

Title of the paper	**Annual Infection & Prevention Control Report 2017- 18**
Agenda Item	**12/64**
Lead Executive	**Tracey Carter, Chief Nurse and Director of Infection Prevention & Control Team**
Author	**Annesha Archyangelio, Deputy Director of Infection Prevention & Control Team** **Dr Prema Singh, Infection Control Doctor**
Executive Summary **(including resource implications)**	The Clinical Outcomes & Effectiveness Committee discussed the report and were assured by the summary of the Infection Prevention and Control (IPC) work undertaken in the organisation for the period 1st April 2017- 31st March 2018. The committee was assured by the report and meeting Health and Social Care Act (2008) 2015. The Annual Report outlines how the IPC team has continued to support infection control practice to the divisions. The trust have performed well within the national trajectories for infection prevention and control. This demonstrates that the Trust is providing a clean and safe environment. The rate of clostridium difficile infection (CDI) was lower than the national average and the region. There were twenty-eight cases against a trajectory of twenty-three. Following appeal, seven cases were approved which means that twenty-one cases were liable for sanctions, which was under the trajectory. We reported one case of post-48hr MRSA and 4 cases of pre-48hr MRSA. The Trust is no longer under national trajectory monitoring due to on-going good performance. There has been an increased focus on Escherichia coli bacteraemia (E.colib) and methicillin sensitive staphylococcus aureus bacteraemia (MSSAb) strategies to support their reduction. Key investigations and discussions around Carbapenemase –Producing Enterobacteriaceae (CPE) management in the Trust has taken place. The Trust continues to embed the CPE toolkit to ensure effective management of cases. There has been a change of screening policy for vancomycin resistant enterococcus (VRE) in ITU, which has seen an increase in positive cases in both Q1 and Q2. In June, there was a cluster of VRE cases, though no evidence of transmission. There was a sporadic case of pseudomonas on SCBU in Q1 and Q2. However, they were all colonisation, no evidence of the isolates being the same as those of the environment. The IPC training rates has lowered in the year and is being reviewed as part of mandatory training following the switch to the new training system. Hand hygiene compliance has remained good throughout the year. Ongoing training on personal protective equipment has equipped staff with the knowledge they require for the control and prevention of infections. This has been evidenced by fewer norovirus and flu outbreaks. These have been well contained within the affected bay/wards, despite high incidences of these in the community and admissions from affected care homes.

	We received a High Outlier Notice from PHE that our surgical site infection (SSI) rate is above the 90th percentile for Total Knee Replacement and Total Hip Replacement for April to June 2017. However, we fared better in comparison to trusts in the region. Validation of theatre ventilation was undertaken in both WGH and SACH, which all have had works undertaken since and are fully operational. Compliance with the Hygiene Code is underpinned by ten compliance criteria, this is monitored by the IPC Panel, which ensures that the Trust continues to maintain and strengthen its compliance.
Where the report has been previously discussed, i.e. Committee/Group	Infection Prevention and Control Panel Quality & Safety Group Clinical Outcomes & Effectiveness Committee
Action required	• The Board is asked to receive the report for assurance of compliance with the Health and Social Care Act 2008 (2015): Code of Practice for health and adult social care on the prevention and control of infections and related guidance (The Hygiene Code).
Trust objectives	• To deliver the best quality care for our patients
Risks attached to this project/ initiatives and how these will be managed	• Failure to achieve compliance with agreed infection targets will affect the rating for the Trust and CQC Outcome 8: Cleanliness and Infection Control. This is discussed at IPC Panel Meetings and elements of the outcome are included in the Annual Plan. The division were requested to undertake a Hygiene Code based Self- Assessment and present the completed audit and action plan at the IPC panel meetings and governance meetings. This formed part of the divisional audit programme which includes environmental, Code of Practice (COP), joint cleaning monitoring with cleaning contractors and other monthly audits which are reflected on the IPC dashboard. • Potential financial penalties from Commissioners if infection prevention and control targets are breached. All infection control criteria are included in the Annual Plan and monitored through the IPC panel through to completion. There is on-going liaison with the Herts Valley CCG to identify where there are risk for breaches and put migratory actions in place to avoid breaches including approving appeals for unavoidable infections. This includes the formation of MRSA and CDI action plan. • The need for a surveillance system is of prime concern as it allows the IPCT to identify and assess all the infected patients in the hospital and is essential to the hospitals infection control management. This is a future priority and a business case is being developed. • Side room availability and storage is on the risk register and managed through infection control policies for bed management and infection control.
Benefits to patients/staff from this project/ initiatives	Compliance with the Hygiene Code will ensure patient will receive safe and effective care with both staff and patient protected against acquiring healthcare associated infections.

Trust Board Meeting – 01 November 2018

Infection Prevention and Control Annual Report

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

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

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

This year the Infection Prevention & Control team has continued to work closely with the divisions attending the monthly divisional governance meetings. There has been ongoing ward-based power training to improve compliance with Infection Prevention & Control (IPC), particularly clostridium difficile and basic IPC practices.

The IPC Team has worked hard in leading on the improvement in the management of clostridium difficile infection (CDI), MRSA bacteraemia (MRSAb), E.coli bacteraemia (E colib), Methicillin-Sensitive Staphylococcus Aureus (MSSA), Outbreaks such as MRSA and CPE, diarrhoea cluster and bed closure, training compliance, Surgical Site Infection (SSI), and environment and infrastructure maintenance.

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

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

Tracey Carter

Chief Nurse / Director of Infection Prevention & Control

1 INTRODUCTION

The purpose of this report is to provide assurance of the Trust's compliance with the Health and Social Care Act 2008 (DH, 2015), The Hygiene Code during 2017-2018.

- To keep the Trust Board informed of IPC performance over the year (This is in addition to the monthly Integrated Performance Report.)
- To highlight the key areas of focus for 2018-2019.

2 INFECTION PREVENTION AND CONTROL ARRANGEMENTS

Infection prevention and control is everyone's responsibility within the organisation. As healthcare workers we all play a role in ensuring that our patient are safe from acquiring a preventable healthcare associated infections (HCAI).

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

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

3 INFECTION PREVENTION AND CONTROL TEAM (IPCT)

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

4 IPC ANNUAL PROGRAMME

The annual programme is prepared by the IPCT and agreed by the IPC Panel (IPCP) and ratified by the Quality and Safety Group (QSG). The programme is mapped to the duties of the Hygiene Code and is monitored by the IPCP. The Health and Social Care Act 2008 provides Trusts with a code of practice for the prevention and control of HCAI and makes clear their statutory responsibilities. Each organisation is expected to have sufficient systems in place to apply evidence-based protocols and to comply with the relevant provisions of the Act so as to minimise risk of infection to patients, staff and visitors. (See Appendix 3 for the programme and update for 2017-2018).

5 MANDATORY SURVEILLANCE REPORTING OF HCAI

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

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

- Methicillin resistant staphylococcus aureus (MRSA) bacteraemia (MRSAb)
- Clostridium *difficile* infection (CDI).
- Escherichia coli (E.coli) bacteraemia (E colib)
- Methicillin sensitive staphylococcus aureus bacteraemia (MSSAb)
- Klebsiella spp
- Pseudomonas aeruginosa

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

The IPC Nursing Team perform a daily review of all alert organisms and report any alert organisms and conditions that are identified. There is no dedicated electronic infection control surveillance software. The IPCT use a manual system which is resource intensive. The need for a surveillance system is of prime concern as it allows the IPCT to identify and assess all the infected patients in the hospital and is essential to the hospitals infection control management. This is on the Risk Register' included in future priorities and a business case will be developed for 2018-2019.

5.1 Trust Assigned Methicillin Resistant Staphylococcus Aureus Bacteraemia

The DH began mandatory surveillance of MRSAb in April 2004. The trajectory set for this financial year 2017-2018 by NHS England was zero tolerance on MRSAb for all Trusts. For all cases of MRSAb a Post Infection Review (PIR) is carried out. The purpose of the PIR is to investigate how a case of MRSAb occurred and to identify actions that will prevent it reoccurring.

In May 2017, we reported one post-48 hour MRSAb. The PIR was attended by the representatives from all the organisations involved in the patient's care pathway including the Herts Valley Clinical Commission Group (HVCCG) Head of IPC, IPCT and the clinical teams looking after the patient. There were four pre-48 hour (non-trust apportioned) MRSAb cases which were led by the CCG.

Key learning:

- Inappropriate flucloxacillin prescription despite recent history of MRSA
- Wound not screened for MRSA on admission
- Alert in medical notes not picked up regarding previous MRSA status
- Paracetamol prescribed "IV/O"
- Usual criteria were not met for blood culture taken
- Cannula could have been removed earlier as not used for 3 days prior to removal
- IV teicoplanin administered more than 3.5 hrs after request from microbiology
- No record of the condition of the left hand on re-admission
- No record of response of cellulitis / thrombophlebitis to IV antibiotics
- Unclear why discharge summary requested resending of MRSA swabs in 2 weeks

Actions

- The antimicrobial leads are embedding good practice across the Trust in line with the CQUIN performance requirements
- Staff are reminded to complete the Infection Control Risk Assessment on admission and screen the wounds accordingly
- IPCN remind the wards at daily follow-up, infection control presentations and in the e-learning

Figure 1a: This illustrates the MRSA bacteraemia from April 2001 to March 2018.

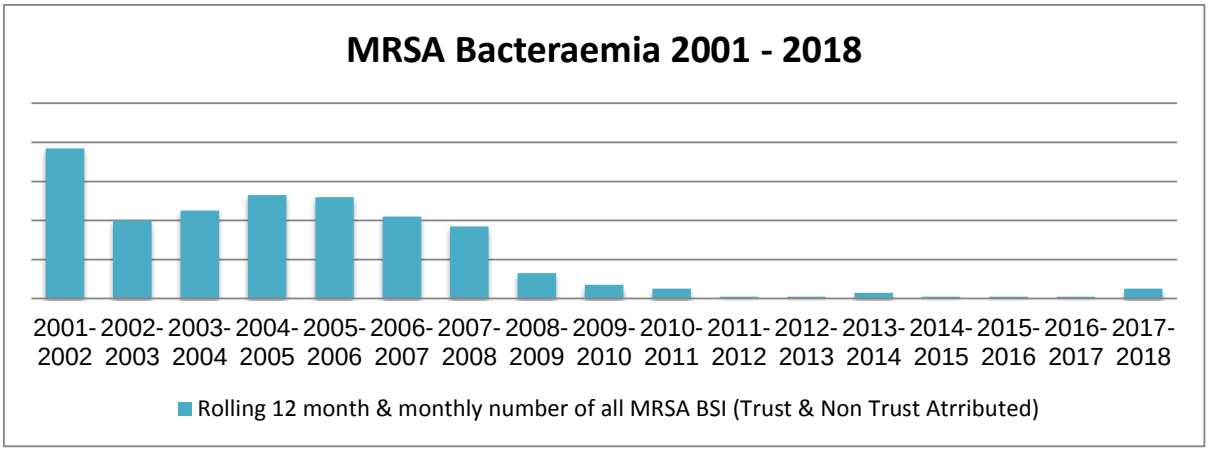


Figure 1b: This illustrates the no. of MRSAb per trust in East of England (2017-18)

During 2017/18 our MRSA bacteraemia (MRSAb) rate per 100,000 bed days was 0.44 which is lower than the national (0.93) and EoE regional (1.0) rates.

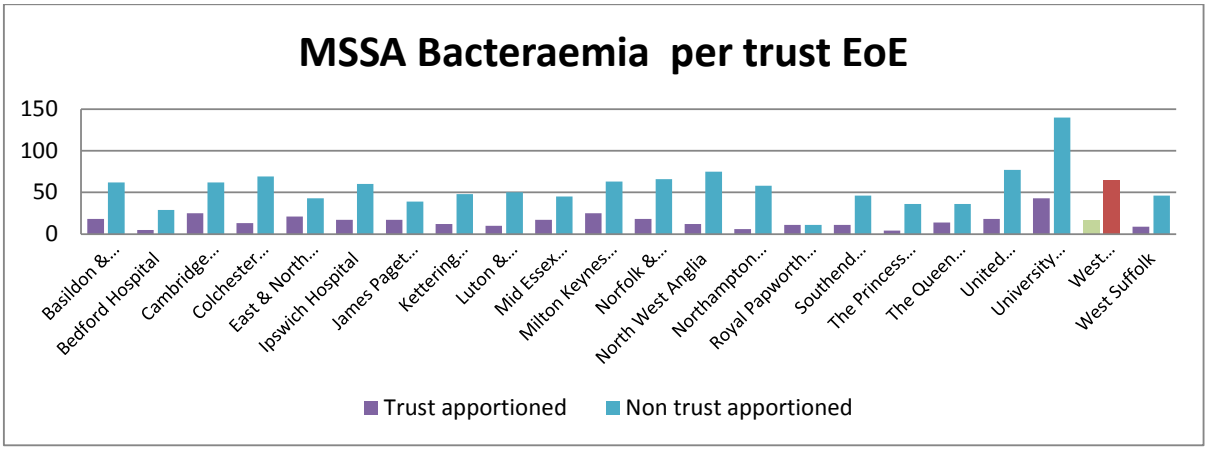
5.2 Methicillin Sensitive Staphylococcus Aureus Bacteraemia (MSSAb)

Reporting of MSSAb has been mandatory since January 2011. There is no trajectory set for MSSAb. In 2017-2018 there were sixteen WHHT apportioned MSSAb. This is a decrease from last year where we reported nineteen cases of MSSAb. There were sixty-four cases of pre-48 hour cases (non-trust apportioned).

Table 1: Comparison from the years 2014-2018

MSSA	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014/15	1	0	0	2	0	2	2	0	2	0	3	0	13
2015/16	0	0	1	0	1	0	0	0	0	0	1	1	4
2016/17	1	1	1	2	1	1	2	1	4	1	1	3	19
2017/18	3	3	1	1	1	1	1	1	1	1	0	0	16

Figure 2: MSSAb Trust apportioned cases versus non Trust apportioned.



The graph above illustrates the number of MSSAb per Trust in Midlands & East of England.

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

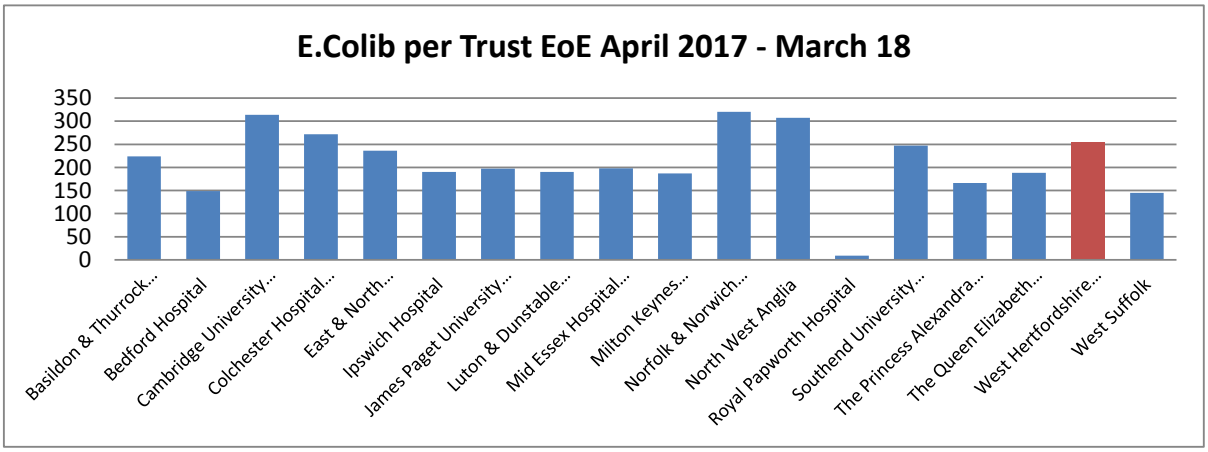
5.3 Escherichia Coli Bacteraemia (E.colib)

The reporting of E.colib became mandatory in June 2011. In this financial year, 2017-2018 there were no targets set for E.colib. Forty-three (43) E.colib post-48 hours' cases were identified as WHHT apportioned for April 2017 - March 2018. This is an increase from previous year which was twenty-nine (29) cases. The common theme for the E.colib is a catheter associated urinary tract infection. There were 229 non-Trust apportioned (community) cases in 2017-2018.

Table 2: Comparison from the year 2014-2018

E.coli	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014/15	1	2	3	2	4	2	3	0	3	1	1	3	25
2015/16	3	3	2	3	2	1	2	2	5	0	3	7	33
2016/17	1	1	1	4	2	2	5	1	4	4	2	2	29
2017/18	1	1	5	8	3	2	4	4	2	2	8	3	43

12



The increase in Escherichia *coli* bacteraemia is reflected regionally and national.

In November 2016, the Secretary of State for Health launched an ambition to deliver a 50% reduction by March 2021, for Gram Negative Bloodstream Infections. The initial focus was on E.colib which represents 55% of all Gram-negative BSIs.

Figure 4a: West Hertfordshire Hospitals NHS Trust (WHHT) 2017-18 E.coli number and rate per 1000 bed days against that of Midlands and East (M&E) and the national data

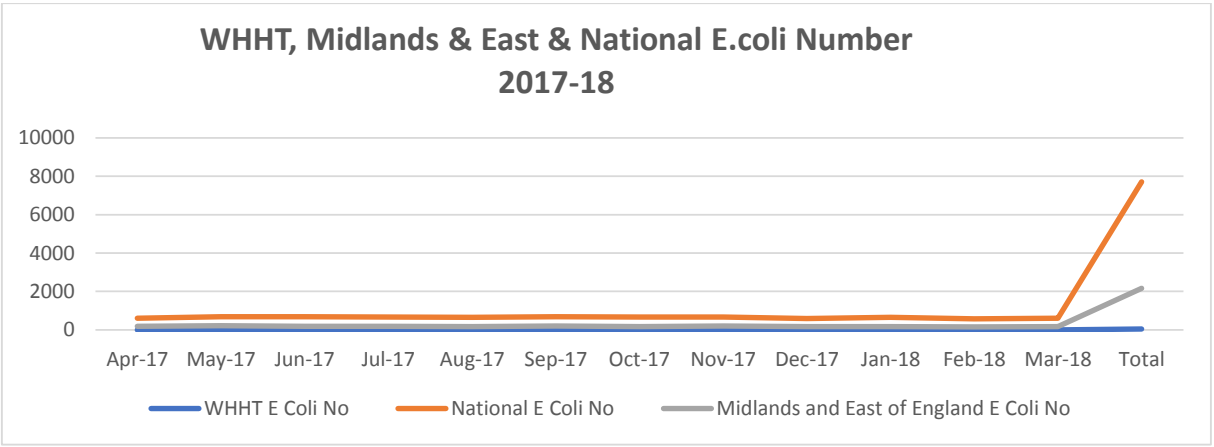
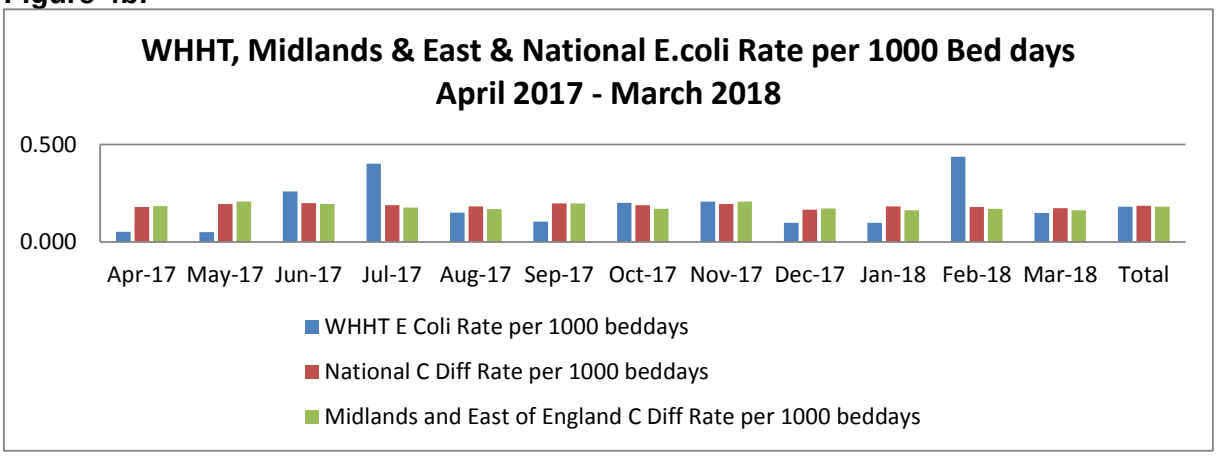


Figure 4b:



The above graphs and figures show the comparison of West Hertfordshire Hospitals NHS Trust (WHHT) 2017-2018 E.coli number and rate per 1000 bed days against that of

Midlands and East (M&E) and the national data. The E.coli number indicates that the cases for WHHT is in line with M&E and the national trend throughout the year and increase in figures at the end of the year is lower than both M&E and the national average.

However, the E.coli rate per 1000 bed days against that of M&E and the national data was varied. All but for 3 months of the year (June, July and February) the Trust E.coli figures were below both M&E and the national average. The higher number in these 3 months has been suggested to be associated with seasonal variation. July's peak may have been associated with risk of dehydration due to heat in an elderly population. There is a need increased compliance with completion of E.colib RCA to validate this information, which will be driven this year. The E.coli rate has been increasing by 6% per year, which is the reason for the national drive around E.coli reduction. There are a number of activities which are underway to reduce E.coli figures nationally, regionally and trust-wide.

Actions

- The trust undertook collection and reporting E.coli figures, undertaking RCA for each case
- Planning strategies through the Continence group and Best Practice Catheter and Urinary Tract Infection (UTI) group
- Feedback on all cases was provided at IPCP and Divisional Governance meetings

The main themes and trend from the RCA investigation of E.coli bacteraemia Catheter associated Urinary Tract Infection (UTI).

5.4 WHHT Apportioned CDI Cases from April 2017 to March 2018

Reporting for clostridium difficile infection (CDI) in patients aged 65 and over has been mandatory since 2004 and in 2007 this was extended to include all episodes in patients aged 2 years and over. The trust trajectory for this financial year was twenty-three.

5.4.1 Root Cause Analysis (RCA)

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

The RCAs are robust; they involve the IPCT (IPC nurse and/or Deputy Director of IPC and consultant microbiologist or ICD and antimicrobial pharmacist) and the clinical team looking after the patient (Consultant, Head of Nursing or Matron and Ward Manager).

The responsibility for completion of the RCA rests with the relevant division. The RCA is discussed and an action plan created and signed off with evidence of completion. A Datix is completed for all cases of CDI.

Each RCA, including the associated action plan is monitored at the Divisional Governance meetings. The IPCT have continued to attend the Divisional Clinical Governance meeting. IPC is a standing item on the agenda of these meetings. The CDI RCA and action plan is also feedback at the IPC Panel for assurance and compliance through the divisional infection control exceptional reports.

5.4.2 Summary of Trends of the Finding from CDI RCA for 2017-18

- Inappropriate testing / incomplete stool chart documentation
- Need for medical review / gastrointestinal disease
- Compliance with trust antimicrobial guidelines

- Review antibiotic course in high risk patients
- Improvement in equipment decontamination score
- Improvement in compliance with IPC training uptake

These trends were addressed using various measures including; a CDI action plan in place which has been implemented to improve CDI management and strategies in the Trust and it is feedback regularly to the Herts Valley CCG for assurance purposes. The IPC team continued to deliver CDI power training on wards, at governance meetings and training days to raise awareness of CDI management. Communications were distributed to increase CDI awareness at all levels, particularly relating to early sampling and isolation. The IPCT antimicrobial rounds and weekly MDT CDI rounds continued, along with increased targeted IPC support for audit and commode training in key clinical areas.

5.4.3 Exclusion from Lapses of Care

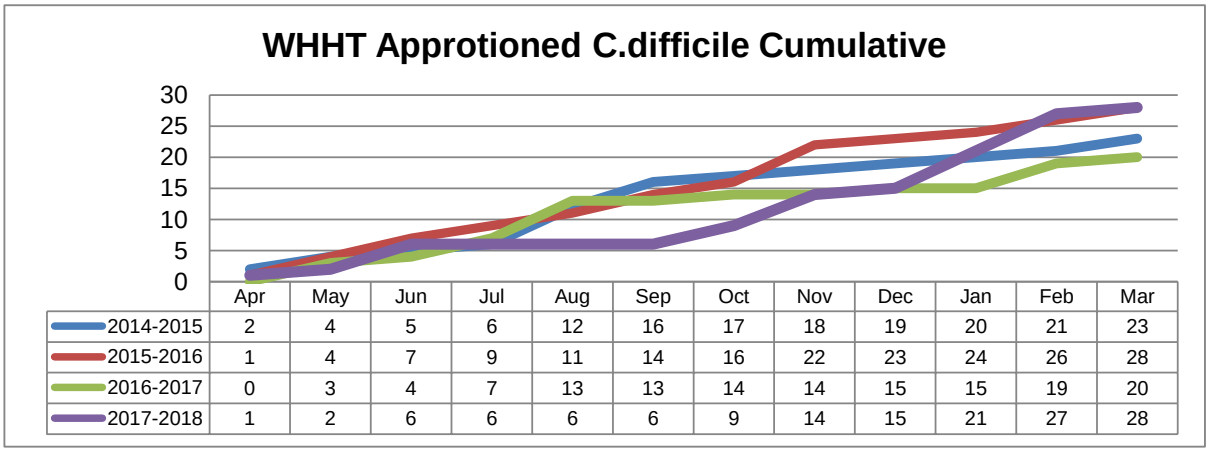
Negotiation is allowed with the commissioners of acute services to determine if any of the CDI cases could be determined to have been unavoidable. Following submission of CDI cases for appeal to the CCG for exclusion from lapses in care by the IPCT, seven cases were upheld and approved, where we demonstrated that the acquisition of CDI was unavoidable.

Seven of the cases were upheld as no lapses in care.

Comparison of WHHT attributed C.difficile cumulative cases (April 2014 to March 2017)

The below C.difficile graph compares the last four financial years. This demonstrates that there has been some slight increase, compared to the last 3 years.

Figure 6a: C.difficile rates for the last four years April 2014 to March 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-2015	2	4	5	6	12	16	17	18	19	20	21	23
2015-2016	1	4	7	9	11	14	16	22	23	24	26	28
2016-2017	0	3	4	7	13	13	14	14	15	15	19	20
2017-2018	1	2	6	6	6	6	9	14	15	21	27	28

Figure 6b:

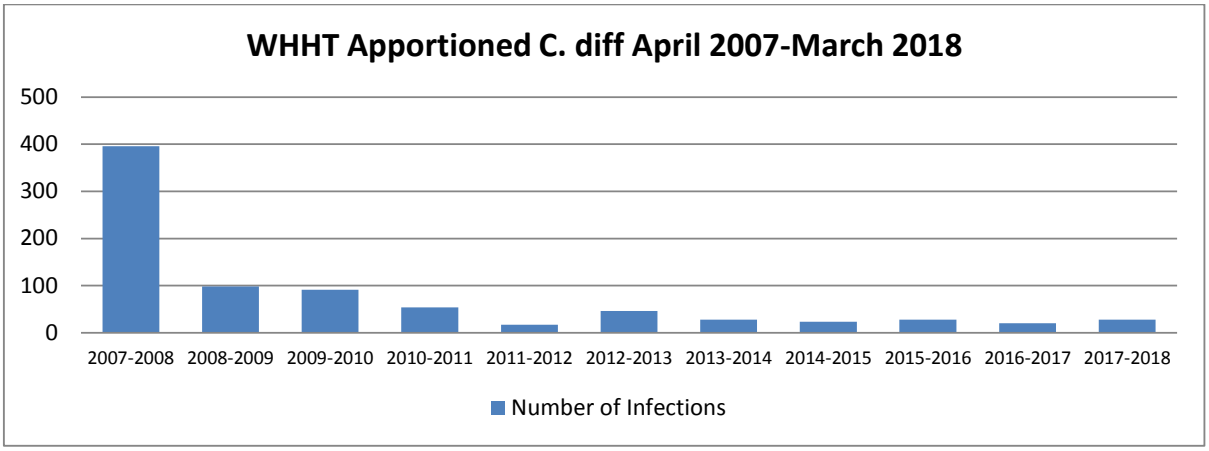
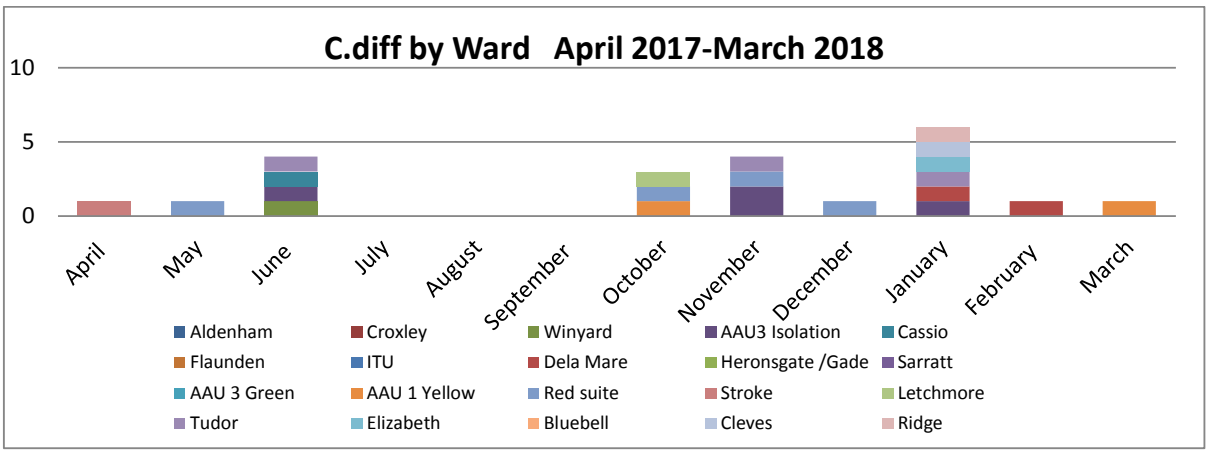
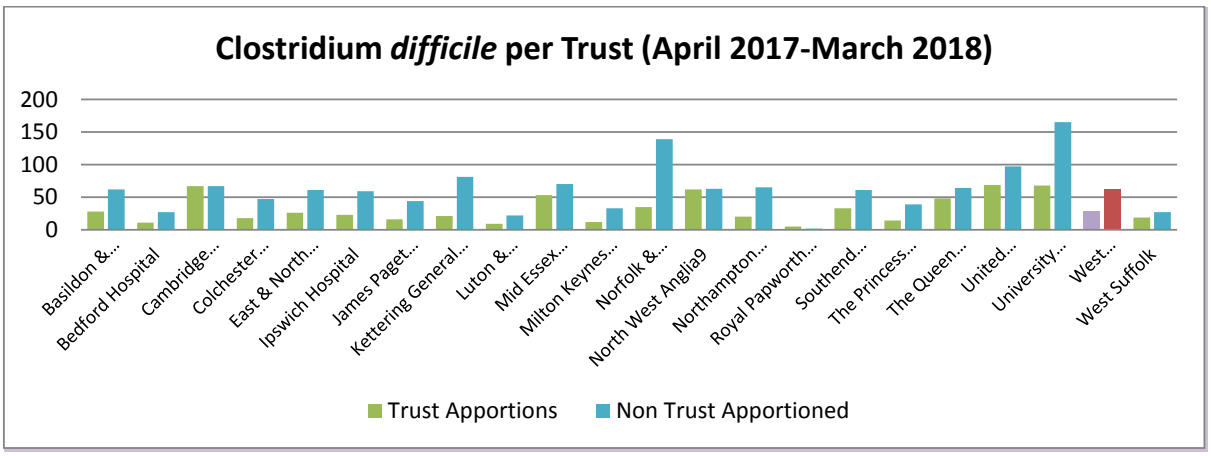


Figure 7: WHHT apportioned Clostridium difficile cases per Ward



This demonstrates that there were more cases reported on Tudor ward. There is also a greater number of side rooms present patients are nursed for isolation purposes.

Figure 8: WHHT C.diff compared with other trusts in East of England in 2017/18



Our CDI Cumulative Provider Rate (per 100k bed/days) is 12.23 as of March 31st 2018, which is lower than the East of England (EoE) being 16.39 and 15.11 for England.

Figure 9a: West Hertfordshire Hospitals NHS Trust (WHHT) 2017-18 C.diff number & rate per 1000 bed days against that of Midlands & East (M&E) and the national data

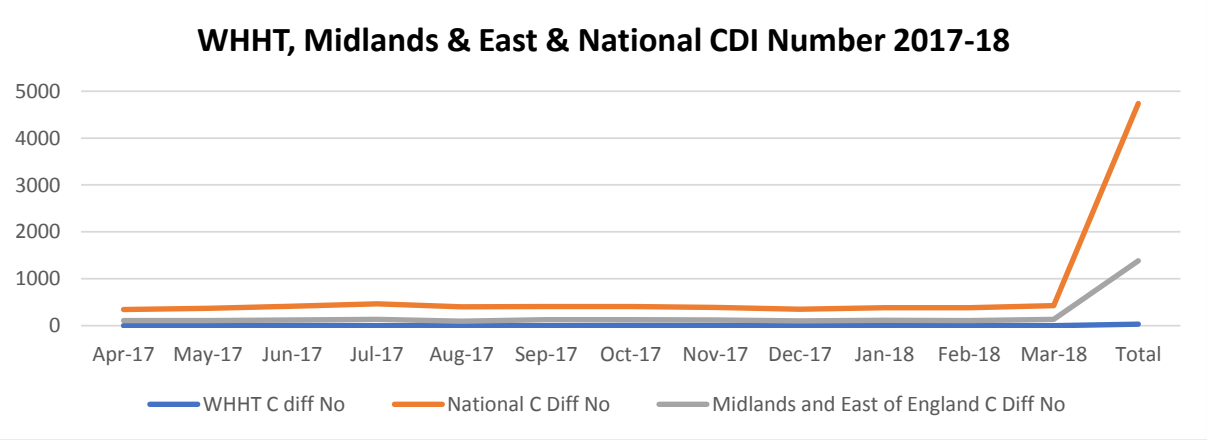
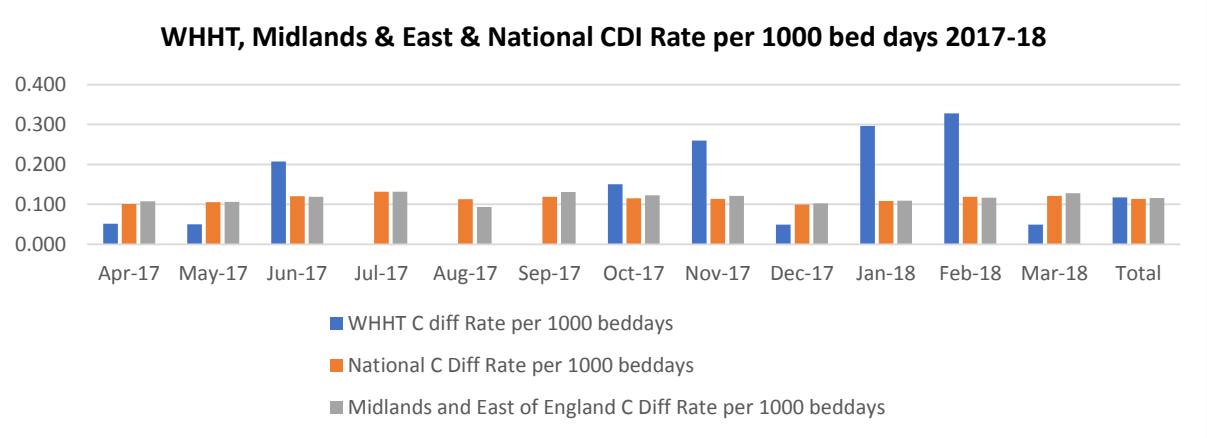


Figure 9b:



The above graphs and figures shows the comparison of West Hertfordshire Hospitals NHS Trust (WHHT) 2017-2018 CDI number and rate per 1000 bed days against that of Midlands and East (M&E) and the national data. The CDI number indicates that the cases for WHHT is in line with M&E and the national trend throughout the year and increase in figures at the end of the year is lower than both M&E and the national average.

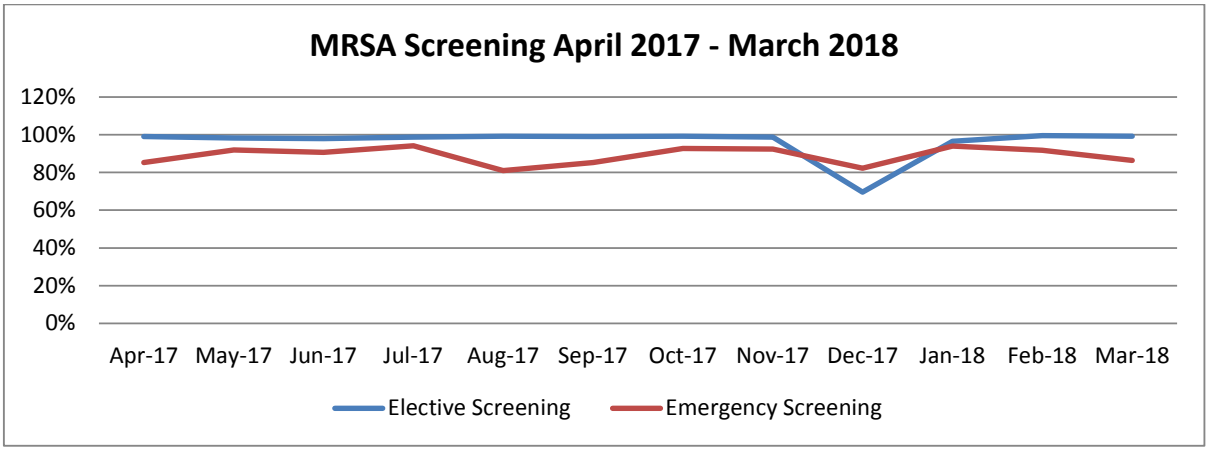
However, the CDI rate per 1000 bed days against that of M&E and the national data is varied. During four months of the year (April, May, December and March) the Trust CDI figures were well below both M&E and the national average. Additionally, during three months of the year (July-September) there were no cases of CDI at all. However, during the remaining four months of the year (June, November, January and February) the CDI rate per 1000 bed days against that of M&E and the national data was higher. This is considered to be in line with the surge in operational activities during those months. There are a number of awareness campaign and environmental review which are underway to reduce the CDI numbers.

5.5 MRSA Screening Compliance

In June 2014 the DH published the implementation of modified admission MRSA screening guidance for NHS trusts, where trusts could implement selective screening for MRSA. The Trust has continued to adopt MRSA screening for all planned and emergency admissions with the exception of some low risk areas. The MRSA screening compliance is

monitored in the monthly IPCP meetings. Patients identified to be MRSA positive are promptly isolated and commenced on the decolonisation protocol.

Figure 12: Below is the graph that shows MRSA screening compliance for both emergency and elective admission in the trust for 2017-2018.

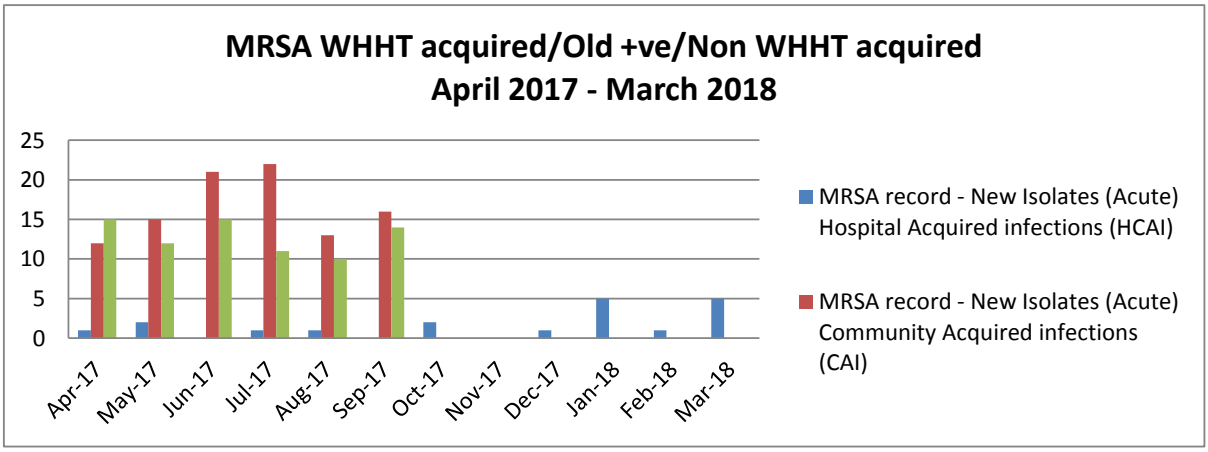


5.6 MRSA Isolates

5.6.1 MRSA isolates for April 2017 - March 2018

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

Figure 13:

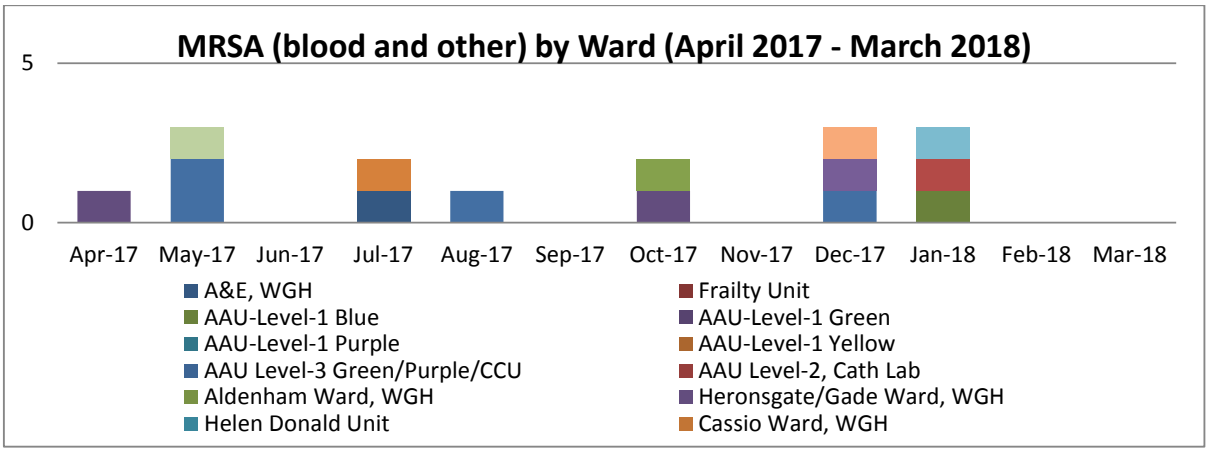


The WHHT apportioned MRSA (colonisation) has been consistently lower than those that are positive on admission.

5.6.2 MRSA isolates per ward

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

Figure 14:



6 ANTIMICROBIAL STEWARDSHIP ACTIVITIES (April 2017-March 2018)

Establishing antimicrobial stewardship programme is crucial to reduce healthcare associated infections (HCAI) and contributes to slowing the development of antimicrobial resistance. Antimicrobial stewardship team focussed on the delivery of the national CQUIN "Reducing the impact of serious infections" which include both timely identification and treatment of sepsis in emergency departments and acute inpatient settings; and AMR (Antibiotic review and reduction in total consumption). Members of the antimicrobial committee meet every two months to discuss the trust antimicrobial strategy and stewardship programme. Minutes of these meetings are submitted to MUSP.

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

Annual Point Prevalence Survey of Antimicrobials was conducted in November 2017. The following is the summary of the survey report

- The percentage of patients prescribed antimicrobials is 40% (230 patients). This is in higher than the national 2016 survey (34.3%) and similar to November 16 surveys (40%).
- The percentage of IV antimicrobial courses is 64% (202/315).
- 29% of patients were prescribed antimicrobials in COE, 23% were prescribed in medicine, 26% were prescribed in surgery, 9% were prescribed in Admissions ward and 13% patients were prescribed in women's and children services division.
- Overall compliance to antimicrobial guidelines is 81%. Co-amoxiclav prescriptions accounted for 61% of non-compliant prescriptions.
- 87% of antimicrobial courses had documented review within 72 hours
- 16% of patients were on PPI and antimicrobials during the survey. This is increased from Nov 16 survey (10%).

This year the team also took part in the national pilot project in December 2017 to quantify the percentage of inappropriate antibiotic prescribing expressed as non-essential days of therapy (DOTs) against appropriate days. The full data analysis for this project is still in progress.

Several interventions were put in place to achieve the National CQUIN target including regular antimicrobial stewardship ward rounds, audits to monitor broad spectrum antibiotics (carpbapenem) and monitoring antibiotic consumption. Antibiotic consumption and other relevant data has been submitted to ESPAUR and CCG for part 2c and 2d targets for the year 2017/18 which the trust have achieved (Table 3)

Table 3:

2c: Indicator 2c Antibiotic review

Date	Numerator	Denominator	%
QTR1	52	53	98
QTR2	50	50	100
QTR3	42	43	98
QTR4	46	48	96

Reduction of 1% or more in total antibiotic consumption against baseline

Date	Baseline 2016 DDD/1000 admission	DDD/1000 admission	Variation % from baseline 2016	YTD %
QTR1	4225	3881	-8	-8
QTR2	4225	3761	-11	-10
QTR3	4225	3846	-9	-9
QTR4	4225	4240	0	-7

Reduction of 2% or more in piperacillin-tazobactam against the baseline

Date	Baseline 2016 DDD/1000 admission	DDD/1000 admission	Variation % from baseline March 16	YTD %
QTR1	190	93	-51	-51
QTR2	190	127	-33	-42
QTR3	190	185	-3	-29
QTR4	190	211	+11	-19

Reduction of 1% or more in carbapenem against the baseline

Date	Baseline 2016 DDD/1000 admission	DDD/1000 admission	Variation % from baseline March 16	YTD %
QTR1	66	83	+25	+25
QTR2	66	60	-9	+8
QTR3	66	86	+30	+15
QTR4	66	69	+5	+13

The antimicrobial stewardship activities in our trust were presented as posters at different international and national conferences. Junior doctors participated in some of these audits. Examples of these audits are: “Appropriateness of UTI management” “Appropriateness of Gentamicin use”. The impact of Antimicrobial stewardship rounds; ECCMID 2017, Vienna. “Evaluation of sonication as a diagnostic tool in orthopaedic implant infections” was given as an oral presentation at ECCMID 2017

Two posters and one workshop on “Antimicrobial stewardship quality indicators for hospital and primary care – progress, outcomes and future” were presented at Federation of Infectious Societies (FIS) in Birmingham in November 17.

The Trust took part in European Antibiotic Awareness Day on 17th November 2017. Staff from pharmacy, infection control and microbiology ran a campaign with quizzes, information sheet on AMR and educational programme throughout the day for public and

staff. This year the team expanded the campaign to children services where a range of activities involving children were conducted. Presentations were also giving in primary schools by microbiology consultants.

Weekly MDT C-diff round, virtual OPAT (outpatient antimicrobial therapy) ward rounds, orthopaedic and diabetic foot infections MDT ward rounds and TB MDT rounds are conducted to ensure high quality of care and safe prescribing of antimicrobials.

The AMS team is very proud to receive the antibiotic guardian award organised by PHE in recognition of our achievements in antimicrobial stewardship for prescribing and stewardship. The award was presented at Marriott Hotel in an international ceremony attended by Dame Sally Davies CMO.

Current Actions and Recommendations:

- Assess appropriateness of antimicrobial prescribing for treatment and prophylaxis.
- Continue to engage junior doctors in antimicrobial stewardship audits
- Continue to deliver educational teaching sessions to medical, nursing and pharmacy staff and to re-enforce microbiology clinical aspects in teaching session
- Implementation of new interventions to ensure appropriate antibiotic prescribing for example antimicrobial review sticker
- Expansion of OPAT service
- Introduction of innovation to improve antibiotic prescribing and ensure appropriate antibiotic use for example rapid diagnostics

7 WHHT SURGICAL SITE INFECTION SURVEILLANCE PROGRAMME 2017-2018.

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

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

WHHT has been participating in continuous hip and knee prosthesis SSI surveillance since July 2010 with the addition of other categories of surgery as agreed within the Divisional SSI Surveillance Programme.

7.1 WHHT Combined Trend in SSI Rate 2017-2018

Figure 15:

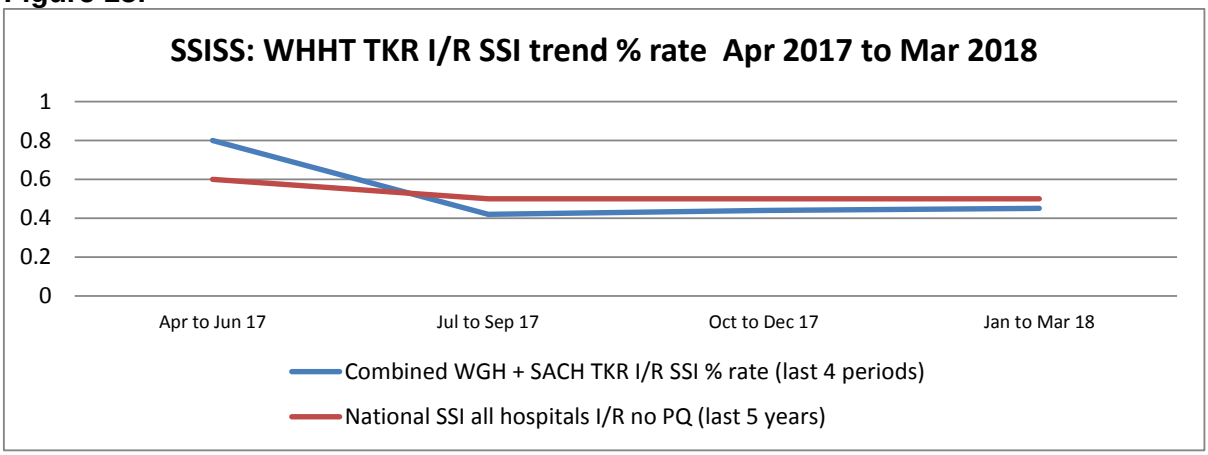
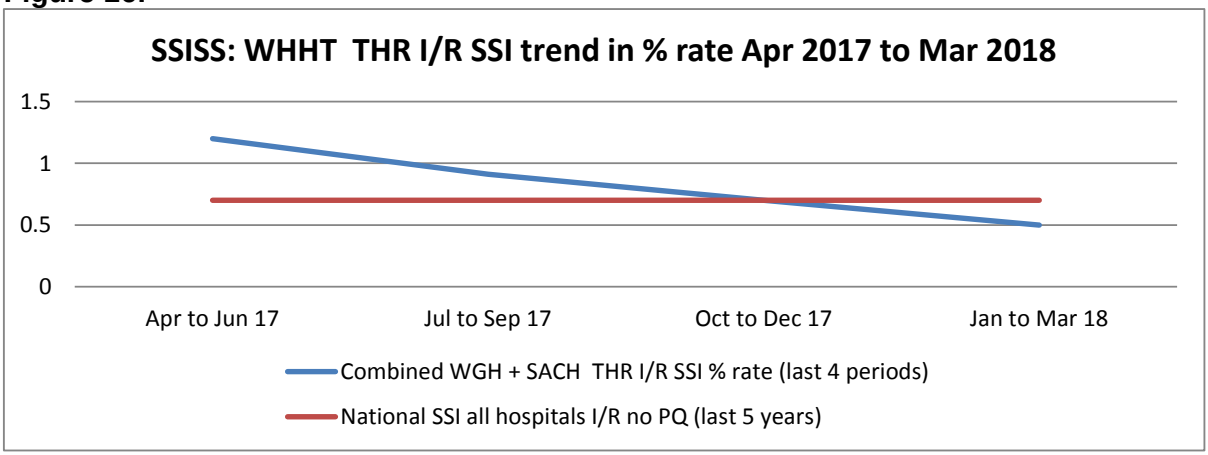


Figure 16:



7.2 High Outlier Notifications

So far in 2017-2018 WHHT received high outlier notifications for the following:

- TKR @ WGH Apr-Jun 2017 (Combined rate over last 4 periods = 1.9%)
- THR @ WGH Apr-Jun 2017 (Combined rate over last 4 periods = 3.6%)
- THR @ WGH Jul-Sep 2017 (Combined rate over last 4 periods = 4.3%)

Worth noting is that due to low quarterly study populations @ WGH (Less than 100), the SSI rate for each period was configured using the combined data from the last four periods, and 0 SSI's have been reported for TKR surgery @ WGH for 2017-2018 so far. No alert notices have been received for the SACH site for 2017-2018 to date.

7.3 Summary of Findings

- WHHT SSI Rates for THR + TKR have decreased, though this remains subject to change as surgical cases involving implants/metalwork are monitored for 365 days, and therefore SSI surveillance is continuous.
- Study population for both THR + TKR has decreased over the last year.

- There were 2 TKR SSIs reported for the SACH site (1 Deep incisional, 1 Organ/Space).
- There were 2 THR SSIs reported for the WGH site (1 Superficial, 1 Organ/Space).
- SSI Rate in Repair of #NOF surgery has remained at 0%.
- One Superficial SSI was reported for spinal surgery giving a rate of 2.5%. However as the study population for this quarter was less than 100, the combined inpatient/readmission SSI rate for the previous four quarters is 1%.
- Pathogens identified as SSI causative @ WGH were Proteus Mirabilis, Staph haemolyticus and Staph epidermidis.
- Pathogens identified as SSI causative @ SACH were Enterobacter aerogenes, MSSA, Staph Epidermidis, Staph haemolyticus.

7.4 Surgical Site Infection Prevention Panel (SSIPP)

The SSIPP is a bi-monthly Surgical Divisional Meeting, Chaired by an Orthopaedic Consultant Surgeon. The vice chair is WHHT's Infection Control Doctor/Consultant Microbiologist.

Following an increase in SSIs during 2016-2017 an orthopaedic SSI action plan was implemented in 2017 and key areas focused on were antibiotic prophylaxis, ring fenced orthopaedic elective wards and SSI care plans. Progress has been made with this action plan. There are now ring fenced orthopaedic wards on both sites (Flaunden A – WGH and De la Mare – SACH). An antibiotic prophylaxis audit was undertaken by the Antimicrobial pharmacist and the policy in the process of being modified and updated.

Topics currently being explored by the SSIP include MSSA screening and decolonisation for elective orthopaedics and elective surgical SOP for SACH is also action plan.

There are Terms of Reference and minutes for these meetings.

8 VASCULAR ACCESS 2017-2018

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

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

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

8.1 Service Improvements Undertaken & Activities

8.1.1 On-line referral system

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

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

The referrals automatically link to the Vascular Access database, which has been in place since August 2017.

8.1.2 Weekly reviews

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

8.1.3 Peripheral IV access device audit

This was undertaken in conjunction with B Braun (supplier).

8.1.4 Summary of recommendations

- Improvements in ongoing care
- Documentation

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

8.2 Teaching

8.2.1 Trust Central Venous Catheter (CVC) study day

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

8.2.2 Teaching in the clinical areas

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

8.2.3 MDT teaching

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

- FY1 & FY2 doctors
- CT1 & CT2 doctors
- Trainee pharmacists

8.3 Future plans

8.3.1 Teaching

- The Trust peripheral IV administration study day is undergoing major changes to concentrate on practical workshops
- An e-module workbook and pre-course test is in the process of being developed and the new style course will commence in January 2018.
- The CVC IV administration course was be evaluated in December 2017 to determine how many attendees have been signed off as competent, the results will determine future course structure and may involve practical days being built into the course, to ensure competencies are met.
- A bi-annual rolling programme for ward-based teaching.

8.3.2 Audits

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

9 INCIDENTS AND OUTBREAKS OF INFECTION

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

9.1 Outbreaks of Infection

There were a number of outbreaks recorded in Hertfordshire in 2017-2018 with a higher proportion coming from care homes in West Hertfordshire. The IPCT continued to inform key areas e.g. A&E, operations team about the closed homes to ensure that patients admitted from these homes were immediately isolated on admission.

9.1.1 Influenza A outbreak

Summary and points regarding Influenza A Outbreak management during 2017-2018

A flu debrief meeting was held to review flu management in the Trust following the flu pandemic, which was led by the Head of Emergency Planning & Resilience. There was an increased number of incidents reported relating to flu. This has been recognised as a national risk and the 'Emergency Preparedness Plan on Pandemic Flu' policy has been in place to provide the necessary information to support incident response. Flu information was received from NHS England and decisions making were in line with plans.

The flu group has utilised the SI Panel scheduled meeting to discuss in broad terms the Trust's responses. A review of the incident data showed nineteen incidents, where flu severity triggers were used as a filter to establish some trends and a number of the results were related to issues around isolation management and capacity.

Flu management during the winter months

Daily meetings were held to discuss the flu cases, includes weekly reports on ITU patients and deaths. Documentation was produced following the daily meetings, which was continued until the end of April 2018. The NHSE and NHSi are also debriefed daily through the uploading of data to UNIFY.

The CCG criteria for the reporting of a Serious Incident relating to infection control such as norovirus was noted and will be used managing similar situations in the future.

It was noted that staff in A&E were aware of the signs and symptoms of flu and that they should highlight any patient's with these symptoms.

The Datix incident reports and themes arising were integrated were used to inform the flu planning for the following year. This was also submitted to Local Health Resilience Partnerships (LHRP) for their combined review.

NHS England provided guidance on reporting of flu after the completion of the increased flu incidence, which was followed accordingly. Plans were in places which were monitored by the IPCT during this period.

The IPCT reviewed all relevant documentation and policies which were used within the debrief review to ensure they meet the new guidelines. Point of Care Testing (PoC) was in use to help identify and manage flu early. Wider learning was identified regarding PoC testing in and out of hours and the flow of patients throughout the hospital. This learning fed through the safety and compliance meeting.

The Trust continued its usual practices and management as part of the Pandemic Flu Policy and IPC until the flu incident was closed.

9.1.2 Norovirus

There were Norovirus and/or diarrhoea and vomiting outbreaks on AAU Level 3 Yellow and Blue, Croxley, Heronsgate and Winyard during the year 2017/18. Outbreak meetings were held with key staff with the minutes from the outbreaks tabled at the IPCP.

Table 7: Norovirus Outbreaks 2017-2018

Ward	No of patients tested	No of patients +ve for norovirus	Ward / Bay closed?	Outbreak duration
AAU3 – Blue	6	3	Yes	25.08 - 03.09.17
Winyard	9	8	Yes	12.09 - 23.09.17
AAU3 – Yellow	6	2	Yes	10.10 - 20.10.17
AAU3 – Blue	6	1	Yes	11.10 - 17.10.17
Croxley	30	5	No	02.12 - 15.12.17
Heronsgate	7	2	Yes	27.02 - 02.03.18

The control measures that were implemented:

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

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

9.1.3 Clostridium difficile period of increased incidents (PII)

Red Suite

Red Suite is a eighteen bedded care of the elderly ward.

There were two cases of CDI on Red Suite within a week of each other during the month of November 2017. There was however no overlap on Red Suite of both cases. However, because we have had two cases of CDI (WHHT apportioned) on the same ward within 28 days, we convened a meeting to discuss this period of increased incident (PII) of CDI cases on Red Suite and to see whether there were any links between CDI cases recently identified in the trust.

Between December 2017 and March 2018 there were no further cases of CDI on Red Suite, with the last case reported in December 2017.

Actions taken following the PII of CDI on Red Suite

Isolation

It was noted that there are no side rooms in Red Suite and the patient with diarrhoea or other infections should not be admitted or treated in Red Suite. It was suggested that staff should always observe strict infection control precautions when caring patient with diarrhoea.

IPC audits

IPCN team continued to support the ward with hand hygiene and Code of Practice audits and there were follow-up of actions from IPC audits and RCAs of CDI cases from Red Suite.

IPC training uptake

IPCN team provided power training sessions exclusively for Red Suite staff and there were good attendances for the power training sessions. There was a follow- up on the compliance with Infection control mandatory training.

9.2 IPC Related Incidents

9.2.1 C.Diff

There were twenty eight CDI cases against a trajectory of twenty-three, following appeal seven cases were approved which means that twenty one cases were liable for sanctions, which was under the trajectory. Six Trust attributed cases of CDI had been reported in January 2018 and February 2018. This pattern shows an upward trend since June 2017 in the six-month moving average of trust apportioned cases. NHS Improvement and Public Health England were invited and have visited the Trust to review our trends and practices. They were assured that the Trust is a in a much stronger position than we were a few years ago. However, there was some areas for improvement around Personal Protective Equipment (PPE), COSHH and the infrastructure. The Trust and CCG reported good working relations in ownership and preventive work to monitor and contain CDI, surveillance and advice to prescribers on antibiotics and proton pump inhibiters which are recognised risk factors. Root cause analysis had been undertaken on all cases and the is a CDI action plan in place.

Actions taken

- Continued with targeted training and education which has been informed by the learning identified from the RCAs

- Weekly C.difficile ward rounds with gastroenterologist joining the rounds bi weekly
- Wider sharing of key issues from the RCAs in the Divisional Governance, IPCP meetings

Weekly Clostridium difficile ward rounds continue with gastroenterologist joining bi weekly.

9.2.2 Pseudomonas in SCBU

During June 2017 there were four cases of colonisation of pseudomonas aeruginosa identified. Following investigation the VNTR typing profile of all patients were different, meaning that there was no connection between each other. Following review it was agreed that this was not an outbreak but was a period of increased incidence.

There was a further cluster of seven spread over June to November 2017 and a PII meeting was convened to determine if there were any links. Following review, although 3 babies had the same VNTR profile, this strain is very common and the investigating team concluded that this could be coincidental as there was no overlap of the babies on SCBU.

In order to address these findings, the key actions included:

- Infection control training
- Cleaning of taps, water sampling and flushing
- Increased observational audit
- Supervision of the domestic staff
- Deep cleaning of the area
- Advice was also sought from PHE and the local Health Protection Team (CCDC) in view of the clusters of cases that occurred
- Weekly screens of the babies on the unit for Pseudomonas aeruginosa has continued

9.2.3 Carbapenemase-Producing Enterobacteriaceae (CPE)

WHHT has adopted a strict policy for the control of these organisms, based on national guidelines and the experiences of other hospitals.

There has been a change in screening practice due to transmission which was investigated as a serious incident (SI). Public Health England (PHE) was asked to visit by the infection prevention and control team (IPCT) to discuss the incident and support further recommendations for practice. A plan has been put in place which is monitored by the IPC panel and as part of the SI Review Group (SIRG).

CPE on Flaunden: July 2017

There were two cases of CPE on Flaunden ward that were linked to time and place, which were potentially CPE transmission. A meeting was held which investigated the source of the PII and discussed and implemented the required IPC measures.

Actions taken

- Assigned a registered nurse to complete the Patient Risk Assessment forms or ensure a qualified nurse verifying the accuracy of the documentation if it has been completed by a HCA
- All staff to informed and educated about the requirement of CPE screening all patients if they have been an inpatient in a hospital abroad or in any UK hospital including WHHT within the last 12 months
- Ensured patient equipment was appropriately decontaminated in between patient use
- Addressed the low compliance with the CoP audit

- Discussed the CPE policy at the ward meeting and provided a copy of the trust CPE policy for staff to read and sign that they have read and understood the policy
- Carried out support audits on CoP and hand hygiene on Flaunden ward until a compliance of >95% was reached for both hand hygiene and CoP audits for three consecutive weeks
- Provided Flaunden staff availability to IPCN team to undertake power training on the ward
- Ensured all doctors in the team were aware of CPE
- Arranged CPE screening for all contacts on Flaunden
- Aldenham ward sent rectal swabs from the affected patient who was transferred from Flaunden for CPE screening
- Alerted all CPE contacts in CLINICOM as 'CPEC' (CPE contacts)
- Informed Herts Valley CCG Head of IPC and PHE Consultant in Communicable Disease Control about the two linked cases of CPE
- Convened other follow-up meetings after receiving the typing results

9.2.4 CPE in Surgery & Medicine January: February 2018

There was no evidence of CPE transmission until the two cases were reported on Flaunden Ward in July 2017. The index case was nursed in single side room and isolated on admission and the second case had been nursed in an open bay. Both patients were cared for by the same staff. There was extensive investigation and two minuted meetings held. Professor Peter Hoffman (Consultant Clinical Scientist) for PHE and Deepti Kumar, PHE Consultant visited the area concerned. A detailed report, including recommendations was received from Prof. Hoffman from which an action plan was produced and implemented. The report focused on sluice rooms, cleaning and decontamination, the environment and an education regarding CPE.

There were six cases of CPE reported during January to February 2018. Three were in the Surgical Division and three in the Medical Division. An investigation meeting was held to review the cases to determine if there was a common source or not. The review included timelines and microbiology background and also a review of the control measures implemented as well as areas for future focus. The VNTR typing profile is the identical for four of the six cases. For the three cases were in the surgical areas, two were in Langley Ward and one on Cleves and all have the same VNTR. Two of the three medical cases identified in medicine had the same VNTR as the three cases in Surgery but there appeared to be no striking association in terms of time, date and ward.

As of the end of March 2018 there have been forty-four cases of CPE reported in WHHT since 2014 following the implementation of CPE screening following the production of PHE national guidance and toolkit in March 2014. Of those cases, thirty-nine were reported from the WHHT lab, four from other hospitals and one from the GP.

We made some changes to our local policy in May 2017 and broadened the screening criteria. As a result, we screen more frequently where all ITU patients are screened on admission to ITU and screened weekly whilst there. CPE screening in other areas is undertaken if they are identified as having been an in-patient in any hospital within the last 12 months, as determined by the Risk Assessment Tool on page 2 of the patient's assessment documentation. There has been a need to further explore if increased screening has had an association with the increase in numbers.

Challenges around CPE management are timely isolation of the patients due to side room availability and staff not checking for alerts on admission. This has caused extensive unnecessary tracing of the contacts, generating a lot of work for the IPCT and clinical staff.

The IPCT have placed alerts on all the contacts to enable them to be screened when there are re-admitted for those that would not have been screened prior to discharge.

9.3 Ventilation Incidents

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

The verification process comprises a series of tests and measurements in accordance with the relevant HTM to determine the performance of the ventilation system(s) serving the clinical area. An inspection of the air handling equipment was undertaken to ascertain whether the performance and general condition of the air handling unit and associated plant complies with the design specification to which they were initially installed.

Following these inspections and verification tests, some of these areas did not achieve the required >75% of the original parameters as set out in HTM 03-01 Part 3. It is worth noting that the guideline recommendation HTM 03-01 is a new guidance for new units.

There have been ventilation requirements identified across the WGH and SACH site to meet the HTM-03-01 requirements taking into account the guidance when built in line with Public Health England (PHE). Mitigations were put in place for laying-up in theatres instead of the prep rooms.

The Endoscopy unit at WGH was inspected and serviced in April 2017 to ensure it met the regulatory requirements.

Side rooms on Aldenham and Starfish were found not to be meeting HTM 03-01 ventilation regulations. SOP are now in place for each area and Estates are working to convert rooms to meet standards. This is being led by the Head of Emergency Management with the support of IPC.

Ventilation validation was undertaken in September 2017 for the Dermatology Minor Operations room WGH followed by works to ensure that they meet regulatory requirements.

There is now a ventilation group which meets monthly to review the ventilation compliance in the Trust. There is a ventilation schedule highlighting all areas where ventilation is used for invasive procedure, indicating when they were last maintained.

10 WATER SAFETY

The Water Safety Group continues during the year to review and manage procedures surrounding the control of legionella and pseudomonas in line with national recommendations.

11 THE INFECTION PREVENTION AND CONTROL 'DASHBOARD'

This is presented at each IPCP meeting. "Exception reports" are produced by the division/departments where areas of non-compliance are identified and discussed. The dashboard has hand hygiene compliance, commode audits, IPC training compliance, MRSA screening compliance, ward cleaning scores and high impact intervention audits. The actions taken are explained below under each key performance indicator below. The

water flushing regimes and temperature are monitored and fed back at the bi-monthly Water Safety Group and then the IPCP meetings.

12 ESTATES AND FACILITIES

12.1 Environmental Cleanliness Joint Monitoring

During 2017-2018, the cleaning service was provided by Medirest and the contract was monitored by the Facilities team. The standards were audited monthly by the trust monitoring officers. Below are the results for 2017-2018, which were discussed at the bi-monthly IPCP and actions for any failures identified and implemented. A trust Cleaning Group is in place which includes the IPCN's, facility team, cleaning contractors and clinical staff. The group discussed the cleaning scores and actions in detail.

See appendix 2 for Ward Cleaning Scores.

12.2 Action taken following failures

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

12.3 Deep Clean Programme

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

12.4 Infection Prevention and Control in the Built Environment

The IPCT has been involved in several refurbishments namely:

- Endoscopy expansion
- Creation of new CDU
- New physiotherapy department
- Flaunden A configuration

12.5 Macerators

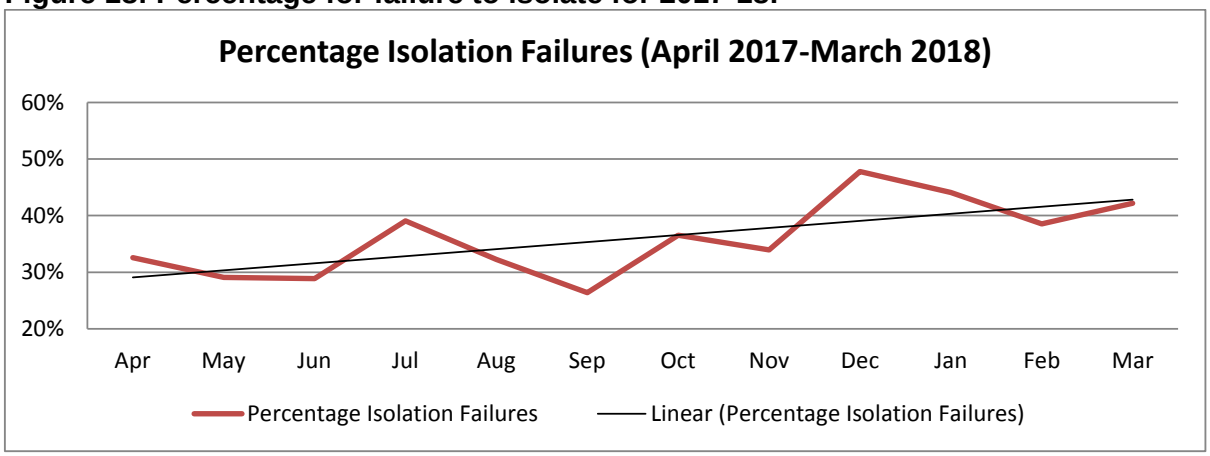
The Estates department has been reviewing macerators across the Trust and has put a replacement programme in place. Macerators with damaged seals or those that are mal-functioning are being prioritised in the first phase.

13 FAILURE TO ISOLATE

There are challenges isolating patients with the availability of side rooms in the Trust and competing priorities. Failure to isolate within two hours is recorded on Datix as an incident and discussed at the bi-monthly IPCP. There is no side room availability in the Granger Suite (Red Suite, Winyard & Bluebell); this is on the Trust Risk Register: Risk number

3436 and scoring is 10. Patients that need isolation in a side room are transferred either to the Isolation Unit or to another ward where a side room is available. Out of hours and weekends there is a senior nurse to support ward staff in prioritising the side rooms, during the week IPCNs support this. The graph below show the percentage for failure to isolate.

Figure 18: Percentage for failure to isolate for 2017-18:



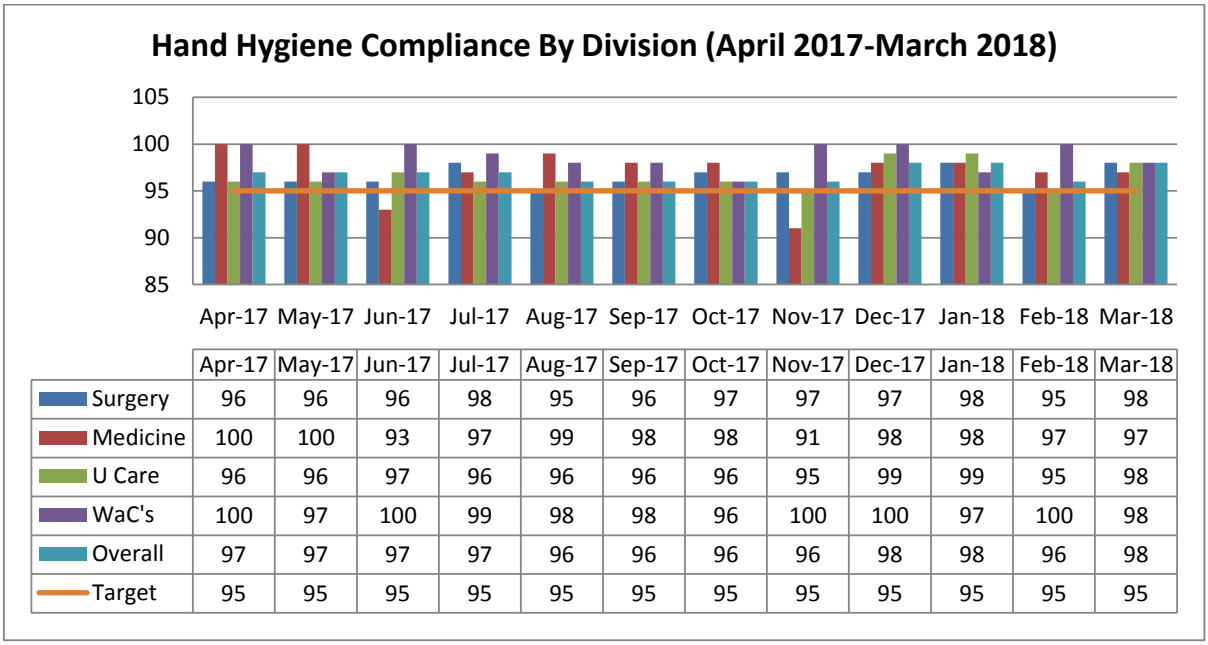
IPCNs continue to support clinical areas that have patients that have not been isolated due to unavailability of side rooms by ensuring appropriate management of these patients. There are regular visits by IPCNs to clinical areas. At times patient are not isolated due to being medical unfit, in these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

14 HAND HYGIENE AUDITS COMPLIANCE

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

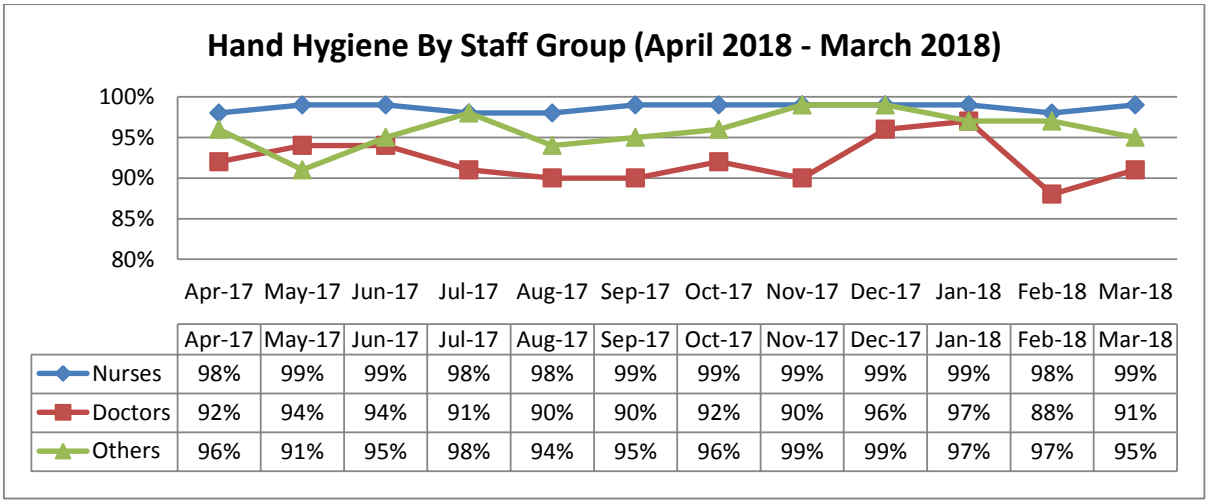
All auditors are trained in undertaking the hand hygiene audits to ensure that there are no variations. The Trust continues to participate in the yearly WHO international hand hygiene awareness day on the 5th of May with different activities undertaken by the IPCNs involving staff and members of the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

Figure 19a:



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Surgery	96	96	96	98	95	96	97	97	97	98	95	98
Medicine	100	100	93	97	99	98	98	91	98	98	97	97
U Care	96	96	97	96	96	96	96	95	99	99	95	98
WaC's	100	97	100	99	98	98	96	100	100	97	100	98
Overall	97	97	97	97	96	96	96	96	98	98	96	98
Target	95	95	95	95	95	95	95	95	95	95	95	95

Figure 19b:



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Nurses	98%	99%	99%	98%	98%	99%	99%	99%	99%	99%	98%	99%
Doctors	92%	94%	94%	91%	90%	90%	92%	90%	96%	97%	88%	91%
Others	96%	91%	95%	98%	94%	95%	96%	99%	99%	97%	97%	95%

12

15 IPC AUDITS

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

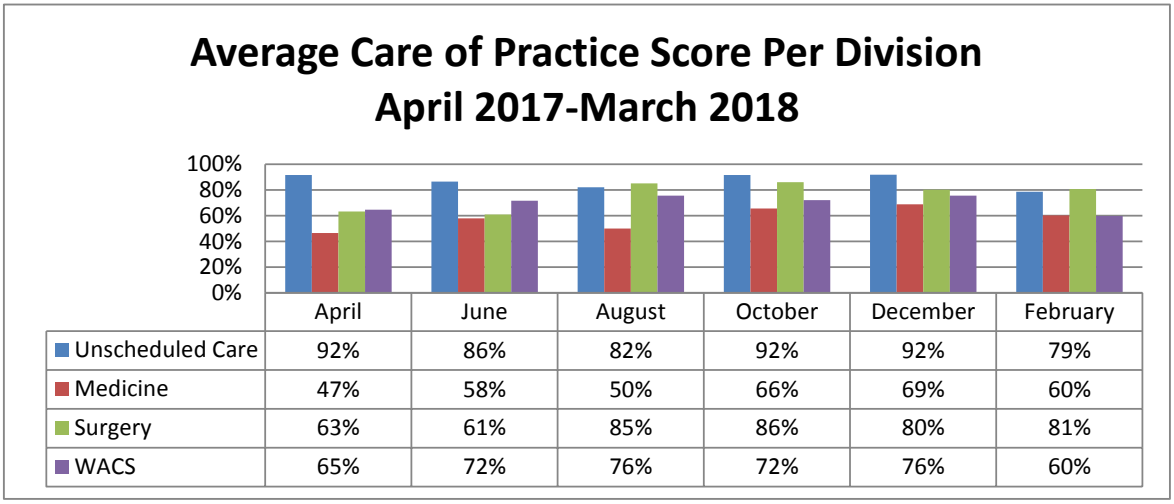
15.1 Code of Practice (CoP) audits

These are undertaken monthly, with the IPCNs and the clinical areas complete them on alternate months.

The key themes

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

Table 9:



	April	June	August	October	December	February
Unscheduled Care	92%	86%	82%	92%	92%	79%
Medicine	47%	58%	50%	66%	69%	60%
Surgery	63%	61%	85%	86%	80%	81%
WACS	65%	72%	76%	72%	76%	60%

16 IPC ACTIVITIES

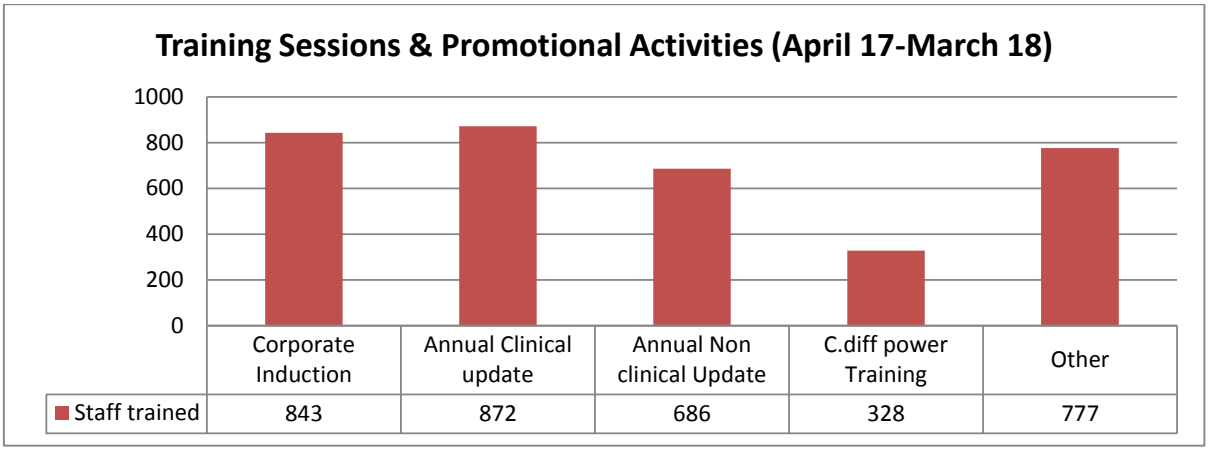
16.1 Training

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

16.2 Power Training

This is well received by staff, where IPCNs deliver short and quick sessions lasting from 10-20 minutes in clinical areas. Topics covered in power training so far are Clostridium difficile, MRSA, hand hygiene, isolation, decontamination, CPE and PPE. IPCNs have introduced a quiz to test staff knowledge of IPC. Norovirus was a key topic in Q3 and Q4 as it was the winter season.

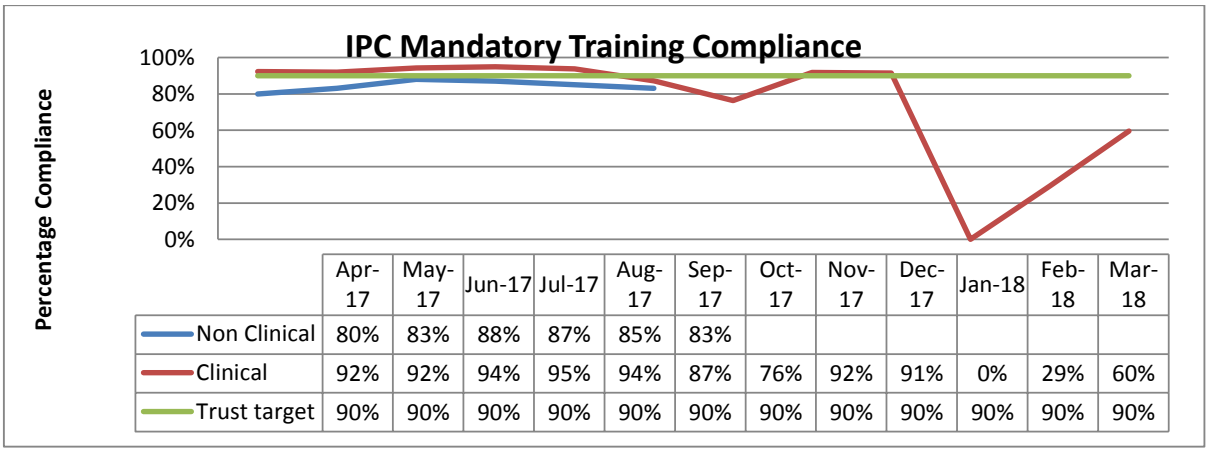
Figure 20: Below are the training activities April 2017 to March 2018



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

Figure 21: Infection Prevention & Control Training Compliance

The Trust target for IPC mandatory training is 90% for clinical staff. Compliance is monitored via bimonthly IPCP meetings.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Non Clinical	80%	83%	88%	87%	85%	83%						
Clinical	92%	92%	94%	95%	94%	87%	76%	92%	91%	0%	29%	60%
Trust target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

17 INFECTION PREVENTION AND CONTROL LINK PRACTITIONERS

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

- Audits
- Clostridium difficile infection
- MRSA care plans
- MRSA screening and decolonisation
- Decontamination of patient equipment
- CPE and screening
- IPC Dashboard

- Norovirus, MRSA, Clostridium difficile infection and documentation
- Dress code and infection prevention & control

18 POLICIES AND PROCEDURES

All IPC policies, guidelines and leaflets that were due for review were updated to reflect current evidence based best practice. Current policies were also amended when relevant new guidance was published to ensure they remained contemporary and that compliance could be monitored. Refer to appendix 5.

19 EXTERNAL VISITS

- Prof. Peter Hoffman visit for Surgery Division (Flaunden)
- CQC Inspection various Trust departments (August 2017)

20 RECOMMENDATIONS:

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

APPENDIX 1:

Future Priorities & Direction – 2018-2019

- IPCT to continue maintain high visibility and engagement in the clinical areas
- Continue to raise awareness amongst staff regarding the importance of Personal Protective Equipment (PPE) in the prevention and control of infection in all educational sessions and on routine visits to clinical areas
- Deliver regular additional IPC mandatory training sessions to compliment the online training acorn
- Provide additional support to IPC Link Practitioners by undertaking introducing an IPC link competence framework and regular full day study days
- More IPC link practitioners to be trained in completing CoP audits for their areas and developing an action plan for improvement
- Improve the turnaround of action plans for HCAI RCAs and clinical audits, and have evidence embedded prior to sign-off
- Encourage increased attendance to the CVC & Peripheral IV administration study day to increase the number of staff compliant in care of PICCs, Midlines and CVCs
- Embed compliance with the outcomes/actions audits for Peripheral IV cannula and CVC audits
- Embed compliance with the IPC admission risk assessment to ensure appropriate management of patients, particularly for CPE, CDI and MRSA
- Agree with CCG a local performance measure to work towards achieving the reduction of E.coli by 50% by 2021
- Support the achievement of the antimicrobial and sepsis 6 CQUIN
- Develop a formal OPAT pathways on antimicrobials management out of hospital
- Continue weekly OPAT ward round and fortnightly MDT including for orthopaedics
- Daily antimicrobial rounds on intensive care
- Weekly carbapenemase stewardship rounds
- Continue to monitor antibiotic consumption
- Continue weekly C.diff ward rounds
- Having a dedicated electronic infection control surveillance software

Trust Board Meeting
01 November 2018

Title of the paper	**End of Life Care Annual Report 2017 – 2018**
Agenda Item	**13/64**
Presenter	Tracey Carter, Chief Nurse
Author(s)	Michelle Sorley, Macmillan Lead Nurse
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: √
Executive Summary	The End of Life Care Annual Report is an account of End of Life Care (EoLC) across West Hertfordshire NHS Hospitals Trust (WHHT). The report covers the period from April 2017 to March 2018. The report has been discussed at both Quality and Safety Group and Clinical Outcomes and Effectiveness Committee and it demonstrates the organisations continued commitment to our patients over the last twelve months, supporting the delivery of high quality, timely, effective, individualised care for our patients with end of life care needs, to ensure support for their families as well as support for our staff providing these services. This improvement work continues, to support our staff in providing compassionate, holistic, patient centred care. End of Life Care is everyone's responsibility and is being recognised more promptly across our clinical areas. During this period the Care Quality Commission inspection recognised areas of good practice and also acknowledged improvement since the previous inspection. However, the Trust was in breach of Health and Social Care Act 2008 Regulation 11: Need for consent as there was no evidence that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms. As a Trust we acted promptly and reviewed our DNACPR forms to incorporate MCA assessment, work is in progress to implement specific DNACPR/MCA forms. Trust wide learning event to take place in April 2018. It was also recognised our palliative care consultant staffing levels at the Trust were insufficient – the levels were below 50% of the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care published collaboratively with the association for palliative medicine of Great Britain & Ireland. A business case has been commenced for an increase in the palliative care consultant establishment. This is a recognised risk on the Surgery Anaesthetics and Cancer Divisional Risk Register. Recommendations from external reviews and national recommendations

	remain a focus for the End of Life Care Team and are included in the 2017/18 work plan. There has been a continued focus on training for our staff and since April 2017 all appropriate new starters to the Trust must now undertake a core essential teaching session in EoLC. During this reporting period we had a change in our End of Life Care Clinical Lead, our Orthopaedic Consultant resigned to take on another Trust role and one of our Colorectal Consultant Surgeons has been successfully appointed and taken up post.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care *Objectives 1-5* — √ Aim 2 Great place to work *Objectives 6-8* Aim 3 Improve our finances *Objective 9* Aim 4 Strategy for the future *Objective 10-12*
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	Committee/Group — Date Quality and Safety Group — 21st September 2018 Clinical Outcomes and Effectiveness Committee — 27th September 2018
Action required	▪ The Board is asked to receive this annual report for information and assurance of the progress in achieving the Trust End of Life Care Strategy.

13

Agenda Item: 13/64

Trust Board Meeting – 01 November 2018

End of Life Care Annual Report 2017 - 2018

Presented by: Tracey Carter, Chief Nurse

1. Purpose

The purpose of this report is to ask the Trust Board receive this report for information and assurance against progress of the End of Life Care Strategy and provides an account and an overview of End of Life Care across West Hertfordshire Hospitals NHS Trust (WHHT) for the period April 2017-March 2018.

2. Background

Caring for people nearing the end of life is one of the most important things we do in hospital and it is everyone's responsibility.

This is in line with the 5 priorities of care set out in "One Chance to get it Right" Leadership Alliance for Care of Dying People (2014):

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

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

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

4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

As a Trust we supported 1555 patients over the age of 18 that died during the period April 2017 – March 31st 2018. This is an increase from the same period in 2016 -17 when we supported 1430 patients.

The numbers of patients referred to the Specialist palliative Care (SPC) team has also continued to increase, 1134 referrals were received for 1054 patients this compares with a

total of 1012 referrals for 947 patients in 2016 -17. This is an increase of 122 referrals and 107 patients.

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

3. End of Life Care Work Plan

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

Key achievements within this reporting period can be found in Appendix 1 and future priorities can be found in Appendix 2.

4. End of Life Care Leadership and Accountability

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

During this reporting period we had a change in our End of Life Care Clinical Lead, our Orthopaedic Consultant resigned to take on another Trust role. Mr Arbuckle one of our Colorectal Consultant Surgeons has been successfully appointed and taken up post.

The CEoLCP oversees all end of life work across the Trust. The panel reports end of life activity to the Quality and Safety Group (QSG) and through the integrated performance report (IPR) to the quality sub-committees of the trust board and also the trust board IPR. A six monthly report on the strategy progress is submitted to the Clinical Outcomes and Effectiveness Committee as part of the work plan.

The CEoLCP meets bi monthly with representation from across the Trust Divisions, the Chair of our Patient Panel as well as external representation for the Clinical Commissioning Group (CCG) and the East of England Ambulance Service.

An Operational End of Life Care Steering Group which is chaired by the End of Life Care Clinical Lead continues to meet bimonthly and reports into the CEoLCP.

Key Achievement – End of Life Care Clinical Lead appointed.

5. Inspections and Reviews

5.1 CQC Inspection August 2017

Following the 2016 inspection considerable work has taken place and a monthly Highlight Report (HLR) is completed as part of the Trust Quality Improvement Plan (QIP). The

Organisations' commitment and the hard work of the team and staff across the Trust resulted in End of Life Care sustaining a "Good" rating in the January 2018 published report following the Trust Inspection in August 2017.

Key End of life care findings included:

- There were systems in place to protect patients from harm and a good incident reporting culture
- The Trust had a replacement for the Liverpool Care Pathway (LCP) called the individualised care plan for the dying person. The document was embedded in practice on the wards visited.

- The service had produced a detailed action plan to address the shortfalls and issues raised by the National care of the dying audit of hospitals (NCDAH). Local audits were in place to measure the effectiveness and outcomes of the service.
- The Trust had an executive and a non-executive director on the Trust Board with a responsibility for EOLC.
- There was a clear vision and strategy for end of life care.
- Do not attempt cardio pulmonary resuscitation (DNACPR) records that were reviewed were signed and dated by appropriate senior medical staff.
- The SPC team saw 91% of patients referred within 24 hours and 100% within 48 hours
- There was evidence of a 7 day face to face SPC team.
- Care and treatment were coordinated with other services and providers.
- Staff demonstrated compassionate patient centred care throughout the inspection
- All wards had compassionate care champions who were trained in providing end of life care and were a direct link to the Specialist Palliative Care Team.
- Evidence was seen in the Board meeting minutes that EoLC was discussed.
- There was evidence of the risks on the EOLC and mortuary risks register being discussed at Board.
- EOLC training is delivered as part of the core essential teaching sessions that must be attended by all new starters.
- There were "Rose symbol" resource boxes on all wards.

However:

- The Trust was in breach of Health and Social Care Act 2008 Regulation 11: Need for consent as there was no evidence that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms

  Progress: Review of our DNACPR forms to incorporate MCA assessment and work is in progress to implement specific DNACPR/MCA forms. Trust wide learning event to take place in April.

- There was insufficient consultant staffing levels in palliative care provision at the Trust – the levels were below 50% of the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care published collaboratively with the association for palliative medicine of Great Britain & Ireland.

  Progress: A business case has been commenced for an increase in the palliative care consultant establishment.

The above issues have been included in the Trust Quality Improvement plan and the EoLC work plan and progress is monitored.

Key Achievement –"Good" CQC Improved rating sustained last inspection

5.2 Human Tissue Authority (HTA) Inspection November 2017

The Mortuary and Trust were inspected by the Human Tissue Authority (HTA) in November as part of the routine inspection timetable.

There were a number of areas praised for good practice including the comprehensive competency logs, the training of new funeral directors in mortuary admission procedures, the use of different coloured pens used to highlight the length of duration of the patients in the mortuary.

However there were 3 shortfalls also identified, and these have been acted upon, two of these were in relation to the Adult Post Mortem consent policy. The other shortfall is in relation to the lack of perinatal Post Mortem consent policy which the Trust is aware of.

Progress: The policy has been reviewed and is now awaiting ratification.

Key achievement a number of areas praised for good practice in the HTA inspection

5.3 NHSI Review August 2017

As part of the NHS Improvement End of Life Care Collaborative 150 day Rapid Improvement Programme that the Trust participated in a review was undertaken by NHSI the team visited the Trust on August 8th 2017.

The report commended the excellent work being undertaken as part of the collaborative and the progress made. They also praised the governance arrangements that were in place for EoLC, the fact that we had a very engaged Chief Nurse and we had a NED linked to EoLC. It was recognised
the challenges of engaging Medical colleagues in the collaborative and other members of the
Multidisciplinary team as well as how we would roll out the project to other areas.

Progress: Currently discussing the further roll out of this with the Surgical Division.

6. Governance and Risk

6.1 End of Life Strategy

Our Trust Strategy 2016 -19 sets out the vision and ambitions for End of Life Care in West Hertfordshire Hospitals NHS Trust (WHHT). It is informed by the national framework and the earlier NHS End of Life Care Strategy.

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

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

The National framework it is based on identifies six ambitions for locally delivered care which are:
Each person is seen as an individual
Each person gets fair access to care
Maximising comfort and wellbeing
Care is coordinated
All staff are prepared to care
Each community is prepared to help

The local priorities that we have identified will help us achieve the national ambitions for end of life care. As a Trust we are measuring our success in delivering this three year strategy against the achievement of our six ambitions and local priorities. These are recorded on the Trust wide End of life Care work plan which is monitored by the CEoLCP.

- Each person is seen as an individual
  Progress: each person is assessed as an individual and over this reporting period we have been embedding our Individualised Plan of Care for the Dying person into practice, across the Trust.
  By 2019, 90% of patients to have their preferred place of death (PPD) documented and if preferred place of death was not achieved 100% of patients to have reason documented. As a SPC team we report this activity to the Board monthly over this reporting period the latter 6 months of this period 100% of our patients had a PPD recorded.

- Each person gets fair access to care
  Progress: there is work across the locality in relation to addressing the issues of inequalities eg due to homelessness, ethnicity, patients with learning disabilities, dementia, non-malignancy long term conditions, as well as in the Trust, the Trust is represented at the Learning Disabilities MDT,

  Cardiology MDT as well as at other cancer MDT's. The non-malignancy caseload for the SPC was 56% which is higher than reported nationally.

- Maximising comfort and wellbeing
  Progress: as we know many people who are approaching death are frightened of being in pain or distress and these can be relieved with expert palliative care and that good and early palliative care can improve outcomes – the Trust vision is to deliver care by competent, confident and compassionate professionals. The number of staff trained in EoLC has increased and from April 2017 all new appropriate members of staff now attend core training at induction.

- Care is coordinated:
  Progress: the expectation is that everyone can expect /have access to 24/7 support.
  As a Trust we provide a 7 day service 364 days a year, this reporting period we achieved 99.45 % with 362/364 days covered by the Specialist Palliative Care Team. There is also a 24 hour telephone access that is available in this locality.
  As a locality we have worked collaboratively in the implementation of the Electronic Palliative Care Coordination System which enables all appropriate Healthcare professionals to view key patient
  records to ensure that we are aware of their wishes. This will be rolled out over the next year to other Trust departments and the ambulance service. All referrals for community care post discharge are now referred to a Single Point of Access - Palliative Care Referral Centre which was launched in April 2017and patients assessed individually for appropriate care/ services.

- All staff are prepared to care
  Progress: Each ward/area has a designated Compassionate Champion who has received additional support and training related to this area. Our Macmillan End of Life Care Educator and SPC team are involved in training staff.

- Each community is prepared to help
  Progress: As a Trust we are in the process of establishing a team of "rose volunteers" who will support our end of life patients and their families this piece of work will be a priority over the next year.

  More information in relation to our progress against these ambitions and priorities can be found in Appendix 3.

6.2 Audit

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

- Patients who died in hospital and whether they were on an EOL care register and had an ACP in place.
- Auditing the time from prescribing to starting syringe pumps
- Re-audit of time from referral to time seen by the specialist palliative care team
- Audit the compliance of the seven day CNS service
- Audit of DNACPR Form completion
- Audit of the correct use of the Individualised Plan of Care for the Dying Person

6.3 Risk Register

The End of Life risk register is discussed at the CEoLCP meetings and actions are monitored. The risks sit as part of the Surgery, Anaesthetics & Cancer division risk register and are reviewed at monthly intervals with our Clinical Governance Lead.

The risks on our register for this period included:

Risk	Ref No.
The reduction in the number of available syringe pumps across the Trust for our patients requiring symptom management subcutaneously	3152
Failure to meet the National Palliative Care Guidance for Consultant establishment	3926
Incomplete / Noncompliance with DNACPR forms	3710
Failure of body store refrigeration and freezer units and associated remote monitoring system at Hemel Mortuary	2952
Lack of Trust wide documentation for our patients who are recognised to be dying.	3709

Progress: The above risks have now been closed with the exception of 3926.

6.4 Complaints

As a specialist palliative care team we have worked very closely with the Head of Litigation and Claims, SIs, Complaints and PALS, who is a core member of the CEoLCP and produces a report for each meeting. We work closely to identify any recurrent themes and learn from these, these are shared for learning across the Divisions. As a Trust there is a shared learning from complaints event in relation to EoLC being held in April and representation is expected from all areas.

7. Specialist Palliative Care Team

7.1 Referrals/ Activity

Over this reporting period the Specialist palliative care team have received a total of 1134 referrals for 1054 patients.

This compares with a total of 1012 referrals for 947 patients in 2016 -17, for the same period 2015-16 there was 826 referrals for 774 new patients to the service for the same period in 2015-16. This is an increase of 122 referrals and 107 patients from previous year.

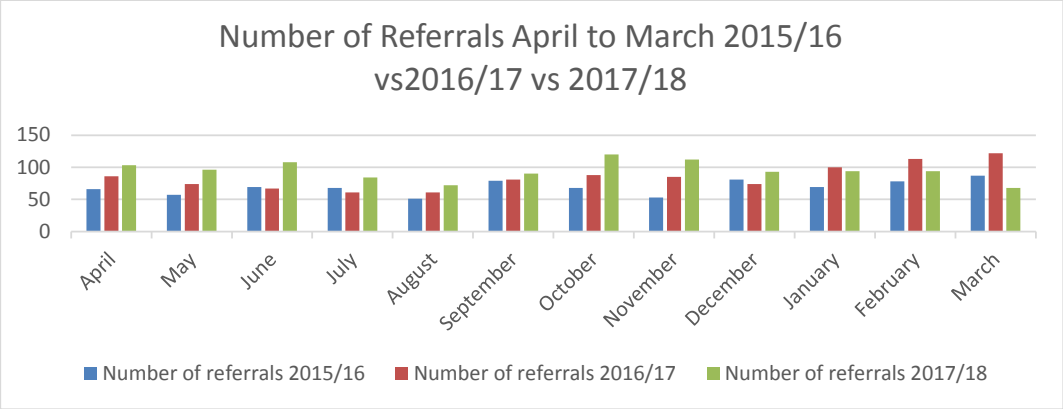
Table 1 shows the distribution of the number of referrals received for patients reviewed over this reporting period April 2017-March 2018 compared with the same periods in 2016- 2017 and 2015 -2016.

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

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

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

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



7.2 Establishment

Over the last year we have had a number of new members of staff join the specialist palliative care team, a full time administrator, including a Macmillan End of Life Care Nurse Educator a Palliative Care Discharge Liaison Nurse and a MDT Coordinator for the locality SPC MDT's – this post is currently funded by the CCG.

There has been a decrease in the number of Palliative Care Consultant sessions in the Trust and that is due to the resignation of the Consultant who also worked at the Peace Hospice, the Peace made the decision not to recruit into the post therefore leaving a reduction in the palliative care hours in the Trust. As a Team we are in the process of submitting a business case for a Trust Palliative Care Consultant.

Seven day working recommenced at the beginning of April 2016 and this has continued since. As a Trust a face to face seven day service was achieved 362 days out of a possible 364 days in this reporting period which equates to 99.45%. Telephone advice was provided on the other 2 days. Out of hours clinical advice continues to be provided by the 24 hour palliative care advice line which is supported by the local hospices.

Key Achievement – a seven day Specialist Palliative Care Service was provided 362 days out of 364 which equates to 99.45%

7.3 Palliative Care Discharge Liaison Nurses

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

8. Workstreams

8.1 Individualised Plan of Care for the Dying Person

The Individualised plan of care for the dying person has now been completed across the acute Trust. Education and training has been pivotal to support the implementation and embedding of the care plan across the Trust. The next step will be to work with our Emergency Department Clinicians to implement and embed this.

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

8.2 Education

One of the key achievements for this period is that end of life training continues to be one of the core essential teaching sessions that must be attended by new starters to the Trust and the team commenced this in April 2017.
The team have continued to deliver a significant amount of education over the last twelve months which includes the following:

- Teaching on the Individualised Plan of Care for the Dying Person
- Teaching to Acute Medicine, Medicine and Care of the Elderly teams on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussions and how to document and correctlycompletethe forms.
- Teaching to FY1s and FY2s on symptom control, breaking bad news and DNACPR discussions
- Teaching at governance meeting on DNACPR and Treatment Escalation Plans (TEPs) by our Palliative Care Consultant and End of Life Care Lead.
- Syringe pump training in conjunction with Medical Devices Trainer.
- External teaching has been provided to the Mortuary and patient affairs staff on communication and training in how to recognise those at high risk of a complicated bereavement has been provided to the staff in patient affairs.

- The Specialist Palliative Care Team continues to have final year medical students from Imperial College shadowing them as part of their Long Term Conditions Placement and this has had good feedback. Following the success of these placements the team have been approached for the students to have longer placements with the team.
- Teaching to Allied Health Professionals.
- Compassionate Champion Study Days
- Training to Sarratt and Croxley as part of the NHSI 150 Day Rapid Improvement Programme

Key Achievement –Successful appointment of a Macmillan End of Life Care Nurse Educator

8.3 Mortuary

This has been a productive and busy year for the mortuary; the number of admissions on both sites increased by 6 %. Watford admitted 1788 patients and Hemel a total of 828 patients.

The number of Post Mortems over the last year has increased by 8 % a total of 681 were conducted during this period. Of these 677 PM's were at the request of the Coroner, 3 were for brain and or spinal cord donations and one was a full consented Post Mortem from a patient who died on ASU.

One of the staff members was awarded the Level 3 Diploma in Anatomical Pathology Technology and became a qualified APT.

The Deputy Mortuary Manager became one of only two people in the county to hold the old style APT qualifications and the new Level 3 top up Diploma and the Mortuary manager successfully completed the Trust Senior Leaders program.

Deputy Mortuary Manager attended the AAPT/HTA consent training day

Staffing was quite challenging in November 2017 therefore the Department had to limit Post Mortem work as staffing levels were down by 50% for two weeks.

In December the Mortuary at Hemel became the forensic centre for Hertfordshire, all deaths in Hertfordshire that a deemed suspicious or Murder by the Major Crime unit will be moved to Hemel so that forensic Post Mortems can be conducted. The Coroner has also designated that Hemel Mortuary will be the regional disaster Mortuary and work is in process with the emergency planning team and the local authority to ensure infrastructure is in place should an incident of mass fatalities occur.

Funds to brighten up the viewing rooms at Watford and Hemel were granted by the Organ Donation Committee; this work will take place in the next reporting period.

8.4 Syringe pumps

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

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

Key Achievement – 15 additional pumps bought following a successful business case

8.5 Advance Care Planning and EPaCCs

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

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

The number of patients known to the SPC team with an Advance Care plan in place and a recognised PPD has increased over the last 6 months. 100% of all patients known to the SPC team have a preferred place of death documented our aim by 2019, is 90% of appropriate patients to have an advance care plan in place and if preferred place of death was not achieved 100% of patients to have reason documented.

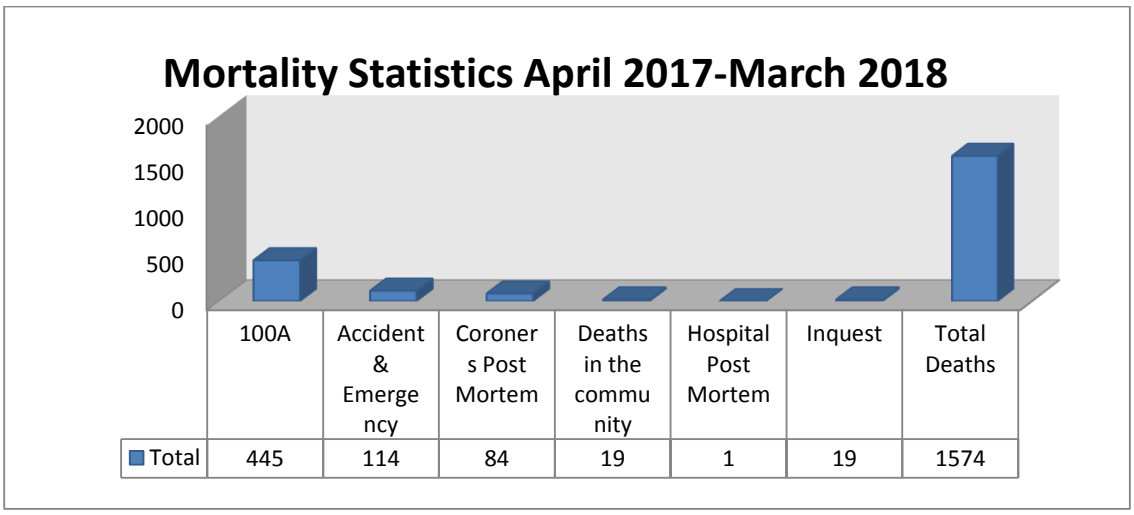
Key Achievements - Working jointly with local providers in the implementation of the Electronic Palliative Care Coordination System (EPaCCS).
100% of all patients known to the SPC team have a preferred place of death documented.

8.6 Patient Affairs

The team provide a full service Monday to Friday between 9am to 4pm with additional support provided on a Sunday between 10am and 4pm to support deaths that have occurred over the weekend/bank holiday period. During this reporting period April 2017-March 2018 the Patient Affairs team dealt with 1574 deaths of those 19 were community deaths and 391 deaths were over a weekend/BH with 9 fast tracks and 10 certificates issued.

Table 2 shows a breakdown of the number of patients deaths dealt with by patient affairs.

Table 2:



Key achievement – Doctors now complete a deceased patient summary which is sent directly to the patients' GP.

8.7 Bereavement Service

As a Trust, it is recognised that we do not provide a bereavement service however we continue to signpost people to local bereavement services as appropriate. This was put in place following a service review and it was agreed that the Patient Affairs Department would continue to be the main contact point for bereaved relatives for information and signposting as required to local agencies. If there are complex bereavement needs the patient affairs staff liaise with the Specialist Palliative Care Team for additional support if required for any bereaved relatives and the Spiritual and Pastoral Care team in respect of any family viewings. The team have also undertaken training in compassionate communication and bereavement care.

The team continue to provide a service on a Sunday to support and advise relatives when a death occurs over a weekend.

The League of Friends has continued to support us in replenishing the Rose Project stock which has allowed Patient Affairs to continue supplying the wards with cloth and plastic rose property bags for placing deceased property in prior to giving to the bereaved family and for stationery items needed by the ward when a patient approaches end of life following a donation of £5031.74

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

8.8 Surveys/ Feedback

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

The number of completed questionnaires continues to increase however as a Trust the response rate is approximately 10% and this was raised by the CQC at previous inspections.

The breakdown of results have been reviewed as part of the compassionate end of life care panel. We are part of the University College London Partners (UCLP) Community of Practice (CoP) and Trust response rates have been discussed at this forum.

Table 3 shows a breakdown of the number of questionnaires returned to the Trust between the months of May 2017 – April 2018 there has been a slight increase compared to previous years in the numbers being returned.

Table 3:

To enable us to understand further how we can improve end of life care in the Trust the Palliative care team are working closely with the Trust Patient and Public Involvement Lead and the Trust Carer Lead we have not held any bereavement focus groups this year as there has not been any uptake from our bereaved relatives. The aim of these previously was to capture and learn from both positive and negative feedback, whilst allowing the families and carers in addressing issues in an informal setting away from the Trust and this feedback will enable us to drive forward improvements.

8.9 Spiritual & Pastoral Care

The Chaplaincy team works in collaboration with local faith communities, secular and humanist representatives to offer a broad range of support and help to patients and families. Visits and support offered to patients are becoming more routinely recorded by the chaplains in the care plan of each patient they are called to support.

People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences via a referral service to the chaplaincy which is available 27/7. While there is not common culture of offering spiritual or religious support among many of the staff in the Trust, the chaplaincy team and palliative care team are working hard to raise awareness of the importance of offering spiritual, pastoral and religious support to patients, relatives and staff.
A Spiritual and Pastoral Care folder has been compiled which is available on the wards as well as on our intranet.

The team visit each ward two or three times a week in addition to the planned visits and requested visits.

Key achievement - Spiritual and pastoral care folder available on every ward and on the intranet.

8.10 Memorial Service

We held our second memorial service was in November 2017 at the Trust for the families of those with loved ones who had died in the Trust.

Over 80 people attended this very special, emotional and intimate multi faith service which was held in the Executive meeting room at Watford General Hospital to remember the life's of those who had died on our wards across the Trust, it was a time of reflection and of remembering those whom they loved.

Each person attending was given the opportunity to light a candle and was also given a pink rose in remembrance of their loved one.

This event was supported by the Trust Organ Donation team.

Key Achievement –Second Trust Memorial Service held in November 2017.

9.0 Recommendations

The Board is asked to receive this annual report for information and assurance of the progress in achieving the Trust End of Life Care Strategy.

Tracey Carter
Chief Nurse

September 2018

Appendix 1:

Key Achievements within the reporting period

- New End of Life Care Clinical Lead appointed.
- End of Life Care sustained “Good” rating from the CQC in the latest inspection.
- Operational End of Life Group continues to be held bimonthly which enables delivery of the key objectives across the Divisions and this group reports into the Compassionate End of Life Care Panel (CEoLCP)
- The team continues to undertake core essential teaching sessions that must be attended by all appropriate new starters to the Trust and this commenced in April 2017.
- Achieving compliance with CCG target for ensuring our patients if appropriate have an Advance Care Plan in progress and achieve their Preferred Place of death (PPD).
- Successful recruitment of a Macmillan End of Life Care Nurse Educator following resignation of previous postholder and post holder commenced in December 2017.
- Trust funded Palliative Care Discharge Liaison Nurse post established and postholder commenced in August 2017.
- Second successful Trust Memorial Service took place on November 19th 2017.
- Continued partnership working across the locality to enhance the care and support our end of life patients receive.
- Working collaboratively with our local providers in the establishment of a coordination centre which provides a single point of referral for all palliative and end of life referrals
- Ensure continued compliance with national and local recommendations with audits and service reviews.
- Continued to raise awareness off end of life care across the Trust.
- Development and implementation of the new Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms across the Trust.
- Continued education of medical staff with regards to mental capacity assessment (MCA) form completion specific to Do Not Attempt Cardio-Pulmonary Resuscitation decisions.
- The use of Treatment Escalation Plans continues to improve to support effective care planning however, work continues to embed these and train clinical staff in their use.
- No serious incidents related to EoLC in this reporting period
- Very involved in the EoLC STP work stream working closely with East and North Hertfordshire NHS Trust and Princess Alexandra Hospital, Harlow.
- Trust Compassionate Care Champions have been identified and training has taken place.
- Participated in NHS Improvement End of Life Care Collaborative 150 day Rapid Improvement Programme – which has enabled us to share learning, best practice and learn more about improvement methodology and how it can be applied to EoLC. This resulted in us being awarded a Certificate of Achievement “for developing the most innovative idea”.

Appendix 2:

Future Priorities 2018-19

- We will focus on delivering our work plan which underpins our End of Life Care strategy and will focus on delivering this in 2018-19
- Continuing to embed our education programme
- Recruitment of Medical Examiners.
- Embedding compliance with the Mental Capacity Act 2005 and associated code of practice when completing 'do not attempt cardiopulmonary resuscitation' forms.
- We will improve use of Treatment Escalation Plans to support effective care planning, through embedding these and training clinical staff in their use
- Continue to work with the Trust Care of the Elderly team to improve the End of Life Care that is delivered, including earlier referrals into End of Life Care team
- Following the NHS Improvement End of Life collaborative to share learning, best practice to other areas in the Trust
- Shared learning event from complaints event in relation to EoLC being held in April
- Continue to support our Compassionate Care Champions.
- Recruit our End of Life volunteers to support patients and their families at this difficult time.
- Business case to be completed for Trust Consultant post and be presented to the Trust Executive Committee.
- Following the designation of Hemel Mortuary as the regional disaster Mortuary to continue working with the emergency planning team and the local authority to ensure infrastructure is in place should an incident of mass fatalities occur
- The Mortuary at Hemel plan to purchase an 8 bay Flexmort so that our capacity is increased for the winter.
- Roll out of Electronic Palliative Care Coordination System (EPaCCS) across the Trust
- National Audit of Care at End of Life (NACEL)
- The chaplaincy team and palliative care team to continue to raise awareness of the importance of offering spiritual, pastoral and religious support to patients, relatives and staff.
- Develop and offer a pastoral support group for those affected by end of life issues.
- Further education and support is planned in order to give ward staff the confidence and awareness to sign post and refer relatives and patients to the spiritual and pastoral support on offer via the chaplaincy team.
- The Resuscitation team have planned a comprehensive training programme for 2019
- Recruitment taking place for Resuscitation Officers which will enable follow up of cardiac arrests identifying failure to rescue events, which are escalated, investigated and result in learning at all levels.
- Resuscitation team to attend ward rounds and visit departments to promote good documentation of the Treatment Escalation Plans, DNACPR forms and MCA forms.
- Patient Affairs to introduce training on legal processes for ward staff to increase awareness of ensuring families are given correct information focussing on coroner's cases, documentation and viewings in the Chapel of Rest.
- Introduction of a wedding box for when weddings have to take place in the hospital setting following granting of a special licence.

Appendix 3: Measures of Success Progress from April 2017 – March 2018.

Local Priority	Measure of Success	Progress to date: April 2017 - March 2018
Individualised care plans	By 2019, 100% of appropriate patients to have individualised care plans in place	The Individualised plan of care for the dying person has now been implemented and embedded across the Acute Trust. Work to commence with ED in the forthcoming period. Audit conducted as part of the NHSI baseline 150 day Rapid Improvement Programme.
Advance care plans	By 2019, 90% of appropriate patients to have an advance care plan in place By 2019, 90% of patients to have their preferred place of death documented and if preferred place of death was not achieved 100% of patients to have reason documented	This is now recorded monthly for the Trust IPR.
Meeting diverse needs of communities	Evidence of engagement and involvement of local communities and religious leaders	We continue to work with local communities and religious leaders eg. Bereavement focus groups held locally. Memorial service held in November 2017. Meeting with Spiritual Leaders planned for later in 2018
7 day palliative care service	By 2016, Specialist palliative care onsite support to be available 364 days per annum and access to out of hours service available 365 days per annum	Of the 364 days in this period with Christmas Day excluded) 362 days were covered by the Specialist Palliative Care Team = 99.45%. Access to the out of hours service has been available for the 365 days.
Improving care for all	Continue to deliver and audit an equitable service to cancer and non-cancer patients ensuring benchmarking against National data	There is no longer a submission of our Palliative care data set (MDS). As a Trust we are in the process of procuring a new Cancer Information system which will enable us to pull this information for future reports
Updated policies and clinical guidelines	Each year to have agreed policies and guidelines that impact on end of life care and to review, ratify and reflect best practice	Policies continue to be reviewed to reflect best practice
Supporting carers and families	By 2016, to have a Patient Experience and Carers strategy in place	Patient and Carers Strategy is in place.
Electronic links between care providers	By 2016, electronic links in place between ourselves, primary and community providers are used to co-ordinate care	This work has been undertaken with the CCG and other local providers and since February 2017 we as a SPC team have had viewing access to the system. We are now working with the CCG to enable other areas eg ED, respiratory and the Cancer CNS's to have access to this

Leadership	By 2016, appointment of End of life Clinical lead, Non-Executive Director lead and Compassionate End of Life Care panel (CELCP) chaired by Chief Nurse	These posts have been appointed to
Continuity in partnership	Regular attendance and engagement with local, network, Academic health science partnerships, strategic clinical networks and national forums.	Engagement continues & Trust is represented at all forums and now represented at the STP meetings
Core and extended training	In 16/17 to have trained 40% of identified staff, in 17/18 to have trained 75% of high risk staff and 40% of others and in 18/19 to have trained 95% of high risk staff and 50% of others	Core training continues and all appropriate new starters to the trust attend this
Bereavement support	Families and carers have increased levels of Families and carers have increased levels of satisfaction with the care of their dying relatives offering signposting to support. Identifying those families at risk.	Bereavement questionnaire continues and Focus groups have been held locally. There have been no focus groups held over the last 12 months as there has been no uptake for these from our bereaved relatives. To review and hold two over the next 12 months Trust Annual Memorial Service held on November 19th 2017.

Trust Board Meeting
01 November 2018

Title of the paper	**Preparations for a 'No Deal' Brexit Scenario**
Agenda Item	**14/64**
Presenter	**Sally Tucker, Chief Operating Officer**
Author(s)	**James Mason, Head of Emergency Planning & Resilience**
Purpose	*Please tick the appropriate box* *For approval* ✓ | *For discussion* | *For information*
Executive Summary	The purpose of this report is to provide the board with an overview of Government preparations for a potential 'no deal' scenario as part of the ongoing negotiations between the United Kingdom and the European Union. As this is a dynamic position and negotiations are ongoing information included within this report is valid as of 25 October 2018 To provide an initial overview of current 'no deal' planning of the UK Government this paper will provide a summary of the following elements • Pharmaceuticals • Blood Products, Organs, Tissues & Cells • Clinical Consumables & Medical Devices • Workforce • Procurement Developments in the UK's plan to withdraw from the EU are monitored on a regular basis by the Trust's Emergency Planning & Resilience Department and by the NHS England National EPRR team. Any requirements for business continuity arrangements as a result of the UK's departure will be coordinated by the EPR department. The Government remains confident that the UK will leave the EU with a good deal for both sides however the risk of supply chain disruption particularly in the event of a 'no deal' scenario exists. Through continued monitoring, the Trust and DHSC contingency planning will enable for this risk to be minimised. The Trust's procurement and Emergency Planning & Resilience departments are proactively reviewing suppliers on the basis of a no-deal Brexit scenario.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care – *Objectives 1-5* ✓ Aim 2 Great place to work – *Objectives 6-8* ✓ Aim 3 Improve our finances – *Objective 9* ✓ Aim 4 Strategy for the future – *Objective 10-12* ✓
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and

14

<table>
<tr><td></td><td>acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Executive Committee</td><td>05/09/2018</td></tr><tr><td>Emergency Planning Group</td><td>28/10/2018</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for information and approval of the recommendations</td></tr>
</table>

Agenda Item: 14/64

Trust Board Meeting – 01 November 2018

Preparations for a 'No Deal' Brexit Scenario

Presented by: Sally Tucker, Chief Operating Officer

1. Purpose

1.1 The purpose of this report is to provide the committee with an overview of Government preparations for a potential 'no deal' scenario as part of the ongoing negotiations between the United Kingdom and the European Union. As this is a dynamic position and negotiations are ongoing information included within this report is valid as of 25 October 2018.

1.2 To provide the initial overview of current 'no deal' planning this paper will provide a summary of the following elements:

- Pharmaceuticals
- Blood Products, Organs, Tissues & Cells
- Clinical Consumables & Medical Devices
- Workforce
- Procurement

2. Background

2.1 On 29 March 2017 the Prime Minister of the United Kingdom issued a letter to the President of the European Union (EU) triggering Article 50 of the Treaty of the European Union to notify the UK's intention to leave the EU. Negotiations are ongoing between the EU and the Department for Exiting the EU; however the UK Government is commencing preparations for an unlikely 'no deal' scenario to ensure there are contingencies in this event.

2.2 As a result of triggering Article 50 the UK is scheduled to leave the EU on Friday 29 March 2019 at 23:00.

3. Analysis/Discussion

3.1 Developments in the UK's plan to withdraw from the EU are monitored on a regular basis by the Trust's Emergency Planning & Resilience Department and by the NHS England National EPRR team. Any requirements for business continuity arrangements as a result of the UK's departure will be coordinated by the EPR department.

3.2 **Pharmaceuticals –** The Department for Health and Social Care (DHSC) earlier this year undertook an analysis of the supply chain for human medicines, this includes radioisotopes and vaccines. To ensure the supply chain to the NHS can be maintained in the event of a 'no deal' scenario which could cause potential delays in the short term with regards to border processes and procedures; the Government as instructed pharmaceutical companies to have a minimum of six weeks additional supply above their business as usual operational buffer stocks.

Contingency planning for pharmaceutical companies applies only to pharmacy-only or prescription-only medicines that come from or via the EU/EEA via road haulage and roll-on, roll-off sea, road and rail routes. Items with short shelf lives which cannot be stockpiled the DHSC has asked pharmaceutical companies to ensure they have robust plans to import these items via air freight to avoid potential border delays. In the event of a no-deal scenario UK and EU airlines would lose the automatic right to operate services between the UK and EU, however the European Commission has acknowledge that a 'bare bones' agreement on air services would be desirable in the event of a no-deal scenario.

Vaccines covered by the national vaccination programme will be subject to contingency planning however this will be separate to the plans outlined above. Vaccines not covered by the national vaccination programme will be subject to the six week stockpiling as outlined above. Pharmaceutical companies are required to provide evidence of stockpiling to DHSC.

In the event of a 'no deal' scenario the DHSC has confirmed that the UK will continue to accept products that have been batch tested and released in accordance with EU rules however it should be noted that membership to the EU medicines regulatory network (EMRN) will cease therefore responsibility for functions will transfer to the Medicines and Healthcare products Regulatory Agency. There will be no impact on clinical trials regulations.

Specifically for the Trust, presently there is no requirement for hospitals to stockpile medicines or for clinicians to write longer NHS prescriptions. Any evidence of over prescribing or potential local stockpiling must be investigated by the Trust's Chief Pharmacist. Clinicians should advise patients that the UK Government has plans in place to ensure supply of medicines is maintained and as such patients should not stockpile at home.

3.3 **Blood Products, Organs, Tissues & Cells –** UK law and the Human Tissue Authority (HTA) already implement EU directives for organs, tissues and cells therefore there will be no significant legislative changes. The UK and EU countries would consider each other as third countries in the event of a 'no deal' scenario, UK and EU law currently allows for organ exchange between third countries therefore this will continue. In terms of numbers for the 2017/18 period 22 organs entered the UK from the EU and 26 organs left the UK with 19 to the EU and 7 to non-EU countries.

In terms of blood products the UK is mostly self-sufficient with fewer than 10 units of red blood cells imported into the UK per year and 6.5% of plasma units imported from the EU. EU blood directives are already incorporated into UK law therefore there will be no change in the safety or quality of blood products. The UK and EU countries would consider each other as third countries in the event of a 'no deal' scenario, UK and EU law currently allows for blood product exchange between third countries therefore this will continue.

There are no actions required by the Trust at this time.

3.4 **Clinical Consumables & Medical Devices –** The DHSC has undertaken an analysis of the supply chain and has identified the proportion that is imported from the EU. The Government is planning to stockpile clinical consumables at a national level; this has been coordinated with NHS Supply Chain to ensure that the infrastructure and logistic capability is available to deal within the increased volumes. Arrangements are being established by DHSC to ensure suppliers who supply directly to NHS organisations can be maintained in the event of a 'no deal' scenario.

The UK will continue to recognise and accept medical devices approved in the EU market and CE-marked. The UK will continue to comply with all key elements of the Medical Devices Regulations.

There are no actions required by the Trust at this time.

3.5 **Workforce –** The DHSC has announced that doctors and nurses are now exempt from the cap on skilled worker visas; this means that there is no limit on the number of doctors or nurses who can be employed through Tier 2 visa route enabling the Trust to continue to recruit international doctors and nurses without limitation on numbers. The HomeOffice has launched a new toolkit to assist employers in supporting EU citizens who are already resident in the UK and their dependents to apply for settled status.

Within the Trust all users messaging has been used to provide information to EU citizens who work within the Trust however to date the HomeOffice toolkit has not been launched. This report recommends that Human Resources and Workforce launch the HomeOffice toolkit and provide a targeted communications campaign to employees who are non-UK, EU citizens.

The HomeOffice is launching an EU Settlement Scheme pilot from 29 November 2018 – 1 December 2018 for individuals who work within the health or social care sector in England, Northern Ireland, Scotland or Wales.

In the event of a no-deal scenario the UK will no longer recognise the Mutual Recognition of Professional Qualifications (MRPQ) direction which applied to doctors, nurses, dental practitioners, midwives and pharmacists. EEA professionals already employed by the Trust will not be affected however future applicants will be subject to future arrangements yet to be published.

3.6 **Procurement –** The Government continues to negotiate a trade deal with the EU. At present it is not known whether the Official Journal of the European Union (OJEU) will still be used in the event of a 'no deal' scenario. The UK Government has advised that publishing of tenders will still be required however through which means is still to be determined.

The Trust's procurement department is undertaking a review of all Trust contracts in line with the Department of Health & Social Care self-assessment tool; this will identify highly impacted suppliers. Subsequently in collaboration with the Emergency Planning & Resilience department, Procurement will identify mitigations for those highly impacted suppliers. The Trust will submit a list of highly impacted suppliers alongside Trust mitigations to the Department of Health & Social Care by the 30 November 2018.

3.7 **Business Continuity Planning –** The Secretary of State for Health and Social Care specifically highlights Business Continuity planning as part of his letter on Government preparations for 'no deal' (Appendix A). Although for many elements there is not a requirement for the Trust to stockpile the Emergency Planning & Resilience Department will undertake a business impact analysis of the Trust in the event of a 'no deal' scenario when the UK leaves the EU.

3.8 **EU Direct Suppliers –** The Emergency Planning & Resilience department has reviewed the Trust's seven direct EU suppliers in terms of Brexit preparations. The analysis has identified that each supplier is commencing preparations including relocation of the business to the UK and stockpiling supplies within the UK.

4. Risks

4.1 The Government remains confident that the UK will leave the EU with a good deal for both sides however the risk of supply chain disruption particularly in the event of a 'no deal' scenario exists. Through continued monitoring, the Trust and DHSC contingency planning will support this risk in being minimised.

5. Recommendation

5.1 The Board should note this report for information and approve the following recommendations:

- Any evidence of over prescribing or potential local stockpiling must be investigated by the Trust's Chief Pharmacist.
- Clinicians should advise patients that the UK Government has plans in place to ensure supply of medicines is maintained and as such patients should not stockpile at home.
- Human Resources and Workforce launch the HomeOffice toolkit and provide a targeted communications campaign to employees who are non-UK, EU citizens. To assist applications to the EU Settlement Scheme pilot between 29 November 2018 – 1 December 2018.
- Procurement Team to submit a list of highly impacted suppliers alongside Trust mitigations to the Department of Health & Social Care by the 30 November 2018
- Emergency Planning & Resilience Department will continue to undertake business impact analyses against the Trust in the event of a 'no deal' scenario when the UK leaves the EU as the lead responsible department.
- To appoint an executive senior responsible officer for Brexit. It is recommended this is either the Chief Financial Officer for their procurement portfolio or the Chief Operating Officer as the accountable executive officer for emergency planning & resilience.

Sally Tucker
Chief Operating Officer

25 October 2018

APPENDIX A – LETTER FROM SECRETARY OF STATE FOR HEALTH & SOCIAL CARE

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

23 August 2018

Dear Colleagues,

GOVERNMENT'S PREPARATIONS FOR A MARCH 2019 'NO DEAL' SCENARIO

I am writing to provide an update on the Government's ongoing preparations for a March 2019 'no deal' Brexit scenario and what the health and care system needs to consider as we step up preparations over the autumn and in the period leading up to March 2019.

The Government has made significant progress in negotiations with the EU and remains confident we will leave with a good deal for both sides, that supports existing and future healthcare collaboration. However, as a responsible government, we continue to prepare proportionately for all scenarios, including the unlikely outcome that we leave the EU without any deal in March 2019.

Along with other Government departments, the Department of Health and Social Care has stepped up its planning for a 'no deal' scenario. We now have robust plans in place to protect patient safety and healthcare provision. Today's announcement concerns our preparations to ensure that the NHS, other service providers, and ultimately patients continue to get the supplies they need, in a timely way.

Continuity of Supply

Today the Government has set out a new scheme to ensure a sufficient and seamless supply of medicines in the UK in the event of a 'no deal' Brexit. In the unlikely event we leave the EU without a deal in March 2019, based on the current cross-Government planning scenario we will ensure the UK has an additional six weeks supply of medicines in case imports from the EU through certain routes are affected. This is the current planning assumption but will of course be subject to revision in light of future developments.

Under the medicines scheme, pharmaceutical companies should ensure therefore they have an additional six weeks supply of medicines in the UK on top of their own normal stock levels. The scheme also includes separate arrangements for the air freight of medicines with short shelf-lives, such as medical radioisotopes. The

Government is working closely with companies who provide medicines in the UK to ensure patients continue to get the medicines they need. I am today also writing to pharmaceutical companies with more details.

Hospitals, GPs and community pharmacies throughout the UK do not need to take any steps to stockpile additional medicines, beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions. Local stockpiling is not necessary and any incidences involving the over ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

Clinicians should advise patients that the Government has plans in place to ensure a continued supply of medicines to patients from the moment we leave the EU. Patients will not need to and should not seek to store additional medicines at home.

I am also today writing to medical devices and clinical consumables companies to set out further details of plans to ensure a continuity of supply of these products as well.

Given the significant amount of work that has now been done, I am confident this gives a clear basis for the health and care sector and the life sciences industry to plan so that patients can continue to receive high quality care unhindered.

Other Preparatory Activity

The Government is also putting in place measures to manage the other potential implications for the health and care sector, including, for example, future immigration rules; continuity of research funding and pan-European clinical and research collaborations; and future reciprocal healthcare arrangements.

There are three points in particular that I would note at this stage.

First, I would like to take this opportunity to reiterate that the Government recognises the valuable contribution that EU citizens make to the UK, including those working in the health and care system. The Home Office have recently launched a toolkit to assist employers in reassuring and supporting EU citizens already resident in the UK and their dependents to apply for settled status. Details have already been communicated to you and I would encourage you to draw these to the attention of your staff.

Second, the Government recently announced that doctors and nurses are now exempt from the cap on skilled worker visas. This means that there will be no restrictions on the number of doctors and nurses who can be employed through the Tier 2 visa route – giving you the ability to recruit more international doctors and nurses to provide outstanding patient care when required.

Third, the Treasury is extending the government's guarantee of EU funding to underwrite the UK's allocation for structural and investment fund projects under this EU Budget period to 2020. The Treasury is also guaranteeing funding in event of a no deal for UK organisations which bid directly to the European Commission so that they can continue competing for, and securing, funding until the end of 2020. This ensures that UK organisations, such as charities, businesses and universities, will continue to receive funding over a project's lifetime if they successfully bid into EU-funded programmes before December 2020.

We have created a new page at https://www.gov.uk/government/collections/information-for-the-health-and-care-sector-about-planning-for-a-potential-no-deal-brexit that brings together this and other information relevant to your organisations and it will continue to be updated over the coming months. Our intention is that where you need to take specific action, you will be given sufficient notice and clear guidance on the steps to be taken.

Business Continuity Plans

In the meantime, where appropriate, preparations for a March 2019 'no deal' scenario should be seen in the context of the work you are already doing to update your existing business continuity plans in line with the NHS England EPRR Core Standards and the NHS England EPRR Annual Assurance process. As it is a requirement that the EPRR assurance report is taken to your public board meetings I am assured your Accountable Emergency Officer will have oversight of this work. You will wish to have your business continuity teams/directorate leads, and other relevant colleagues as necessary who may not normally be involved in this process, ready to refresh those plans as new information becomes available over the coming months.

Further Information

You will already have well-established points of contact in national organisations to assist on specific areas. Please use these if you have queries about any areas which require further clarification. For updates on this, and other health-related issues, please visit https://www.gov.uk/government/collections/information-for-the-health-and-care-sector-about-planning-for-a-potential-no-deal-brexit where key information will be collated.

Yours ever,

MATT HANCOCK

Trust Board Meeting
01 November 2018

Title of the paper	Strategy update
Agenda Item	**15/64**
Presenter	Nick Kennell, Interim Director of Strategy
Author(s)	Nick Kennell, Interim Director of Strategy
Purpose	Please tick the appropriate box For approval: For discussion: ☑ For information:

Executive Summary	This paper provides an update for the Board on the overall strategic roadmap, the key initiatives that are planned to be delivered and the benefits, milestones and risks associated with these changes.
	
	The paper is provided to give the Board assurance and to enable a discussion about the overall progress in delivering the strategy.
	Key headlines from the report are:
	• The roadmap is structured around three core elements of change:
	  ○ Managing delivery today
	  ○ Improving for tomorrow
	  ○ Transforming the future
	• Within this there are a total of 21 initiatives
	• These initiatives will be managed through SDB TEC who will report on progress to the Board
	• Of the 21 initiatives, the status of these is as follows:
	  ○ 12 are rated as having a plan, and being on track to deliver this
	  ○ 6 are rated as having a plan, with some risk attached to them:
	  ▪ Majors assessment space
	  ▪ Theatres improvement
	  ▪ Staff rest rooms
	  ▪ Car Park
	  ▪ SDIP
	  ▪ Planned Care STP work
	  ○ 3 require further work to fully develop the plans:
	  ▪ Scanning project
	  ▪ Electronic Patient Record – this programme is yet to be mobilised
	  ▪ Acute Redevelopment implementation – this will follow completion of the SOC in 2019

Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care – *Objectives 1-5* Aim 2 Great place to work – *Objectives 6-8* Aim 3 Improve our finances – *Objective 9* Aim 4 Strategy for the future – *Objective 10-12* ☑

<table>
<tr><td>Links to well-led key lines of enquiry</td><td>☐Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☐Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
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<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>SDB TEC</td><td>17th October 2018</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive the report and note the progress made in developing the strategic plan, the proposed next steps for further development, and confirm the further guidance / advice as to the information it requires to be assured of the strategic plan.</td></tr>
</table>

Agenda Item: 15/64

Trust Board Meeting – 01 November 2018

Strategy update

Presented by: Nick Kennell, Interim Director of Strategy

1. Purpose

1.1 This paper provides an update on the Trust strategic roadmap, the progress of key delivery priorities and the next steps in managing the plan. The paper is intended for discussion and to provide assurance for the Board as to the overall roadmap delivery.

2. Background

2.1 In order to realise the vision of ***the very best care for every patient, every day***, the Trust is delivering a number of changes to:

- Manage delivery today
- Improve ways of working for tomorrow
- Transform the organisation for the future

2.2 Managing delivery today is achieved by navigating operational demand pressures (through Winter) whilst protecting elective activity. In order to achieve this we are:

- Improving how we manage beds and ED flow by:
  - Creating additional assessment space for majors by moving the orthopaedic clinic from ED
  - Creating additional assessment space in PMOK and Shrodell's
  - Creating more majors space by switching COB and CDU
- Improving planned care by:
  - Expanding surgical activity on SACH through piloting more activity of increased complexity on the site
  - Redeveloping Holywell to accommodate Orthopaedic procedures

2.3 Improving ways of working for tomorrow is achieved by continuing to invest in our estate, improve our pathways and work with our partners, including:

- Interim estates investments:
  - Investing in theatres at Watford to address compliance issues
  - Investing in Women's and Children's facilities to address quality and compliance issues with neonatal and birthing suite
  - Investing in rest space for our staff
  - Supporting the development of the car park
  - Investing on new pathology services
- Promoting quality improvement across our pathways through:
  - Launching the Clinical Pathway Groups in partnership with the Royal Free
  - Working with the CCG and STP on the Service Development Improvement Plan (SDIP), including:
    - Responding to tenders
    - Working on the Planned Care and Unplanned Care STP groups

    - Implementing the Getting It Right First Time (GIRFT) programme of pathway / speciality reviews
  - Working with in partnerships to secure the best outcomes and the best value, including implementing our clinical partnership with the Royal Free
  - Undertaking the organisational development to ensure we continue to attract, develop and retain the workforce we need, working to a quality improvement culture

2.4 Transforming for the future by delivering the following transformational changes for the organisation:

  - Delivering digital transformation to harness information, analytics and technology, through:
    - Implementing the scanning contract for patient records
    - Delivering a full Electronic Patient Record
  - Securing investment to redevelop our estate through the acute redevelopment programme

The sum of these changes are illustrated in the roadmap in **appendix 1**.

3. Analysis/Discussion

3.1 Programme definition

In order to manage these programmes we have undertaken a large scoping, governance and reporting exercise to ensure that each of the initiatives has a clearly defined set of objectives, clear accountabilities and a clear set of milestones against which we can report. The table below describes the key accountable leads and objectives for each of the initiatives described above:

Initiative	Exec Lead	Objectives
MANAGING DELIVERY TODAY		
Maintaining ED flow during Winter		
Assessment Space for Majors (Orthopaedic clinic move Phase 1) Includes ED business case	**Nick Kennell**	To create additional ED space at WGH, as part of the Trust's 2018/19 winter plan by relocating elective orthopaedic outpatient clinics from L1 PMoK at Watford to SACH.
Assessment Space (PMoK6 & Shrodells)	**Sally Tucker**	PMoK L6 admissions space to be refurbished to provide additional space for surgical assessment when needed.
COB/CDU Switch to Create Majors Space Includes ED business case	**Sally Tucker**	To pilot the re-provision of COB from old CDU to enable ED to use the current COB space for assessment.
Maintaining elective performance		
SACH Enhanced Surgical Activity Pilot (Phase 1)	**Mike van der Watt**	To trial a 6-week enhancement of surgical activity at SACH for more complex patients (e.g. co-morbidities) undergoing elective orthopaedic surgery. This will reduce length of wait for procedures and thereby positively impact other patient experience, RTT performance and maximise the use of theatre capacity at the Trust.
Holywell Development & Orthopaedics (Orthopaedic clinic move phase 2)	**Nick Kennell**	*See Assessment Space for Majors (Orthopaedic clinic move Phase 1)*

Initiative	Exec Lead	Objectives
IMPROVING PERFORMANCE FOR TOMORROW		
Interim Estates investments		
Theatres FBC ***(Watford Hospital Theatre Complex)***	**Sally Tucker**	To upgrade and improve the theatre complex to comply with modern standards, including addressing CQC concerns. To provide sufficient theatre capacity to meet anticipated demand for emergency and elective care until longer-term plans for acute care come to fruition. To provide a 'hybrid-enabled' theatre.
Neonatal FBC	**Nick Kennell**	To upgrade and improve the environment on the Woodland's Neonatal ward; reviewing the lay out and space around cots which is c<40% of required size; addressing clinical safety and quality of care for patients; improving the environment in its entirety to support patient and staff flow around the unit.
Staff Areas and Admin Space	**Paul da Gama**	To create more Staff Rest Areas in PMoK. To relocate as many non-clinical (back-office) areas off the Watford site as possible.
Pathology OBC	**Don Richards**	To inform the Trust of the best way of providing a Pathology Service for the future.
Car Park Approval	**Don Richards**	To provide a sustainable car parking solution to support staff and patients at WGH.
Improving our pathways through partnerships and quality improvement		
Launch the CPG programme with the Royal Free (first 7 CPGs in 18/19 then expand in 19/20)	**Nick Kennell**	To join a Clinical Partnership with the Royal Free, with an immediate focus on establishing CPGs to drive out unwarranted clinical variation across 7 priority pathways.
CCG Service Delivery Improvement Plan (SDIP)	**Fran Gertler**	Service Development Improvement Plan (SDIP) - West Hertfordshire Hospitals NHS Trust (WHHT) and Herts Valleys Clinical Commissioning Group (HVCCG) have been working on the development of agreed service improvement schemes as part of the 2018/19 joint QIPP
Responding to CCG tenders	**Fran Gertler**	Tenders - To ensure that services provided to the Herts Valleys population meet the priority areas identified in Your Care, Your Future, to improve healthcare services for the registered population.
STP Planned care programme	**Fran Gertler**	Planned Care STP - To deliver high quality care to our STP population by removing unwarranted variation within clinical pathways, reduce overall cost and improve efficiencies through the delivery of high quality, personalised care, which enables patients
GIRFT National Programme	**Mike van der Watt**	To improve the quality of care within the NHS by reducing unwarranted variation Sharing best practice between trusts to help improve care and patient outcomes To deliver efficiencies and cost savings
Clinical Partnership with the Royal Free	**Nick Kennell**	To secure the best outcomes at the best value, through our Clinical Partnership with the Royal Free to deliver benefits across a range of clinical, clinical support, back-office and digital elements.
Implementing the West Herts Way as part of our OD strategy	**Tracey Carter / Paul de Gama**	Undertaking the organisational development to ensure we continue to attract, develop and retain the workforce we need, working to an embedded culture of quality improvement and learning

Initiative	Exec Lead	Objectives
TRANSFORMING FOR THE FUTURE		
Digital transformation		
Scanning Contract	**Sean Gilchrist**	Scanning patient records to begin the process of holding patient records in a digital format. (This is the first necessary step of moving towards a digitised patient record.) To free up space in Shrodells and improve working conditions for those staff situated in medical records.
Electronic Patient Record Programme	**Sean Gilchrist**	Implementing a full electronic patient record across the Trust.
Acute redevelopment		
SOC refresh	**Nick Kennell**	To update the Trust strategic Outline Case to secure investment funds to redevelop the acute sites.
Acute redevelopment implementation	**Nick Kennell**	To implement the redevelopment of the acute estate subject to SOC approval

Next step: Incorporate within the broader strategy refresh to ensure a clear overarching picture of how these changes support our vision and clinical strategy.

3.2 Governance and reporting

These initiatives will then report to Strategy Delivery Board (SDB TEC) on a monthly basis providing the following updates:

- Summary of progress
- Reporting against milestones
- Reporting of risks
- Reporting against benefits

We are also establishing the baseline costs associated with these initiatives and will include cost reporting alongside this going forwards.

Next step: Complete baselining exercise and establish benefits and cost metrics

3.3 Milestones and current status

As part of the ongoing definition, we are baselining milestone plans. Below is a list of milestones completed this month, and milestones that are due for completion this Quarter.

Completed milestones this month

Project / Programme	Milestone / Decision	Status
Majors Assessment Space – orthopaedic clinic phase 1	- Business case for winter plans approved at TEC (24th Oct) - Estates works completed at Runcie wing (22nd Oct)	Milestone complete Milestone complete
Majors Assessment Space – POA move	- Business case for winter plans approved at TEC (24th Oct)	Milestone complete
SACH pilot – provision of more complex elective cases	- Go / no go decision taken to continue the provision of more complex cases at SACH following pilot	Decision taken
Car Park development	- Submission of letter of intent from Trust to inform car park tender specification (26th Oct)	Milestone complete
CPG programme	- Kick-off workshop with Royal Free (1st Oct) - CPG workshops across pathways	Milestone complete Milestone complete
Implementing the West Herts Way	- Quality hub launch agreed at TEC and COEC	Milestone complete
Acute Redevelopment	- Launch clinical engagement (9th Oct) - Launch public engagement (17th Oct)	Milestone complete Milestone complete

	- Resubmit wave 4 application (31st Oct)	Milestone forecast complete (will have been submitted prior to Board)

Upcoming milestones

Project / Programme	Milestone / Decision	Due date
Majors Assessment Space – orthopaedic clinic phase 1	- Orthopaedic clinic move complete	12th Nov
Pathology transformation	- Outline Business Case (OBC) to TEC and FIC	For Nov FIC (22nd Nov)
Car Park	- Tender commences	Nov
Neonatal improvements	- Pre-business case to be presented to TEC	30th Nov
Staff rest rooms	- Decision on choice of area for staff rest rooms	Nov
CPG programme	- Recruitment commenced on CPG roles	30th Nov [posts in place by Q4]
CCG tenders	- Submit non-obstetric ultrasound (NOUS) tender - Dietetics transition complete and service goes live	31st Oct 30th Nov
Implementing the West Herts Way	- Commence recruitment on Quality Hib roles (see CPG programme)	30th Nov [posts in place by Q4]
GIRFT	- Breast surgery deep dive visit - Ophthalmology findings presented to COEC	2nd Nov Nov
Scanning project	- CAG and TEC to review recommendations for next steps / forward approach	30th Nov
Acute Redevelopment	- Complete long-list to short-list process - Meet with NHSE/I to agree approval and business case reqts - Complete engagement and evaluation panels on short-list	30th Nov 4th Dec 22nd Dec

The Board will be provided with a summary status update against these milestones / decisions as part of the next report.

Next step: Complete baselining exercise to develop a full milestone chart for future reporting

4. Risks

4.1 The 21 initiatives defined is this plan are rated as follows:

- 12 are rated as having a plan, and being on track to deliver this
- 6 are rated as having a plan, with some risk attached to them:
    - Majors assessment space – challenging timeframe to complete the full sequence of moves and works required
    - Theatres improvement – preferred option has been identified, further work needed to understand the do minimum scenario
    - Staff rest rooms – the final decision depends on Winter plans and final resolution of space available
    - Car Park – ensuring the Trust requirements are fully fed into the final specification in time. Mitigated through the letter of intent
    - SDIP – timelines have slipped on cardiology referral management service. Once modelling has been agreed, the CCG will take this to their Exec Committee to discuss
    - Planned Care STP work – high-level agreement is in place to overall model, but further detailed planning work is needed to understand the implications of this

- 3 require further work to fully develop the plans:
    - Scanning project – need to agree recommendations / replan for the project
    - Electronic Patient Record – this programme is yet to be mobilised
    - Acute Redevelopment implementation – this will follow completion of the SOC in 2019

Next step: Formalise risk reporting against programmes / projects as part of the SDB governance and oversight

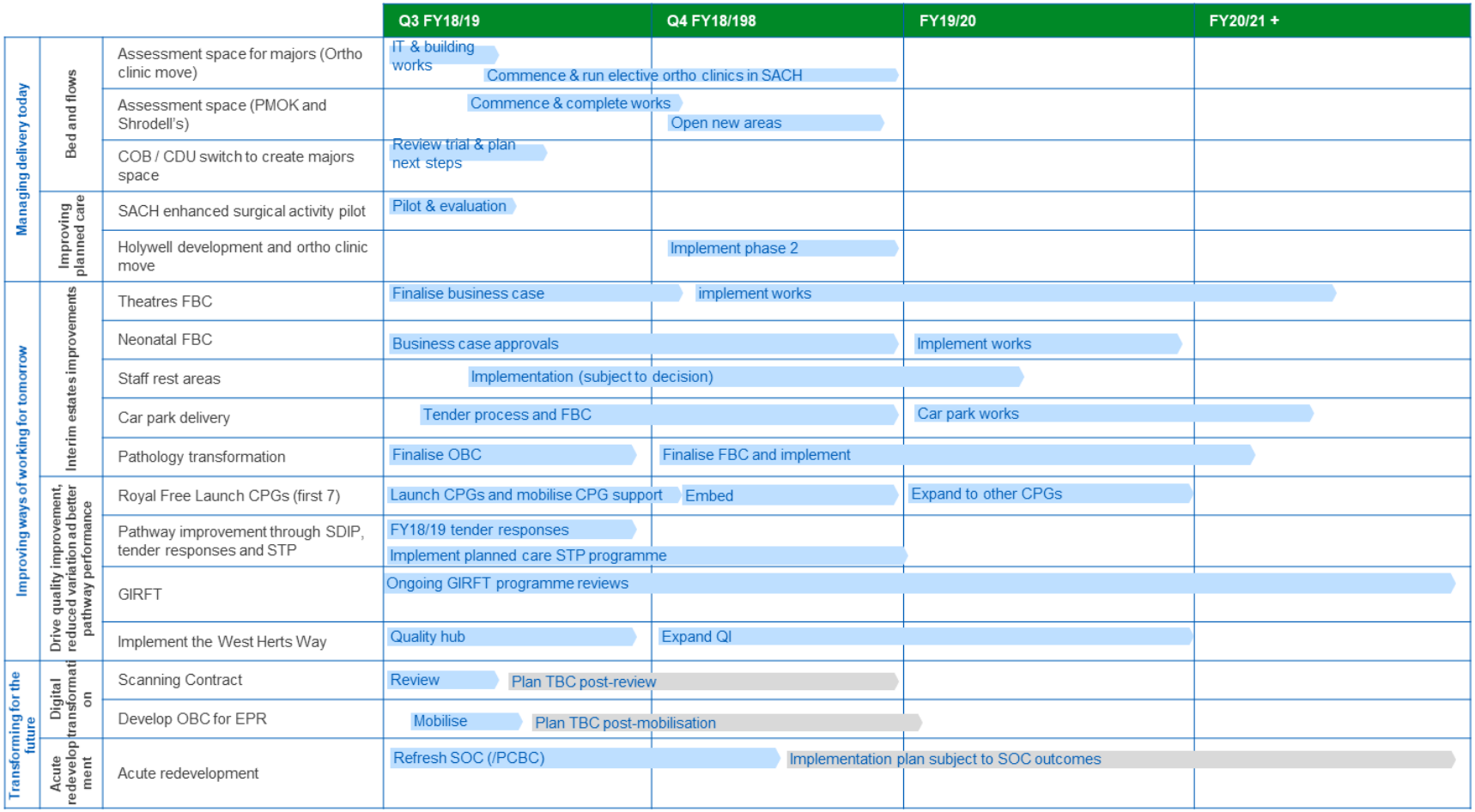
5. Recommendation

5.1 The Board is asked to receive the report and note the progress made in developing the strategic plan, the proposed next steps for further development, and confirm the further guidance / advice as to the information it requires to be assured of the strategic plan.

Nick Kennell
Interim Director of Strategy

24 October 2018

Appendix 1 – Draft strategic roadmap (subject to further milestone planning and baselining exercise)



Trust Board meeting
01 November 2018

Title of the paper	Outcome of well-led framework review
Agenda Item	16/64
Presenter	Professor Steve Barnett, Chair Helen Brown, Acting Chief Executive
Author(s)	Jean Hickman, Trust Secretary
Purpose	Please tick the appropriate box For approval: X For discussion: For information:
Executive Summary	NHS Trusts are required to commission an independent assessment against the NHS Improvement's (NHSI) well-led framework every three years. The framework supports Trusts to maintain and develop effectiveness of their leadership and governance arrangements. An assessment using the well-led framework was carried out for the Trust by Frontline Consultant in September 2018. This report is presented to the Board to advise on the outcome of the assessment. It includes the key findings and suggested recommendations of areas where improvements could be made. The Board can access the full report in the resources section of the diligent system. The Board received a presentation of the high level findings and discussed the recommendations and next steps at a development session on 11 October 2018. The audit committee and the trust executive committee have also reviewed the outcome of the assessment. The findings were agreed by all three forums to be a fair and accurate reflection of the Trust. Following Board approval, the agreed recommendations will be developed into an improvement plan which will be monitored through the safety and compliance committee. The Board will receive a bi-annual progress report. In line with national guidance, once the action plan has been developed, the Trust will inform NHSI that the review has been completed. The findings from this review will be provided to the Care Quality Committee (CQC) as part of the preparatory documentation for a formal CQC well-led framework review on 28 to 30 November 2018.
Trust strategic aims (please indicate which of the 4 aims is relevant to the subject of the report)	Aim 1 Best quality care – Objectives 1-5: X Aim 2 Great place to work – Objectives 6-8: X Aim 3 Improve our finances – Objective 9: X Aim 4 Strategy for the future – Objective 10-12: X

<table>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Board development session</td><td>11 October 2018</td></tr><tr><td>Audit committee</td><td>19 October 2018</td></tr><tr><td>Trust executive committee</td><td>31 October 2018</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to review the outcome of the well-led framework review and approve the recommendations, prior to confirmation to NHSI.</td></tr>
</table>

Agenda Item: 16/64

Trust Board meeting – 01 November 2018

Outcome of well-led framework review

Presented by: Professor Steve Barnett, Chair and Helen Brown, Acting Chief Executive

1. Purpose

1.1 This report is presented to the Board to advise on the outcome of an externally facilitated well-led framework review. It includes the key findings and suggested recommendations of areas where improvements could be made.

2. Background

2.1 NHS Trusts are required to commission an independent assessment against the NHS Improvement's (NHSI) well-led framework every three years. The framework supports Trusts to maintain and develop effectiveness of their leadership and governance arrangements. An assessment was carried out for the Trust by Frontline Consultant in September 2018.

2.2 The structure of the assessment is shared with the Care Quality Commission (CQC) and under-pins the CQC's regulatory assessments of the well-led question. This means that information prepared for regulation can also be used for development, and vice versa.

2.3 The review focused on the well-led framework's eight key lines of enquiry and used a wide range of forums, including a document review, one to one meetings with key staff, focus groups and interview with external stakeholders.

2.4 The Trust will have a formal CQC well-led framework review carried out between 28 to 30 November 2018.

3. Findings of the well-led framework review 2018

3.1 Overall, the findings from the well-led framework review were positive. A brief summary of the findings is detailed below:

Summary of good practice points

- Staff are proud to work for the Trust
- There is evidence of a clear focus on, and commitment to, the delivery of high quality services
- The chair and chief executive are well regarded and perceived as making a positive impact internally and externally
- The medical director and chief nurse provide clear clinical leadership
- The Trust has a clear vision and values which are articulated throughout the Trust
- Non-executive directors hold organisational knowledge and show evidence of maturity
- There is commitment and good professional working relations within the Board

- The Trust positively engages in strategic partnerships
- There is evidence of a maturing clinical leadership
- Improving relationships with external stakeholders offers a good opportunity to enter into integrated care environment
- There is evidence of good corporate management processes with established reporting lines
- The Board focuses on the most significant risks of finance, estate and ICT
- A comprehensive integrated report of data is available at divisional, directorate, committee and Board level

Summary of learning points

- There is a lack of clarity of the over-arching approach to leadership development
- Non-executive directors need to step back and hold the trusted executives to account
- More staff engagement is needed by non-clinical Board members
- There is a lack of clarity around the Trust's strategy, which needs to be communicated to staff
- Linkage between the Royal Free partnership and the sustainability and transformation partnership (STP) is not fully understood
- There are a large number of committees in the corporate governance structure and wide memberships
- Board needs to delegate operational accountabilities to allow more focus on strategy
- Divisional performance review meetings need to be further developed from problem solving into holding to account
- Data needs to be turned into information/intelligence to allow executives to demonstrate understanding and lead to more insightful challenges
- The opportunity for the sharing of lessons learned across divisions needs to be increased

3.2 Board members can access the full well-led framework report from the resources section of the diligent system.

4. Recommendations

4.1 The Board received a presentation of the findings of the review at a development session on 11 October 2018. The audit committee and the trust executive committee have also reviewed the outcome of the assessment. All three forums agreed that the findings were a fair and accurate observation.

4.2 The Board discussed the twelve recommendations listed below:

- Appointment of a substantive chief executive to provide leadership stability
- Clarify an over-arching Trust strategy and engage with internal and external stakeholders, putting into perspective the estate strategy, medium term financial plan and partnership with the Royal Free London NHS Foundation Trust
- Formalise and prioritise an external stakeholder engagement plan to support the move to integrated care, becoming a more effective system player
- Develop an over-arching organisational development strategy to pull all the strands of existing good practice together
- Keep under review the committee structure to ensure focus is on obtaining assurance with working groups and executives focusing on problem solving
- Review the function of the divisional performance review meetings to ensure focus is retained on performance review and holding clinical leaders/divisions to account e.g. for CIP delivery

- Refine action capture and monitoring to facilitate prioritisation, ownership and oversight of timely implementation
- Undertake a further board stocktake of skills for the next stage of the Trust's journey and develop succession plans
- Executive and divisional directors to further develop their corporate role alongside their functional capabilities
- Enhance information reporting through use of real-time data, streamlined reports with clear executive summaries covering "What this tells us is…" along with clear proposals on next steps
- Develop middle management capacity to enable the Board to step up and focus on strategic priorities
- Evaluation of implementation plans and strategies – what's worked and what hasn't, and how we can learn from this across the Trust

5. Next steps

5.1 Following Board approval, the agreed recommendations will be developed into an improvement plan with timescales and owners, which will be monitored regularly through the safety and compliance committee. The Board will receive a bi-annual progress report.

5.2 Once the action plan has been developed, the Trust will confirm with NHSI that the review had been completed, advise on any material issues that have been found and any areas of good practice that could be shared with others.

5.3 The findings from this review will be provided to the CQC as part of the preparatory documentation for a formal CQC well-led framework review on 28 to 30 November 2018.

6. Risks

6.1 Failure to act on the recommendations arising from the review could give rise to risk in a number of areas including staff engagement and satisfaction, patient experience, influence with stakeholders and an inability to effectively identify and manage risk and incident trends.

7. Recommendation

7.1 The Board is asked to review the outcome of the well-led framework review and approve the recommendations, prior to confirmation to NHSI.

Professor Steve Barnett
Chair

November 2018

Trust Board meeting
01 November 2018

Title of the paper	Corporate meetings schedule 2019-20
Agenda Item	17/64
Presenter	Jean Hickman, Trust Secretary
Author(s)	Jean Hickman, Trust Secretary
Purpose	Please tick the appropriate box For approval: For discussion: For information: X
Executive Summary	This schedule provides an overview of the Board and committee meetings which are required in 2019-20. This year's schedule includes meetings of the short-term ICT infrastructure transition committee. Board and committee members and attendees will receive invitations via the governance@ email account to the meetings that they are expected to attend.
Trust strategic aims (please indicate which of the 4 aims is relevant to the subject of the report)	Aim 1 Best quality care – Objectives 1-5: X Aim 2 Great place to work – Objectives 6-8: X Aim 3 Improve our finances – Objective 9: X Aim 4 Strategy for the future – Objective 10-12: X
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	N/A
Action required	The Board is asked to receive the Board and committee meeting schedule 2019-20 for information.

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

** DRAFT ** BOARD AND COMMITTEE MEETING SCHEDULE 2019/20

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Monday	1			1	2		4		2		3	2
Tuesday	2 DIVISIONAL PERFORMANCE			2 DIVISIONAL PERFORMANCE		3 DIVISIONAL PERFORMANCE	1 DIVISIONAL PERFORMANCE	5	3 DIVISIONAL PERFORMANCE		4 DIVISIONAL PERFORMANCE	3 DIVISIONAL PERFORMANCE
Wednesday	3 TRUST EXECUTIVE	1 TRUST EXECUTIVE		3 TRUST EXECUTIVE		4 TRUST EXECUTIVE	2 TRUST EXECUTIVE	6 TRUST EXECUTIVE	4 TRUST EXECUTIVE	1 BANK HOLIDAY	5 TRUST EXECUTIVE	4 TRUST EXECUTIVE
Thursday	4 TRUST BOARD	2 TRUST BOARD REM		4 TRUST BOARD ANNUAL GENERAL MTG	1	5 TRUST BOARD REM	3 TRUST BOARD	7 TRUST BOARD	5 TRUST BOARD REM	2	6 TRUST BOARD	5 TRUST BOARD REM
Friday	5	3		5	2	6	4	8	6	3	7	6
Saturday	6	4	1	6	3	7	5	9	7	4	8	7
Sunday	7	5	2	7	4	8	6	10	8	5	9	8
Monday	8	6 BANK HOLIDAY	3	8	5	9	7	11	9	6	10	9
Tuesday	9	7	4 DIVISIONAL PERFORMANCE	9	6	10	8	12	10	7	11	10
Wednesday	10 TRUST EXECUTIVE	8 TRUST EXECUTIVE	5 TRUST EXECUTIVE	10 TRUST EXECUTIVE	7 TRUST EXECUTIVE	11 TRUST EXECUTIVE	9 TRUST EXECUTIVE	13 TRUST EXECUTIVE	11 TRUST EXECUTIVE	8 TRUST EXECUTIVE	12 TRUST EXECUTIVE	11 TRUST EXECUTIVE
Thursday	11 SC	9 BOARD DEVELOPMENT	6 TRUST BOARD	11 BOARD BUSINESS WORKSHOP	8	12	10 BOARD DEVELOPMENT	14	12 CF PSE	9 TRUST BOARD	13	12 BOARD BUSINESS WORKSHOP
Friday	12	10 AUDIT	7	12	9	13	11	15	13	10	14	13
Saturday	13	11	8	13	10	14	12	16	14	11	15	14
Sunday	14	12	9	14	11	15	13	17	15	12	16	15
Monday	15	13	10	15	12	16	14	18	16	13	17	16
Tuesday	16	14	11	16	13	17	15	19	17	14	18	17
Wednesday	17 TRUST EXECUTIVE	15 TRUST EXECUTIVE	12 TRUST EXECUTIVE	17 TRUST EXECUTIVE	14 TRUST EXECUTIVE	18 TRUST EXECUTIVE	16 TRUST EXECUTIVE	20 TRUST EXECUTIVE	18 TRUST EXECUTIVE	15 TRUST EXECUTIVE	19 TRUST EXECUTIVE	18 TRUST EXECUTIVE
Thursday	18 PSE	16	13 PSE	18	15 SC PSE	19 CF	17 SC PSE	21 BOARD BUSINESS WORKSHOP	19 FI SC	16	20 SC PSE	19
Friday	19 BANK HOLIDAY	17	14	19 AUDIT	16	20	18 AUDIT	22	20	17	21 AUDIT	20
Saturday	20	18	15	20	17	21	19	23	21	18	22	21
Sunday	21	19	16	21	18	22	20	24	22	19	23	22
Monday	22 BANK HOLIDAY	20	17	22	19	23	21	25	23	20	24	23
Tuesday	23	21	18	23	20	24	22	26	24	21	25	24
Wednesday	24 TRUST EXECUTIVE	22 TRUST EXECUTIVE	19 TRUST EXECUTIVE	24 TRUST EXECUTIVE	21 TRUST EXECUTIVE	25 TRUST EXECUTIVE	23 TRUST EXECUTIVE	27 TRUST EXECUTIVE	25 BANK HOLIDAY	22 TRUST EXECUTIVE	26 TRUST EXECUTIVE	25 TRUST EXECUTIVE
Thursday	25 Informal Audit ICT FI	23 COE ICT FI	20 SC CF	25 COE ICT FI	22	26 COE ICT FI	24 FI	28 COE FI	26 BANK HOLIDAY	23 BOARD DEVELOPMENT	27 FI	26 FI COE CF
Friday	26 DIVISIONAL PERFORMANCE	24 Extra Audit Committee	21	26 DIVISIONAL PERFORMANCE	23	27 DIVISIONAL PERFORMANCE	25 DIVISIONAL PERFORMANCE	29 DIVISIONAL PERFORMANCE	27	24	28 DIVISIONAL PERFORMANCE	27 DIVISIONAL PERFORMANCE
Saturday	27	25	22	27	24	28	26	30	28	25	29	28
Sunday	28	26	23	28	25	29	27		29	26		29
Monday	29	27 BANK HOLIDAY	24	29	26 BANK HOLIDAY	30	28		30	27		30
Tuesday	30 DIVISIONAL PERFORMANCE	28	25	30 DIVISIONAL PERFORMANCE	27		29 DIVISIONAL PERFORMANCE		31	28		31 DIVISIONAL PERFORMANCE
Wednesday		29 TRUST EXECUTIVE	26 TRUST EXECUTIVE	31	28 TRUST EXECUTIVE		30 TRUST EXECUTIVE			29 TRUST EXECUTIVE		
Thursday		30	27 FI ICT		29 FI ICT		31			30 FI COE		
Friday		31 DIVISIONAL PERFORMANCE	28 DIVISIONAL PERFORMANCE		30 DIVISIONAL PERFORMANCE					31 DIVISIONAL PERFORMANCE		
Saturday			29				1					
Sunday			30				2					

KEY

PLEASE NOTE THE MEETING TIMES STATED BELOW MAY CHANGE ON OCCASION AND THE MEMBERSHIP WILL BE ADVISED VIA DIARY INVITATIONS, VENUES AND PAPER DEADLINES CAN BE FOUND ON THE INDIVIDUAL TABS SUPPORTING THIS SPREADSHEET

TRUST EXECUTIVE	10AM - 1PM
EXECUTIVE PERFORMANCE REVIEWS (TEC)	10AM - 1PM
STRATEGY DELIVERY BOARD (TEC)	10AM - 1PM

TRUST BOARD	9.30AM - 2PM
BOARD DEVELOPMENT SESSION	10AM - 4PM
BOARD BUSINESS WORKSHOP	9.30AM - 12.30PM

PATIENT AND STAFF EXPERIENCE	
FINANCIAL AND INVESTMENT	
ICT INFRASTRUCTURE TRANSITION	
DIVISIONAL PERFORMANCE	

CLINICAL OUTCOMES AND EFFECTIVENESS	
AUDIT	
SAFETY & COMPLIANCE	

CHARITABLE FUNDS	
REMUNERATION	

LAST UPDATED 29 October 2018

Agenda Item 18/64

Report to:	Trust Board
Title of Report:	Assurance report from Finance and Investment Committee
Date of meeting:	1 November 2018
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 25 October 2018.
Background	The Committee meets monthly and provides assurance on: Scheduled reports from all Trust operational committees with a finance and investment brief according to an established work programme.

<u>Financial Performance</u>

i. I&E deficit

The Committee reviewed the September month and year to date performance versus budget and the actions and plans in place to recover underperformance, and manage forward risks, to deliver the full year budgeted deficit of no more than £52.9m.

The Committee reviewed the £4.3m deficit in the month, which was an improvement on budget of £0.7m and on the latest forecast of £0.4m. However, the Committee noted that the improvement was due to a reduction, against both budget and forecast, of £1.6m in the provision for contract penalties, following agreement by HVCCG to cap penalties in the year at £7.6m compared to the budget of £10.0m. This means that the underlying deficit in the month was worse than budget and forecast by £0.9m and £1.2m respectively. The Committee reviewed the causes of the increased deficit from forecast, which was primarily the result of lower revenues of £0.7min the Surgery Division, most of which is elective income.

The Committee reviewed the half year results, and variances from plan, prior to seeking assurance that the plans and actions in place were on track to deliver the full year deficit target. Compared to budget for the first half year revenues of £164.7m are £2.9m lower, due mainly to a provision of £1.5m to cover prior year challenges,

£0.8m due to lower elective activity, mainly within Surgery, and £0.6m due to lower birth rates in maternity. Pay costs of £122.4m are £0.6m lower than budget, with higher levels of clinical pay offset by non-clinical, and non-pay costs of £72.5m are £1.9m lower than budget, driven by lower contract penalties. The resulting deficit of £30.2m is £0.4m worse than budget.

The Committee noted the high level of challenge to be met in the second half year to achieve the full year budget deficit of no more than £52.9m, and reviewed the status of plans to achieve it. Success requires reducing the average monthly deficit by 25%, from £5.0m to £3.8m, requiring a growth in revenue, in particular in elective, and a reduction in costs. Key enablers include increasing CIPs of £6.0m at the half year to £15.9m, and further reducing the rate of agency costs from £7.4m at the half year to no more than £14.0m for the year.

The Committee reviewed the recovery plans on all the above, including a further deep dive into the most financially challenged division, Surgery. The latest plans with underpinning actions would result in a deficit of £59.3m. To achieve the target requires a further £6.4m of recovery actions to be delivered, £2.2m more than the task reviewed at the September meeting, due to forecast reductions in revenues, mainly in elective, partly offset by reductions in costs.

The Committee reviewed the recovery actions, comprising a further £2.2m of CIPs to achieve the £15.9m deficit budget, and additional initiatives to deliver a further £4.2m contribution, and targeted the December Committee for having all underpinned.

The Committee noted the risk to the forecast from winter pressures breaching the extensive plans in place working with local system colleagues, and recognised that whilst the plans were robust there was no guarantee against a very severe winter having a significant impact on operational, and therefore financial, performance.

The Committee concluded that it was not assured that the full year's deficit target would be achieved as plans were not yet sufficiently underpinned.

The Committee recommends that the latest deficit forecast for the year, to deliver the full year budget of no more than £52.9m, together with the key assumptions, recovery actions and risk mitigations, is presented to Part 2 of the November Board.

ii Divisional review of Surgery, Anaesthetics and Cancer

The Committee reviewed a presentation by the Division's leadership team covering the division's I&E performance to date and forecast recovery actions to recover to plan for the year.

The Division is the most financially challenged in the Trust, primarily due to lower than planned revenues in elective surgery and

outpatients, and the Committee requested a follow up review on progress since the review at the August Finance and Investment Committee. The planned corrective actions to improve bed capacity have yet to have a positive impact, and in the months of August and September actual revenues were £1.2m lower than forecast, resulting in a lower than forecast profit contribution of £1.0m.

Compared to budget for the first half year revenues of £44.6m are £3.4m below budget, of which £1.7m relates to elective surgery and £1.0m to outpatients, and the profit contribution of £0.2m is £3.3m lower than budget.

The Committee reviewed the actions in place to improve bed availability, and thereby elective activity, including the pilot to evaluate the increase in the range of surgical procedures at St Albans.

The division's revenues are expected to increase in the second half year, starting with the month of October, but not sufficiently to avoid a further reduction from the forecast reviewed in August, down by £2.6m to £90.9m, which is £5.7m below budget. The forecast cost reduction is only £0.3m resulting in a lower profit contribution of £2.3m, down to £1.6m, £6.9m below budget. This forecast has been built into the Trusts base revised forecast of £59.3m.

The Committee reviewed recovery actions underway with a potential £1m to £2m profit contribution, and asked for a paper to be presented to the November meeting, covering the actual financial performance in October, and the latest forecast for the full year, including a detailed review of the recovery actions, and the extent to which there is confidence of delivery.

iii Capital Spend

Capital spend in the month of £0.1m resulted in £1.3m m spend for the first half year. The authorised spend for the year, including the recent award of £1.2m from the Government' s winter funding programme, which will increase capacity in ED, now stands at £14.4m.

The Committee again sought assurance that there would need to be a rapid acceleration in the rate of spend to ensure the full £14.4m, all on much needed improvements, is spent this year.

The Committee was assured that this acceleration would be seen in the third quarter with the aim of achieving the full year's authorised spend.

iv Revenue funding

Funding of revenue spend by NHS is subject to monthly approval, and following review, the Committee recommends ratification by the November Board of an NHS revenue support loan of £2.3m to meet the funding requirements for October.

Draft STP-wide medium term financial plan

The Committee reviewed the draft plan, and the Trust's inputs to it. The Committee supported the Trust's inputs to the plan, and the objectives and principles upon which the STP plan is based, including full alignment across the STP to produce an integrated plan, system wide governance arrangements to enable timely actions to address system wide challenges, and ongoing transparency between Trusts. The Committee was assured that the STP plans, assumptions and principles had been agreed by each Trusts CEOs and CFOs, and that 2019/20 would be the first year of an integrated plan.

The Finance and Investment Committee and Board will review and approve as appropriate the 2019/20 STP plan development along with the Trust's own plan with the aim of achieving approval from the Regulator by April 2019.

The Committee recommends the paper is presented to Part 2 of the November Board for information and discussion.

Acute Development Programme

As delegated by the October Board, the Committee reviewed, for approval, the Trust's Wave 4 submission to NHSI, seeking public sector capital funds to support the Trust in redeveloping its hospital estate. The submission does not prejudice the outcome of the estate's redevelopment SOC refresh, and following feedback from NHSI/E has a phased expenditure approach.

The submission for all Trusts has to be made by 31 October. Following review, the Committee approved the submission and recommends it is presented to Part 2 of the November Board for information and discussion.

Watford Theatres' Refurbishment Project

The Committee received a verbal update on the project which aims to make the theatres clinically compliant and improve productivity and efficiency. The OBC is expected to be presented to the December Committee and January Board for approval.

The Committee recommends that there should also be a verbal update to Part 2 of the November Board.

Risks to refer to risk register

None

Issues to escalate

The Committee recommends the following:

To Part 1 of the Board for ratification

- The NHS revenue support loan of £2.3m to cover funding

requirements in October 2018

To Part 2 of the November Board

For assurance

- The latest deficit forecast for the year, for both revenue and costs, together with the key assumptions, recovery actions and risk mitigations, to deliver the full year budget of no more than £52.9m.

For information and discussion

- The Wave 4 capital submission to NHSI for development of the Trust's estate

- A verbal update on the Watford theatres' refurbishment project

Attendance record

Attended
John Brougham, Non-Executive Director (Chair)
Don Richards, Chief Financial Officer
Helen Brown, Acting Chief Executive
Mike van der Watt, Medical Director
Nick Kennell, Interim Director of Strategy
Sally Tucker, Chief Operating Officer
Soheb Rafiq, Head of Financial Management
Prof Steve Barnett, WHHT Chair
Jeremy Livingstone, Divisional Director, Surgery, Anaesthetics and Cancer
Phil Townsend, Non-Executive Director
Tom Drabble, Patients' Representative
Rodney Pindai, Head of Finance
Victoria Houghton, Chair, Staffside
Stephen Dunham, Associate Director of Financial Productivity
Paddy Hennessy, Director of Environment
Jason McKee, Deputy Divisional Manager, Surgery, Anaesthetics and Cancer (for item 9.4)
Jonathan Wise, STP Finance Lead (by invitation for item 8)

Notes
Clare Ransom

19

Agenda Item: 19/64

Report to:	**Trust Board**
Title of Report:	**Assurance report from Clinical Outcomes and Effectiveness Committee**
Date of meeting:	**01 November 2018**
Recommendation:	**For information and assurance**
Chairperson:	**Jonathan Rennison, Chair**
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Clinical Outcomes and Effectiveness Committee at its meeting on 27 September 2018
Background	The Committee meets bi-monthly and provides assurance to the Board on: • Safe and effective patient care • Prevention, early intervention, recovery and rehabilitation • Ensure that the Trust's responsibility for infection control is effectively fulfilled • Promoting a culture of learning and continuous improvement. • Measure change using clinical outcome measures to monitor the impact of the services provided by the Trust.
Business undertaken	**<u>Integrated Performance Report (IPR)</u>** The Committee received and reviewed the IPR. Where performance was not meeting the required standard the committee was assured that there was an understanding of the problems preventing the Trust from hitting targets and were largely assured that there were appropriate plans in place to address areas of under-performance. Areas of concern which were discussed included the continuing poor performance on DNACPR – the committee were assured that this had been thoroughly reviewed and that changes made to forms and new training was being rolled out to tackle the issue. Despite considerable focus VTE Assessments continue to perform poorly. The committee were assured that a new approach was being piloted and that in a number of wards the pilot included the VTE assessment on the Drug Chart, an approach that is used elsewhere and seems to be effective.

Update on GIRTH

The committee received two reports on getting it right first time (GIRTH) on urology and orthopaedics

For both reports, the committee were assured that the relevant leads and teams understood the issues and had ideas for how they could be addressed. The committee were, however, not assured that there was a clear structured action plan, with timelines, deadlines and clearly articulated outcomes in place. In some cases a lot of the information that would be required to create a structured action could be found in the reports, however, the reports fell short of providing the committee with assurance that there were robust and well-structured improvement plans in place.

The committee have asked that further work be done on these reports and that they would be brought back to the next committee meeting.

C-Section and MBRACE action plan update

The committee received updates on the c-section action plan and MBRACE compliance update. The committee were assured that actions were being completed in a timely manner and that the Trust was now compliant with MBRACE. The reports and the presentation of the reports were very good and provided high levels of assurance for the committee.

Corporate Risk Register and BAF Action Tracker:

The committee were assured that Corporate Risks assigned to the committee were being appropriately managed and mitigated.

The committee raised concerns about the movement of day-to-day operational ICT risks on the Corporate Risk Register to the ICT transformation committee, it was felt that as a time-limited committee focused on delivering the new ICT Contract and ICT Transformation this may not be an appropriate place to address operational issues. Additionally, all BAF related ICT risks remain with COEC, while the related Corporate Risks move to the ICT Committee. The committee would ask that this be considered and discussed further by the board to receive assurance the operational risks relating to ICT receive appropriate challenge and discussion in the ICT Transformation Committee.

The committee raised concerns that the BAF Action Tracker was very limited in its utility in its current presentation and that the action tracker could provide false assurance. The action tracker is presented without any of the Principle Risks that the actions relate to making it extremely difficult to judge if the actions are addressing the underlying risks.

The actions assigned to the committee are largely on track – most are green and blue. It gives assurance that the actions are

progressing well. However, behind this there are 17 risks, five of which that score 15 or above. Three relate the emergency care pathway, one relates to RTT and one relates to inaccurate or incorrect diagnostic coding.

The BAF action tracker does not provide any assurance that those risks are being appropriately managed and mitigated. The committee request that further work is undertaken in order to ensure the committees remain focused on assurance concerning their principal risks.

Annual Reports – we received two annual reports:

1. Infection Prevention and Control Annual Report
2. End of Life Care Annual Report

Both reports were well written and provided evidence of strong performance and management of each of these important areas of work.

The committee were assured that appropriate mitigations and processes are in place to manage the infection prevention and control related risks that are posed by our estate and lack of space. The committee found evidence and excellent performance in managing infections when they occur to prevent their spread to other patients. The committee were further assured that the Trust had excellent processes in place and thanked the team for their performance in this area.

End of life care demonstrated clear progress and improvement on last year, with an increase in referrals to the team. The team have implemented many of their planned changes throughout the year and seen the quality of End of Life care improve throughout the year. A clear set of actions and plans for the coming year are in place. The committee were assured of the Trusts performance and plans to improve performance further and the committee extended the thanks to the team for their continued hard work in this area.

Risks to refer to the risk register	None
Attendance	Jonathan Rennison, Non-Executive Director Ginny Edwards, Non-Executive Director Tracey Carter, Chief Nurse & DIPC Mike van der Watt, Medical Director Sally Tucker, Chief Operating Officer Martin Keeble, Chief Pharmacist Jane Shentall, Director of Performance Alison Fuller, Interim Associate Chief Nurse Divisional Representatives
In attendance for specific Items	Freddie Banks, Clinical Lead Ben Spielberg, Clinical Lead

Agenda item: 20/64

20

Report to:	Trust Board
Title of Report:	Safety and Compliance Committee Assurance Report to Trust Board
Date of board meeting:	01 November 2018
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 18 October 2018.

Background

The Committee meets bi-monthly and provides assurance on:

- CQC standards
- Compliance with external bodies, e.g. 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

Annual Review of Work plans
The Committee reviewed the committee work plans for 2018/19.

Safety & Quality Integrated Performance Report (IPR)
The Committee reviewed the July and August data in the performance report and noted and discussed particular areas of good performance and areas requiring performance improvement.

Joint Corporate Risk Register and BAF framework report
The Committee received an update on the status of the corporate risk register and a review of the status and progress of actions in the board assurance framework as at the end of September 2018.

Serious incidents annual report
The Committee received assurance regarding the improvements in compliance against key performance indicators between 2017 and March 2018 and noted the opportunities to continue to improve.

Risk Management Strategy and Risk Management Procedure
The Committee approved the Risk Management Strategy & Procedure subject to a couple of alterations. The growth of risk awareness and process continues across the Trust.

Health Safety and Fire Safety update and Security Management Violence and aggression report

The Committee received two reports from the Director of Estates - Health, Safety & Fire; and Security Management Violence and Aggression. Although the reports were considered rich in content the committee felt that work needed to be done to better integrate the key compliance metrics to the IPR and mark essential actions.

Biannual Establishment Review – Adult Inpatient Wards

The Committee received information and assurance on the adult inpatient ward establishment review conducted in May 2018 with the summary of recommendations and the view that the establishments remain unchanged.

Quality Improvement in Hospital Trusts 'Sharing learning from Trusts on a Journey of QI report briefing'

The Committee reviewed the early work on the introduction of a methodology as recommended by the CQC in the form of QI. It was noted that the Executive were targeting the introduction and training and the Committee recognised the need to shape this introduction in the context of leadership training.

Medical Devices update

The Committee received an update and agreed that very good progress has been made post the audit on Medical devices and agreed assurance had been provided and the special attention from the committee was no longer required.

Internal Audit Report – Medical Devices including procurement

The Committee received the Internal Audit Report with Sam Abbas invited from RSM Ltd as the opinion of the auditors was 'no assurance'. It was agreed that this was a fair and accurate report. However, members were assured that, since the report was produced, plans and activities were in place and controls strengthened.

Internal Audit report – Medicines Management and Controlled Drug

The Committee received the report and noted that the opinion of the auditors was that the Board could take reasonable assurance that the controls in place to manage this risk were suitably designed and consistently applied.

Quality Compliance Programme (QCP) Report
Members noted the overall status of the QCP Programme at the end of August 2018.

Risks to refer to risk register

The risks on the corporate risk register aligned to the Safety and Compliance Committee (scored at 15 and over).

Key decisions taken	1. The Committee approved the Risk Management Strategy & Procedure subject to a couple of alterations.
Issues to escalate	1. That very good progress had been made post the audit on medical devices and the committee agreed assurance has been provided and the special attention from the committee was no longer needed. 2. The two reports from the Director of Estates - Health, Safety & Fire; and Security Management Violence and Aggression. Although the reports were considered rich in content the committee felt that work needed to be done to better integrate the key compliance metrics to the IPR and mark essential actions. 3. The Committee reviewed the early work on the introduction of a methodology as recommended by the CQC in the form of QI. It was noted that the Executive were targeting the introduction and training and the Committee recognised the need to shape this introduction in the context of leadership training.
Challenges and exceptions	None
Future exceptional items	None

Attendance record
Phil Townsend, Non-Executive Director Jonathan Rennison, Non-Executive Director Helen Brown, Acting Chief Executive Don Richards, Director of Finance Patrick Hennessy, Director of Estates Sally Tucker, Chief Operating Officer Mike Van der Watt, Medical Director Anna Wood, Assistant Medical Director Angela Wellman, Head of Nursing, Emergency Care Martin Keble, Divisional Manager, Clinical Support David Thorpe, Deputy Chief Nurse Marsha Hunt, Associate Chief Nurse, Quality Governance Allen Howe, Compliance Manager, Estates Jean Hickman, Trust Secretary Lisa Morris, Minutes

Agenda Item: 21/64

21

Report to:	The Trust Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	01 November 2018
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 19 October 2018.
Background	The committee meets four times a year for regular business and has two additional meetings in relation to the year-end sign off process. It provides assurance to the Board: • on all aspects of internal audit and those aspects of external audit not reserved to the Audit Panel. The Audit Panel deals with the appointment and removal of the external auditor. • on the appointment of the internal auditor • that effective assurance controls, structures, systems and processes for integrated governance, risk management and internal controls are in place
Business undertaken	**Assurance report from the Safety and Compliance committee** The committee received a detailed update from Phil Townsend, chair of the safety and compliance committee and Anna Wood, deputy medical director. The update included a desktop review which had concluded the safety and compliance committee was meeting its required remit. The committee was subject to an observation by NHSI in June 2018 and had received positive feedback with two recommendations for improvement. The committee was assured on the shape and direction of travel of the safety and compliance committee, that it was meeting its terms of reference with a well-structured work plan that included a programme of internal audit review. **Deep Dive into staff salary overpayments** An update on salary overpayments that had occurred in the Trust from July – September 2018 was received, along with a full year update and any areas required for remedial action.

The committee expressed concern at the continued numbers of overpayments that had worsened over the period, one specifically relating to an overpayment over a three year period.

The committee did not feel assured on procedures to address staff salary overpayments and requested an update on actions to remedy this ongoing issue to come back to the Audit Committee in spring 2019.

Freedom to speak up update

The committee noted and was assured at the clear effort being undertaken to establish the freedom to speak up campaign and promote the culture.

Annual review of standing financial instructions, standing orders and scheme of delegation

The committee reviewed and approved the documents, but asked that the suite of documents is updated with modern terminology.

Review of Clinical Audit annual report

The committee received an overview of the clinical audit annual report. It was noted that the precise report accurately hit the ten points raised in the HFMA audit committee manual. The committee was assured that the strategy, planning and resource of the clinical audit were effective.

Review of risk and governance arrangements

The committee received a paper summarising the controls in place to manage risk in the organisation. The standard operating procedure (SOP) developed with the aim of ensuring clear, standard procedure for monitoring and updating the Board Assurance Framework was approved, subject to risk being included in the list of definitions. The definition would be based upon risk being approached as the need to avoid damage.

Internal audit progress report

The internal audit plan was still considered appropriate for the risks and issues faced by the trust. Neither the committee nor internal audit believed that amendments were required at this stage. Internal auditors advised that the plan for next year was underway.

Local counter fraud service (LCFS) report

The committee reviewed the open LCFS progress report and current cases. The counter fraud lead was scheduled to meet with the medical director to discuss three recent investigations and to work out what needed to be done to ensure that the scope for misunderstanding and miscommunication in the future was contained. The committee was assured on the direction of travel on NHS counter fraud authority self review tool and would be looking for recommendations at the next meeting that would enable the Trust to

start to move in 2019 from partial compliance (currently all amber) to full compliance with the standard (turning as many ambers into green as possible).

External audit

It was reported that planning for the external audit for 2018/19 was proceeding on schedule and had uncovered nothing worthy of note

Register of Declarations

A revision to the declarations of interest policy was suggested with the senior independent director (and in his absence audit chair) to approve chair's expenses.

Risks to refer to risk register	No risks to refer
Issues to escalate	Deep dive into the salary overpayments
Attendance record	Paul Cartwright, Non-Executive Director (Chair) John Brougham, Non-Executive Director Don Richards, Chief Financial Officer Stephen Dunham, Assistant Director of Finance & Commercial Development Onali Mohamedali, Financial Controller Jean Hickman ,Trust Secretary Gemma Higginson, Managing Consultant, RSM Clive Makombera, Director, RSM Anna Wood, Deputy Medical Director Ade Oyerinde, Grant Thornton Ciaran McLaughlin, Grant Thornton

Agenda Item: 22/64

Report to:	Trust Board
Title of Report:	Charity Committee Assurance Report to Board
Date of meeting:	01 November 2018
Recommendation:	For discussion
Chairperson:	Jonathan Rennison, Non-Executive Director

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Charitable Funds Committee at its meeting on 27 September 2018.

Background

The Committee meets quarterly and provides assurance to the Board:

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

Business undertaken

Approval of annual report and accounts

The committee reviewed the annual report and accounts of the Charity. It was assured that the annual report and annual accounts were correct and appropriate.

The report and accounts were subject to an independent examination by our auditors (Grant Thornton) and no issues of concern were raised. Once they have been approved they will be formatted for publication on the Charity website and submitted to the Charity Commission.

The Charity committee asks the Corporate Trustee to approve the annual report and accounts.

Letter of Representation

The committee received a letter of representation, which forms part of the annual accounts and the independent examination of the Trust's charity accounts.

The committee was satisfied that they fulfil the conditions and requirements set out in the letter and recommend it to the Corporate Trustee to be signed.

Re-branding of the charity

The committee conducted a consultation and staff vote to select the new brand. The voting was very close with only a handful of votes between the two final brands. The Charity Committee reviewed the two final brands and has chosen to endorse the vote of the staff and recommend 'Raise' as the new brand for the Charity. The Charity will now work with brand designers to roll-out the brand over the coming year, starting with the annual report and accounts.

The committee requests that the Corporate Trustee support the recommendation and adopt Raise as the new name and brand identity for the West Herts Hospital Charity.

Charity Director

The Charity Director has been very successful in her role and has significantly raised the profile of the charity and increased income in the past year. The role was first appointed as an interim role. The Committee has reviewed this and agreed with a recommendation from the Executive Team that this role is confirmed as a permanent post.

The Committee requests that the Corporate Trustee approves the recommendation to make this role permanent.

Royal Free Charity collaboration

There have been renewed discussions on this collaboration and there are a number of meetings confirmed to discuss key points on this collaboration to support the West Herts Charity to be a stronger and more sustainable charity in the longer term.

Strategy and policies

Progress is continuing on the charity strategy and the development of new policies to underpin sustainable growth, while also mitigating potential risks. The Committee was assured that this is on track and performing well.

Escalation to the Corporate Trustee

The Charity committee asks the Corporate Trustee to:

- Approve the annual report and accounts
- Approve that the letter of representation is signed by the Corporate Trustee.
- Support the recommendation and adopt Raise as the new name and brand identity for the West Herts Hospital Charity.
- Approve the recommendation to make the Charity Director role permanent.

Attendance record

Jonathan Rennison, Non-Executive Director
Ginny Edwards, Non-Executive Director
Tracey Carter, Chief Nurse
Don Richards, Chief Financial Officer
Louise Halfpenny, Director of Communications
Paul da Gama, Director of Human Resources
Samantha Sherratt, Charity Director
Onali Mohamadali, Financial Controller
Jean Hickman, Trust Secretary

TRUST BOARD MEETING IN PUBLIC
AGENDA

06 December 2018 at 9.30am – 12.00noon

Executive Meeting Room, The 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
01/65	**Opening and welcome**	To note	N/A	Chair	Verbal
02/65	*Presentation to be advised*				Presentation
OPENING					
03/65	**Apologies for absence**	To note	N/A	Chair	Verbal
04/65	**Declarations of interest**	To note	N/A	Chair	Paper
05/65	**Minutes of the meeting held on 01 November 2018**	For approval	N/A	Chair	Paper
06/65	**Board action log from 01 November 2018 and previous meetings and decision log**	To note	N/A	Chair	Paper
07/65	**Chair's report**	For information	N/A	Chair	Paper
08/65	**Chief Executive's report**	For information	N/A	Chief Executive	Paper
PERFORMANCE					
09/65	**Integrated performance report – month 7**	For information and assurance	Trust Executive Committee	Chief Operating Officer	Paper
10/65	**Emergency department and referral to treatment performance update**	For information	Trust Executive Committee	Chief Operating Officer/Director of Performance	Paper
AIM 1: BEST QUALITY CARE (OBJECTIVES 1 – 5)					
11/65	**Complaints and patient advice and liaison annual report**	For information and assurance	Clinical Outcomes and Effectiveness Committee	Chief Nurse	Paper

12/65	**Quarterly learning from deaths report**	For information and assurance	Safety and Compliance Committee	Medical Director	Paper
13/65	**Briefing on winter readiness**	For information and assurance	Trust Executive Committee	Chief Operating Officer	Paper
14/65	**Bi-annual establishment review**	For information and assurance	Clinical Outcomes and Effectiveness Committee	Chief Nurse	Paper
AIM 2 : A GREAT PLACE TO WORK AND LEARN (OBJECTIVE 6-8)					
15/65	**Bi-annual workforce and development strategy update**	For information and assurance	Patient and Staff Experience Committee	Director of Human Resources	Paper
AIM 4: A STRATEGY FOR THE FUTURE (OBJECTIVE 10-12)					
16/65	**Herts and west Essex sustainability and transformation partnership (STP) update**	For information	Trust Executive Committee	Interim Director of Strategy	Paper
RISK AND GOVERNANCE					
17/65	**Report on board assurance framework and corporate risk register**	For information and assurance	Trust Executive Committee	Trust Secretary	Paper
COMMITTEE REPORTS					
18/65	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
19/65	**Assurance report from Patient & Staff Experience Committee**	For information and assurance	Patient & Staff Experience Committee	Committee Chair/Director of Human Resources	Paper
ANY OTHER BUSINESS					
20/65	**Any other business previously notified to the chair**	N/A	N/A	Chair	Verbal
QUESTION TIME					
21/65	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
22/65	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
23/65	**Draft agenda for next meeting**	To approve	N/A	Chair	Paper

24/65	**Date of the next board meeting in public:** 10 January 2019	To note	N/A	Chair	Verbal

DRAFT