TRUST BOARD MEETING IN PUBLIC
AGENDA

05 December 2019 at 9.30am – 12.30pm
Executive Meeting Room, Watford Hospital

Apologies should be conveyed to the Trust Secretary, Jean Hickman on jeanhickman@nhs.net or call 01923 436 283

Time	Item ref	Title	Objective	Accountable officer	Paper or verbal	Link to BAF
9.30	01/77	**Opening and welcome**	Information	Chair	Verbal	
	02/77	**Presentation on the critical care service**	Information	Chief Nurse	Present-ation	
INTRODUCTION TO THE MEETING						
9.50	03/77	**Apologies for absence**	Information	Chair	Verbal	
	04/77	**Declarations of interest**	Information	Chair	Paper	
	05/77	**Minutes of the meeting held on 07 November 2019**	Approval	Chair	Paper	
	06/77	**Board action log from 07 November 2019 and previous meetings and decision log**	Information	Chair	Paper	
	07/77	**Chair's report**	Information	Chair	Paper	
	08/77	**Chief Executive's report**	Information	Chief Executive	Paper	
	09/77	**Board assurance framework**	Approval	Chief Executive	Paper	
PERFORMANCE						
10.10	10/77	**Performance report on access standards**	Information and assurance	Chief Operating Officer	Paper	4a&b
	11/77	**Integrated performance report (month 7)** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Finance Officer •	Information and assurance	Chief Operating Officer	Paper	4a&b
AIM ONE: BEST QUALITY CARE (OBJECTIVE 1 – 4)						
10.50	12/77	**Annual report on infection prevention and control**	Information and assurance	Chief Nurse	Paper	

	13/77	**Annual report on complaints and the patient advice and liaison service**	Information and assurance	Chief Nurse	Paper	
	14/77	**Quarterly learning from deaths report**	Information and assurance	Deputy Medical Director	Paper	1a
	15/77	**Bi-annual Board engagement report**	Information and assurance	Chief Nurse	Paper	
STRATEGY						
11.15	16/77	**Strategy update**	Information and assurance	Deputy Chief Executive	Paper	12 a-d
RISK AND GOVERNANCE						
11.25	17/77	**Corporate risk register report**	Approval	Chief Medical Officer	Paper	
	18/77	**Completion report on well-led improvement plan**	Approval	Chair/ Chief Executive/Trust Secretary	Paper	
ASSURANCE FROM COMMITTEES						
11.35	19/77	**Assurance report from Trust Management Committee**	Information and assurance	Chief Executive	Paper	
	20/77	**Assurance report from Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper	
	21/77	**Assurance reports from Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper	
CORPORATE TRUSTEE						
11.45	22/77	**Report from the Charity Committee**	Information and assurance	Chair of Committee/ Deputy Chief Executive	Paper	
ADMINISTRATION						
11.45	23/77	**Any other business previously notified to the chair**	N/A	Chair	Verbal	
QUESTIONS FROM THE PUBLIC						
11.50	24/77	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal	
	25/77	**Questions from our patients and members of the public**	N/A	Chair	Verbal	
CLOSING						
12.00	26/77	**Draft agenda for next meeting**	Approval	Chair	Paper	
	27/77	**Date of the next board meeting in public:** 09 January 2020, Executive Meeting Room, Watford	Information	Chair	Verbal	

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
DHSC	Department of Health and Social Care
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
HWE STP	Hertfordshire & West Essex Sustainability and Transformation Parternship

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 Partnership
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

NHS
West Hertfordshire Hospitals
NHS Trust

Declaration of board members and attendees interests
05 December 2019

Agenda item: 04/77

Name	Role	Description of interest	Relevant dates	
			From	To
Phil Townsend	Chairman	• Son works for ATOS Sintel a separate legal entity wholly on work associated with the BBC	Jan 2019	
Christine Allen	Chief Executive	• None		
Paul Bannister	Chief Information Officer	• None	January 2019	Present
Dr Andy Barlow	Divisional Director, Medicine	• Barlow Medical Services Ltd • Director, London & Hertfordshire Respiratory Diagnostics Ltd	April 2011 Sept 2018	Present Present
John Brougham	Non-Executive Director	• Non-Executive Director and Chair of the Audit Committee of Technetix Ltd	2010	Present
Helen Brown	Deputy Chief Executive	• None		
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	• None		
Paul Cartwright	Non-Executive Director	• Charitable Funds for West Hertfordshire Hospitals NHS Trust • Member of the Council for Kings College London.	Nov 2015 August 2019	Present Present
Paul da Gama	Chief People Officer	• None		
Ginny Edwards	Non-Executive Director (Vice-Chair)	• Trustee Peace Hospice Care • Director of Edwards Consulting Ltd • Charity Committee for West Hertfordshire	2011 2011 2014	Present Present Present

Last updated : August 2019

Name	Role	Description of interest	Relevant dates	
			From	To
		Hospitals NHS Trust • Volunteer organisation 'Help Force' advisor • In Touch networks - coaching consultant • Husband is CEO of The 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	2019 2019 2011 2011 2011	Present Present Present Present Present
Natalie Edwards	Associate Non-Executive Director	• None		
Mr Jeremy Livingstone	Divisional Director of Surgery , Anaesthetics and Cancer	• Jeremy Livingstone Ltd – Private practice		Present
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 - Associate • Association of NHS Charities • The Teapot Trust - Coaching • London Plus - Business Planning • In Touch networks - coaching consultant • Charity Committee for West Hertfordshire Hospitals NHS Trust • Governance, strategy and business planning support to London North West University Healthcare NHS Trust - work is focused on their NHS Charity. • Organisational development, change management, leadership development with Quo Vadis Trust - mental health residential care and supported housing service.	May 2015 March 2017 Aug 2012 April 2015 Sept 2016 June 2016 Oct 2016 Feb 2019 Jan 2019 August 2019 August 2019	Present Present Present Present Present Present Apr 2019 Present Present Present Present
Don Richards	Chief Financial Officer	• None		

Last updated : August 2019

Name	Role	Description of interest	Relevant dates	
			From	To
Sally Tucker	Chief Operating Officer	• None		
Dr Mike van der Watt	Chief Medical Officer	• Owner and Director Heart Consultants Ltd	2010	Present
Dr Anna Wood	Deputy Medical Director/Director of Clinical Standards and Audit	• None		

Last updated : August 2019

TRUST BOARD MEETING IN PUBLIC
07 November 2019

Seminar Room, Training and Education Centre,
Hemel Hempstead Hospital, Hertfordshire

Chair	Title	Attendance
Phil Townsend	Chairman	Yes
Voting members		
Christine Allen	Chief Executive	Yes
John Brougham	Non-Executive Director	Yes
Helen Brown	Deputy Chief Executive	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	Yes
Ginny Edwards	Non-Executive Director (Vice-Chair)	Yes
Jonathan Rennison	Non-Executive Director (Senior Independent Director)	Yes
Don Richards	Chief Financial Officer	Yes
Dr Mike van der Watt	Chief Medical Director and Director of Patient Safety	Yes
Non voting members		
Dr Andy Barlow	Divisional Director, Women's and Children's	Yes
Paul da Gama	Chief People Officer	Yes
Natalie Edwards	Associate Non-Executive Director	Yes
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	Yes
Anna Wood	Deputy Medical Director/Associate Medical Director for Clinical Audit	Yes
Sally Tucker	Chief Operating Officer	Yes
In attendance		
Dr Richard Burridge	Guardian of Safe Working Standards	Yes (item 14)
Meg Carter	Representative, Healthwatch	Yes
Louise Halfpenny	Director of Communications	Yes
Jean Hickman	Trust Secretary (notes)	Yes
Mr and Mrs P	Wife and son of patient, Dr P	Yes (item 2)
Emma Pope		Yes (item 2)
Dawn Moore		Yes (item 2)
Debbie Green		Yes (item 2)

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/76	**Opening and welcome**		
01.01	The chairman opened the meeting and welcomed the Board and members of the public. He reminded the Board that the country was now in a pre-election period and advised that matters must be restricted to those that needed a decision or required oversight. The chairman also reported that since the last Board meeting the Trust had hosted a visit from the prime minister, Boris Johnson and from the secretary of state, Nick Hancock.		
02/76	**Patient story**		
02.01	The chief nurse introduced Mr and Mrs P and invited them to explain to the Board the experience of their deceased husband/father, Dr P when he was an inpatient at Watford hospital. She also introduced three of the nursing staff that had been involved in the care for Dr P during his stay. The family reported that Dr P had experienced an error with an operation at a different hospital in 2014 which had resulted in paralysis from the neck down from a severe spinal cord injury. The Board was informed that during two subsequent admissions to Watford hospital Dr P did not receive the appropriate level of treatment required for his complex needs. This had largely been due to not having access to a 24 hour carer which had been stopped by external services when he was admitted to hospital. The family related a series of issues, including delays in seeing a specialist consultant, communication with the staff, dehydration caused by not being given IV fluids when he was on nil by mouth and the support he required to be able to have hydration and the development of two pressure ulcers.		
02.02	The chief nurse apologised to Mr and Mrs P and the family on behalf of the Trust and thanked them for working with staff to learn from their experience. She stated that Dr P should have had the benefit of the enhanced care team which would have helped to provide him with the holistic care that he needed. The nurses present at the meeting assured the family that the wards had looked in detail at what had gone wrong including how to better use the enhanced care team to support long term patients with complex needs. They noted that there had been real benefit from having a local resolution meeting with the family rather than writing a letter response as it had helped staff to fully understand the family's concerns. The nurses acknowledged that the patient's complex care needs should have been discussed with the Royal National Orthopaedic Trust where he was a long term patient and assured the family that a number of measures had been introduced to improve the care, including enhanced training, using red trays/jugs to highlight patients with special needs, hourly rounding and trying to ensure patients with complex care requirements were admitted to designated wards to manage their care needs.		
02.03	Mrs P suggested that the Trust should consider entering into an agreement with Herts Valley Clinical Commissioning Group (HVCCG) on continuing access to 24 hour carers for patients with complex needs as this would provide continuity of care which was an important element in protecting the dignity of patients who could not help themselves. The chief nurse assured the family that she would discuss this with HVCCG's director of nursing to consider how to provide better continuity of care.	TC	02/20

Agenda item	Discussion	Lead	Dead-line
02.04	The chairman thanked the family for attending the meeting and sharing their experience. He also thanked the staff and acknowledged that it was not easy to explore issues which had not gone as well as expected.		
OPENING			
03/76	**Apologies for absence**		
03.01	There were no apologies received.		
04/76	**Declarations of interests**		
04.01	No further interests were declared than those circulated prior to the meeting.		
05/76	**Minutes of the meeting held on 03 October 2019**		
05.01	Minute 10.04. Jonathan Rennison pointed out that his point had not related to training, but to the indicators in the integrated performance report and what the Board chose to focus on.		
06/76	**Board action log from 03 October 2019 and previous meetings and decision log**		
06.01	The actions on the action log had either been completed or had not reached their due date.		
07/76	**Chairman's report**		
07.01	The Board received a report from the chairman and he highlighted that Kathryn Magson, chief executive of HVCCG would be leaving to take up a secondment at the end of December 2019. He acknowledged that the Trust had built up a good working relationship with Kathryn over the last year and noted that she would be a significant loss to the local healthcare system, particularly the sustainability and transformation partnership. The chairman confirmed that HVCCG was in the process of appointing a joint accountable officer.		
07.02	The Board was informed that the chairman's term of office as a non-executive director had been extended from 01 December 2019 to 30 November 2020.		
07.03	The chairman congratulated Bonita Sparkes, clinical nurse specialist for safeguarding adults for being awarded nurse of the year in the Nursing Times awards. The chief nurse reminded the Board that the Trust had also won the accolade of the best UK employer of the year in the Nursing Times awards and pointed out the importance of celebrating these significant achievements and using them in the Trust's branding.		
08/76	**Chief Executive's report**		
08.01	The chief executive presented her report and brought the Board's attention to some key points. She noted that early signs from a pilot to improve the medical 'take' were encouraging and work was ongoing to collate data to fully assessment the impact on performance and patient experience. The chief executive advised that the Board would receive a progress report once appropriate levels of data were available.		
08.02	The Board was advised that there had not been any significant initial issues since the Central London Community Healthcare NHS Trust had become the main provider of adult community health services. The chief executive pointed out the continued planning for a potential no-deal EU exit and noted that the Board would receive an update on the urgent and emergency treatment and the staff flu campaign later on the agenda. She concluded her report by advising the Board that a new reverse mentoring initiative had received a good response from staff		

Agenda item	Discussion	Lead	Dead-line
	and over the next month staff would be urged to complete the national staff survey.		
PERFORMANCE			
09/76	**Board assurance framework**		
09.01	The Board received the board assurance framework (BAF) from the chief executive. She pointed out that this was a live document and focused on the risks to the delivery of the Trust achieving it objectives and not the wider risks which were picked up in the corporate risk register. The Board agreed that it was useful to see the list of objectives and underpinning detailed objectives at its inaugural presentation, however agreed for these to be removed from future updates of the BAF. The chief executive brought the Board's attention to the wording of risk 4a and 4b which related to the delivery of national standards and noted that no NHS trust was achieving the national standards. She recommended that the wording be amended to 'non-delivery of the Trust's improvement plan for emergency care' and 'non-delivery of the Trust's improvement plan for planned care'. The Board approved this amendment to the BAF risks. John Brougham pointed out that the objectives had the quality committee named as monitoring access performance when it should be the finance and performance committee. The Board also agreed that in light of improved planned care performance, the 'high' rating should be reviewed.	JH	12/19
09.02	Paul Cartwright and John Brougham welcomed the new format of the BAF as it was easier to understand. Paul Cartwright stated that that the BAF should now be used to drive the agenda of the Board and its sub-committees.		
09.03	The trust secretary reported that specific elements of the BAF had been reviewed by assurance committees in October 2019 and asked the Board to approve recommended changes to risk 5c (failure to identify clinical capacity to support enhanced research) and for risk 10a to be removed from the BAF following a successful transition to a new IT provider.		
09.04	Resolution: The BAF was reviewed and recommended changes were approved.		
10/76	**Performance report on access standards**		
10.01	The Board received an overview of performance against the national access standards from the chief operating officer. She identified factors which had affected performance and the actions that were being taken to ensure a return to compliance. In particular, the chief operating officer reported that there had been improvement in emergency department (ED) performance and performance against the RTT 92% standard was just below plan. She advised that ED attendance was higher than in the previous month and was 11.4% higher than the same period the previous year. The number of arrivals by ambulance had also increased from the previous year and the chief operating officer advised that the Trust was working closely with the ambulance service to consider actions to address this. It was reported that the Trust had formally submitted its winter plan to NHS England/Improvement and the Board was pleased to be informed that funding had been approved to support a hospital ambulance liaison officer for 12 hours a day for six months.		

Agenda item	Discussion	Lead	Dead-line
10.02	Paul Cartwright thanked the chief operating officer for the informative report and asked for data on the predicted attendances to be added to future reports to aid Board understanding.	ST	12/19
10.03	Natalie Edwards asked for clarification on the actions in place to prevent ambulance delays. The chief operating officer responded that an agreed improvement plan was in place with monthly handover improvement meetings established to review progress against the actions. She noted that prior notification from the ambulance service when a patient was being transported to the hospital would be helpful, as would consideration by the ambulance service to convey patients to other suitable services, such as the urgent treatment centre.		
10.04	Jonathan Rennison asked for assurance on the sustainability of maintaining the improved performance. The chief operating officer responded that significant improvements made the previous year to increase capacity continued to have an impact and this year's winter plans were underway and expected to improve this further. The Board was informed that a pilot for patient flow was also demonstrating improvements and the Trust was refreshing its winter surge plan. The chief operating officer warned that a harsh winter had been forecast which was a significant risk factor and she stressed the importance of the Trust being reactive to internal triggers. The chief operating officer assured the Board that services recovered quicker after a significant busy period than a number of other NHS organisations.		
11/76	**Integrated performance report**		
11.01	The chief operating officer presented the integrated performance report and noted that despite increased attendance in September, performance against the ED four-hour standard was better than the same period in 2018/19. It was noted that two business continuity incidents had been declared; one being over a weekend which was the first weekend incident for some time. The chief operating officer reported that issues with the patient transport service which resulted in a number of failed patient discharges and was the subject of ongoing discussions with HVCCG. The Board was informed that winter plans to expand assessment capacity and relocate a fluid store in order to increase the footprint of the emergency department were continuing. Work to move the CT scanner into the emergency department had also commenced. The chief operating officer concluded her report by informing the Board that the Trust had been asked for the first time to submit an operational plan for the October half term period.		
11.02	The chief nurse reported on falls, although she assured the Board that the number remained below average. There had also been a small number of category three pressure ulcers reported in recent months although this remained comparable to the national average, and the chief nurse advised that work continued with ward staff to promote best practice in tissue viability. The Board was informed that a hydration improvement project had been completed which would support the Trust' quality improvement programme and a new end of life care volunteer coordinator had been funded through charitable contributions which would add to the recognised benefits of the Rose volunteers.		
11.03	The chief medical officer reported that mortality indicators had been rebased across the NHS and the Trust's performance remained good. The roll out of a medirota programme was near completion, proving much better control of team job plans and reducing cancellations. The		

Agenda item	Discussion	Lead	Dead-line
	chief medical officer advised that initial indicators of a pilot of the medical 'take' in ED were promising, however it was difficult to be precise on the benefits realised at the current time as the parameters for data collection were still fluid. It was expected that sufficient data would be available by the end of the two month period to be able to make an informed evaluation of the benefits achieved. Ginny Edwards asked whether the analysis would include benefits to patient experience and readmission and reattendances. The divisional director for medicine confirmed that this would be included and confirmed that a set of key performance indicators had been agreed. The chief medical officer completed his report by advised that significant capacity issues had been identified in the urology services which would be discussed in detail in the private session of the meeting.		
11.05	The chief information officer was asked for an update on IT services following the transition onto a new provider. He reported some small improvement areas had been seen, however he reminded the Board that significant improvements had not been predicted at this stage. He assured the Board that a monitoring programme was due to start in December 2019 and confirmed that the Board was scheduled to receive a progress report in quarter one 2020/21.		
11.04	The Board was advised by the chief people officer that the key workforce metrics continued to perform well. He reported that a flu vaccination campaign had begun well with around 50% of patient facing staff being vaccinated to date, however the response rate to the national staff survey was disappointing and this would be a focus over the next few weeks. The chief people officer noted that a number of good initiatives had taken place during black history month and improvements were expected to be seen in some diversity areas when a new diversity manager took up post. The Board was informed that a significant joint tender exercise was underway with two other NHS trusts to procure a new provider for staff bank services. This would be completed in December 2019. The chief people officer advised that locum rates were now shared between trusts in the east of England and the Trust's performance rate was positive when compared to its peers.		
11.05	The chief financial officer reported that the Trust continued to remain on track to achieve its financial target of a £17.8m deficit. He advised that elective activity and income had improved in September 2019, however overall charges to HVCCG remined within contract values which supported the move to a minimum income contract. The chief financial officer advised that the highest risk to meetings the financial control total were clinical and nursing pay costs and assured the Board that good systems of control were in place to monitor nursing spend and actions had started to control medical expenditure. The chief financial officer reported that capital expenditure spend was relatively slow and there was a risk that the Trust would be underspent at the end of the financial year. The Board was advised that this would be discussed in detail in the private session of the meeting.		
11.06	Ginny Edwards noted that one of the biggest concerns raised by staff on a recent Board visit to the outpatient department was around the patient transport service. She enquired whether the Trust was confident that the service would deliver in light of the increase in demand. The chief operating officer informed the Board that capacity concerns had been raised with HVCCG who managed the contract and advised that the Trust had a key set of performance indicators in place.		

Agenda item	Discussion	Lead	Dead-line
11.07	Ginny Edwards asked whether the purchase of equipment was being managed through the procurement process in a timely manner. The chief financial officer confirmed that divisions were being supported to develop business cases as quickly as possible to ensure equipment was purchased when required.		
11.08	The chief financial officer questioned whether the Trust could expand its connection with social services to design services which would meet the diversity agenda, such as supporting patients with sickle cell. It was noted that this would be picked up as part of the patient engagement strategy.		
11.09	Natalie Edwards enquired on the Trust's approach to inclusivity. The chief people officer reported that plans to maintain an established inclusive approach were working well. He advised that more resource would be available once a new equality and diversity manager took up post and added that a reverse mentoring programme would be launched at the end of November 2019.		
11.10	The chief executive asked for future IPRs to include more detail in relation to delayed transfers of care.	ST	12/19
11.11	The chairman brought the Board's attention to the crude mortality indicators and the medical director provided an explanation on what this demonstrated. He assured the Board that the Trust's rate mirrored the national average and advised that the summary hospital-level mortality indicator (SHMI) and hospital standardised mortality ratios (HSMR) provided a better oversight into mortality performance than the crude mortality indicator. It was agreed that the quality committee would consider the value of this indicator and, if appropriate, to recommend to the finance and performance committee for it to be removed from the IPR.	MVDW	01/20
11.12	Natalie Edwards enquired on how confident the Trust was in meeting its financial trajectory. The chief financial officer responded that the Trust would have a better indication on the expected end of year position by the meeting in December. He advised that the Board would be looking in detail at the financial recovery plan in the private session of the meeting.		
11.13	Jonathan Rennison highlighted that the caesarean section rate continued to be above the target rate and the medical director advised that the maternity team was undertaking a benchmarking exercise against other similar sized maternity units. He reported that as a level two unit, the Trust treated more complicated patients than most other units. He assured the Board that there had been a significant reduction in the number of babies in trouble during labour and advised that the service was considering having an obstetrician on site on a 24 hour basis. Ginny Edwards enquired whether the patient numbers in the long term plan took into account the falling birth rate. The chief financial officer confirmed that birth numbers were expected to increase in the future and the plans reflected this.		
12/76	**12.02/76**		
12.01	The chief medical officer presented a report which outlined the outcome of a seven day services self-assessment and advised that this was due for submission to NHS Improvement by 29 November 2019. He reported that there was improved performance towards compliance and this would be further improved from a pilot of the medical 'take' in the emergency department. The chief medical officer reported that the enablers for full compliance with seven day working were effective job		

Agenda item	Discussion	Lead	Dead-line
	planning (currently 87% of consultants had fully compliant job plans) and electronic rostering. The chief information officer advised that installation of the Medirota tool was almost complete and this would offer a better oversight into team job plans and ensure that the right staff were in the right place.		
12.02	Resolution: The Board approved the seven day board assurance framework self-assessment for submission to NHSI.		
13/76	**Annual freedom to speak-up report and update**		
13.01	The chief people officer presented an update on the Trust's approach to freedom to speak up over the previous 12 months. He reported that the Trust had taken a focused approach to freedom to speak up and had been fully compliant with the original national guidance. It was noted that updated guidance had been published in July 2019 and assurance was provided that actions were in place to address any gaps which had been identified, including more focus on bullying and harassment and staff engagement. It was noted that the Trust was expected to recruit a freedom to speak up guardian with ring fenced time and adequate resources. The Board was asked to approve a recommendation for Ginny Edwards to be the nominated non-executive director lead for freedom to speak up. The importance of the new guidance not diluting the Trust's current robust whistle-blowing policy was acknowledged.		
13.02	Resolution: The Board approved a recommendation for Ginny Edwards to be the nominated non-executive freedom to speak up lead.		
14/76	**Guardian of safe working.**		
14.01	The guardian of safe working joined the meeting for this agenda item. He reported that overall the exception reporting rate amongst junior doctors equated to around one in three reports per trainee per year, which was comparable to other trusts in the region. The Board was advised that although there had been gaps in staffing during the year, the impact had not had a significant detrimental effect on the safe working hours of junior doctors, apart from in vascular surgery where improvements had been made. The guardian of safe working reminded the Board that in June 2019 the British Medical Association (BMA) had agreed changes to the 2016 junior doctor contract and warned that this was expected to increase the number and value of guardian fines, particularly in the emergency department. He advised that these would be built into junior doctors' terms and conditions and offered assurance that controls were in place for senior sign-off of guardian fines. The chief people officer added that the Trust had taken a positive approach which had resulted in issues being dealt with efficiency and effectively and the Trust not receiving any fines. He reported that feedback from the BMA to the Trust's approach had been positive and thanked the guidance of safe working for his excellent management.		
15/76	**Staff seasonal flu vaccination campaign update**		
15.01	The Board received an update from the chief people officer on compliance in relation to NHS England's best practice management checklist for the seasonal flu vaccination programme. The chief people officer reported that the Trust was meeting all the key requirements and was confident that it would achieve 80% compliance by the deadline of February 2020. In response to a question posed by Ginny Edwards about lessons learnt, the chief people officer advised that the Trust would be ordering vegan vaccinations the following year.		

Agenda item	Discussion	Lead	Dead-line
16/76	**Report on long term financial plan**		
16.01	The chief financial officer informed the Board on the process for developing financial plans for 2020/21 and the following four years. He explained the process which was set out in the paper and, in particular, he informed the Board on the importance of centring future plans on quality improvement and the integrated provision of services between different parts of the NHS. The chief financial officer advised that improved software would be required in order to support better management of the capital planning. The Board was assured that the trust management committee and the finance and performance committee had reviewed the plans in detail and it was recommended that the Board ratify the financial trajectories as set out in the report. The chief financial officer advised the Board that the 2020/21 plan would include consequences for providing services as an integrated care provider and would be regulated within a minimum income contract. It was noted that further discussion on the minimum income contract would be discussed in the private session of the meeting.		
16.02	Resolution: The Board ratified the financial trajectory for 2020/21 (deficit no greater than £3.242m); 2021/22 (deficit no greater than £1.934m) and a break even state thereafter.		
17/76	**Strategy update**		
17.01	The Board received a report from the deputy chief executive which provided a progress update on delivery of the 2019/20 strategic plan and a refresh of the Trust's five year strategy. It was reported that work continued to strength private patient services including pricing and discussions with specialists on how to maximise the available opportunities. Significant work was also continuing to develop business cases to deliver the capital programme, including a case relating to health records standardisation and local area network, both of which were essential to the delivery of the five year strategy. It was reported that the trust management committee had approved a business case to commence the enabling works for the redevelopment of the neonatal unit with the full business case expected to come to the Board for approval in quarter three to enable early decision-making for the 2020/21 capital programme. The deputy chief executive reported that complex planning works for winter was a further key area of focus which would be hugely beneficial for the Trust. It was noted that some public challenge of the acute redevelopment of services remained and a judicial review continued to require a great deal of time and resource. The deputy chief executive advised that the Trust would be hosting a number of visits from regulators which were an important part of the business case approval process. She also advised that the Trust was discussing possible support from the Royal Free London NHS Foundation Trust, as well as commissioning some additional external support. The deputy chief executive concluded her report by advising that the Trust's five year strategy was being refreshed and a draft would be circulated to the Board for information and comment. An internal and external engagement plan was underway, including a stakeholder event in November 2019 with the aim of the Board receiving a draft of the five year strategy for approval in December 2019.		
17.02	The chairman brought the Board's attention to a delay in plans to build a multi-storey car park in Watford and asked for an update. The Board was informed that the delay had been due to Kier and Watford Borough Council being unable to reach a decision on an independent provider.		

Agenda item	Discussion	Lead	Dead-line
	Despite this, the Board was advised that plans were continuing for the business case to be reviewed by the financial and performance committee in November and for the Board to receive a draft for approval in December 2019.		
17.03	The chief information officer informed the Board that significant IT network challenges over the past months had resulted in a potential preferred provider reconsidering its original quote and was investigating the current network in detail. He advised that negotiations were continuing with the aim of the Board receiving a draft business case in December 2019.		
17.04	The divisional director of medicine asked for an update on changes at Mount Vernon hospital which could impact on elective and acute services. The deputy chief executive advised that issues had been raised with inpatient cancer services which were currently managed by Hillingdon Hospitals NHS Foundation Trust and a clinical review was underway with the intention of finding a new tertiary provider. In the meantime, immediate additional clinical support had been established and potential long term future service models were being considered. The deputy chief executive reminded the Board that the inpatient cancer service was an important service with complex needs and as the nearest acute Trust, a clinical meeting was being convened in order to discuss what this might mean for the Trust. Assurance was provided that no changes would be made in the current financial year and the Board would receive an update in January 2020. The chief executive added that whilst the Trust was keen to support its neighbouring trusts, this must be managed in a well-structured way.		
18/76	**Full business case for urgent and emergency care**		
18.01	The deputy chief executive presented a full business case for approval to award a contract for the provision of an urgent treatment centre at Watford, the expansion of the ambulatory service at Watford and transition funding to support a move to a new clinical model. The Board was reminded that it had received the outline business case and advised that the case had been approved by HVCCG. John Brougham confirmed that the business case had been fully supported by the financial and performance committee. It was reported that a preferred supplier for the urgent treatment centre had been found, subject to finalisation of a contract which would go back through the financial and performance committee for final approval. The Board was informed that the service would come into operation in April 2020 and would support the maximum use of the ambulatory care service. A similar service was planned to be established in Hemel Hempstead and St Albans by October 2020.		
18.02	Paul Cartwright asked for assurance around the termination clauses in the contract with the preferred provider. The Board was advised that terms and conditions of the contract would be discussed by the finance and performance committee in November 2019 and all non-executive directors were invited to attend.		
18.03	Resolution: The Board approved the award of the contract to Greenbrook Healthcare, acknowledging that this would be subject to finalisation and signing of the contract.		
19/76	**Corporate risk register update**		
19.01	The chief medical officer updated the Board on the movement of risk on the corporate risk register as agreed by the risk review group. He advised that the rating of two risks had been increased, one relating to		

Agenda item	Discussion	Lead	Dead-line
	a potential shortage of parts to repair the CT scanner in the acute admissions unit when it frequently broke down and the other relating to challenges in the recruitment of emergency medicine staff. It had been agreed by the risk review group that three risks should be deescalated and a further two risks were considered but did not meet the criteria to be added to the corporate risk register.		
19.02	Resolution: The Board approved changes to the corporate risk register.		
20/76	**Progress report on well-led improvement plan**		
20.01	The chief executive presented a report which set out the significant progress which had been undertaken against reports from various internal and external assessments. She advised that many of the areas of the plan had either been completed or had reached a point whereas they had become business as usual. The Board acknowledged that improving culture was a perpetual area of work and the chief executive recommended for the plan to be reviewed to confirm the future governance of each area. The non-executive directors welcomed this approach and it was agreed that an updated report would be presented to the Board in December 2019 to provide final assurance and closure to the improvement plan.		
20.02	The trust secretary was thanked for her work in the coordination of the well-led improvement plan.		
21/76	**Assurance report from the trust management committee**		
21.01	The chief executive presented an assurance report from the trust management committee and pointed out that the report demonstrated that it had been a busy time for the Trust. The non-executives thanked the chief executive for the useful report.		
22/76	**Assurance report from the finance and performance committee**		
22.01	The Board received an assurance report from John Brougham on the work of the finance and performance committee. He brought the Board's attention to a number of reports which had been recommended and received, both in the public and private sessions of the Board meeting.		
23/76	**Assurance report from the quality committee**		
23.01	Jonathan Rennison asked the Board to receive a formal report on the quality committee meeting in September, which had previously been reported verbally. He provided a verbal report on the October quality meeting, noting some of the areas covered including a robust discussion with the medical division, an update on key metrics and targets, strong assurance received on annual infection prevention and control report, review of the seven day board assurance framework, quality improvement action tracking and CQC self-assessments preparation.		
24/76	**Assurance report from the audit committee**		
24.01	Paul Cartwright presented a report on the work of the audit committee. He highlighted two particular area of focus for the committee; ensuring that the Trust's standing financial instructions were consistent with the Herts and West Essex Sustainability and Transformation Partnership and understanding why investigations into counter fraud cases took a long time to come to a final conclusion. The committee also requested for executive directors to send a deputy if they were unable to attend meetings. It was reported that the Board would receive a report on the outcome of a tender to commission internal, external and counter fraud services in the private session of the Board meeting.		

Agenda item	Discussion	Lead	Dead-line
25/76	**Assurance report from the people, education and research committee**		
25.01	The Board received an assurance report from Natalie Edwards on the work of the people, education and research committee. She advised that the committee had reviewed an initial draft of the research and development strategy and had requested further work to be carried out to ensure it was ambitious and functional prior to the Board receiving a draft in January 2020.		
26/76	**Assurance report from the charity committee**		
26.01	Jonathan Rennsion presented a formal assurance report following a verbal update at the previous meeting. He reminded the Corporate Trustee that an email had been circulated outside of the meeting which to update members on the creation of a standalone website for the charity's Christmas appeal and also on a proposal to use PayPal as a way to manage donations to the charity. Jonathan Rennsion asked the Corporate Trustee to approve the use of PayPal in order to support more effective management of charitable donations and help to build up a database of donators.		
26.02	Resolution: The Corporate Trustee approved the use of PayPal.		
27/76	**Any other nosiness**		
27.01	No other business was reported.		
28/76	**Questions from Hertfordshire Heathwatch**		
28.01	Meg Carter, representative for Hertfordshire Healthwatch noted that a pilot was underway in the emergency department and suggested that it would be helpful to have patient feedback from this pilot and other initiatives and surveys, including follow-up discharge calls at future Board meetings. The chief executive advised that patient experience was considered as part of the governance and acknowledged that it would be useful to provide updates from a patient perspective.		
29/76	**Questions from patients and members of the public**		
29.01	There were no questions raised.		
30/76	**Draft agenda for next meeting**		
30.01	The draft agenda was approved.		
31/76	**Date of the next Board meeting in public**		
31.01	The next meeting will be held on 05 December 2019 in the executive meeting room, Watford hospital.		

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda item: 06/77

Action log Part 1 – 05 December 2019

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	09.01/76	The list of objectives and underpinning detailed objectives to be removed from future updates of the Board Assurance Framework	Trust Secretary	Dec-19	Action closed. The list of objectives has been removed as evidenced in the Board Assurance Framework on the agenda.
2	10.02/76	Data on the predicted attendances to be added to future performance reports to aid Board understanding.	Chief Operating Officer	Dec-19	Action closed. Data included in the performance reports as demonstrated in the report on the agenda.
3	11.10/76	Future integrated performance reports to include more detail in relation to delayed transfers of care.	Chief Operating Officer	Dec-19	Action closed. More details on delayed transfers of care is in the IPR on the agenda
4	02.03/76	The chief nurse to discuss the possibility of entering into an agreement with Herts Valley Clinical Commissioning Group (HVCCG) on continuing access to 24 hour carers for patients with complex needs	Chief Nurse	Feb-20	Due Feb 2020.

Agenda item: 06

BOARD AND CORPORATE TRUSTEE DECISION LOG 2019/20 PART 1			
Board meeting/decision date	**Decision reference (from minutes)**	**Item presented to Board for action**	**Comments/outcome**
07/11/2019	26.02/76	Assurance report from Charity Committee	The Corporate Trustee approved the use of PayPal.
07/11/2019	19.02/76	Corporate risk register report	The Board endorsed the changes to the corporate risk register.
07/11/2019	18.02/76	Full business case for urgent and emergency care	The Board approved the award of the contract to Greenbrook Healthcare, acknowledging that this would be subject to finalisation and signing of the contract.
07/11/2019	16.02/76	Assurance report from Finance and Performance Committee	The Board ratified the financial trajectory for 2020/21 (deficit no greater than £3.242m); 2021/22 (deficit no greater than £1.934m) and a break even state thereafter.
07/11/2019	13.02/76	Annual freedom to speak-up report and update	The Board approved a recommendation for Ginny Edwards to be the nominated non-executive freedom to speak up lead.
07/11/2019	12.02/76	Seven day board assurance framework report	The Board approved the seven day board assurance framework self-assessment for submission to NHS Improvement.
07/11/2019	09.04/76	Board assurance framework	The Board approved the recommended changes to the BAF
03/10/2019	22.03/75	Assurance report from Charity Committee	The Corporate Trusteee approved the 2019/20 terms of reference and work plan.
03/10/2019	19.01/75	Assurance report from Finance and Performance Committee	The Board ratified an NHS revenue support loan of £3.7m for September 2019.
03/10/2019	17.02/75	2019/20 committee terms of reference and work plans	The terms of reference and work plans for the finance and performance committee and the terms of reference for the auditor panel and remuneration committee were approved.
03/10/2019	16.02/75	Corporate risk register report	The Board endorsed the changes to the corporate risk register.
03/10/2019	15.02/75	Development of integrated care partnership	The Board confirmed its support for the proposed development of an integrated care partnership for west Hertfordshire and agreed the key future steps.
05/09/2019	22.02/74	Assurance report from Finance and Performance Committee	The Board ratified an NHS revenue support loans of £2.7m for July 2019 and £3.9m for August 2019.
05/09/2019	19.02/74	2019/20 terms of reference and work plans	The terms of reference and work plans for the Board, audit committee, quality committee and people, research and education committee were approved.
05/09/2019	16.03/74	Workforce race equality standard report 2018/19	The report was approved for publication.
05/09/2019	15.03/74	Workforce disability equality standard report 2018/19	The report was approved for publication.

05/09/2019	14.03/74	Proposal to change the Trust's name to West Hertfordshire Teaching Hospital NHS Trust	The application was approved for submission.
05/09/2019	13.03/74	Annual medical appraisal report and statement of compliance	The Board approved the submission to NHS England/Improvement
05/09/2019	12.03/74	Emergency planning and business continuity report	The Board approved the self-asessment against the emergency planning and resilience standards
04/07/2019	11.02/72	Clinical negligence scheme for Trusts – Maternity incentive scheme submission	The Board delegated authority to Jonathan Rennison to sign-off the submission.
04/07/2019	14.03/72	Proposal to move oesophagogastric cancer surgery to Hammersmith Hospital	The Board approved the proposal
04/07/2019	15.02/72	Outline business case for urgent care services	The Board approved the outline business case and commencement of procurement
04/07/2019	16.02/72	Joint corporate risk register and board assurance framework report	The Board reviewed and endorsed changes to the corporate risk register
04/07/2019	18.02/72	Assurance report from Finance and Investment Committee	The Board ratified an NHS revenue support loan of £4.5m for June 2019 to cover funding requirements
04/07/2019	22.02/72	Assurance report from Charity Committee	The Corporate Trustee received the report for information and assurance. It approved the recruitment of a new charity director and delegated authority to the committee to approve the charity's annual report and accounts
02/05/2019	20.02/70	Assurance report from Finance and Investment Committee	Approved the NHS revenue support loan for £6.3m
02/05/2019	17.02/70	Annual statement of modern slavery and human trafficking	Approved for publication on website
02/05/2019	15.05/70	Future services in west Hertfordshire	The Board confirmed the decision made on 07 March 2019 to move forward with options one to four and exclude new build emergency care hospital options.
02/05/2019	13.01/70	Gender pay gap report 2017/18	Approved for publication on website
02/05/2019	12.05/70	Public sector equality duty report 2017/18	Approved for publication on website
04/04/2019	12.03/69	Busines case for overseas nursing recruitement	Approved the business case for overseas nursing recruitment and investment of £1.55m
04/04/2019	13.03/69	Corporate risk register and board assurance framework	Approved the board assurance framework
04/04/2019	15.02/69	Assurance report from Finance and Investment Committee	Approved the NHS revenue support loan for £0.5m
04/04.2019	18.02/69	Assurance report from the Charity Committee	The Corporate Trustee approved in principle the use of designated haematology special purpose funds towards the redevelopment of the Helen Donald unit.

Trust Board Meeting
05 December 2019

Title of the paper	**Chairman's report**
Agenda Item	**07/77**
Presenter	**Phil Townsend, Chairman**
Author(s)	**Jean Hickman, Trust Secretary**
Purpose	**For approval** | **For discussion** | **For information** ✓
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* ✓ 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: N/A; Date:
Action required	The Board is asked to receive the report for information.

7

Agenda Item: 07/77

Trust Board Meeting – 05 December 2019

Chairman's report

Presented by: Phil Townsend, Chairman

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

General election

2.1. As the Board will be aware, the country is currently in a pre-election period, until the day after polling day, 13 December 2019, or the date at which a government is formed. This means that the Trust is required to be sensitive to the impact of its work on the outcome of local and national elections and election campaigns.

2.2. The practical implications of this include a reduced Board agenda and means that the planned external engagement activities around the Trust's five year strategy have been paused and therefore the draft strategy will not be received by the Board until January or possibly February 2020.

Funding for cancer screening equipment

2.3. The Department of Health and Social Care announced in October 2019 that the Trust is one of 78 trusts that will benefit from funding for new cancer testing and detection technology. The new machines will improve screening and early diagnosis of cancer, and are part of the government's commitment to ensure 55,000 more people survive cancer each year. Each trust has been allocated funding for new machines based on an assessment of local infrastructure and local population need.

2.4. This investment will be factored into the Trust's future strategy and will mean that the it will be able to purchase a new MRI scanner and a CT scanner.

3. LOCAL NEWS AND DEVELOPMENTS

Staff choir

3.1. As mentioned in previous reports, the Trust is partnering with TV presenter and choirmaster Gareth Malone and production company Swan Films to make a documentary for a major broadcaster to be shown this Christmas.

3.2. Over 60 staff are involved in the choir which has met a number of times and the filming of interviews has begun around the hospital sites to capture the work of staff and the experience of patients, as well as the performance of the choir.

3.3. A multi-faith concert will be held at Watford hospital in the run up to Christmas, which will be broadcast over the Christmas period.

Celebrating staff

3.4. Congratulations to Dr Hala Kandil, Tejal Vaghela and the antimicrobial stewardship team for once again gaining national recognition for their achievement in the field of antimicrobial stewardship. Last year, they received the highly commended antibiotic award from Public Health England and this year they were finalists at the prestigious and competitive HSJ awards, nominated in the Innovation of the year category.

3.5. Well done to the Macmillan information and support centre at Watford for reaching its tenth anniversary. Volunteers who work for this valuable service by offering support to patients, family, friends and staff who are affected by cancer were thanked at an afternoon tea party in November 2019.

Supporting national healthcare campaigns

3.6. Thank you to staff who organised the following events in November 2019 in support of national healthcare campaigns:

- HertsPrems raised awareness of World Prematurity Day with a cake sale in the Women's and Children's unit at Watford.
- The occupational therapy team supported National Occupational Therapy Week with an information stand in the restaurant at Watford.
- The antimicrobial stewardship team marked European Antibiotic Awareness Day by supporting the implementation of an antibiotic review tool in new drug charts
- The education team, along with newly qualified nursing associates, celebrated Nursing Association Awareness Week by taking a trolley to different departments and holding a quiz to determine levels of understanding about the programme.
- Alcohol Awareness Week was marked by raising awareness of people's drinking habits, how to prevent alcohol related illness and gaining access to a wide range of resources and information.
- As part of World Diabetes Day, staff were reminded that diabetes is an invisible disability which is covered under the Equality Act 2010. They were encouraged to update their staff records to allow reasonable adjustments to be made to their working lives, such as regular breaks to eat, drink and test blood levels.
- World Stop the Pressure Day was marked by a host of activities, including ward trolley dashes, a workshop and a promotional display board in the restaurant at Watford.
- Transgender Day of Remembrance is an annual observance to honour the memory of transgender people who lost their lives in acts of anti-transgender violence. To mark this day, staff were invited to get involved in the development of a policy against the discrimination of a person due to the gender identity.
- Male staff were reminded that they had access to a 24/7 employee helpline as part of International Men's Day.

4. BOARD NEWS

4.1. The Trust is very fortunate to have a strong non-executive director team and I'm therefore delighted to report that non-executive directors, Ginny Edwards, John Brougham, Paul Cartwright and Jonathan Rennison have agreed to extend their contracts with the Trust.

4.2. The Board met for a development session on 14 November 2019 when Nick Hulme, Chief Executive, East Suffolk and North Essex NHS Foundation Trust gave a useful presentation on the development of an integrated care partnership. The session also included discussion on a self-assessment in advance of the submission to the CQC as part of pre-inspection formalities and also an update on new national freedom to speak-up guidance.

4.3. On 21 November 2019, the Trust met with the Herts Valley Clinical Commissioning Group (HVCCG) as part of its regular engagement and development programme. This session included an item from two acute consultants which explained what a typical day in their life was like and also focused on progress towards the development of an integrated care partnership.

4.4. As part of the monthly Board visit programme, the Board visited four areas at Hemel Hempstead hospital in November 2019, namely the main outpatient department, paediatric outpatient department, blood clinic, the mortuary and the dermatology department. Verbal feedback from the visits was received by the Board in the private session of the Board meeting in November and is included in a bi-annual engagement report on this meeting's agenda.

5. KEY MEETINGS

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

- Hosted a visit to Watford hospital from Paul Burstow, independent chair of the sustainability and transformation partnership
- Attended an East of England Leaders event
- Chaired a Board development session
- Met with HVCCG's chairman
- Represented the Trust at a High Sheriff event
- Attended an integration day to advance the development of the integrated care partnership
- Chaired appointment panels to recruit consultants in general surgery and ophthalmology
- Chaired a Board to Board meeting with HVCCG
- Attended a HVCCG Board meeting
- Presented a number of staff awards
- Attended key assurance committees

6. RECOMMENDATION

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

Phil Townsend
Chairman

December 2019

Trust Board Meeting
05 December 2019

Title of the paper	**Chief Executive's report**
Agenda Item	**08/77**
Presenter	**Christine Allen, Chief Executive**
Author(s)	**Jean Hickman, Trust Secretary**
Purpose	*For approval*: *For discussion*: *For information*: ✓
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	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: N/A Date:
Action required	The Board is asked to receive the report for information.

8

Agenda Item: 08/77

Trust Board meeting – 05 December 2019

Chief Executive's report

Presented by: Christine Allen, Chief Executive Officer

1. PURPOSE

1.1. The aim of this paper is to provide an overview of the work of the executive team since the previous Board meeting.

2. LOCAL NEWS

Strategy refresh

2.1. I mentioned in my previous report that work was underway to create a five year strategy that reflects the achievements of the Trust over the past few years and the priority plans that will continue this journey and deliver the 'very best care, for every patient, every day'. The draft strategy was originally planned for Board review at this meeting, however due to pre-election guidance which requires that matters of future strategy should be deferred until a new government is formed, it was necessary to reschedule a strategy engagement event from November 2019 to January 2020. Therefore, a draft of the strategy will be presented to the Board in January 2020 with a view to a final strategy being formally signed off by the Board in February 2020.

Frailty pathway

2.2. When frail older adults are admitted to hospital, they are at an increased risk of adverse events including falls, delirium, and disability. The Trust has recently implemented a process which ensures that the admission summary for every patient over 65 who has had an unplanned admission includes their Rockwood Clinical Frailty Score as part of their discharge plan. The Rockwood Clinical Frailty Scale is a practical and efficient tool for assessing frailty.

2.3. This new process allows patients to be supported to the most appropriate community services to help maintain their levels of independence and reduce future avoidable unplanned attendances.

2.4. Similarly, the patient's admission summary also includes a mandatory question to check that a falls risk assessment has been completed. Again this is to support identification of patients most at risk and also for those who have sustained a fracture whether this is as a result of frailty.

Integrated diabetes team

2.5. The integrated diabetes service, led by the Trust in partnership with Hertfordshire Community NHS Trust and Hertfordshire Partnership University Foundation NHS Trust, has secured funding with the Herts Valleys Clinical Commissioning Group through to April 2021. This will enable continuation of a pilot of a multidisciplinary diabetic foot service which was started in 2017 following a successful application to NHS England.

2.6. Prior to the pilot, there was a very limited outpatient diabetes specialist foot service (MDFT) with no inpatient podiatry or formal inpatient MDFT. The service was not compliant with NICE guidance and was amongst the bottom ten acute trusts nationally in terms of outcomes.

2.7. The integrated diabetes service pilot has achieved a streamlined referral process, an educational tool to raise awareness and prompt early referrals, reduced waiting times and admissions and generated savings in 201/19 of around £201,000 across the health economy. Feedback on the pilot has been positive with 89.4% of patients reporting to be satisfied or very satisfied with the service.

Flu vaccination programme

2.8. The Board received a full report at its November meeting on the Trust's vaccination campaign for 2019. As well as causing unpleasant illness in otherwise healthy people, flu can cause severe illness and death among high-risk groups, such as older people, pregnant women and those with existing health conditions.

2.9. I'm pleased to report that to date 65% of patient-facing staff have been vaccinated against the flu. This is great news and the Trust will continue to make it as easy as possible for staff to get the vaccine to ensure that patients and staff stay safe and protected from the virus.

National staff survey

2.10. Each year NHS staff are invited to take part in the NHS staff survey, the largest survey of staff opinion in the UK. It gathers views on staff experience at work around key areas, including, appraisal and development, health and wellbeing, staff engagement and involvement and raising concerns.

2.11. This year's national staff survey closed on 29 November 2019 and staff have been strongly encouraged to be honest and say what they think works well and where there's room for improvement. The results will be published next year and the Trust will use the feedback to advance the work its doing to try to improve the working lives of all staff.

Charity

2.12. Following last year's success, the Trust's charity has once again launched it's 'Raise a smile this Christmas' appeal, asking the public to donate presents for older patients spending the festive season in hospital. The special Christmas project will make sure that every patient in across the hospitals will have at least one gift to open on Christmas day. There are three ways well-wishers can help:

- Donate a gift at one of the drop off points at Watford, Hemel Hempstead or St Albans City Hospitals (see location list on the Raise website, address below)
- Make a donation to the older people's services team via www.justgiving.com/campaign/raiseasmile so they can buy the presents for patients

For further details, please go to the appeal website www.raiseasmile.org.uk.

Thefts from car park

2.13. There is a widespread increase of thefts of catalytic converters across west Hertfordshire and London and over the last couple of months the Trust has had a number of these thefts, mainly from the Cardiff Road car park at Watford. The Trust's security team is working closely with the police and has put in a number of measures to try and stop these crimes from taking place on the hospital sites.

3. RECOMMENDATION

3.1. The Board is asked to receive this report for information.

Christine Allen
Chief Executive

December 2019

Trust Board Meeting
05 December 2019

Title of the paper	Board assurance framework report
Agenda Item	09/77
Presenter	Christine Allen, Chief Executive
Author(s)	Jean Hickman, Trust Secretary
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	This report is to provide the Board with assurance that risks to achieving the Trust's strategic objectives are being appropriately mitigated, to consider those elements that report direct to Board and any recommendations of changes from assurance committees. Following discussion at the Board meeting in November 2019, it was agreed that risk 4a (non-delivery of the national emergency access standards) and 4b (non-delivery of the national planned care access standards) would be re-worded to indicate that the risk related to the delivery of the Trust's improvement plans rather than national standards. This revision has been made to the BAF. On 28 November 2019, specific components of the BAF were reviewed by the Quality and Finance and Performance committee. A recommended change by the Finance and Performance is detailed in the report for approval. The report also includes a section on strengthening the Board's risk management framework by the use of risk appetite to support the Board's decision making process. A draft risk appetite statement and threshold matrix is included in the report for consideration and approval.
Trust strategic aims	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	• Finance and Performance Committee – 28 November 2019 • Quality Committee – 28 November 2019
Action required	The Board is asked to: • consider the latest version of the BAF • approve the recommended change made by the Finance and Performance Committee • approve the risk appetite statement and threshold matrix

Agenda Item: 09/77

Trust Board meeting – 05 December 2019

Board Assurance Framework report

Presented by: Christine Allen, Chief Executive

1. Purpose

1.1 This report aims to provide the Board with assurance that risks to achieving the Trust's objectives are being appropriately mitigated, to consider those elements that report direct to Board and any recommended changes from the committees.

2. Background

2.1 All NHS Trusts are required to use a Board Assurance Framework (BAF), not least because it's been proven good practice for many years in both healthcare and a whole range of complicated high-risk organisations. The BAF is a "live" document that changes over time, and in particular it picks up all the controls that the Trust has in place to manage, minimise and/or remove the identified risks and points towards concise and comprehensive evidence that the controls are working.

2.2 The BAF forms part of the Trust's overall board assurance and integrated risk management arrangements. It brings together three things:

- The Trust's four aims and twelve underpinning strategic objectives
- A headline summary of all the issues (risks) that might get in the way of achieving those objectives
- A headline summary of what the Trust is doing about those issues, along with a concise description of how the Board can be assured that what is being doing is working.

2.3 Where appropriate the BAF is cross-referenced against operational risks on the corporate risk register. It should be noted that the BAF and corporate risk register are complementary but not the same thing.

2.4 The difference between "assurance" and "reassurance" is vital to make the BAF work. Reassurance is when someone tells you all's well; Assurance is when they tell you what's happening, show you the evidence, and you can judge for yourself if all's well. The diagram below demonstrates this in more detail.

Reassurance **Assurance**

• It is OK because management say it is • Strong management personalities may dominate • Track record of success • Professional background or expertise • No contradictory evidence	• It is OK because how management have responded to questions from the Board has given me confidence by: – Clear and logical explanations from Board members – What has happened; why it has happened and what is the response – Management explanations are consistent	It is OK because I have reviewed various reliable sources of information, such as: – Independent information source – Evidence of historical progress, outcomes – Triangulation with other information

3. Monthly review

3.1 The current BAF can be found in appendix 1, (not inclusive of the recommended change set out below).

3.2 Elements of the BAF were reviewed on 28 November 2019 by the Quality Committee and the Finance and Performance Committee. The following changes are recommended to the Board for approval.

Risk ref no.	Risk description	Executive lead	Lead committee	Recommendation	Trend
4b	Non-delivery of the Trust's improvement plan for planned care - diagnostic waiting time standard - referral to treatment waiting time standard - cancer waiting time	Chief Operating Officer	Finance and Performance Committee	As some performance measures are better than planned, with a number of other measures are showing steady improvement against plan, it is recommended that the rating of this risk is decreased from 'high' to 'medium'.	

3.3 There is one area of extreme risk (assessed as red) where only limited assurance can be gained by the Board.

Risk no.	Risk description	Board assurance
10e	Failure to deliver upgrade to local area network (LAN), telephone services	A business case to upgrade the LAN will be presented to the Board for approval in the private session of this meeting.

3.4 The following risks are assessed as high (amber) and only limited assurance can be gained by the Board:

Risk no.	Risk description	Board assurance
4a	Non-delivery of the Trust's improvement plan for emergency care	The performance report on access targets and the integrated performance report under item 10 and 11.
4b	Non-delivery of the Trust's improvement plan for planned care	
10b	Failure to secure improved service from new IT provider due to ineffective relationship and management of ITO provider and failure to address capacity/capability gaps within the Trust in-house IT team	A number of mitigating actions are underway within the IT department to manage this risk. A report outlining the improved quality of service from the new provider will be received by the Board at the end of quarter one 2020/21.

4. Risk appetite

4.1 The Board acknowledges that some of the Trust's activities may, unless properly controlled, create organisational risks, and/or risks to staff, patients and others. Every effort is made to eliminate risk or ensure that risks are contained and controlled so that they are as low as reasonably practical. However it is not always possible to reduce or mitigate an identified risk completely and it may be necessary to make judgments between the cost of managing a risk and the benefits to be gained.

4.2 The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions".

4.3 At a development session, the Board discussed the amount of risk, on a broad level, that it was willing to accept in the pursuit of the Trust's strategic objectives. This discussion led to the development of the draft statement and threshold matrix set out below.

Draft risk appetite statement

4.3.1 West Hertfordshire Hospitals NHS Trust recognises that its long term sustainability depends upon the delivery of its strategy ambitions and its relationships with its service users, carers, staff, public and partners. As such, the Trust will not accept risks that materially provide a negative impact on quality.

However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greater appetite to pursue commercial gain, partnerships, clinical innovation, financial/value for money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The Trust accepts a higher than normal risk appetite in relation to its estates, due to the age and condition.

4.4 Risk tolerance is the minimum and maximum risk that the Trust is willing to accept. The table below sets out the draft risk appetite themes and the scoring attributed to each.

Category	Risk Appetite	Risk Appetite Score
Quality safety	VERY LOW risk appetite for risks that may compromise safety	1 - 5
Quality effectiveness	LOW risk appetite for risks that may compromise the delivery of outcomes for service users	6 - 9
Statutory compliance	LOW risk appetite for risks that may affect statutory compliance	6 - 9
Clinical innovation	MODERATE risk appetite for clinical innovation that does not compromise quality of care	10 - 12
Compliance/regulatory	MODERATE risk appetite for compliance/regulatory risks ***where there are no risks or compromise in quality safety***	10 - 12
Finance/value for money	MODERATE risk appetite for financial/value for money which may grow the size of the organisation whilst ensuring the Trust is minimising the possibility of financial loss and comply with statutory requirements	10 - 12

Category	Risk Appetite	Risk Appetite Score
Reputation	MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation	10 - 12
Quality experience	MODERATE risk appetite for risks that may affect the experience of service users	10 - 12
Workforce	MODERATE risk appetite for actions and decisions taken in relation to workforce	10 - 12
Partnerships	HIGH risk appetite for partnerships which may support and benefit the people the Trust serves	15 - 25
Commercial	HIGH risk appetite for commercial gain whilst ensuring quality and sustainability to service users	15 - 25

4.5 The risk appetite statement and threshold matrix is dynamic and represents an iterative process that reflects the challenging environment facing the Trust and the wider health and social care environment in which it operates. Both documents will be periodically reviewed at least biennially.

5. Next steps

5.1 If approved, the Board will utilise the risk appetite statement and threshold matrix as part of its decision making processes.

5.2 The trust secretary is currently working with assurance committee chairs and executive leads to cross reference the BAF against the 2019/20 committee work plans to ensure all aspects of risk to the Trust achieving its strategic objectives are covered across the breadth of the corporate governance structure.

5.3 The Board reporting template is currently being updated to align it with the BAF risks.

6. Risks

6.1 There is a risk that failure to keep effective oversight of the Trust's key risks may lead to the Trust not achieving its organisational strategic aims and objectives.

7. Recommendation

7.1 The Board is asked to:

- consider the latest version of the BAF
- approve the recommended change made by the Finance and Performance Committee
- approve the risk appetite statement and threshold matrix

Christine Allen
Chief Executive

December 2019

Appendix 1. Board Assurance Framework

BOARD ASSURANCE FRAMEWORK 2019/20

Strategic Objective 2019/20	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)	Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc	Low/Medium/ High/ Extreme	Are the identified actions being achieved?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific action)	Time scale	Update
AIM 1: BEST QUALITY CARE														
OBJECTIVE 1. **TO DELIVER EXCELLENT CLINICAL OUTCOMES FOR OUR PATIENTS** **-MORTALITY** **- HARM FREE CARE**	1a	Failure to sustain expected or better than expected performance on key mortality indicators (SHMI and HSMR)	Chief Medical Officer	Quality Committee		CQC	Low		1. Morbidity and mortality meetings 1. Structured judgement review process fully embedded 1. Divisional Governance meetings 1. Consultant coders and medical examiners fully established 2. Quality, Mortality review group 2. Quality Committee reports 3. Dr Foster	None known				
	1b	Failure to deliver quality priorities set out in the Quality Account with a focus on harm free care and Patient Safety.	Chief Nurse	Quality Committee		CQC, NHSLA, HSE	Medium	Practice development gap to support skill mix and ward leaders to develop practice.	1. Quality Account. 1. Monitoring of patient safety and effectiveness through quality safety group and patient experience metrics at patient experience group. 1. Ward leaders supervisory and supporting delivery of harm free care with specialist nursing teams. 1. Matrons part of QI forum reviewing overall ward dashboard metrics and harm free care. 1. Senior NMAHP staff going 'Back to the Floor'. 1. Divisional quality summits held by heads of nursing 2. Quarterly monitoring of progress with quality priorities by Quality Committee 2. Each priority is assigned an executive lead. 3. Quality assurance visits by HVCCG.	None known	Development of practice development nursing team. Using 'Back to the floor' to test what we are hearing and seeing, and using themes to support development. QI Forum to develop and review actions. Discharge phone back system and utilising to ascertain themes and actions for patient experience. To undertake patient engagement and experience events.	Chief Nurse	Mar-20	
OBJECTIVE 2. **TO IMPLEMENT BEST PRACTICE, INTEGRATED CARE PATHWAYS AND REDUCE UNWARRANTED CLINICAL VARIATION IN CARE AND OUTCOMES**	2a	Failure to implement standardised 'in hospital' pathways, with improvement in consistency of care and improved outcomes (working with the Royal Free Partnership group)	Chief Medical Officer	Quality Committee			Medium	Funding and recruitment for additional clinical leadership sessions.	1. CPG progress dashboard 1. Quality team meetings. 1. Leadership and supervision from Royal Free Associate Director 2. Trust management committee updates 2. Quality committee reports 3. Royal Free Partnership Board Strategy update papers to Trust Board		Proposal for additional resource for manual data collection. Standardisation of clinical time to provide leadership for the pathway.	Director of Integrated Care/CPG Lead	Nov-19	Action completed. Proposal was reviewed by the Trust Management Committee in November 2019. Divisions are reviewing clinical job plans to support time commitment required. The proposal will be a considered for approval at the corporte finance review meeting.
	2b	Failure to deliver integrated pathway developments agreed with HVCCG as set out within the service delivery implementation plan (SDIP)	Deputy Chief Executive	Quality Committee			Medium		2. Trust management committee 3. QIPP Board (HVCCG)					
	2c	Failure to develop patient centred planned and ambulatory care pathways including maximising planned surgery on the St Albans City Hospital site, medical specialties at Hemel Hempstead General Hospital and women's and children's services	Deputy Chief Executive/ Chief Operating Officer	Quality Committee			Medium		1. Divisional performance reviews 1. Acute redevelopment programme executive 3. QIPP Board (HVCCG)		Review St Albans pilot	Deputy Chief Executive/ Chief Operating Officer	Mar-20	

Strategic Objective 2019/20	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)	Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc	Low/Medium/ High/ Extreme	Are the identified actions being achieved?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific action)	Time scale	Update
OBJECTIVE 3. **TO IMPLEMENT AND EMBED OUR 'QUALITY COMMITMENT' AND 'WEST HERTS WAY' QUALITY IMPROVEMENT METHOLODY**	3a	Failure to roll out recognised quality improvement (QI) methodology - developing internal capacity to support QI and suite of training for clinical staff.	Chief Nurse/ Deputy Chief Executive	Quality Committee		CQC	Low		1. Quality account agreed 1. Proactive quality improvement culture within the Trust 2. Monitoring of progress with quality priorities by quality committee 2. The following actions agreed as next steps: Source and connect current staff who have a Quality Improvement (QI) title/aspect within their existing role. 3. CQC report	Awareness of QI methodology being embedded. Widespread training of staff in QI.	Awareness campaign to commence. Dosing programme being developed. QI projects linked to quality priorities and application process.	Chief Nurse	Oct-19 ~~Sept-19~~ Jan-20 ~~Nov-19~~ Jan 20	Action completed. Campaign started. Paper received by Quality Committee Programme developed. Awaiting approval from Trust Management Committee
OBJECTIVE 4. **TO IMPROVE THE PATIENT EXPERIENCE AND THE RESPONSIVENESS OF OUR SERVICES**	4a	Non-delivery of the Trust's improvement plan for emergency care	Chief Operating Officer	Finance & Performance Committee		NHS	High	incomplete/not fully embedded. Performance measures are adverse to plan. Inability to accurately and timeously track patient after admission. Lack of senior decision makers on presentation to ED.	1. ED escalation, improvement and transition plans 1. Discharge Working Group 1. Patient Flow Transformation Board 1. ED team check ins with CEO 2. Trust Management Committee 2. Finance and Performance Committee 3. Joint Urgent Care Programme Board (with HVCCG) 3. System resilience group 3. Local Delivery Board 3. NHSI Progress Review Meeting 3. HVCCG Contract & Quality Review meeting	None known	Medical take is being redesigned, with pilot of embedding cardiology/respiratory/frailty and Gen med in ED. Increase utilisation of Ambulatory Care	Chief Operating Officer	Jan-20	
	4b	Non-delivery of the Trust's improvement plan for planned care - diagnostic waiting time standard - referral to treatment waiting time standard - cancer waiting time	Chief Operating Officer	Finance & Performance Committee	3828	NHS	High	Some performance measures are better than planned, with a number of other measures showing steady improvement against plan	1. RTT Improvement Plan 1. Cancer Improvement Plan 1. Weekly Access meetings 1. Divisional Performance reviews 1. Elective Care Programme Board 2. Trust Management Committee 2. Finance & Performance Committee 3. NHSI Progress Review Meeting 3. HVCCG Contract & Quality Review meeting	None known				
	4c	Failure to deliver patient experience improvement actions as set out in the quality account.	Chief Nurse	Quality Committee		CQC	Medium	None known	1. Developed Trust Carer Lead role 1. To develop bespoke local patient surveys 1. Follow up calls on discharge for communication 2. Patient experience metrics. 2. Evidence of assurance for actions from national surveys 2. Divisional reports including learning from complaints, incidents and claims 2. Patient Experience & Carers Strategy progress updates 3. CQC National patient survey reports 3. CCG quality assurance visits 3. PHSO reports 4. GIRFT reviews	None known	Develop and implement communication bundle. Discharge phone back system and utilising to ascertain themes and actions for patient experience. Map patient engagement and develop PPI events twice a year a steering group. Commission Healthwatch review of patient engagement and use to develop strategy and action. Develop the governance and dashboard for MH patients in partnership. Implement LD patient end of life care pathway.	Chief Nurse	Mar-20	

BOARD ASSURANCE FRAMEWORK 2019/20

Strategic Objective 2019/20	Risks Identified		Executive Lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering the objective	Control gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)	Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the risk to the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc	Low/Medium/ High/Extreme	Are the identified actions being achieved?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific action)	Time-scale	Update
AIM 2:									**A GREAT PLACE TO WORK AND LEARN**					
OBJECTIVE 5. **TO FURTHER DEVELOP THE TRUST'S PARTICIPATION IN RESEARCH AND DEVELOPMENT**	5a	Failure to meet Clinical Research Network recruitment targets	Chief Medical Officer	People, Education and Research			Medium	For the current year. This has to be reviewed on a yearly basis	1. Continual presence at each clinical divisional level to reinforce good practice and encourage research recruitment. 2. Research and Development steering group 2. Quarterly report to People, Education and Research Committee 3. North Thames Clinical Research Network		Director Research and Development, or deputy to continue presence at divisional clinical governance meetings to highlight research needs in the trust. To have an open door policy to discuss any new research interests.	Chief Medical Officer	Mar-20	
	5b	Failure to secure a higher level of support from the National Institute for Health Research (NIHR) for commercial studies	Chief Medical Officer	People, Education and Research			Medium	For the current year. This has to be reviewed on a yearly basis	1. To apply lean strategies of working. 1. To look for opportunities to apply for additional funding 2. Continual review by People, Education and Research Committee to look at additional funding streams 2. Quarterly report to People, Education and Research Committee	The research funding is not under Trust control and is centrally driven and changes on a yearly basis				
	5c	Failure to identify clinical capacity within job plans to support enhanced research capability	Chief Medical Officer	People, Education and Research			Medium	To be trialled as an initiative in one or two clinical areas	1. Consider adding funded PA's to new consultant contracts in a bid to secure accountable research time 2. Quarterly report to People, Education and Research Committee	Time taken to get funded PA's into practice	To trial funded PA time for research in one or two clinical departments	Chief Medical Officer	Mar-20	
OBJECTIVE 6. **TO HAVE HAPPY, HEALTHY, WELL SUPPORTED STAFF WHO FEEL ABLE TO DELIVER GREAT CARE AND 'MAKE A DIFFERENCE' IN AN INCLUSIVE ENVIRONMENT AND TO BE A CLINCALLY LED ORGANISATION**	6a	Failure to achieve improved results in the national staff survey through implementation of corporate and divisional staff engagement improvement plans	Chief People Officer	People, Education and Research			Low	Staff survey is annual. Mixed results in quarterly F&FT in whether staff would recommend the Trust as a place to work	1. Developed Big 5 programme 1. Used various communication channels to promote Big 5 1.Regular updates to TMC 1. Implemented onboarding questionnaires for new starters 2. Report performance to PERC 3. Benchmark against other organisations	Some signifcant culture issues within organisation that are being addressed, but may impact on results	OD interventions to address hot spots in organisation where concerns exist in terms of staff engagement	Chief People Officer	Feb-20	
	6b	Failure to improve performance against the workforce race equality standard indicators to improve the experience of staff from BME and other under represented groups	Chief People Officer	People, Education and Research			Medium	Annual staff survey still shows that BAME staff report less positive experience and engagement	1. Developed and published workforce race equality scheme (WRES) with a set of actions to deliver race equality indicators 1. Established BAME staff network 1. Communicated Trust commitment through the focus on race equality as part of the BIG 5 programme 1. Executive directors have a equality objective 2. Provide regular updates to trust management committee and provide assurance to PERC 3. Publish results which enables benchmarking	Creation of organisational weide pisitive action programme to demonstrate commitment	To further promote development opportunities for BAME staff To establish programme of reverse mentoring	Chief People Officer	Mar-20	

OBJECTIVE 7. **TO REDUCE VACANCY RATES AND REDUCE OUR RELIANCE ON AGENCY WORKERS**	7a	Failure to achieve and maintain a positive vacancy rate	Chief People Officer	People, Education and Research	3995		Medium	National vacancies in particular professional groups including nursing and doctors. Impact of Brexit difficult to predict.	1. Approved business case for o/s nursing and established recruitment campaigns with good supply currently. 1. Workforce information shared with TMC and PERC in monthly workforce report. 1. Divisional action plans focused on recruitment strategies monitored through Divisional Performance Reviews	Need more work on strategy for recruitment to medical vacancies and difficult to recruitment positions such within Paeds/ theatreas	Currently recruiting to Head of Medical Resourcing and seeking to strengthen team with better skill mix. Production of overall plan to recuit internationally for doctors. Recruitment for nurses from Australia	Chief People Officer	Apr-20	
	7b	Failure to achieve and maintain a positive turnover rate	Chief People Officer	People, Education and Research			Medium		1. Good staff engagement programme with Big 5. 1. Established onboarding questionnaires as well as exit questionnaires to pick up staff at risk of leaving. 1. Divisional action plans monitored through Divisional Performance Reviews. 1. Established career development support under 'Developing You' to improve retention. 2. Report to TMC and PERC via workforce performance reports.	Need abetter staff benefits package to help retain our staff	Production of business case to offer staff discounted food. Proudction of new package of staff benenfits	Chief People Officer	Apr-20	
OBJECTIVE 8. **TO BECOME AN EXCELLENT ORGANISATION FOR EMPLOYEE DEVELOPMENT**	8a	Failure to demonstrate Trust meets criteria for Teaching Hospital Status	Chief People Officer	People, Education and Research			Low	A formal senior workforce group has been established where progress can be tracked and will report to TMC and PERC on progress.	1. Project plan developed to track progress. 1. Existing team resourced to undertake work required. 2. Report on progress to People, Education and Research Committee	Further work to establish governance around this and monitoring progress.	School NHS Comms. to check our proposed name is OK Ket stakeholder engagement Collate our 'Significant Teaching [and learning] Commitment'* Submit to DoH to amend our Establishment Order	Chief People Officer	Dec-20	
	8b	Failure to maintain high levels of compliance in core and essential training	Chief People Officer	People, Education and Research			Low	Core mandatory training above target of 90%. Essential training on improving trajectory towards target.	1. Acorn 2 established with elearning and reminders to staff when training due. 2. Reported to TMC 2. People, Education and Research Committee workforce performance report. 3. Benchmark against organisations in STP quarterly.	ABLS and Fire Training which are face to face have lower levels of comliance	Plans in place to bring in additional support for both these elements to ensure 90% compliance	Chief People Officer	Mar-20	
	8c	Failure to provide clear development options in place for every banding of role within the Trust	Chief People Officer	People, Education and Research			Medium	Work on portal at STP level still at early stage and being fully scoped. Leads for all areas to be identified.	1. Developed apprenticeships approach locally for clinical staff and non clinical staff in junior roles. 1. Developed First Line Leadership Programme, Senior Leader Programme and Clinical Leadership Programmes. 1. Mapping career development options for all staff. 2. People Education and Research Committee 3. Linking with STP to develop portal for development activity across region.	Need to agree upon prefered approach to management of apprenticeships, likely to be lead provider model for whole of ICP	Work being undertaken to devised our strategic apprenticeship approach. Launch of lead provider model	Chief People Officer	Jul-20	

BOARD ASSURANCE FRAMEWORK 2019/20

Strategic Objective 2019/20	Risks Identified		Executive Lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering the objective	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)	Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the risk to the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc	Low/Medium/High/Extreme	Are the identified actions being achieved?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific action)	Time-scale	Update
AIM 3:														
OBJECTIVE 9. **TO DELIVER BEST VALUE CARE**	9a	Failure to deliver the in-year financial plan.	Chief Finance Officer	Finance and Performance	4204 4205		Low	Clarity is not yet secured regarding actions required to secure Financial Recovery Fund beyond simple achievement of annual control total Ability to manage reduction in costs to match reduced funding Prevention or identification of spending outside required control processes	1. Documented budget meetings, analysing variances and taking corrective actions 1. Accurate forecasting and development of recovery plans. 2. Trust Management Committee 2. Finance & Performance Committee 3. Financial Assurance Meeting - NHSI/E 3. Oversight and Support Meeting - NHSI/E	Formal written communications from NHSI/E explicitly stating the terms and conditions required to secure FRF payments Guarantee that all service changes have not adversely affected the financial position Assurance that changes in medical staff capacity are fully controlled	Complete medical workforce control project and implementation of medirota software.	Chief Financial Officer	Jan-20	
	9b	Failure to achieve year on year improvement in the underlying financial position	Chief Finance Officer	Finance and Performance			Medium	Capital availability for schemes which require it, irrespective of governance compliance. Limited CIP plan beyond the current year. Division / directorate capacity for identification, compliance & delivery. Limited SLR and benchmarking take-up reduces opportunity to identify potential new CIPs.	1. Detailed reporting of delivery against plan and variance in context of overall financial performance. 1. CIP forecast reviewed on at least a monthly / twice monthly basis within divisions 1. Monthly Trust Management Committee 2. Monthly Finance & Performance Committee 3. Detailed deep-dives by NHSI, other external bodies, and internal audits as validation of scheme management and underlying controls.	Project management software capacity not fully utilised, including integration with programme management processes	Complete drivers of deficit analysis. Further develop 5 year rolling cost improvement programme. Complete roll out of project management software.	Chief Financial Officer	Jan-20 Mar-20 Mar-20	
	9C	Failure to achieve performance targets against key value for money metrics. (e.g. model hospital, Carter metrics)	Chief Finance Officer	Finance and Performance			Medium	More frequent reporting and action planning to improve performance against Model Hospital metrics.	1. Outcome of a comprehensive assessment against Model Hospital metrics undertaken in 2018/19. 1. Outcome of financial benchmarking exercise undertaken at department/ cost centre level in 2017/18	Report demonstrating improvements against last set of assessment.	Introduce reporting framework to assess improvements against model hospital metrics.	Chief Financial Officer	Mar-20	

BOARD ASSURANCE FRAMEWORK 2019/20

BOARD ASSURANCE FRAMEWORK 2019/20

Strategic Objective 2019/20	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)	Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the risk to the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc	Low/Medium/ High/Extreme	Are the identified actions being achieved?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific action)	Time-scale	Progress
AIM 4: A STRATEGY FOR THE FUTURE														
OBJECTIVE 10. TO IMPROVE OUR IT AND MOVE TOWARDS FULL DIGITILISATION	~~10a~~	~~Failure to achieve a successful and safe transition to a new IT provider~~	~~Chief Information Officer~~	~~Board~~	~~4114~~		~~High~~	~~A lack of documentation around infrastructure and routing and technical processes from CGI~~	~~1. ICT and Business continuity incident control rooms during transition 1. ICT resource engaged to manage a controlled and documented programme course~~					The Board approved for this risk to be removed as the Trust had transitioned onto a new IT provider.
	10b	Failure to secure improved service from new IT provider due to ineffective relationship and management of ITO provider & failure to address capacity / capability gaps within the Trust in-house IT team.	Chief Information Officer	Board			High	Insufficient non technical skills to deploy the new governance and contractual processes	1. A divisional restructuring that will help us obtain the right seniority and balance of skills across technical and non technical resources appropriate to working in a hybrid ITO model.	Any restructure will not be complete during 2019	Personal involvement and leadership of key commercial relationship and meetings by the CIO	Chief Information Officer	Mar-20	
	10c	Failure to meet the compliance requirements of the general data protection regulations and data security toolkits and associated audits	Chief Information Officer	Board	3897		Medium	A cultural and educational programme needs to be wrapped around the re-formed information group that is monitoring the DSPT action plan	2. Trust management committee		Promotion of the importance of information governance and security and a structured training programme	Chief Information Officer	Mar-20	
	10d	Failure to implement remote access to radiology and other specialty images	Chief Information Officer	Board			Low	None - specialist technical advice being sought to complete the pilot - no other reason the actions will not be achieved	1. Directorate team meetings					
	10e	Failure to deliver upgrade to local area network (LAN), telephone and services. (Subject to approval of business cases for capital funding).	Chief Information Officer	Board	3896		Extreme	At present actions are on target - there are no obvious control gaps	1. Directorate team meeting. 2. Trust management committee 3. Trust Board	N/A				LAN business case completed. Presented and recommended for Board approval by the Trust Management Committee and Finance and Performance Committee.
	10f	Failure to improve 'paper' medical records and groundwork to support future implementation of electronic health records. (progress may be limited subject to approval of business case for capital funding).	Chief Information Officer	Board	3120		Medium	We are behind schedule due to the lack of a clear plan, ownership of delivery and dedicated resource	1. Production of a clear plan -signed off by TMC 1. Resource to deliver the plan	Resource not yet funded	Request to get capital resource to enable us to award the tender to develop the plan and manage delivery	Chief Information Officer	Nov-19	Action completed. Funding identified. Consultants, Prederi have been commissioned and are currently writing the business case with the expectation that it will be completed by the end of January 2020.

	10g	Failure to develop outline business case for electronic health record implementation	Chief Information Officer	Board			Medium	Lack of experienced resource	1. Directorate team meeting. 2. Trust management committee 3. Trust Board		Resource to support the development of the Strategic and Outline business case has been commissioned	Chief Information Officer	Nov-19	Action completed. Funding secured from HVCCG. Procurement process completed and Deloitte have been commissioned to write the business case. It is expected that the strategic outline case wil be completed by mid-January 2020 and the outline business case by mid-March 2020.
OBJECTIVE 11. **TO WORK WITH LOCAL STAKEHOLDERS AND PARTNER ORGANISATIONS TO IDENTIFY WHERE, BY WORKING TOGETHER, WE CAN IMPROVE CARE FOR OUR PATIENTS**	11a	Failure to proactively communicate and engage with local communities and stakeholders in the development and delivery of our services	Deputy Chief Executive	Board			Medium	Stakeholder strategy/plan to be reviewed and updated	1. Executive team meeting. 2. Trust management committee 3. Healthwatch review of trust engagement strategy		Stakeholder strategy / plan to be developed	Deputy Chief Executive	Mar-20	
	11b	Failure to actively engage in the development of an integrated care partnership for West Hertfordshire	Deputy Chief Executive	Board			Low		2. Trust management committee 3. Sustainability and transformation partnership and HVCCG local delivery board		Joint work & OD programme with HVCCG and system partners to develop an IPC in development. Agree and implement internal governance to oversee transition to ICP	Deputy Chief Executive/ HVCCG Programme Director (TBC)	Dec-19	
	11c	Failure to work with Herts Valleys Clinical Commissioning Group to test new contractual forms that share risk and support innovation.	Deputy Chief Executive	Board			Low		2. Trust management committee 2. Finance and Performance Committee		Agree minimum income guarantee Agree full business case for UEC	Chief Financial Officer Deputy Chief Executive	Oct-19 Nov-19	Completed. Board report - Nov-19 Completed. Full business case Nov-19
	11d	Failure to demonstrate active engagement in the West Herts and Essex Sustainability and Transformation Partnership		Board			Low		3. Sustainability and transformation partnership governance 3. Sustainability and transformation partnership chair's meetings					

OBJECTIVE 12. **TO IMPROVE THE QUALITY OF OUR ESTATE AND IMPLEMENT OUR SERVICE DRIVEN ESTATES STRATEGY**	12a	Failure to deliver agreed capital programme within agreed capital allocation.	Deputy Chief Executive/ Chief Financial Officer	Finance and Performance Committee			Low		1. Capital Finance Planning Group 2. Trust Management Committee		Bring forward annual prioritisation process & develop multi-year view. Continue regular calls with (new) Regional team to ensure joint understanding of opportunities and expectations and problem solve.	Deputy Chief Executive/ Chief Financial Officer	Jan-20	
	12b	Failure to develop and achieve approval of development control plans and business cases to deliver the strategic priorities set out within the interim estate strategy	Deputy Chief Executive	Board			Medium		2. Acute redevelopment executive 2. Trust Management Committee 2. Capital Programme Finance Group 2. Finance and Performance Committee	New terms of reference for delivery executive agreed - to be enacted	Terms of reference for delivery executive to be enacted	Deputy Chief Executive	Dec-19	
	12c	Failure to develop and achieve approval of outline business case/s for the long term redevelopment of our hospitals	Deputy Chief Executive	Board			Medium		1. Redevelopment team weekly catch-ups 2. Programme executive 2. Trust Management Committee 2. Finance and Performance Committee	Internal governance arrangements only partially effective and require review	Complete development Control plans for SACH and Hemel. Business case for priority schemes Secure approval for strategic outline case for the redevelopment of services and agree next steps	Deputy Chief Executive	Mar-20	
	12d	Failure to maximise capital funding via the full range of funding options (emergency capital applications, STP capital bids, other sources e.g. Salix)	Deputy Chief Executive/Chief Financial Officer	Finance and Performance Committee			Low		2. Capital Programme Finance Group 2. Finance and Performance Committee		Confirm emergency capital (external) Opportunistic bids (e.g. winter, diagnostics) Prepare for wave 5 bids	Deputy Chief Executive	Mar-20	

Trust Board Meeting
05 December 2019

Title of the paper	Performance report on access standards
Agenda Item	10/77
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	This paper provides assurance on the monitoring of compliance with national Access standards in September 2019, identifying factors affecting performance and the actions to ensure a return to compliance.

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	83.4%	↑
Diagnostic waits	99%	99.9%	↑
RTT incomplete pathways < 18 weeks	92%	86.8%	↑
52 week waits	0	0	↑
2 week wait referrals	93%	94.2%	↑
2 week wait breast symptomatic referrals	93%	100.0%	↔
31 day first definitive treatment	96%	94.2%	↓
31 day subsequent - surgery	94%	78.9%	↓
31 day subsequent - drug	98%	100.0%	↑
31 day subsequent - palliative	94%	100.0%	↔
31 day subsequent - other	94%	N/A	
62 day referral to first treatment	85%	78.6%	↓
62 day screening referral to first treatment	90%	66.7%	↓

↑ improved non-compliant	↓ deteriorated non-compliant	↔ no change non-compliant	↑ improved compliant	↓ deteriorated compliant	↔ no change compliant

Consistent compliance with the diagnostic waiting times standard has been maintained for many months, and this continues with 99.9% achieved in October.

There has been further improvement in ED performance at 83.4% (from 83%) although the position remains adverse to plan (87.8%).

Performance against the RTT 92% standard continues to improve, this month at 86.8% and is just below the trajectory plan (87.1%) for the month.

There were no 52 week breaches at month end.

	At the time of reporting (21 November), 2 week wait and 2 week wait breast symptomatic are compliant with the standard. The target for the 31 day first standard has not been achieved and neither has the 31 day subsequent surgery standard been met. Performance in both 62 day pathways is non-compliant.. While pathway complexity and patient choice continue to be factors affecting compliance, escalation (timely escalation and timely response to escalation) is a factor noted as contributing to delays.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	<table><tr><td>Aim 1 Best quality care  *Objectives 1-5*</td><td>Aim 2 Great place to work  *Objectives 6-8*</td><td>Aim 3 Improve our finances  *Objective 9*</td><td>Aim 4 Strategy for the future  *Objective 10-12*</td></tr><tr><td>✓</td><td></td><td>✓</td><td></td></tr></table>
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	<table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Finance & Performance Committee</td><td>28 November 2019</td></tr><tr><td></td><td></td></tr></table>
Action required	The Board is asked to receive this report for information and for assurance of ongoing monitoring of performance against nationally mandated waiting times.

10

Agenda Item: 10/77

Trust Board Meeting – 05 December 2019

Performance report on access standards

Presented by: Sally Tucker, Chief Operating Officer

1. Purpose

1.1 The purpose of this report is to provide clarity and context for performance against access targets, to identify the relevant factors where standards have not been achieved, and to describe the actions in place to improve waiting times and achieve compliance.

1.2 The relevant standards and guidance are included in appendix 1.

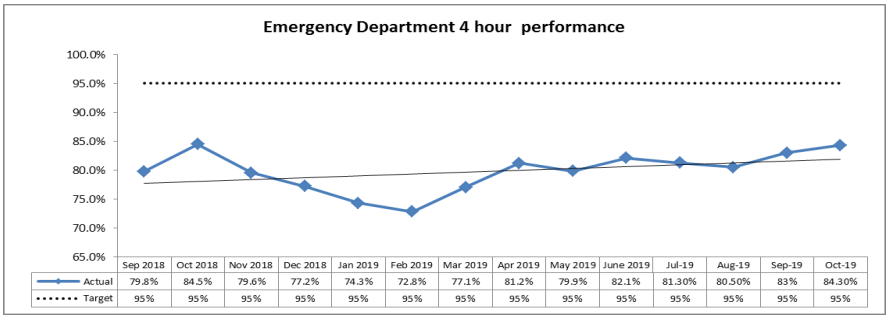
2. Indicators not achieved in the reporting period

2.1 At the time of reporting the following standards and indicators were not achieved in October.

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	83.4%	↑
Ambulance handovers between 30-60 minutes	0	402	↓
Ambulance handovers over 60 minutes	0	116	↓
RTT incomplete pathways < 18 weeks	92%	86.8%	↑
31 day first definitive treatment	96%	94.2%	↓
31 day subsequent - surgery	94%	78.9%	↓
62 day referral to first treatment	85%	78.6%	↓
62 day screening referral to first treatment	90%	66.7%	↓

3 A&E 95% target

3.1 Performance continues to improve, now at 83.4% (from 83%). Compliance with the standard was maintained at MIU (100%) and UTC (99.7%). Minors performance has improved further, at 97.3% (last month 94.7%), as has Majors at 58.8% (from 58.2%). CED performance is also better than the previous month (92.9%) at 93.4%.

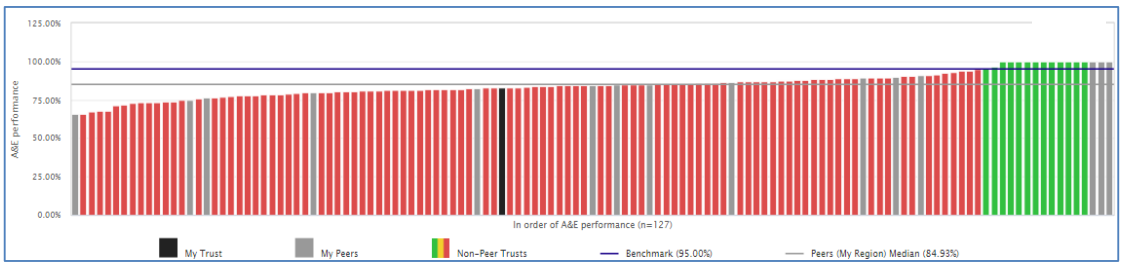


	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	June 2019	Jul-19	Aug-19	Sep-19	Oct-19
Actual	79.8%	84.5%	79.6%	77.2%	74.3%	72.8%	77.1%	81.2%	79.9%	82.1%	81.30%	80.50%	83%	84.30%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

3.2 Performance against the 4 hour standard for non-admitted pathways has improved, up from 83.4% in September, to 84.9% in October. Admitted pathway performance has also improved, now at 61.1%, up from 59.5% the previous month, but the highest achieved year to date.

3.3 Benchmarking using Model Hospital shows WHHT achieving a better performance against the standard than peers and is now placed 76th of 127 providers (last month 100th) in terms of A&E performance in September 2019 (latest available period) with a regional peer median of 84.9% and a national median of 84.3%.

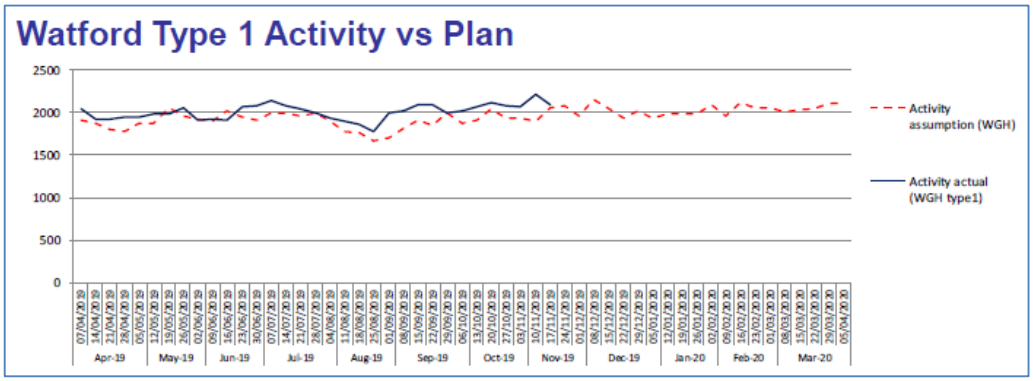
The chart below benchmarks WHHT with the Nightingale Group[1] – other acute providers with more than one site (shown in grey) where the median is 82%.



3.4 Increasing demand (above plan) continues as shown in the table and chart below. Year to date the growth is currently 11.6% across all 3 sites, and 8.2% at WGH.

2019/20 Month	Cummulative attendances			Cummulative attendances		
	% Increase on 2018/19 YTD	Total atts 2019/20	Total atts 2018/19	% Increase on 18/19 YTD	WGH atts 2019/20	WGH atts 2018/19
April	15.3%	13127	11383	10.3%	8586	7787
May	12.3%	26833	23896	6.8%	17404	16303
June	10.3%	40355	36578	5.8%	26054	24619
July	10.3%	54895	49760	6.6%	35370	33197
August	11.3%	68058	61173	7.7%	43907	40776
September	11.6%	81895	73353	8.3%	52902	48851
October	11.6%	95779	85784	8.2%	62087	57374

[1] East Kent University NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Mid-Yorkshire Hospitals NHS Trust
North Cumbria University Hospitals NHS Trust
Royal Cornwall Hospitals NHS Trust
United Lincolnshire Hospitals NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust

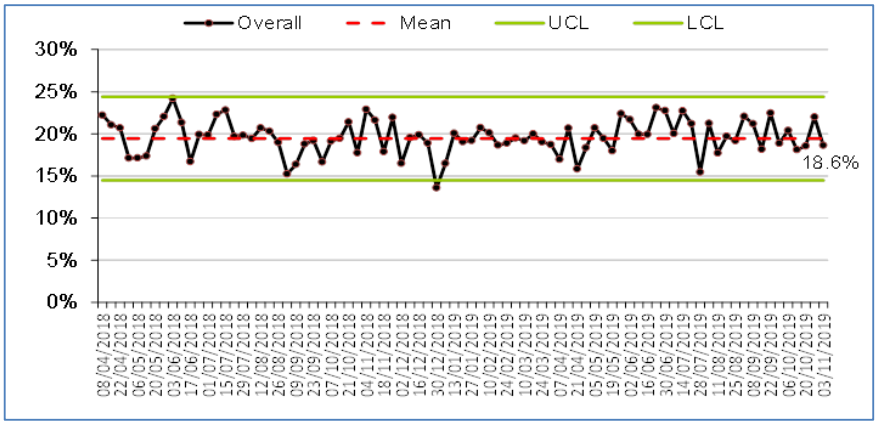


3.5 The number of ED arrivals by ambulance was 6.8% higher than the previous month (October 2820 vs September 2641). However, comparison with 2018/19 shows that the for 2019/20 year to date at M7 ambulance arrivals have increased by 7.7% higher when compared with the same point last year.

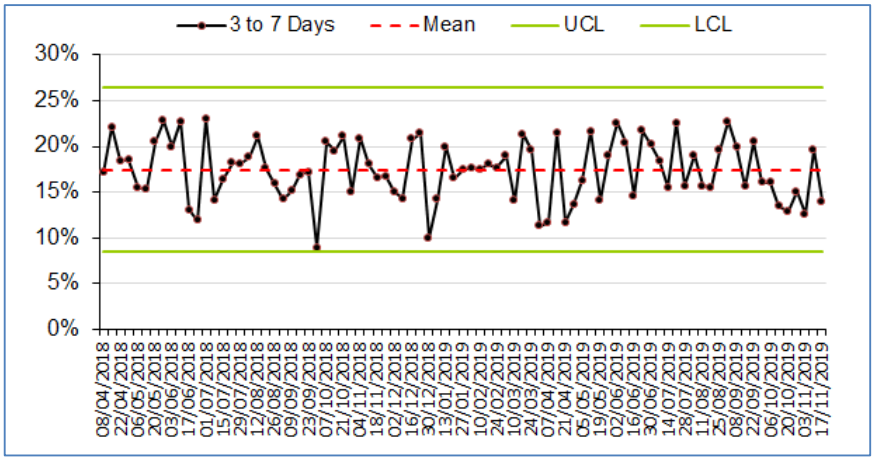
4 Ambulance Handover Delays

4.1 Delays between 30 and 60 minutes have increased (402 vs 351), as have delays over 60 minutes (116 vs 102). Monthly handover improvement meetings have been established with EEAST where current actions will be refreshed and a jointly owned action plan developed and progress monitored.

4.2 Patient flow is also dependent upon timely availability of inpatient beds. The Discharge Working Group, chaired by the Chief Medical Officer, oversees a number of work streams focusing on improving discharge processes, one of which is intended to increase the number of discharges before midday. The chart below shows the overall rates of early discharges since April 2018 which are consistently within the expected range.



This second chart shows the discharge times of patients with a LOS of between 3 and 7 days, where there is also considerable variation but within the upper and lower control limits.

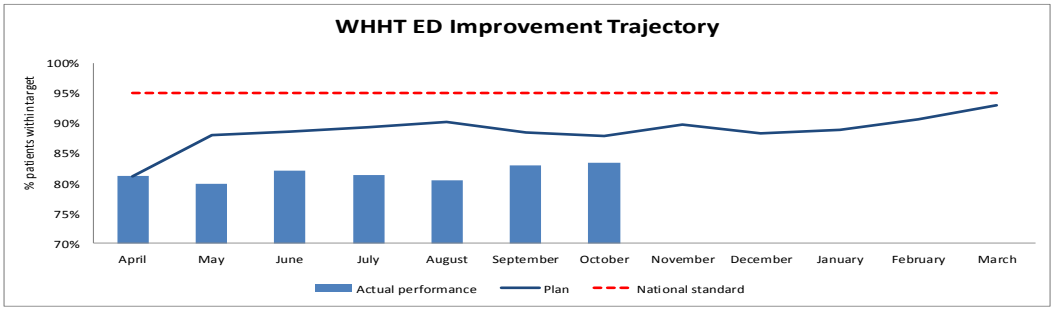


5 Progress against the ED improvement plan

5.1 The gap between actual and planned performance is closing, although there is still some way to go to bring performance in line with the recovery trajectory. Demand above the planned/expected level of activity is a factor in the adverse variance to plan. Although demand management initiatives are in place in the system, the impact is limited. The implementation of an Urgent Treatment Centre at Watford, acting as the single point of entry and streaming patients to the appropriate area for onward care, is expected to have a significant impact on performance improvement.

Trajectory plan - ED

Trust	April	May	June	July	August	September	October	November	December	January	February	March
National standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Plan	81.1%	88.0%	88.5%	89.3%	90.2%	88.4%	87.8%	89.8%	88.2%	88.8%	90.6%	93.0%
Actual performance	81.2%	79.9%	82.1%	81.3%	80.5%	83.0%	83.4%					

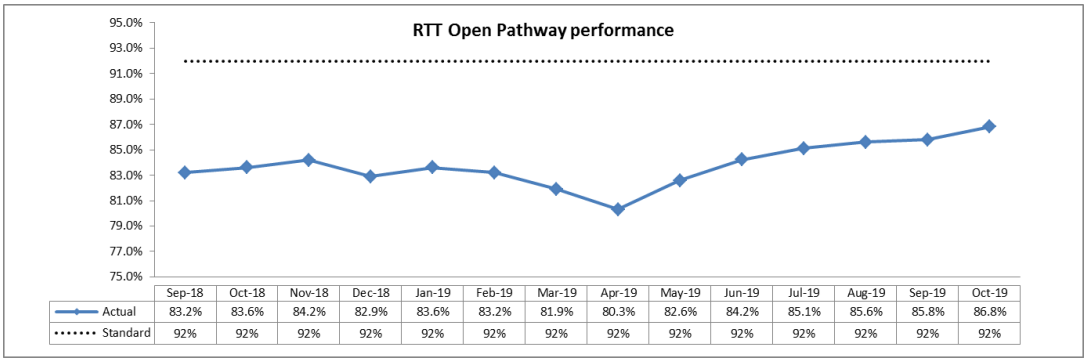


5.2 The medical take pilot (SMART) began in early October and the information collected to date suggests a positive impact, with a lower conversion rate to admission for medical patients, a reduction in length of stay and a contribution to performance against the 4 hour standard. The pilot currently runs to 2100 hours Monday to Friday and discussions have now begun regarding the inclusion of weekends in the pilot.

5.3 The ambulance handover improvement action plan has been reviewed and is now jointly owned by the trust and EEAST. Monthly meetings are in place and there has been good improvement in the number of delays recorded as noted above. Funding for a HALO (Hospital Ambulance Liaison Officer) has been secured for winter and it is expected that this will support further improvements in ambulance turnaround times.

6 RTT Incomplete pathways

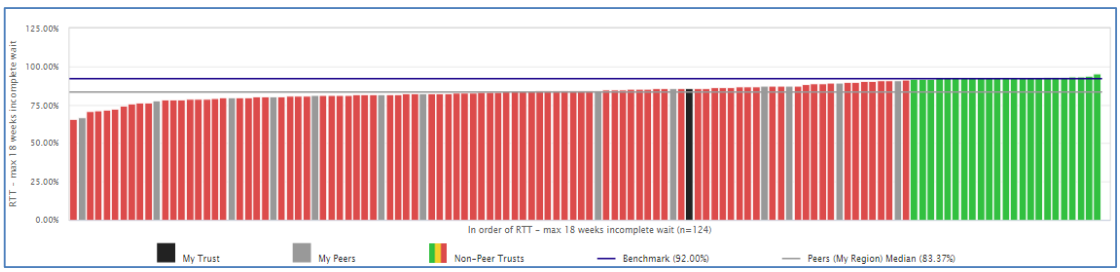
6.1 The ongoing performance against the 92% RTT standard has continued and in October 86.8% of patients with open pathways were waiting less than 18 weeks, up from 85.6% the previous month.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Actual	83.2%	83.6%	84.2%	82.9%	83.6%	83.2%	81.9%	80.3%	82.6%	84.2%	85.1%	85.6%	85.8%	86.8%
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

6.2 Benchmarking using Model Hospital shows WHHT is placed 50th (previously 72nd) of 124 providers in terms of RTT incomplete pathway performance in September 2019, the national sector median being 84.5% and the regional median 83.4%. Trust performance in September (85.8%) was better than all benchmarking groups.

The following chart benchmarks WHHT with the Nightingale Group (see p4) where the median is 81.8%.



6.3 The total PTL size is slightly higher than the previous month (October 23112 / September 22738) but remains lower than that of March 2019 (24178) and there has been a good reduction in the backlog over 18 weeks, when compared with the previous month (3036 vs 3219) and April 2019 (4653).

6.4 Four breaches of the 28 day rebooking rule occurred in October, 3 in Ophthalmology as a result of temperature control problems and 1 in General Surgery due to prioritisation of an emergency case.

7 52 week waits

7.1 At the end of October there were no patients whose waiting time exceeded 52 weeks.

7.2 Harm reviews for patients whose wait exceeds 48 weeks continue. There has been no change in the number of harms identified, which remains 12 Orthopaedic and 7 Urology patients (previously 3) are considered to have experienced harm (low degree,) in the form of prolonged or increased levels of pain as a result of the long waits for treatment in Orthopaedics and in Urology, patients have had prolonged catheter use and need for catheter changes.

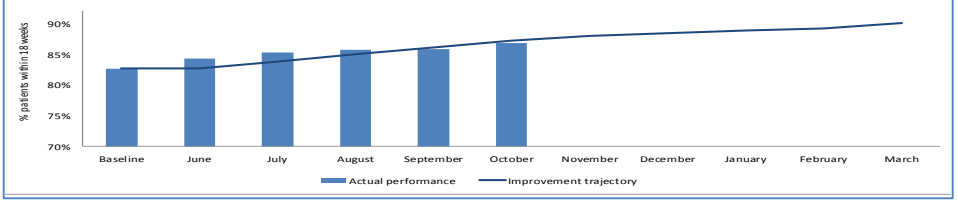
However, there has been an incident relating to non-compliance with the long established practice of processing waiting list cards, which has resulted in delays in a number of Urology pathways. This was a human factor issue and it has been addressed through the appropriate policies and procedures. The incident has been logged on Datix and the Chief Medical Officer is leading the clinical discussions in this matter and harm reviews are underway. A separate group has been established to deliver an electronic alternative to the paper based system.

8 Progress against the RTT improvement programme

8.1 October's performance of 86.8% is just below the plan target of 87.1%. There continues to be a pensions effect on the number of additional in house waiting list initiatives undertaken, but outsourcing continues and recent discussions with commissioners have resulted in agreement to work more collaboratively in terms of identifying additional capacity in the private sector and other NHS organisations with a view to increasing activity further.

Trajectory Plan - RTT

Trust	Baseline	June	July	August	September	October	November	December	January	February	March
National standard		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Plan	82.6%	82.7%	83.8%	84.9%	86.0%	87.1%	87.9%	88.4%	88.8%	89.2%	90.0%
Actual performance	82.6%	84.2%	85.2%	85.6%	85.8%	86.8%					



8.2 While many services are delivering month on month improvements, there are some whose performance is stagnant or deteriorating. The Pain Service has struggled to achieve compliance with the RTT target for a significant period of time. This patient group often have complex issues and needs and pathways are usually very long, having begun in other services prior to referral for pain management. There is a significant capacity shortfall both in outpatient and theatre and while this is under review, there are limitations on realising additional capacity with other services also competing for additional sessions, often with higher priority.

While demand and capacity modelling is undertaken and a long term plan agreed, a large number of pathways have been outsourced, some from referral and others for treatment.

Commissioners are working with the trust to identify additional outsourced capacity to offer further opportunities for recovery and improvement.

9 Cancer Waiting Times Performance

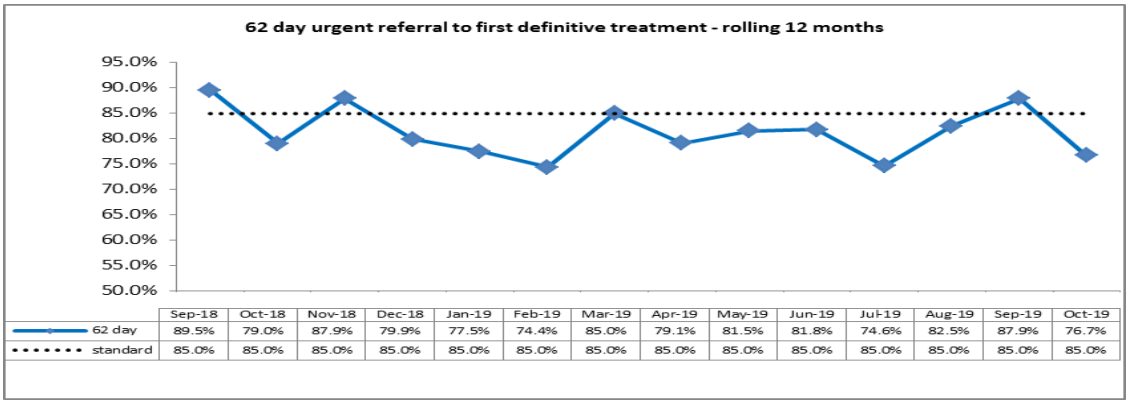
9.1 Two week wait and two week wait breast symptomatic performance improvements have been maintained, with compliance in both standards, with 100% for breast for the second consecutive month.

9.2 At the time of reporting, at 94.2%, the 31 day first definitive treatment standard has not been achieved (target 96%) but this may improve up to the submission deadline. To date there are 10 breaches, in Lower GI, Breast and Urology, some of the latter being related to the incident described above.

9.3 The 31 day subsequent surgery standard (94%) has also not yet been achieved, although the position (78.9%) is not final at the time of writing. There have been 4 breaches, in Urology and Lower GI.

9.4 Neither of the 62 day standards have been achieved at the time of writing. Performance against the 62 day referral to first treatment standard has fallen to 78.6%. However, this is not the final position. Currently there are 21 breaches of the standard, across the tumour sites, the largest number being in Urology. The 62 day screening target has also not been achieved, although again, validation is ongoing and the position may change. The current position of 66.7% reflects 2 breaches (Breast and Lower GI) out of 6 pathways. One was a late referral (shared breach), there was a delay due to the patient's ill health, and one was delayed at a number of points in a complex pathway.

A rolling 12 month summary of performance is included in appendix 3.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
62 day	89.5%	79.0%	87.9%	79.9%	77.5%	74.4%	85.0%	79.1%	81.5%	81.8%	74.6%	82.5%	87.9%	76.7%
standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

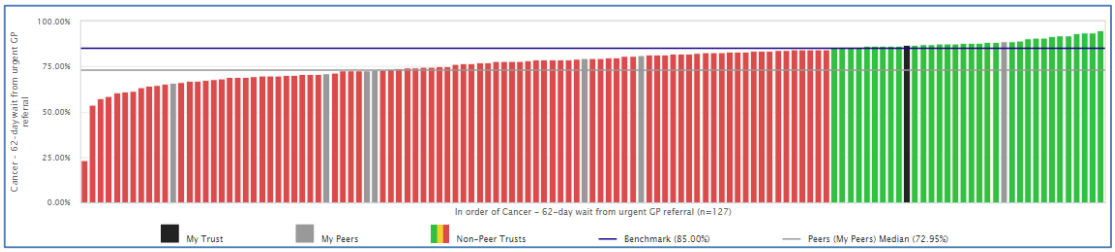
9.5 Benchmarking using Model Hospital shows WHHT ranked 25th (previously 92nd) of 127 providers in terms of the 62 day urgent referral to first definitive treatment standard in September 2019, the national sector median being 79.4% and the regional median 70.5%.

The chart below benchmarks WHHT with the Nightingale Group (see p4) where the median is 72.9%.

9.6 Harm reviews have traditionally always been undertaken for patients whose waiting time exceeded 104 days and the RTT harm review process was built on the cancer model. The trigger for a cancer RCA and harm review has been reduced to patients treated beyond 62 days as described in the regional inter-trust referral policy, with the responsibility for completion of the RCA with the treating hospital.

9.7 Given that a number of WHHT cancer pathways are closed with treatment at tertiary centres, RCAs should be led by the treating hospital. However, following discussion with HVCCG, it was agreed that WHHT would implement a local RCA and review process, obtaining details from treating hospitals where possible.

9.8 It was agreed that this would start formally in Q3 and therefore the new process will be implemented for September's breaches and details will be included in the Quality IPR and referenced in this paper going forward.



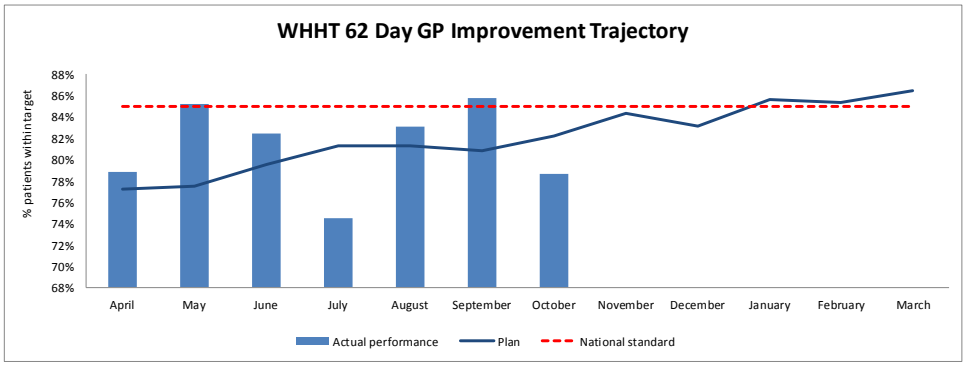
10 Progress against the cancer improvement plan

10.1 At 78.6%, performance is adverse to plan (82.2%). However, this is not the final position and while compliance with the target is not anticipated, there may be some improvement on the current position.

Trajectory plan - 62 day

Current month is provisional

Trust	April	May	June	July	August	September	October	November	December	January	February	March
National standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Plan	77.2%	77.4%	79.5%	81.3%	81.3%	80.8%	82.2%	84.3%	83.1%	85.6%	85.3%	86.4%
Actual performance	78.8%	85.2%	82.4%	74.5%	83.1%	85.7%	78.6%					



10.2 As noted above earlier, there have been some administrative issues resulting in delays which have contributed to breaches in Urology. However, escalation (from MDT but also responses to requests for action) has been identified as a factor in a number of October's breaches. As a result, the escalation SOP is under review and additional levels of escalation are being added (now up to Director level) and a separate escalation tracking process is being considered.

A lung action group has been established in Medicine, with work planned on pathway redesign, review of MDT meetings and supporting systems and processes.

Cross divisional/service meetings have begun to review pathways in Lower GI with a view to reducing delays that sometimes occur between the TAS service and the surgical team.

10.3 The number of pathways reported against the 62 day screening standard are very small which makes compliant performance vulnerable. These pathways are in Breast, Lower GI and Gynaecology and patient choice is a particular issue in Lower GI, where patients often cancel and defer appointments, particularly for colonoscopy etc. Discussions with the Endoscopy service have resulted in the provision of additional sessions and these should improve the position.

9 Risks

9.1 The risk relating to RTT waiting times and performance (3828) with a score of 20, has been reviewed and updated. The principal focus is now patient safety and with the significant reduction in the number of long waits and the established clinical harm reviews, although the risk remains on the corporate risk register, this is with a reduced score of 15.

Risks to achievement of the Access standards include:

- Failure of system wide demand management schemes resulting in
- Increases in demand, above plan
- Insufficient capacity to meet demand
- A reduction in the uptake of vacated theatre sessions (surgeon and/or anaesthetist) both in week and at weekends, as a result of the pensions issue.
- Reduced flow of inpatients from the hospital in to community capacity
- Failure to deliver the core ED improvements required to improve flow in the department.
- Estate (theatre) infrastructure.
- Urgent care admissions to the elective care bed base at WGH.
- Prioritisation of cancer and urgent treatment resulting in cancellation of routine surgery.
- Patient choice / patient initiated treatment delays.

10 Recommendation

10.1 The committee is asked to note the contents of this report and to confirm that the actions being taken are sufficient assurance to bring performance back in line with the relevant Access standards.

Sally Tucker
Chief Operating Officer

November 2019

Appendix 1

The Access 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 below).
- 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

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

Specialty level RTT performance against 92% open pathway standard – October 2019

Service	18 Weeks Plus	% Under 18 Weeks
GENERAL MEDICINE	0	100.00%
OTHER	0	100.00%
PAED ENDOCRINOLOGY	0	100.00%
PAED CLINICAL HAEMATOLOGY	0	100.00%
PAED DIABETIC MEDICINE	0	100.00%
NEPHROLOGY	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
CLINICAL NEUROPHYSIOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
GYNAECOLOGICAL ONCOLOGY	0	100.00%
ORTHOPTICS	0	100.00%
ORTHOTICS	0	100.00%
CLINICAL ONCOLOGY	0	100.00%
PAED GASTROENTEROLOGY	1	98.82%
GYNAECOLOGY	12	98.41%
RESPIRATORY MEDICINE	11	97.92%
CLINICAL HAEMATOLOGY	7	97.19%
CARDIOLOGY	51	96.94%
HEPATOLOGY	2	96.92%
GERIATRIC MEDICINE	3	96.81%
PAED DERMATOLOGY	2	96.30%
DERMATOLOGY	76	96.12%
PAEDS	31	96.00%
PAED CARDIOLOGY	4	95.88%

Service	18 Weeks Plus	% Under 18 Weeks
GASTROENTEROLOGY	80	95.42%
BREAST SURGERY	13	94.92%
PAED EPILEPSY	1	94.44%
ENDOCRINOLOGY	24	94.31%
UPPER GI SURGERY	5	92.96%
DIABETIC MEDICINE	5	92.86%
RHEUMATOLOGY	31	92.64%
PAED OPHTHALMOLOGY	15	92.57%
NEUROLOGY	85	92.55%
COLORECTAL SURGERY	45	88.64%
PAED UROLOGY	28	86.00%
STROKE MEDICINE	1	85.71%
GENERAL SURGERY	243	84.34%
OPHTHALMOLOGY	286	83.29%
TRAUMA & ORTHOPAEDICS	410	81.21%
VASCULAR SURGERY	33	80.59%
ENT	416	78.06%
UROLOGY	490	73.51%
ORAL SURGERY	384	73.09%
ORTHODONTICS	40	69.92%
PAIN MANAGEMENT	199	66.61%
ANAESTHETICS	1	50.00%
CARDIAC SURGERY	1	0.00%
Total	3036	86.86%

Appendix 3

Cancer waiting times performance – update (at 29/11/19)

Standard	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD
2ww	93.0%	93.1%	93.3%	94.1%	94.8%	93.2%	93.0%	91.3%	93.0%	92.3%	91.1%	92.5%	93.2%	94.2%	92.9%
2ww breast	93.0%	96.0%	91.6%	90.8%	91.1%	90.7%	88.0%	87.4%	94.1%	90.8%	97.0%	98.4%	100.0%	100.0%	95.3%
31 day 1st	96.0%	94.1%	96.9%	97.9%	97.5%	97.7%	97.7%	99.4%	96.8%	98.2%	98.9%	96.5%	95.0%	94.2%	97.0%
31 day surgery	94.0%	95.7%	100.0%	100.0%	92.6%	96.3%	100.0%	100.0%	95.0%	93.8%	100.0%	100.0%	100.0%	78.9%	95.0%
31 day drug	98.0%	100.0%	100.0%	100.0%	97.1%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	99.5%
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%	100.0%
31 day other	94.0%	63.6%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	N/A	100.0%	N/A	N/A	100.0%	N/A	100.0%
62 day	85.0%	77.6%	87.4%	78.7%	77.5%	74.3%	84.2%	78.9%	83.1%	81.8%	74.6%	82.5%	85.7%	78.6%	81.0%
62 day screening	90%	92.6%	66.7%	86.7%	90.0%	80.0%	75.0%	100.0%	100.0%	64.7%	90.3%	83.3%	64.0%	66.7%	82.2%

NB: performance is provisional at the time of writing

Trust Board Meeting
05 December 2019

Title of the paper	**Integrated Performance Report** ***(November 2019 reporting period – October data)***
Agenda Item	**11/77**
Presenter	**Sally Tucker, Chief Operating Officer**
Author(s)	**Jane Shentall , Director of Performance**
Purpose	*For approval* [ ] *For discussion* [ ] *For information* [✓]
Executive Summary	In this reporting period: **Safe Care & Improving Outcomes** • Mortality indicators remain stable, within the as expected range – HSMR 99.5, SHMI 99, but crude mortality, although improved, is above target at 4.2% (slides 4, 21) • There were 2 cases of hospital and healthcare apportioned clostridium difficile cases (slides 4, 22-23) • At 31.5%, C-section rates are lower, but remain outside of the national target (28%); the elective rate at 15.5% and the emergency rate at 16% are above the ceiling targets (11% & 15%) (slides 4, 25). • The indicator for safe care, nursing shift fill, at 101.9%, is better than target (95%) (slides 4, 26) • The percentage of patient safety incidents that are harmful, is better than the previous month, at 7.9% (was 8.4%) (slides 4, 30) • Safety thermometer new harms, at 98.2% are better than the national picture, with 1 category 3 and no category 4 pressure ulcers) (slide 4, 32-33) • VTE assessment is just below target at 94.4% (slides 4, 34) • Stroke indicator performance shows 71% of patients were admitted to the Stroke unit within 4 hours (target 90%, national average 56.3%), and 92% of patients spent 90% of their admission on the unit (target 80%, national average 83.6%) (slides 4, 35) **Caring & Responsive Services** • Ambulance turnaround delays between 30 and 60 minutes have increased (to 402 from 351) as have delays over 60 minutes (to 116 from 102) (slides 5, 36) • Delayed transfers of care (DToCs) have increased further, at 6.5% (from 6.3%) against a target of 3.5% (slides 5, 38) • Inpatient, Day Case and Maternity Friends & Family positive scores remain above the 95% target but A&E scores have fallen further (from 92.9%) to 90.6% (slides 5, 39-40) • Complaints response times are just below target (80%) at 78.6% but with fewer (3) reactivated complaints received in the reporting period (slides 5, 41) • ED 4 hour performance was better this month at 83.4% (from 83%) (slides 5, 36) • RTT (incomplete) performance improvement continues, at 86.8% (from 85.8% with no 52 week breaches (slides 5, 43) • At 94.2% cancer 2 week wait and 100% for 2 week wait breast symptomatic, the waiting time targets (93%) have been achieved (slides 5, 43) • Cancer 31 day first (94.2%) and subsequent surgery (78.9%) performance have not yet reached the standard (96% and 94%) (slides 5, 44) • 62 day urgent referral to first treatment is currently below target (85%) at 78.6% and 62 day screening has not achieved the standard (90%) at 66.7% (slides 5, 46) • At 5.4% outpatient short notice appointment cancellations have risen above target (5%) (slides 5, 47) • Outpatient DNA rates have increased to 9.1% (from 8.6%) (slides 5, 47)

11

Workforce & Finance

- 12 month turnover rates are unchanged, at 14.7% and remain above target (13%) and the vacancy rate is unchanged and almost on target (10%) at 10.7% (slides 5, 48)
- Sickness absence rates have increased to 3.9% and are above target (3.5%) (slides 6,
- All staff appraisal rates are compliant with target (90%) at 90.8% (was 87.9%) (including medical staff) (slides 5, 49)
- Mandatory training rates remain consistently better than target, at 92.7% and Essential training rates, at 90.3% are also now better than target (90%) (slides 5, 49)
- Bank pay is within the target range at 11.4%, but agency pay is above target (4.4%) at 5.1% (slides 6, 16)
- Within the new finance indicators, the actual deficit above plan in month by £17k.
- An in month actual surplus of £119k was delivered against a planned surplus of £102k.
- Year to date the Trust is better than plan by £19k.
- A £17.688m deficit has been delivered against the year to date deficit plan of £17.707m. The forecast is more or less in line with plan (slides 6, 10-11)
- CIP delivery is behind plan in month (£1.388m has been delivered against a plan of £1.494m).
- The year to date position shows over delivery of £2.215m against a year to date plan of £5.385m (slides 6, 18).
- A range of activity counts are now included for information(slide 6):
  - Elective spells (overnight) are behind plan (629) at 549
  - Elective day cases are above plan (3641) at 3332
  - Total elective spells are very slightly behind plan (4270) at 3881
  - Outpatient attendances are lower than planned (22927) at 21755
  - Non-elective spells are higher than planned (4138) at 4788
  - Births are lower than planned (408) at 390

Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)

Aim 1	Aim 2	Aim 3	Aim 4
Best quality care	Great place to work	Improve our finances	Strategy for the future
Objectives 1-5	*Objectives 6-8*	*Objective 9*	*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
Finance & Performance Committee	28 November 2019

Action required

The Board is asked to receive this report for information and assurance.

11

NHS
West Hertfordshire Hospitals
NHS Trust

Integrated Performance Report

November 2019

Reporting Period: October 2019

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

How Are we Doing?

Safe Care & Improving Outcomes	Caring & Responsive Services	Workforce & Finance
Safety Thermometer New Harm Free Care 98.2% Target 95%	**Complaints response times** 78.6% Target 80%	**Mandatory Training** 92.7% **Appraisal Rates** 90.8% Target 90%
Clostrioides Difficile cases 3 Target 2	**ED 4 hour standard** 83.4% Target 95%	**Agency pay** 5.1% Target 4.4%
VTE assessment 94.4% Target 95%	**RTT open pathways** 86.8% Target 92%	**Vacancy rate** 10.7% Target 10%
Inpatient Friends & Family positive scores 95.6% Target 95%	**CWT: 62 day referral to first treatment** 78.6% Target 85%	**I&E forecast** (Full year) -£22,741 **I&E actual** (YTD actual & YTD plan) -£17,688 Target -£ 17,707

The very best care for every patient, every day

Essential Measures – Executive Summary

NHS
West Hertfordshire Hospitals
NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Within as expected range and stable	SHMI 99.0 HSMR 99.5	**Complaints response times** Below target	78.6% YTD 81.7%	**All staff appraisal** Improved and better than target	90.8% YTD 87.3%
Infection Control – clostrioides Difficile Hospital & healthcare associated cases – variable	3 (Cat1: 2 + Cat 2:1) YTD 33	**Inpatient Friends & Family Test** Positive scores mainly compliant but variable, ED below target	Resp 22.3% + ve 95.6%	**Mandatory training** Consistently achieved and stable	92.7% YTD 91.9%
Serious incidents & Never Events (NE) Variable	SI 4 YTD 19 NE 0 YTD 1	**Mixed sex accommodation** Improved	0 YTD 23	**Turnover at 12 months** Worse than target but stable	14.7% YTD 14.9%
Patient safety incidents which are harmful Stable but worse than target	7.9% YTD 8.7%	**Outpatient DNA rates** Variable and worse than previous month	9.1% YTD 8.7%	**Income & Expenditure**	£0.12m YTD (£17.69)m
Combined Caesarean Section Standard not achieved - variable	31.5% YTD 32.0%	**ED waiting times** Improving performance but below target and adverse to plan	83.4% YTD 81.6%	**Capital Spend**	(£0.90)m YTD (£4.50)m
VTE assessments Compliance below target, consistent with recent months	94.4% YTD 95.1%	**RTT waiting times** Improving, below target, just below plan	86.8% YTD 84.4%	**CIP Efficiency** Full year savings of £15.15m identified (target £15m)	£1.39m YTD £7.60m
Stroke Indicators Admission to the Stroke Unit within 4 hrs – variable & not achieved 90% admission spent in the Stroke Unit – variable, achieved	4 hr 71.0% YTD 64.0% Adm 92.0% YTD 93.9%	**Cancer waiting times** 2ww achieved and improving 62 day not achieved and variable	2ww 94.1% YTD 92.4% 62 day 78.6% YTD 80.9%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 3 Elec 3881 vs 4270 Non-Elec 4788 vs 4138
Reporting Sub-Committee **Quality Committee**		**Reporting Sub-Committees** **People, Education & Research Committee** **Finance & Performance Committee**		**Reporting Sub-Committees** **People, Education & Research Committee** **Finance & Performance Committee**	

The very best care for every patient, every day

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Aug-19	Sep-19	Oct-19	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Safe care & Improving Outcomes	Safe	**Quality of Care: Mortality Indicators**												
		SHMI (Rolling 12 months)	21	100	Performance deteriorated but better than target	96.5	95.4	99.0			May-19	National	100	May-19
		HSMR - Total (Rolling three months)	21	100	Performance deteriorated but better than target	96.2	98.3	99.5			Jul-19	National	100	Jul-19
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	22		Performance stable but worse than target	1	4	2	22		Oct-19	National		
		Clostridioides Difficile - Healthcare associated (Cat 2)	22		Performance stable but worse than target	4	0	1	11		Oct-19	National		
		Clostridioides Difficile - Hospital and Healthcare associated Total	22	2	Performance stable but worse than target	5	4	3	33	24	Oct-19	National		
		Hand Hygiene Compliance	23	95%	Performance stable and better than target	98.0%	98.3%	96.5%	97.5%	95%	Oct-19	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	24	4.3%	Performance stable and better than target	3.5%	3.5%	4.0%	4.0%	4.3%	Apr-19	National	4.3%	Apr-19
		30 Day Emergency Readmissions - Emerg *	24	13.8%	Performance stable and better than target	11.3%	11.9%	12.3%	12.3%	13.8%	Apr-19	National	13.8%	Apr-19
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	25	28.0%	Performance stable but worse than target	28.4%	34.4%	31.5%	32.0%	28.0%	Oct-19	Local	26.7%	Apr15-Aug15
		Caesarean Section rate - Emergency*	25	15.0%	Performance stable but worse than target	14.6%	16.3%	16.0%	16.3%	15.0%	Oct-19	Local	15.3%	Apr15-Aug15
		Caesarean Section rate - Elective*	25	11.0%	Performance stable but worse than target	13.7%	18.1%	15.5%	15.6%	11.0%	Oct-19	Local	11.4%	Apr15-Aug15
		Patient Safety												
		% nursing hours (shift fill rate)	26	95.0%	Performance stable and better than target	103.0%	100.2%	101.9%	101.9%	95.0%	Oct-19	National	n/a	
		Serious incidents - number*	30	0	Performance stable but worse than target	4	3	4	19	0	Oct-19	National	n/a	
		Serious incidents - % that are harmful*	30	0.0%	Performance stable but worse than target	100.0%	100.0%	100.0%	100.0%	0%	Oct-19	National	n/a	
		% of patients safety incidents which are harmful*	30	0.0%	Performance stable but worse than target	8.0%	8.4%	7.9%	8.7%	0%	Oct-19	National	n/a	
		Never events	30	0	Performance stable and better than target	1	0	0	1	0	Oct-19	National	n/a	
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	32	95.0%	Performance stable but worse than target	91.7%	89.5%	92.2%	91.3%	95.0%	Oct-19	National	94.0%	Oct-19
		Safety Thermometer % New Harm Free Care (acquired within Trust)	32	95.0%	Performance stable and better than target	99.0%	97.6%	98.2%	98.5%	95.0%	Oct-19	National	97.7%	Oct-19
		Category 4 pressure ulcers - New (Hospital acquired)	33	0	Performance stable and better than target	0	0	0	0	0	Oct-19	Local		
		Category 3 pressure ulcers - New (Hospital acquired)	33	0	Performance stable but worse than target	1	2	1	12	0	Oct-19	Local		
		VTE risk assessment*	34	95.0%	Performance deteriorated and worse than target	94.8%	94.7%	94.4%	95.1%	95.0%	Oct-19	National	95.6%	Q1 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	35	90.0%	Performance stable but worse than target	58.1%	65.3%	71.0%	64.0%	90.0%	Oct-19	National	56.3%	Jun-19
		Stroke patients spending 90% of their time on stroke unit	35	80.0%	Performance stable and better than target	92.3%	97.6%	92.0%	93.9%	80.0%	Oct-19	National	83.6%	Jun-19

Key	Description
	Performance better than target/threshold
	Performance worse than target/threshold

	Performance improved - *statistically significant change compared to previous 12 months (2 standard deviations SPC)*	**Performance deteriorated** - *statistically significant change compared to previous 12 months (2 standard deviations SPC)*	**Performance stable** - *no statistically significant change compared to previous 12 months (2 standard deviations SPC)*
Performance better than target/threshold			
Performance worse than target/threshold			

11

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Aug-19	Sep-19	Oct-19	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Caring & Responsive Services	Effective	**Patient Flow: Emergency Department**												
		Ambulance turnaround time between 30 and 60 mins		0	Performance deteriorated and worse than target	332	351	402	2336	0	Oct-19	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	195	102	116	983	0	Oct-19	National	n/a	
		% Patients admitted through A&E - 0 day LOS		TBC	Performance deteriorated but better than target	33.2%	36.7%	37.3%	32.9%	TBC	Oct-19	National		
		Patient Flow: In hospital flow												
		Discharges between 8am and 12pm (main adult wards excl AAU)			Performance stable and better than target	19.7%	19.9%	18.7%	19.5%		Oct-19	National		
		Mixed sex accommodation breaches	37	0	Performance stable and better than target	3	4	0	23	0	Oct-19	National	53 Trusts breaching	Sep-19
		LOS > 21 days	38	74	Performance stable but worse than target	91	98	91	91	74	Oct-19	National	n/a	
		Delayed Transfers of Care (DToC)*	38	3.5%	Performance deteriorated and worse than target	3.4%	6.3%	6.5%	4.6%	3.5%	Oct-19	National	6.0%	Feb-16
		Delayed Tranfers of Care (DToC) beddays used in month	38	n/a	Performance deteriorated but better than target	835	832	1088	5710	n/a	Oct-19	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	38	n/a	Performance deteriorated but better than target	27	28	35	30	n/a	Oct-19	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	39	95%	Performance stable but worse than target	95.4%	92.9%	90.6%	91.3%	95%	Oct-19	National	85.3%	Sep-19
		Inpatient Scores FFT % positive	39	95%	Performance stable and better than target	95.8%	95.4%	95.6%	94.7%	95%	Oct-19	National	95.9%	Sep-19
		Daycase FFT % positive	39	95%	Performance stable and better than target	98.2%	99.4%	98.9%	97.9%	95%	Oct-19	National	n/a	
		Maternity FFT % positive	39	95%	Performance stable and better than target	95.2%	95.7%	96.5%	96.1%	95%	Oct-19	National	97.1%	Sep-19
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	41	80%	Performance stable but worse than target	73.1%	81.5%	78.6%	81.7%	80%	Oct-19	National	n/a	
		Reactivated complaints	41	0	Performance stable but worse than target	5	7	3	30	0	Oct-19	National	n/a	
		Patient Experience: End of life care												
		New indicators to be included in Q3		TBC										
		New indicators to be included in Q3		TBC										
	Responsive	**Access to Services**												
		ED 4hr waits (Type 1, 2 & 3)	36	95.0%	Performance improved but worse than target	80.5%	83.0%	83.4%	81.6%	95.0%	Oct-19	National	83.6%	Oct-19
		Referral to Treatment - Incomplete*	43	92.0%	Performance improved but worse than target	85.6%	85.8%	86.8%	84.4%	92.0%	Oct-19	National	84.8%	Sep-19
		Referral to Treatment - 52 week waits - Incompletes	43	0	Performance improved and better than target	1	3	0	0	0	Oct-19	National	1305 (all Trusts)	Sep-19
		Cancer												
		Cancer - Two week wait *	44	93.0%	Performance stable and better than target	92.3%	93.2%	94.1%	92.4%	93.0%	Oct-19	National	90.2%	Q2 19/20
		Cancer - Breast Symptomatic two week wait *	44	93.0%	Performance improved and better than target	98.4%	100.0%	100.0%	95.0%	93.0%	Oct-19	National	85.3%	Q2 19/20
		Cancer - 31 day *	45	96.0%	Performance deteriorated and worse than target	96.5%	95.0%	94.4%	97.1%	96.0%	Oct-19	National	96.0%	Q2 19/20
		Cancer - 31 day subsequent drug *	45	98.0%	Performance improved and better than target	100.0%	100.0%	100.0%	100.0%	98.0%	Oct-19	National	99.2%	Q2 19/20
		Cancer - 31 day subsequent surgery *	45	94.0%	Performance deteriorated and worse than target	100.0%	100.0%	88.2%	96.5%	94.0%	Oct-19	National	91.3%	Q2 19/20
		31 Day - Subsequent Treatment at WHHT - Palliative Treatments	45	94.0%	Performance improved and better than target	100.0%	100.0%	100.0%	100.0%	94.0%	Oct-19	National		
		31 Day - Subsequent Treatment at WHHT - Other Treatments	45	94.0%	Performance deteriorated but better than target	100.0%	100.0%	94.3%	98.8%	94.0%	Oct-19	National		
		Cancer - 62 day *	46	85.0%	Performance stable but worse than target	84.1%	87.9%	78.6%	80.9%	85.0%	Oct-19	National	77.7%	Q2 19/20
		Cancer - 62 day screening *	46	90.0%	Performance stable but worse than target	83.3%	64.0%	61.5%	78.6%	90.0%	Oct-19	National	86.7%	Q2 19/20
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	47	5.0%	Performance stable but worse than target	5.2%	3.6%	5.4%	4.5%	5.0%	Oct-19	Local	n/a	
		DNA rate	47	TBC	Performance stable and better than target	8.5%	8.6%	9.1%	8.7%	TBC	Oct-19	National	n/a	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain	Theme	Page	Target	Trend	Aug-19	Sep-19	Oct-19	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Workforce and finance	Well led	**Recruitment & Retention**											
	Staff turnover rate (rolling 12 months)	48	13.0%	Performance stable but worse than target	15.1%	14.6%	14.7%	14.9%	13.0%	Oct-19	National	15.4% (Beds and Herts orgs)	Q1 18/19
	% staff leaving within first year (excluding medics and fixed term contracts)	48	n/a	Performance improved and better than target	21.2%	17.2%	16.7%	19.1%	n/a	Oct-19	National	n/a	
	Vacancy rate	48	10.0%	Performance stable but worse than target	10.5%	10.5%	10.7%	10.5%	10.0%	Oct-19	National	13.5% (local survey)	Q1 18/19
	Sickness rate	48	3.5%	Performance deteriorated and worse than target	3.4%	3.5%	3.9%	3.3%	3.5%	Oct-19	National	3.8% (EoE orgs)	Q1 18/19
	Developing Staff												
	Appraisal rate (Total)	49	90.0%	Performance improved and better than target	86.6%	87.9%	90.8%	87.3%	90.0%	Oct-19	National		
	Mandatory Training	49	90.0%	Performance improved and better than target	91.4%	91.4%	92.7%	91.9%	90.0%	Oct-19	Local	88.0% (local survey)	Q1 18/19
	Essential Training	49	90.0%	Performance improved and better than target	88.6%	88.4%	90.3%	86.6%	90.0%	Oct-19	Local		
	Finance overview												
	Financial Risk Rating	10-19	3	Performance improved and better than target	3.00	3.00	3.00			Oct-19	Local		
	Income & Expenditure Actual	10-19	£102	Performance stable and better than target	-£2,336	-£2,144	£119	-£17,688	-£17,707	Oct-19	Local		
	Income & Expenditure forecast	10-19	-£22,741	Performance improved and better than target	-£22,741	-£22,741	-£22,741	-£22,741	-£22,741	Oct-19	Local		
	Cash balance at the end of the month	10-19	£332	Performance stable and better than target	£5,752	£6,585	£3,693	£3,693	£332	Oct-19	Local		
	Capital expenditure	10-19	-£1,332	Performance improved but worse than target	-£380	-£472	-£900	-£4,502	-£13,081	Oct-19	Local		
	CIP delivery against plan	10-19	£1,494	Performance stable but worse than target	£1,731	£1,077	£1,388	£7,603	£5,533	Oct-19	Local		
	% Bank Pay**	10-19	12.0%	Performance stable and better than target	12.3%	11.4%	11.4%	11.5%	12.0%	Oct-19	Local	n/a	
	% Agency Pay**	10-19	4.4%	Performance stable but worse than target	4.2%	4.2%	5.1%	5.2%	4.4%	Oct-19	Local	7.5% (local survey)	Q1 18/19
	Activity (chargeable)												
	GP referrals		8,665	Performance stable and better than target	7,570	7,693	9,121	56,249	55,817	Oct-19	National		
	A&E attendances		10,042	Performance stable but worse than target	10,342	10,849	10,936	74,466	69,322	Oct-19	National		
	Elective spells (overnight)		629	Performance stable but worse than target	480	509	549	3,582	4,053	Oct-19	National		
	Elective daycase		3,641	Performance stable but worse than target	2,920	3,370	3,332	23,043	23,589	Oct-19	National		
	Total elective spells		4,270	Performance stable but worse than target	3,400	3,879	3,881	26,625	27,642	Oct-19	National		
	Non-elective spells		4,138	Performance deteriorated and worse than target	4,165	4,352	4,788	29,771	27,750	Oct-19	National		
	Births		408	Performance stable and better than target	344	346	390	2,528	2,819	Oct-19	National		
	Outpatient attendances		22,927	Performance stable but worse than target	17,904	20,268	21,755	140,666	142,244	Oct-19	National		

* No official cash target
** Straight line target

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Key messages for the Board

Safe Care & Improving Outcomes

Chief Medical Officer

The Medical take pilot is showing definitive improvements in our performance. During the same period last year, our ED performance was 7-8% below the EoE average. We had improved this to about 3% below the EoE average prior to the pilot, but are now averaging 2% above regional average. Our median length of stay remains low, and stable. There has been significant interest and support from the wider health system, and a formal report is due shortly regarding how we propose to make this "business as usual".

A new electronic procedure booking form is being trialled and should be launched shortly. This should prevent any further issues with requests being misplaced, and enable scheduled repeat procedures (ie surveillance tests) to be automatically scheduled.

Chief Nurse

A review of new pressure ulcers in the trust is being undertaken and will be presented at the February quality committee. A review of the data presentation to show trends in the quality committee IPR and in the board IPR slide will also be undertaken.

A QI awareness campaign has begun across the organisation and is being discussed at divisional governance meetings.

An establishment has been agreed and put in place for the provision of the winter ward staffing from early December. All other staffing levels required as part of winter surge plan have been further reviewed by the Heads of Nursing and signed off by myself.

During October we continued with our plan that was put in place to support the reduction of clostrioides, working in partnership with the CCG to have a table top review in November of the work undertaken. Thirty cases have been reviewed with the clinical teams responsible for the patients and the CCG. Twenty-five have been agreed as no lapses in care at the time of writing this report. The quality committee will receive a further update in December in the quality IPR.

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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Caring & Responsive Services

Chief Nurse

Preparation for rollout of electronic bed management across the wards has taken place through October and November to support improved patient flow through the hospital. Our 4th annual bereavement service was held in November with the local gospel choir and attendance from families and carers has continued to increase. This has been a welcomed initiative by families with positive feedback.

The new FFT guidance issued earlier this year is being reviewed and a meeting has been arranged this month with NHSEI and a proposal will be presented to the quality committee in the new year.

We have held two '**Living Well with Cancer events'** this year. All of our cancer patients are invited to attend with their partners & carers. There is a market stall area with representatives from local partner organisations, eg Macmillan, Council Benefits Service, the Spring and Starlight Centres (located at the local hospices), cancer charities, Herts Carers, exercise groups, Boots No 7 makeovers, complimentary therapy taster sessions. At each event we ask a senior colleague to talk to the group about cancer care and our CNSs are available to provide advice and support, patients can be signposted to other appropriate services as needed. Between 75 – 100 people attend each event. Feedback from these events helps the service to continue to plan further improvements.

Chief Operating Officer

ED Performance against the four hour standard was sustained with a small improvement against the previous month. This was despite attendances being higher than plan for every week during October 2019.

One business continuity incident was declared due to capacity pressures with the incident being declared on 28/10/19 and stood down on 30/10/19 demonstrating positive recovery within 48 hours.

The Trust continues to experience intermittent issues with patient transport services which is provided by EEAST. This is monitored on a daily basis with established escalation processes now in place with both EEAST and the CCG. This is further underpinned by a monthly performance meeting led by the CCG with the Trust and EEAST in attendance.

Following Board approval in September of the Trusts self assessment compliance of EPRR Core Standards the COO and Emergency Planning Lead presented to the Local Health Resilience Panel , whilst our self assessment demonstrated a 'substantially compliant' status as opposed to 'fully complaint' due to non compliance with the Data Security Protection Toolkit standard. On the basis of having a plan that seeks to deliver compliance by 31.3.20 we await the panels consideration on this element as we were highly commended for all other aspects.

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Key Messages for the Board

Workforce & Finance

Chief People Officer

Our key workforce metrics continue to perform well, with these either being met or falling marginally short, although there has been an increase in our sickness rates. Our overall assessment of performance in relation to key workforce metrics remains green. 65% of our patient facing colleagues have now received their flu vaccinations and we are on track to achieve 80% vaccination rate early in the new year. Response rates to staff survey stands at 40%, unfortunately there have been a number of IT issues which has made it difficult for some staff to access the survey.

There has been significant movement in relation to the pension issue facing many staff working within the NHS and the Trust is currently considering a number of proposals. The Trust has also been working with NHSP to look at an opportunity where by UK citizens who have completed their medical undergraduate degrees in Bulgaria come and work at the hospital. The Trust has also approved funding for an electronical Occupational Health System which is fundamental to being able to take the service forward and we are currently working with the Royal Free to appoint a new joint Head of OH.

Chief Finance Officer

The plan for the month of October (Month 7) was to break-even, in month, due to a target to step up cost improvements and increase income in line with the profile for PSF and FRF income. The Trust met this challenge, maintaining the ytd I&E deficit at £17.8m and a forecast that the deficit for the year would not exceed £22.741m.

There are signs that the Trust is managing capacity more effectively when noting a significant increase in A&E attendances and associated income (£0.2m in excess of plan in month, £0.9m in excess ytd), while admitted care income value fell £1.0m short of plan in the month. Accrued income has, however, been adjusted for agreements with our host Commissioner to contract under a Minimum Income Contract which essentially fixes the income level.

After 7 months we're achieving more efficiencies than planned for at the start of the year (£7.6m, vs £5.4m planned). We expect savings to rise to 15.2m by the end of the year. Pay costs overspent again this month but the overspend has slowed to only £0.3m in the month. The continued overspend signals the need for actions to ensure the Trust does not miss its Control Total. Continued, unexpectedly high, emergency care pressures have contributed to overspending, but new controls and patient care pathways have helped to ease the pressure on pay costs. At the start of the year our plan to improve services included a plan to spend £25m on new and replacement assets. Our revenue prices secure £7m of this investment requirement, so this year we rely on £18m of extra funds. £13m of this in total has now been approved. £5m was earmarked for the Trust, but dependent on approval of a full business case to improve our emergency department facilities. Approval of this business case will not come before the end of this financial year, therefore the Trust at this stage expects to spend £20m on its capital expenditure programme. The Trust is now re-doubling efforts to (in particular) complete spending plans for fire safety improvements.

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Workforce & Finance: Income and Expenditure October 2019

Trust Definition	Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance		YTD Budget	Actual	Variance	
Income	Divisional Income	55,877	5,123	5,028	(95)	Bii	29,811	29,872	61	Fii
	NHS Revenue	324,083	28,746	28,519	(227)	Bi	191,512	189,919	(1,593)	Fi
	Income Unallocated CIPs	515	56		(56)		106		(106)	
Income Total		**380,476**	**33,926**	**33,547**	**(378)**	**B**	**221,428**	**219,791**	**(1,638)**	**F**
Pay	Medical Pay	(78,763)	(6,525)	(6,535)	(10)		(45,841)	(47,021)	(1,180)	
	Non-Clinical Pay	(51,658)	(4,318)	(4,416)	(98)		(29,521)	(28,638)	883	
	Nursing Pay	(75,930)	(6,233)	(6,231)	1		(44,200)	(45,409)	(1,209)	
	Other Clinical Pay	(28,656)	(2,344)	(2,341)	4		(16,591)	(16,590)		
	Scientific, Technical & Profes	(25,811)	(2,148)	(2,188)	(40)		(15,054)	(15,596)	(542)	
	Pay Unallocated CIPs	3,370	143		(143)		(56)	42	98	
Pay Total		**(257,448)**	**(21,427)**	**(21,712)**	**(285)**	**C**	**(151,263)**	**(153,212)**	**(1,949)**	**G**
Non Pay	Clin Supp Serv	(31,038)	(2,836)	(2,554)	282		(18,180)	(17,973)	207	
	Drugs	(22,476)	(2,136)	(2,016)	119		(13,339)	(12,462)	877	
	OTHER (NON CLIN)	(81,565)	(6,533)	(6,086)	447		(49,105)	(46,838)	2,267	
	Non Pay Unallocated CIPS	1,607	142		(142)		(121)		121	
Non Pay Total		**(133,472)**	**(11,363)**	**(10,656)**	**706**	**D**	**(80,746)**	**(77,273)**	**3,473**	**H**
Recharges	Recharges				()			()	()	
Recharges Total					**()**			**()**	**()**	
Financing Charges	Depreciation	(8,999)	(759)	(789)	(30)		(5,204)	(5,152)	51	
	Trust Debt Redemption	(3,241)	(270)	(270)	()		(1,889)	(1,834)	55	
	Unwinding Discount	(57)	(5)	(1)	4		(33)	(7)	27	
Financing Charges Total		**(12,297)**	**(1,034)**	**(1,060)**	**(26)**	**E**	**(7,126)**	**(6,993)**	**133**	**I**
Total		**(22,741)**	**102**	**119**	**17**	**A**	**(17,707)**	**(17,688)**	**19**	**J**

A – The trust reported favourable position in month by delivering an over performance of £17k in October. The YTD position is also on plan with an actual £17.68m deficit, which is £20k better than plan (J).

B- The in month income position showed an under performance of £378k against plan.
Bii – Divisional income showed an under performance of £95k against plan in month. This is due to lower research and education income which is offset with non pay recharges. The YTD divisional income position remains better than plan by £61k (Fii).
Bi- NHS Revenue underperformed in month by £227k. At a high level this is attributed to lower pass through expenditure on high cost drugs. This is fully offset by the non pay position. After allowing for the impact of pass-through items, the trust was broadly in line with its NHS revenue plan due to the positive impact associated with the minimum income contract. Despite this, large underperformances within elective and non elective of £372k and £594k, should be noted. The YTD position on NHS revenue shows under performance of 1,593k of which £1,709k relates to pass through items (Fi).
C – The overall pay bill for the month was £21,712k which was £285k overspent. Despite an improved pay position , Medical and Nursing pay positions represent 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 is explained further on the pay slides. The YTD pay position is £1,949k overspent (G).

D – The non pay position reported an underspend of £706k in month. The clinical divisions reported a combined underspend of £163k which was driven by lower spend to reflect fewer electives performed. The majority of the remaining underspend was attributed to corporate and represented reduced R&D expenditure, lower ICT transition costs in month and a reduction in the level of bad debt provision. .
E – Financing charges overspent by £26k . This is linked to the timing of interest payable on revenue loans.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Finance overview dashboard

Financial Overview as at 31 October 2019

Month 7 FY20 Income & Expenditure

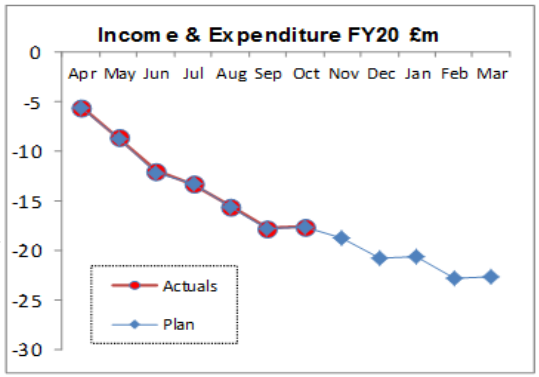
£m	Plan	Actual	Var
Surplus / (Deficit)	0.1	0.1	0.0

£m	Year to Date		
Surplus / (Deficit)	(17.7)	(17.7)	0.0

Statutory / Regulatory Duties

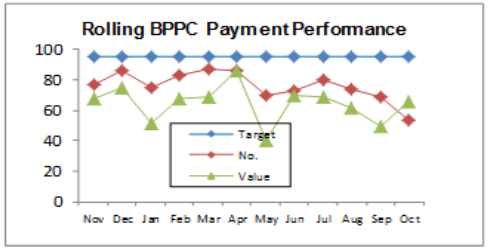
Breakeven	The Trust has a deficit plan of £22.7m for FY20.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 31/10/19 equated to 4 days' spend	R
BPPC	Month 7 performance - 66% on number, 54% on value (95% target)	R

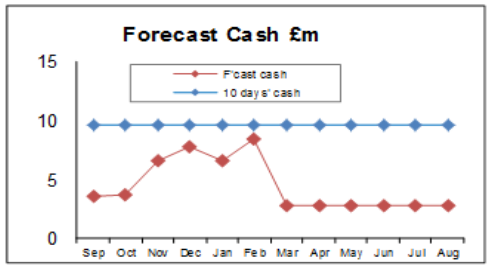
Financial Risk Rating	FY20	3

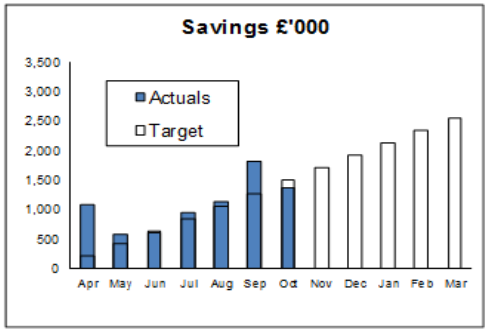


Variances by Division £m

	M7	YTD
Medicine	(0.1)	(1.0)
Unscheduled Care	(0.1)	1.9
Surgery	(0.8)	(3.1)
Women's	0.3	0.2
Clinical Support	(0.2)	(0.4)
Estates & Facilities	(0.1)	(0.6)
Corporate	(0.1)	(1.2)
Other	1.1	4.2
Total	**0.0**	**0.0**







Commentary

- See earlier pages for I&E detail.
- A financial risk rating of 3. Five divisions: Medicine, Surgery, Corporate, CSS and Environment are adverse to budget.
- The Better Practice Payment statistics show 66% on number and 54% on value. This represents a deterioration compared to previous months.
- The cash balance at the end of October was £3.6m.
- Savings were £1.4m in October.

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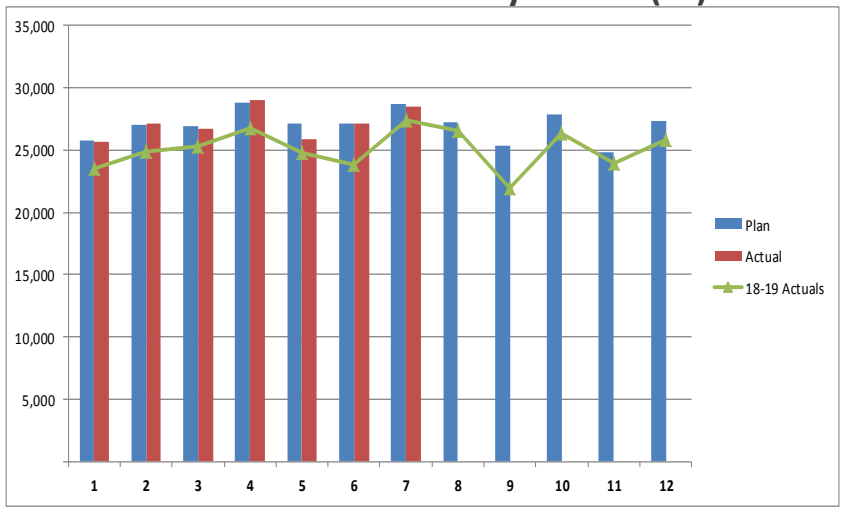
Workforce & Finance: Trust Income - October 2019

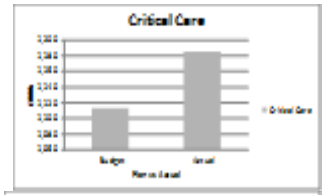
NHS Revenue: Performance by Month (£s)

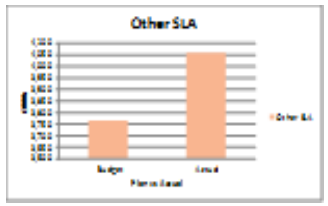


NHS Revenue in October under performed by £227k by delivering £28.5m against a plan of £28.7m.

This can be explained at a point of delivery level:

A&E over performed by £175k which was linked to both an increase in volume and complexity of attendances.
Critical care showed an over performance of £73k. Occupancy levels continue to remain consistent.
Elective performance was £372K away from plan. The underperformance was centered around the surgical division.
For Non Elective the in month position was £594k below plan. £369k of the underperformance was attributed to the Surgery division and represented fewer trauma discharges and general surgery emergencies.
Outpatient performance was £198k better than plan. Over performance within Women and Children (£237k) were partially offset by Surgical division underperformance of 198k.
Finally other SLA income over performed by £293k. An underperformance against pass-through drugs was offset with the wider benefit associated with the minimum income contract.





In Month Performance (£s)

Expense Type	POD	Annual Budget	In Month (£000's) Budget	Actual	Variance
NHS Revenue	A&E	20,052	1,697	1,872	175
	Critical Care	13,147	1,113	1,186	73
	Elective	55,082	5,012	4,641	(372)
	Non elective	117,497	10,358	9,764	(594)
	Other SLA	43,180	3,764	4,058	293
	Outpatient	75,125	6,801	6,999	198
	NHS Rev Unallocated CIPs				
NHS Revenue Total	**Total**	**324,083**	**28,746**	**28,519**	**(227)**

In Month Performance (spells)

Expense Type	POD	Annual Budget	In Month (Activity) Budget	Actual	Variance
NHS Revenue	A&E	124,013	10,533	11,399	866
	Critical Care	21,831	1,907	1,169	-738
	Elective	46,421	4,237	4,050	-187
	Non elective	51,550	4,560	5,295	735
	Other SLA	3,731,065	340,346	362,745	22,399
	Outpatient	453,623	41,257	42,382	1,125
NHS Revenue Total	**Total**	**4,428,503**	**402,840**	**427,040**	**24,200**

Divisional Income

Divisional income showed an under performance of £95k against plan in month. The majority of this is driven by Overseas patients income.
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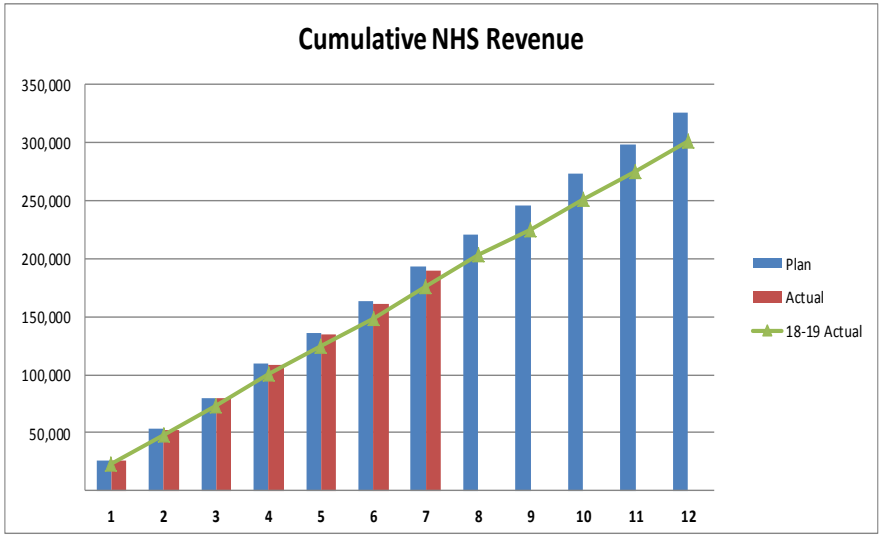
Workforce & Finance: Trust Income - Year to date

NHS Revenue: Performance by Month (£s)



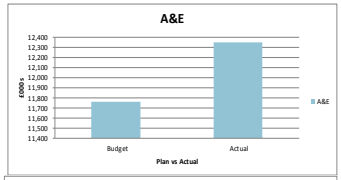
Month 6 YTD Shows Income under recovery of £1.4m. £161.4m has been generated against plan.

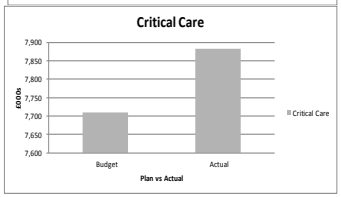
A&E has a YTD over performance of £415k which is linked to a price and volume variance. Critical care is £102k better than plan and has seen an average occupancy rate of 74%. Elective performance is £1,359k away from the YTD plan. This is mostly driven by underperformances across the Surgery division linked to reduced uptake of consultant additional sessions.

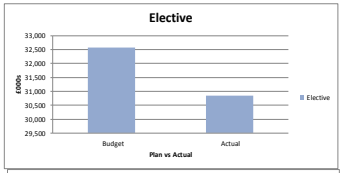
Non Elective activity continues to be the feature of the YTD over performance with a surplus against plan of £1,483k. However, a consistent lower birth rate within maternity is masked within the performance.

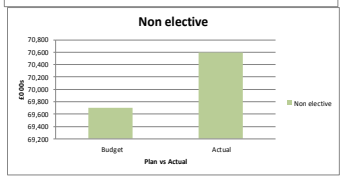
YTD Outpatient performance shows a breakeven position. Combined under performances within Surgery, and Women's of £1,130k are offset by over performances within Medicine (£637k) , Emergency medicine (£88k) and Clinical support (£400k). The impact of QIPP and associated mitigations will play a key role in the Trusts' ability to meet its full year outpatient income target.

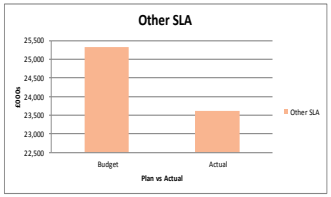
Other SLA income was £2m away from plan. This is mostly driven by lower pass-through drugs and devices which are mostly offset within the non pay position.

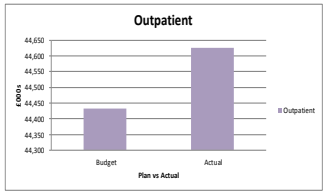












YTD Performance (£s)

POD	YTD (£000's) Budget	Actual	Variance
A&E	11,757	12,347	590
Critical Care	7,709	7,883	174
Elective	32,580	30,849	(1,731)
Non elective	69,705	70,593	888
Other SLA	25,330	23,620	(1,709)
Outpatient	44,431	44,626	194
NHS Rev Unallocated CIPs			
Total	**191,512**	**189,919**	**(1,593)**

YTD Performance (spells)

POD	YTD (Activity) Budget	Actual	Variance
A&E	72,709	77,523	4,814
Critical Care	12,904	8,012	-4,892
Elective	27,447	26,802	-645
Non elective	30,581	32,553	1,972
Other SLA			
Outpatient	268,811	276,225	7,414
Total	**412,453**	**421,115**	**8,662**

Divisional Income

The YTD shows divisional income to be £61k above plan. Despite the overseas patients income in month increased , there was reduced private patient income within cardiology in April.

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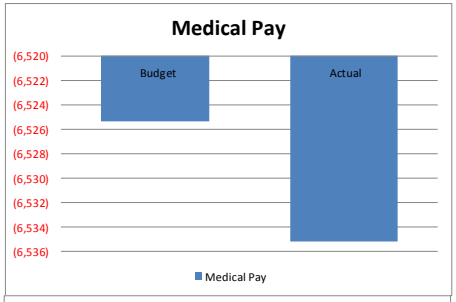
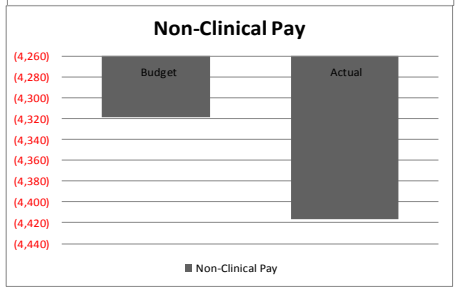
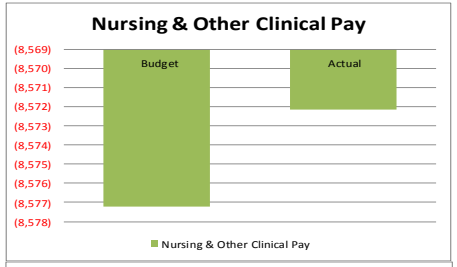
Workforce & Finance: Trust Pay October 2019

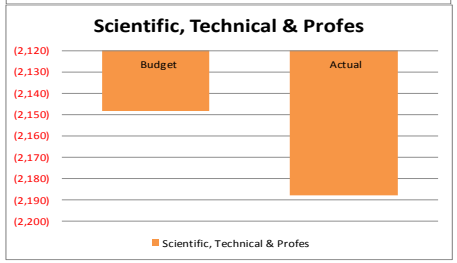
Trust Pay Performance

Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	WTE Budget	Actual	Variance
Medical Pay	(78,763)	(6,525)	(6,535)	(10)	680.98	723.00	-42.02
Non-Clinical Pay	(51,658)	(4,318)	(4,416)	(98)	1,253.57	1,209.77	43.80
Nursing Pay	(75,930)	(6,233)	(6,231)	1	1,619.22	1,635.23	-16.01
Other Clinical Pay	(28,656)	(2,344)	(2,341)	4	1,018.03	999.86	18.17
Scientific, Technical & Profes	(25,811)	(2,148)	(2,188)	(40)	508.64	509.89	-1.25
Pay Unidentified CIPs	3,370	143		(143)	0.00	0.00	0.00
Total	**(257,448)**	**(21,427)**	**(21,712)**	**(285)**	**5,080.44**	**5,077.75**	**2.69**









The Trust reported an in month underperformance of £285k.

The key areas of spend are;

The Medical pay overspent by £10k. Within this it should be noted:

There was a £123k overspend within Emergency Medicine. This is linked to temporary staffing premiums for medical cover within A&E.
This was offset by an underspend within the Surgical division of £106k in month.

Nursing pay performed in line with plan. This was driven by a YTD realignment of budgets between non clinical pay and nursing pay. After allowing for this, Nursing pay is slightly better than trend for the month. The following points should be noted:

The division of Medicine was over spent by £98k. This is attributed to both temporary staffing cover and additional costs relating to outpatient attendances.
The cost for enhanced care nursing was £128k in month which generated a £44k overspend.

Agency premium to cover scientific and professional vacancies across clinical support, theatres and cardiology generates a combined overspend of £40k in month.

The phasing of the CIP target created a negative variance within the pay lines of £143k.

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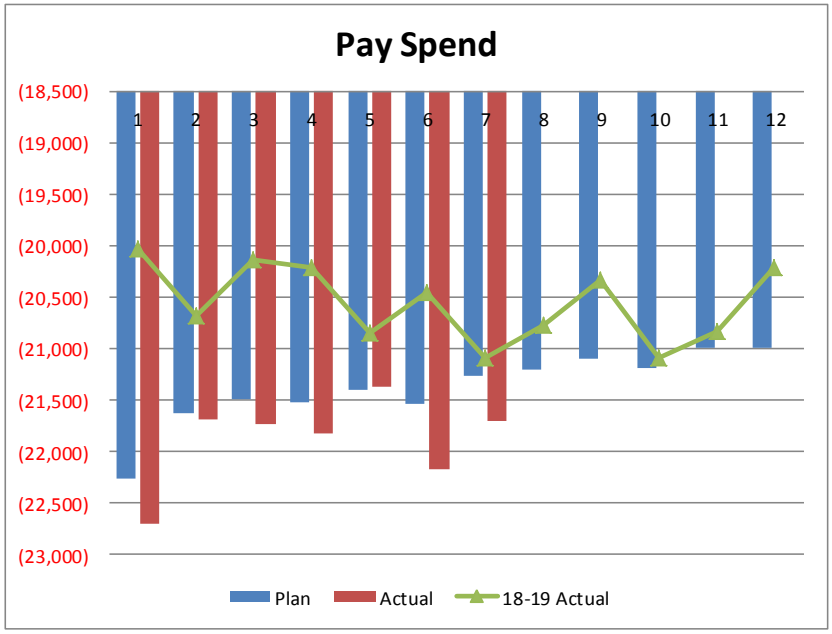
Workforce & Finance: Trust Pay year to date

YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(78,763)	(45,841)	(47,021)	(1,180)
Non-Clinical Pay	(51,658)	(29,521)	(28,638)	883
Nursing Pay	(75,930)	(44,200)	(45,409)	(1,209)
Other Clinical Pay	(28,656)	(16,591)	(16,590)	
Scientific, Technical & Profes	(25,811)	(15,054)	(15,596)	(542)
Pay Unallocated CIPs	3,370	(56)	42	98
	(257,448)	**(151,263)**	**(153,212)**	**(1,949)**



1) The year to date reported position shows an overspend of ££1,949k.

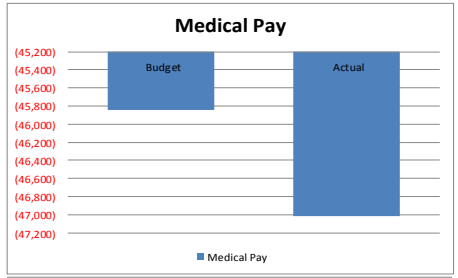
Key year to date themes to note are:

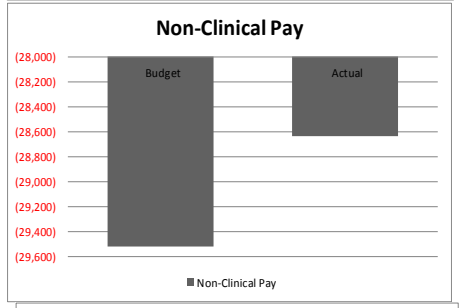
1) Medical pay – is showing an overspend of £1,180k. This is a significant cost pressure for future months and represents agency premium to cover vacancies and pockets of sickness across all divisions. An element of this also related to unfunded posts in relation to winter surge at the start of the year.

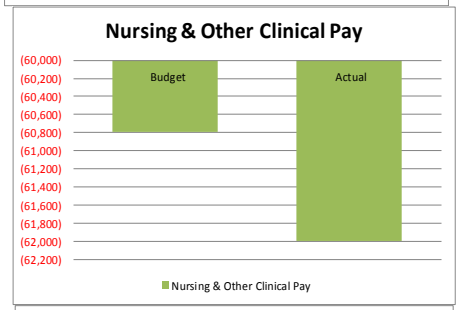
2) Nursing and Other clinical pay combined overspent by £1,209k – The majority of this overspend relates to double running costs associated with qualified nursing. In addition to this, 1:1 nursing care continues to be a key driver for spend. The YTD overspend on 1:1 nursing care is £231k.

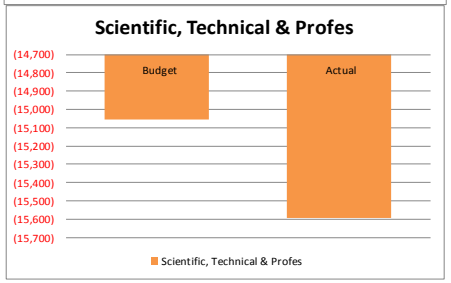
3) Scientific & therapeutic vacancies across clinical support, theatres and cardiology are causing a £542 YTD overspend.

4) The above overspends are buffered by unutilised growth monies sitting on the non clinical pay line.









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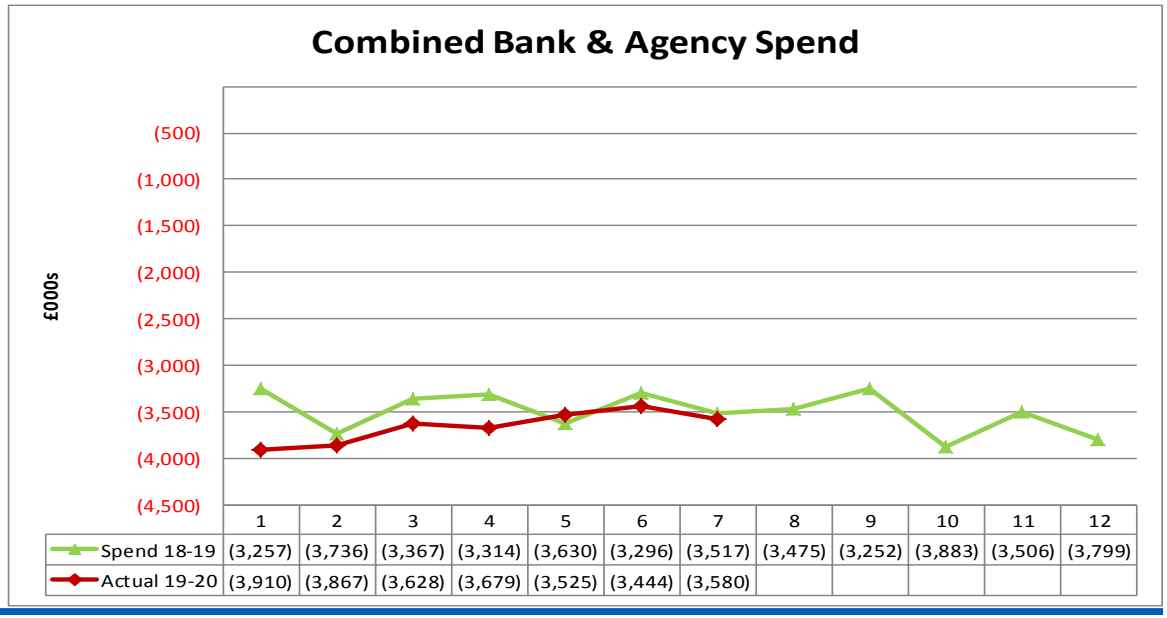
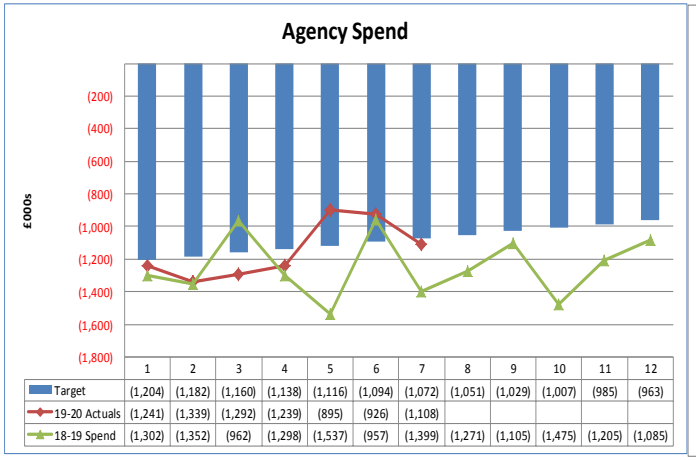
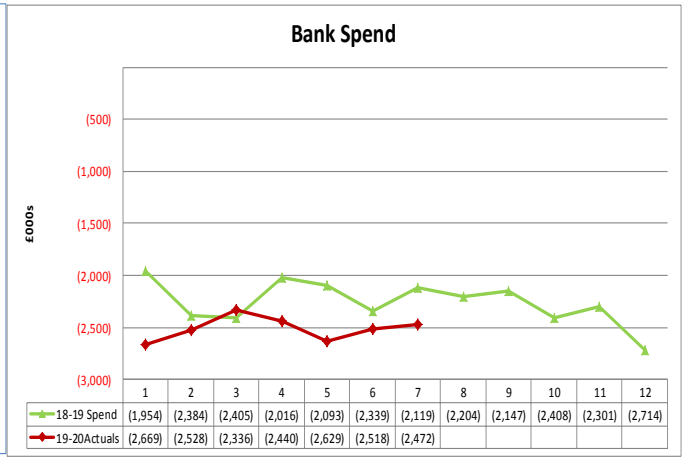
Workforce & Finance: Bank & Agency Spend October 2019



	1	2	3	4	5	6	7	8	9	10	11	12
Spend 18-19	(3,257)	(3,736)	(3,367)	(3,314)	(3,630)	(3,296)	(3,517)	(3,475)	(3,252)	(3,883)	(3,506)	(3,799)
Actual 19-20	(3,910)	(3,867)	(3,628)	(3,679)	(3,525)	(3,444)	(3,580)					



	1	2	3	4	5	6	7	8	9	10	11	12
Target	(1,204)	(1,182)	(1,160)	(1,138)	(1,116)	(1,094)	(1,072)	(1,051)	(1,029)	(1,007)	(985)	(963)
19-20 Actuals	(1,241)	(1,339)	(1,292)	(1,239)	(895)	(926)	(1,108)					
18-19 Spend	(1,302)	(1,352)	(962)	(1,298)	(1,537)	(957)	(1,399)	(1,271)	(1,105)	(1,475)	(1,205)	(1,085)



	1	2	3	4	5	6	7	8	9	10	11	12
18-19 Spend	(1,954)	(2,384)	(2,405)	(2,016)	(2,093)	(2,339)	(2,119)	(2,204)	(2,147)	(2,408)	(2,301)	(2,714)
19-20Actuals	(2,669)	(2,528)	(2,336)	(2,440)	(2,629)	(2,518)	(2,472)					

Agency

The Trust has set an internal target of £13m for 19-20.

This is £1m lower than the internal target set last year and total spend for 18-19 amounted to £14.9m.

Agency expenditure in the month totaled £1.1m. This was lower than the in month target of £1.4m.

YTD the Trust is £0.1m adrift of its internal agency target but well within the ceiling set by NHSI.

Bank

Bank spend for October was £2.5m.

There continues to be a shift from agency to bank as shown by the graphs. However the Trust has spent £0.1m more on bank & agency when compared to the same period last year. Cumulatively, 19-20 spend for temporary staffing is £1.6m higher than the same period last year.

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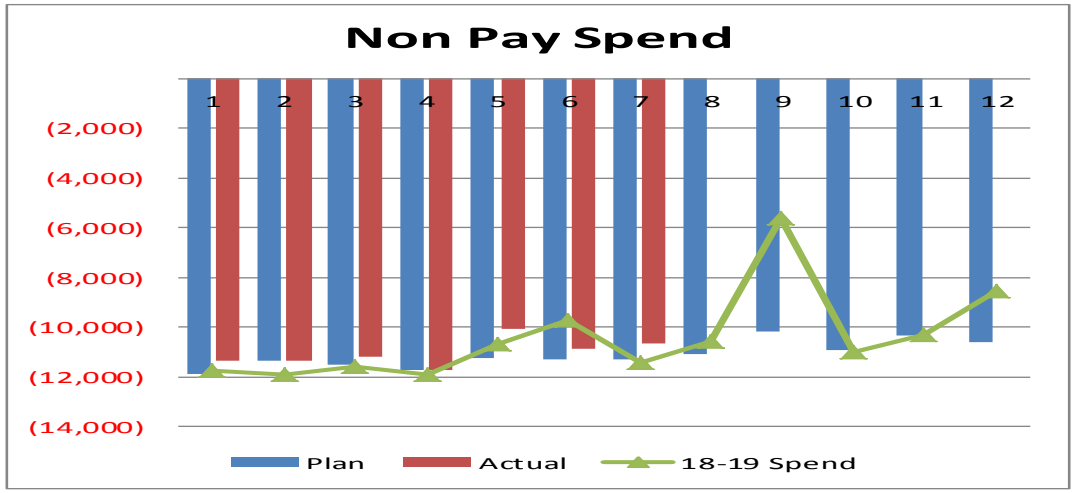
Workforce & Finance: Non Pay October 2019

Non Pay Performance

Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	YTD Budget	Actual	Variance
Clin Supp Serv	(31,038)	(2,836)	(2,554)	282	(18,180)	(17,973)	207
Drugs	(22,476)	(2,136)	(2,016)	119	(13,339)	(12,462)	877
OTHER (NON CLIN)	(81,565)	(6,533)	(6,086)	447	(49,105)	(46,838)	2,267
Non Pay Unallocated CIPS	1,607	142		(142)	(121)		121
Total	**(133,472)**	**(11,363)**	**(10,656)**	**706**	**(80,746)**	**(77,273)**	**3,473**



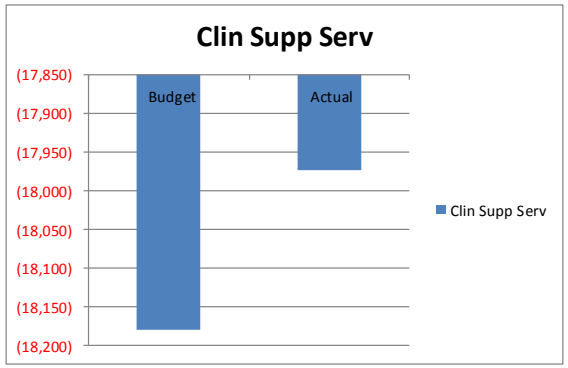
The in month non pay position reported an overspend of £706k. Actual Spend was £10.7m against a budget of £11.3m.

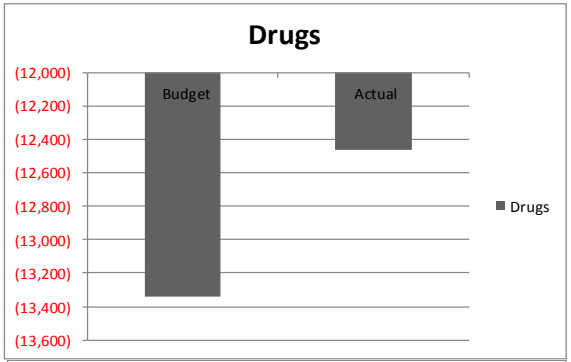
The main drivers of the position include:

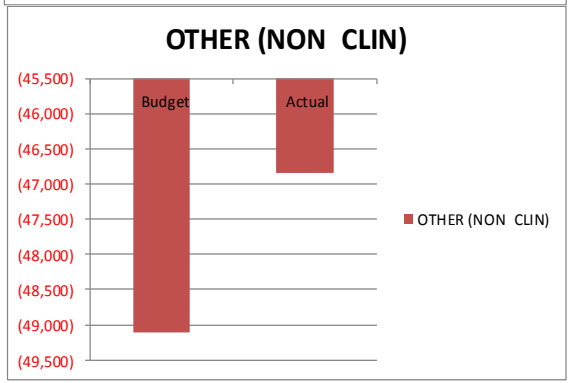
An underspent position against Clinical Supplies of £282k. At a high level, this was volume driven and is linked to the reduced activity levels seen within Surgery,
A £119k underspend against Drugs. The majority of this relates to pass-through items and is offset by income.
A £447k underspend spend on Other Non Clinical. This was mostly attributed to a reduction in the levels of bad debt provision and reduced ICT transition costs in month.

The YTD non pay position shows an underspend of £3.5m. This is driven by lower pass through expenditure on drugs and unutilised growth monies. In addition to this, the prior month release of a central provision, VAT rebates and revenue to capital corrections mask specific non pay challenges that divisions are facing. These are covered by the divisional slides later on in this pack.

YTD Performance







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Workforce & Finance: Efficiency Programme

WHHT - FY20 M7 CIP Efficiency Performance Summary

FY20 M7 Performance - CIP Efficiency Divisional Trust Target	In Month (M7)			Year to Date (M7)			Full Year FY20		
Division	Trust Target £000	Delivery £000	Variance £000	Trust Target £000	Delivery £000	Variance £000	Trust Target £000	Delivery £000	Variance £000
Medicine	377	412	35	1,510	2,295	785	4,206	4,215	9
Emergency Medicine	116	108	(8)	462	770	308	1,287	1,324	37
Surgery & Anaesthetics	400	480	80	1,601	2,480	879	4,461	4,465	4
Womens & Children	166	170	4	665	720	55	1,852	1,618	(234)
Clinical Support	125	107	(18)	500	680	180	1,393	1,137	(256)
Environment	161	19	(142)	645	234	(411)	1,796	370	(1,426)
Corporate	149	93	(56)	598	421	(177)	1,665	646	(1,019)
Trustwide			-			-	-	1,436	1,436
Total	**1,494**	**1,388**	**(106)**	**5,981**	**7,600**	**1,619**	**16,661**	**15,211**	**(1,450)**

FY20 M7 Performance - CIP Efficiency Divisional Control Target	In Month (M7)			Year to Date (M7)			Full Year FY20		
Division	Control Target £000	Delivery £000	Variance £000	Control Target	Delivery £000	Variance £000	Control Target £000	Delivery £000	Variance £000
Medicine	340	412	72	1,359	2,295	936	3,786	4,215	429
Emergency Medicine	104	108	4	416	770	354	1,159	1,324	165
Surgery & Anaesthetics	360	480	120	1,442	2,480	1,038	4,017	4,465	448
Womens & Children	150	170	20	599	720	121	1,668	1,618	(50)
Clinical Support	113	107	(6)	450	680	230	1,254	1,137	(117)
Environment	145	19	(126)	581	234	(347)	1,617	370	(1,247)
Corporate	135	93	(42)	538	421	(117)	1,499	646	(853)
Trustwide		-	-		-	-	-	1,436	1,436
Total	**1,347**	**1,388**	**41**	**5,385**	**7,600**	**2,215**	**15,000**	**15,211**	**211**

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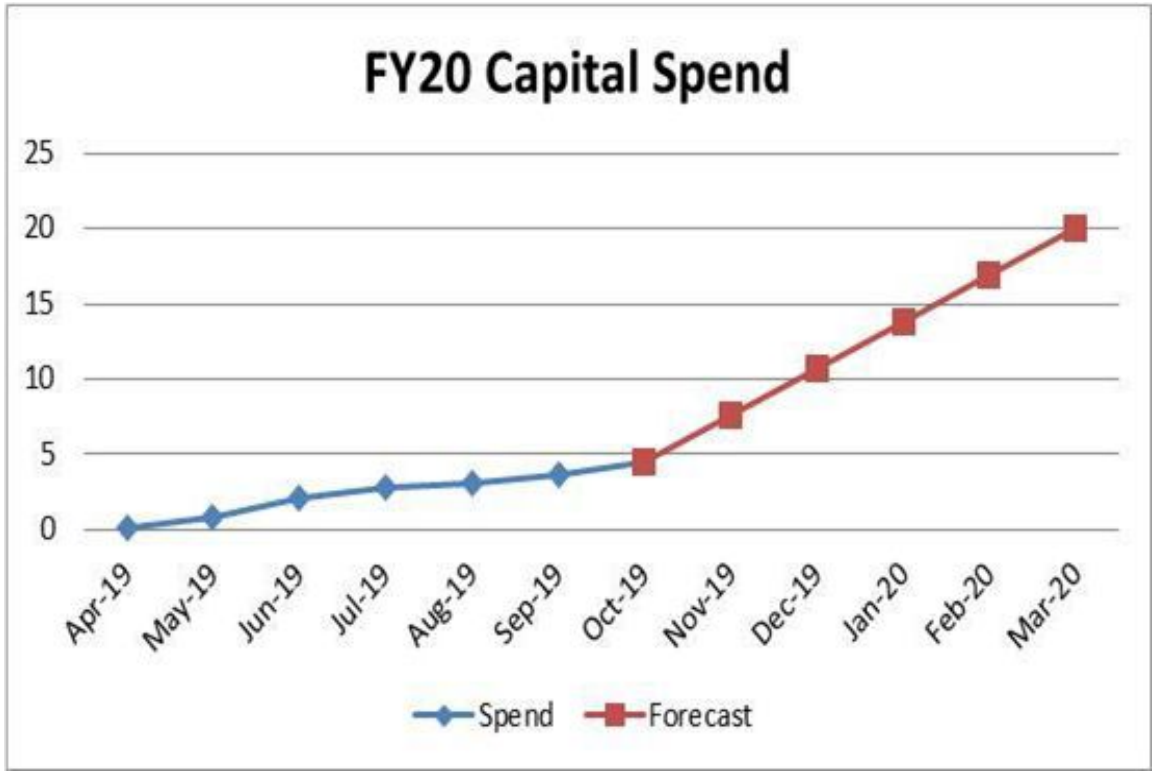
Workforce & Finance: Capital Expenditure October 2019



The Annual Plan for 2019/20 has reverted to £25m with revised capital forecast of £20m.

YTD Capital spend by Scheme

Month	Scheme	Spend (£m)
1	Bought Forward schemes	0.15
	Month 1 Total Spend	**0.15**
2	Your Care Your Future	0.2
2	Winter Pressure	0.2
2	Tactical Servers & NHSMail2	0.1
2	Fire Safety	0.1
2	OCT Scanner and Server	0.1
	Month 2 Total Spend	**0.7**
3	Acute Redevelopment	0.2
3	IT infrastructure	0.8
3	Fire Safety	0.2
	Month 3 Total Spend	**1.2**
4	Your Care Your Future	0.1
4	NHS mail2	0.1
4	Isolation Rooms	0.2
4	Fire Safety	0.2
4	Estates projects	0.1
	Month 4 Total Spend	**0.7**
5	Your Care Your Future & Strategic Estate development	0.05
5	NHS mail2 & Tactical Servers	0.1
5	Isolation Rooms	0.05
5	Fire Safety	0.05
5	UPS Cardiac Cath Lab batteries	0.07
5	Estates projects	0.06
	Month 5 Total Spend	**0.38**
6	Your Care Your Future & Strategic Estate development	0.12
6	IT Cyber Resilience	0.07
6	Fire Safety	0.2
6	Hotwell project	0.05
6	Estates projects	0.03
	Month 6 Total Spend	**0.47**
7	Power Tools for Theatres	0.2
7	Lift 5&6	0.1
7	Fire Safety	0.2
7	Estates projects	0.4
	Month 7 Total Spend	**0.90**

West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

In this reporting period:
The latest available (June 2018 to May 2019) Summary Hospital Mortality Indicator's (SHMI) was 99.23 and within the 'as expected' range (band 2). SHMI data had a new baseline calculated in May and the Trust has been informed by Dr Foster that this increased all trusts SHMI by approximately 3%. For the 12 month period (July 2018 to August 2019), the Trust's overall HSMR of 100.7 was in the 'as expected' range.

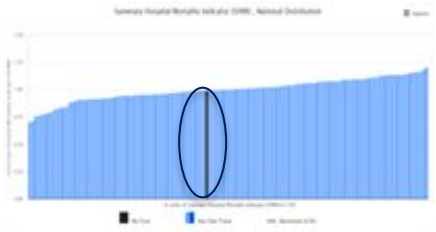
Factors / Themes:
A case note deep dive review is undertaken for each 'outlying' primary diagnostic SMR group with a speciality or senior trust consultant and the coding manager.

Next steps:
Monthly specialty/departmental Mortality Review meetings continue, cases from which are then referred for Structured Judgement Review in accordance with criteria described in the Trust's 'Learning From Deaths' policy.

A large percentage of cases are now being referred in a timely way by the Medical Examiners and the backlog of SJRs is being worked through and with more training on SJR scheduled for July . This will increase the available pool of SJR reviewers.

Performance improved
Better than target/threshold

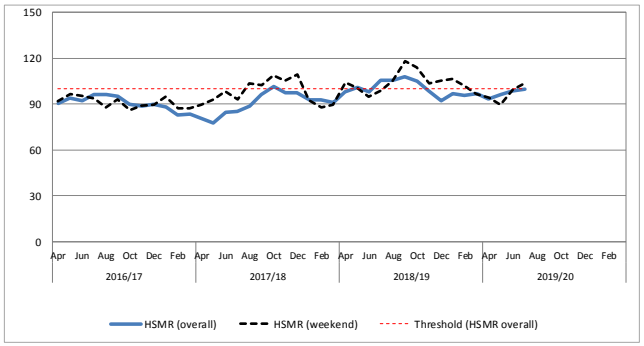
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



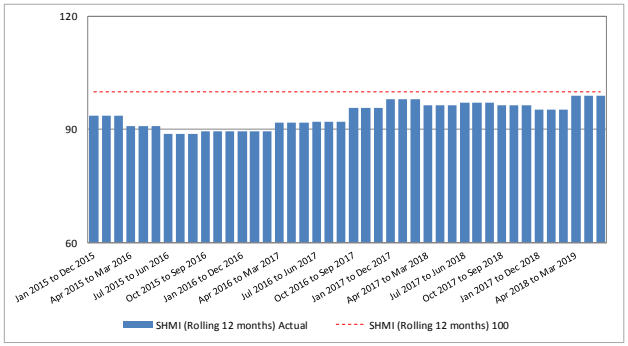
Period: 31/04/19

WHHT 0.99 **Sector: 1.00**

HSMR – rolling 3 months



SHMI – rolling 12 months



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee		

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Safe care & Improving Outcomes: Infection Control (1 of 2)

In this reporting period:
Clostrioides (previously Clostridium) *difficile* Infection (CDI)
Clostrioides infection objectives for 2019/20 are based on a new criteria for apportioning of cases; this system commenced on 1 April 2019: Hospital onset healthcare associated – cases detected 2 days or more after admission (cat 1). Community onset healthcare associated – cases that occur in the community that have had a hospital admission/inpatient in the previous 4 weeks (cat 2). Community onset indeterminate association – cases detected in the community when a patient has had an admission or been an inpatient in the previous 12 weeks but not the most recent 4 weeks (cat 3). Community onset community associated – cases that occur in the community when the patient has not had an admission or been an inpatient in the previous 12 weeks (cat 4). Objectives for acute providers are based on the first 2 categories and the Trust has a trajectory of no more than 34 cases with identified lapses in care for the full year. The IPC Team has developed and implemented a CDI action plan, which includes data review and visits to clinical areas to support the meeting of the new CDI objectives. In October, 2 x cat 1 cases and 1 x cat 2 case. Monthly RCA meetings are undertaken with community and CCG colleagues, appeals for lapses in care were also undertaken. Six cases were successful at the November appeal meeting,, plus one will be removed from the figures, bringing our total appeals to 25 cases with no lapses in care identified.

MRSA bacteraemia (MRSAb): There is no formal target set for MRSAb, a zero tolerance approach is in place. No cases of MRSAb were identified in October.

Factors / Themes:
All CDI cases are now having an individual review meeting, in addition to the monthly meeting with the CCG. Learning from all CDI cases are included in action plans and fed back to the IPC panel. CDI management and awareness continues, including deliver weekly CDI power training to embed compliance with the learning from the RCA reviews. Divisional governance meeting were attended to feedback on CDI and support division to deliver local actions to improve CDI management. Matron's meeting attended to provide divisional support with RCA and action plans from IPC. CCG CDI Deep dive review undertaken, which found that overall our CDI management was good and not many had lapses in care, which provided good oversight and assurance the CCG IPC team.

Next steps: Areas for continued improvement are: antimicrobials, CDI policy, cleaning /products, relapses, internal transfers and working with GPs.

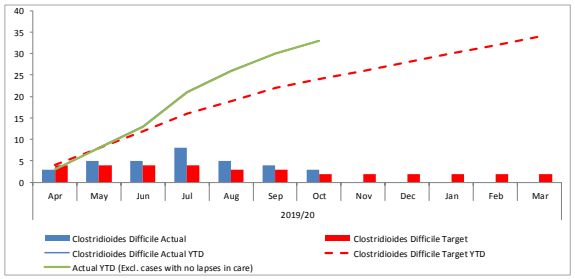
Performance stable
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Rolling 12 month trust apportioned Cdiff infections / 12 month avg occupied bed days

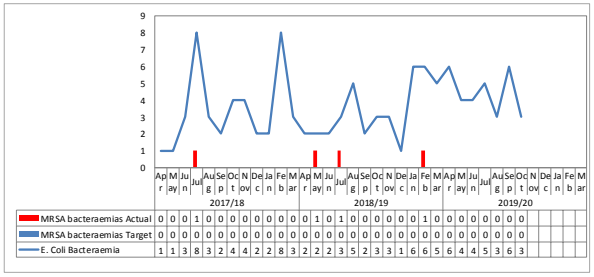
Period: to March 2019
WHHT 6.42 Peer 13.68
National 11.11

(Peers = Nightingale Group – acute multi-site trusts)

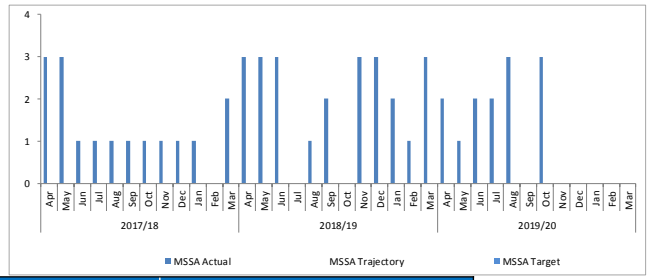
Clostrioides Difficile Infection (CDI)



MRSA



MSSA



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee		

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Safe care & Improving Outcomes: Infection Control (2 of 2)

In this reporting period:

***E. Coli bacteraemia* (E colib)**

There were 3 post-48hr (trust apportioned) cases and 25 pre-48 hour cases (non-trust) reported in October. There is no target for the trust but the national target is to deliver a 50% reduction by 2021, and this is set as a quality indicator with the CCG. Thematic data is gathered for post-48 hour cases and reviewed alongside microbiology review of the pre-48 hour cases. Broader work with partner other organisations, which includes a 90 day quality improvement project which was completed in October 2019, with representation from 2 wards from WHHT. The work looked at improving hydration in patients and the prevention of UTIs. Our new antimicrobial pharmacist is now in post and will lead a programme on improving antimicrobial stewardship, which aims at reducing gram-negative resistance.

***Methicillin-sensitive Staphylococcus aureus* (MSSAb)**

There were three post-48 hour (trust apportioned) cases and five pre-48 hour (non-trust) cases of MSSAb reported in October. Each case is reviewed by a microbiologist using an RCA tool to identify and share learning. Our new antimicrobial pharmacist will contribute to this work.

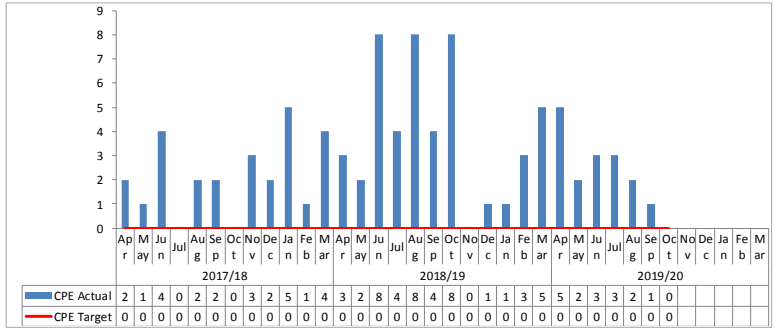
Infection Prevention Control (IPC) Progress Update

The IPC Code of Practice (CoP) audits continues. The IPCT provide ward-based support for areas that have not met the required audit standards. Scores below 80% are escalated to departmental leads, divisional senior teams and the DIPC. During October work on the use of PPE, hand hygiene practices, ANTT, Sharps, Chlorclean and environmental review occurred. CoP audits are undertaken by IPC, wards and department, who are reminded to complete their COP audits on alternative months and update the IPC dashboard. The top COP and IPC audits themes continues to include the need to focus on cleaning of equipment such as chairs, fans and commodes, antibiotic review and the use of Chlorclean. Meetings are held with matrons to discuss measures to improve these areas. Following the review of the cluster of Serratia & Pseudomonas in Endoscopy, there were no non-compliances/failings identified. Scope 17 which is involved was sent for full examination , the was de-escalated from a SI to a divisional RCA following presentation at the SI panel. There is continued monitoring of water quality, ventilation, decontamination, antimicrobial stewardship and cleaning across the trust.

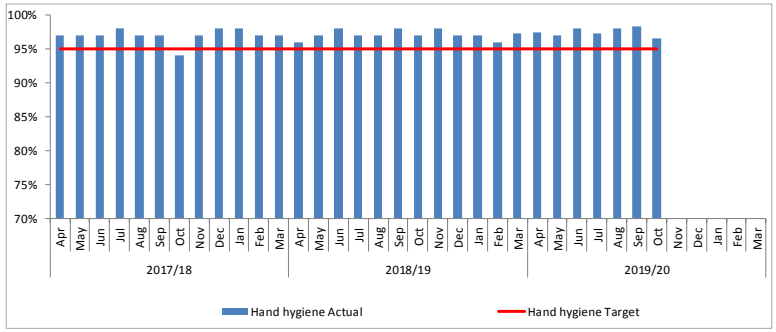
Factors / Themes: IPC monitoring of alert organisms is time consuming, increased ownership is required for IPC ensuring this is everyone business. Continued effort is required to improve environment al cleaning compliance , sharps and waste management in some areas.

Next steps: The 'Glove Factor' campaign is in progress to raise awareness with compliance with PPE. All divisions have now agreed to develop one divisional action plan for IPC where the top 5 five learning from audits are identified and addressed. Daft the business case for electronic IPC monitoring commenced . Weekly senior environmental walk around and Increase IPC engagement in progress.

Carbapenemase-producing Enterobacteriaceae (CPE)



Hand hygiene compliance



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee		

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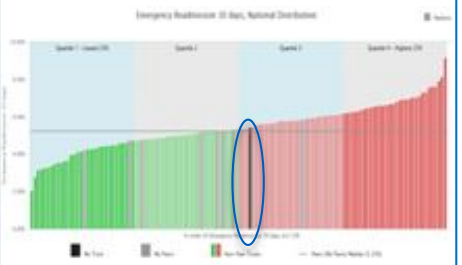
Safe care & Improving Outcomes: Emergency Readmissions

In this reporting period:
The readmission rate, benchmarked against the most up to date national position (April 2019) was better than the national average overall, and for readmissions following an elective and emergency (original) admission.

Factors / Themes:
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.

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Readmission 30 days

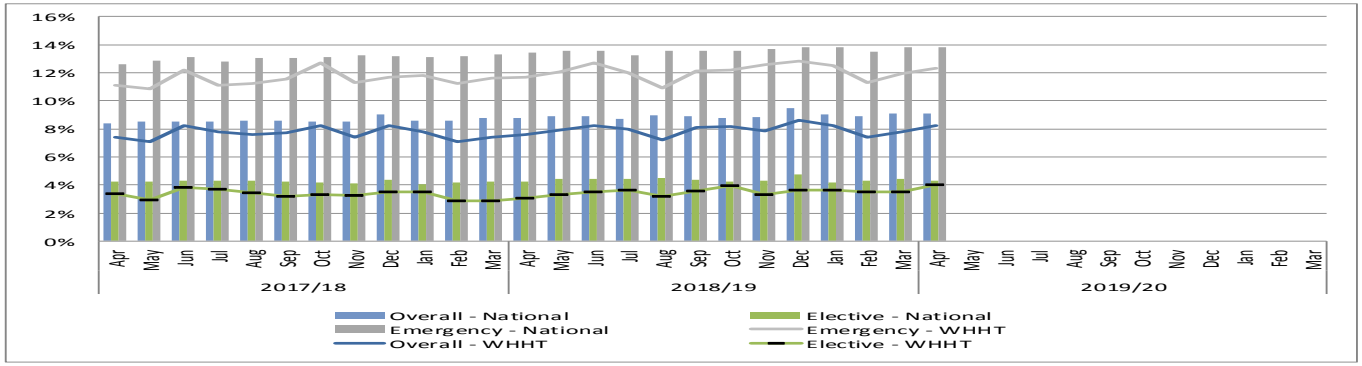


Period: Q2 2019/20

WHHT 5.43% Peer 5.23%
National 5.36%

(Peers = Nightingale Group – acute multi-site trusts)

Emergency Readmissions



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee		

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Safe care & Improving Outcomes: Caesarean Section rates

C-section rate
The daily Caesarean Section review is taking place, with learning in a more consistent manner and with time there should be a reflection on the trajectory of the Emergency Caesarean Section rate.

Next steps:

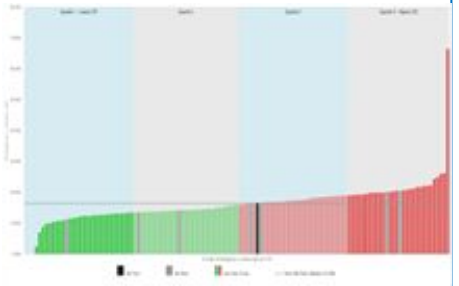
1. Continuous monitoring of data.

2. Scrutiny of the findings of the Caesarean section deep dive to identify the group of women who contribute to the preventable caesarean sections.

3. Daily reviews continue and trends identified.

Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate

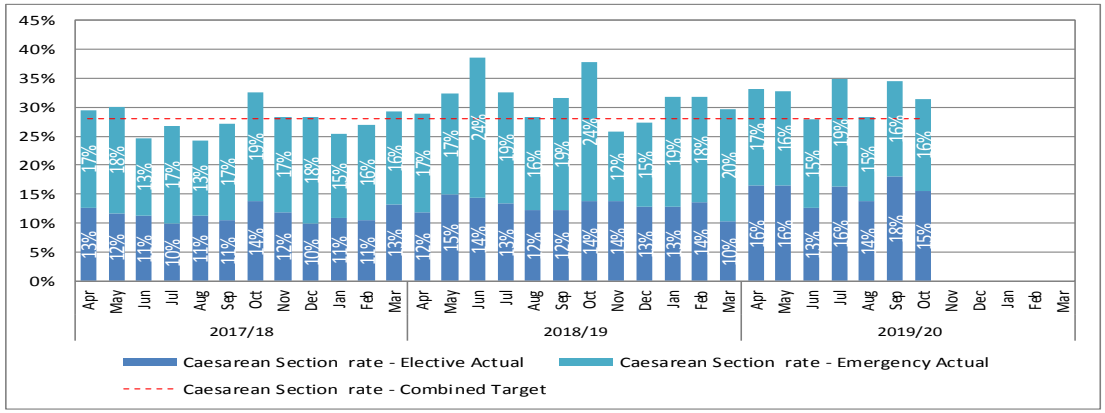


Period: September 2019

WHHT 16.71 Peer: 16.38%
National: 16.09%

(Peers = Nightingale Group – acute multi-site trusts)

Caesarean section rate



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee		

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Safe care & Improving Outcomes: Workforce and CHPPD

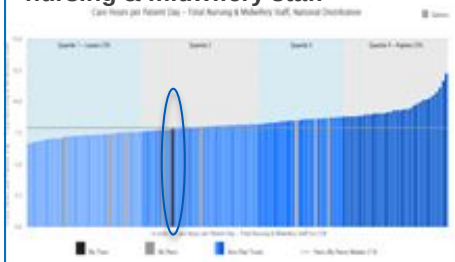
In this reporting period:
Overall fill rate was 103%, above the national threshold of 95%. This equates to 100.1% registered and 100.2% unregistered. 72.6% shifts were RAG rated green, 27.4% shifts were rated amber and 0% rated red.
The current 0% band 5 vacancy rate in adult ward nursing, with turnover at 15.5%, demonstrates a clear correlation between recruitment strategy and good grip and control from ward leaders, matrons and HONs/Midwifery. There were no red flags relating to shifts with less than 2 RNs identified., 3 shifts were reported with 8 hours less than planned. When a NICE 2017 red flag relating to staffing is recorded on safe care the ward manager and matron are alerted and mitigations recorded on safe care and if necessary a datix completed. These are also reported and discussed at the monthly workforce meetings. Ward leaders have to balance supervision with safety of the ward; within the month the supervisory time was 72.4% indicating the majority of their time was focused on promoting patient safety, developing/supporting junior staff and managing the ward. The other 27.6%, is deployed to clinical time supporting safe staffing. Safe Care % utilisation – Of the 31 inpatient areas, 3 had fill rates below 90%. (range: 87.6% - 88.8%). Senior staff attend the daily operational meeting and provide assurance around safe staffing and mitigations taken, including staff redeployment. Staff also report any quality or patient safety issues incurred from staffing decisions made the previous day. Bank and agency requested hours was 62,572 hours with a fill rate of 88.4%; (74.4% bank and 10.9% agency). A number of escalation beds were open - the highest utilisation being 14 August when there were an additional 36 beds open across seven areas, all requiring staff. All shifts requested within hours are have to be authorised by Head of Nursing or Matron and out of hours by the senior nurse in discussion with on call manager. Enhanced care team usage in August was 762 shifts (8766.55hours). CHPPD is currently 7.89 a slight decrease of 0.01 from last month.

Factors / Themes:
For N&M staffing the Trust continues to positively benchmark for CHPPD against our peers on Model Hospital

Next steps:
- ESRGo Project –Pre Prod testing took place on 28 August, additional grade mappings required which have now been completed.
- February Adult Establishment Review Report to be presented to Trust Board in September for assurance.
- Paediatric Establishment review sign off scheduled for September.
- Updated CHPPD National Guidance released which now includes a new requirement for nursing associates and allied health professionals who are rostered in the in-ward establishment to be included as part of CHPPD daily data return via Safe Staffing Strategic Data Collection. Data has been provided and has not impacted on CHPPD.
- Agency and bank usages reviewed by the Chief Nurse, Deputy Chief Nurse and HON/DOM; decision that keys to be placed on all CSW and Band 5 RN shifts from 1st August . Controls and escalation process in place and evaluated in September 2019.
- Due to intelligence gathered a recruitment event is planned in Ireland and will focus on midwifery, paediatric nursing and theatres.
- DHSC has committed to £7 million of capital funding. Bidding is now open to accelerate NHS Providers' utilisation of workforce deployment systems , WHHT submitted a bid in September for Nursing, Midwifery and AHP.

Performance stable
Better than target/threshold

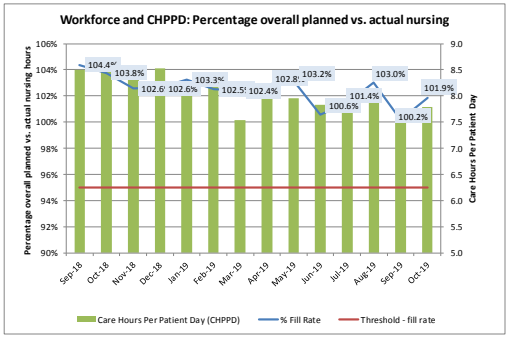
Benchmarking: MODEL HOSPITAL
Care hours per patient day – total nursing & midwifery staff



Period: Jul 2019

WHHT: 7.9 **Peer: 7.9**
National: 8.2

(Peers = Nightingale Group – acute multi-site trusts)



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee		

11

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Ward scorecard: themes from adult IP scorecard & Safety Thermometer

Analysis

Safety Alerts – in October there were 49 safety alerts. Falls with harm and pressure ulcers are the main cause of the safety alerts. As per detailed slide on Pressure ulcers numbers have decreased since last month, however the prevalence is above the national average according to the Safety thermometer.

Process Alerts: In October there were 66 process alerts compared with 62 in September.
Supervisory time scored (21/29 process errors), FFT responses (14/32 process errors) and commode audit(13/27 process errors) were key areas of under performance.

Divisional Nurse Summit meetings continue within medicine, surgery and emergency medicine. Quality Improvement Forum continues to identify, support and guide **quality** initiatives; all matrons now attend.

Next Steps

1. Increased ward based teaching on assessments with clinical staff
2. National Pressure ulcer collaborative on-going on Croxley and Tudor ward
3. Swarming to be introduced to the Trust using a QI approach starting October 2019- first swarm has not yet been assembled, as no falls occurred in pilot site.
4. VTE section added to the discharge checklist.
5. Through the new E Coli steering group – work streams have been instigated to analyse the high use of urinary catheters, use of catheter passports, education and training.
6. MUST training e-learning module developed. Nutrition CNS working with the Sisters to increase uptake of training. Planned collaborative working with the dieticians
7. Harm Free Study Days continued to support nurse development and learning
8. Trial of different style night lights has started.
9. 9 Divisional Nurse Summit to explore the supervisory time scores.

All data is taken to the Quality Improvement Forum (QIF) to drive learning, innovation and improvement. At this forum the wards needing support are identified.

A senior team is then tasked with supporting the clinical area. Sarratt ward was the first clinical area to undergo this process, and continues to be supported. Winyard ward is now receiving targeted support in relation to falls and pressure ulcers. Tudor and Castle Quality improvement work commenced in January 2019 and is ongoing.

Evaluation

- Clinical areas are demonstrating reduction in safety alerts for the third consecutive month
- For falls the safety thermometer data is lower than national average. For HAPU the Trust is above the National average on the Safety Thermometer
- Tissue viability and falls remain a focus within Divisions.

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Ward Scorecard

Ward Scorecard October 2019

Alert Trigger Point		<90%	<90%	<90%	<90%	>0	n/a	n/a	>4	>0	<90%	<90%	>0	>0	>0	<90%	<35%	>0	>1	<90%	<95%	n/a	Number of Alerts	
Number of Alerts	Process	4 / 27	0 / 21	3 / 29	1 / 25						13 / 27	5 / 34					14 / 32		1 / 31	21 / 29	4 / 30	n/a		
	Safety					15 / 34	n/a	n/a	6 / 27	10 / 27			3 / 34	8 / 34	2 / 34	4 / 33		1 / 31						
Division	Ward	Patient Experience	Matron Quality Checks/Staff	TYC Overall	TYC/TVN section	Pressure ulcers cats 2,3 & 4	Pressure ulcers cat 1	Pressure ulcer SDTI	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital acquired C.diff	Hospital acquired MRSA isolate	Hospital aquired Ecoli	% Extremely Likely>90	FFT Response IP 35% Paeds/Mat 25% ED 10%	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	✓ 100%	✓ 92%	✓ 95%	✓ 100%	✓ 0	0	1	! 1	✓ 0	! 75%	✓ 100%	✓ 0	✗ 1	✓ 0	✓ 100%	✗ 13%	✓ 0	✓ 0	✗ 52%	✓ 100%	8.51	1	3
	AAU G1	✓ 94%	✓ 97%	✓ 93%	✓ 94%	✓ 0	4	0	✗ 5	✗ 1	! 75%	✓ 100%	✓ 0	✗ 1	✓ 0	✓ 100%	✗ 17%	✓ 0	✓ 0	✗ 65%	✓ 100%	8.68	3	3
	AAU P1	✓ 96%	✓ 99%	✓ 94%	✓ 100%	✗ 1	1	1	! 4	✓ 0	! 75%	✓ 95%	✓ 0	✓ 0	✓ 0	✓ 90%	✗ 10%	✓ 0	✓ 0	✗ 30%	✓ 99%	8.90	1	3
	AAU Y1	✓ 93%	✓ 100%	✓ 97%	✓ 100%	✓ 0	0	0	! 2	✓ 0	! 75%	✓ 100%	✗ 1	✗ 1	✓ 0	✓ 100%	✗ 18%	✓ 0	✓ 0	! 78%	✓ 102%	9.15	2	3
Medicine	AAU B/Y 3	! 89%	✓ 90%	! 85%	✓ 93%	✗ 1	0	0	✗ 8	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 91%	✓ 81%	✓ 0	✓ 0	✓ 91%	✓ 103%	7.28	3	2
	Frailty	✓ 100%	✓ 100%	NA	NA	✓ 0	0	0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 97%	! 34%	✓ 0	✓ 0	NA	NA	NA	0	1
	CCU/ P/G 3	✓ 98%	✓ 92%	✓ 98%	✓ 100%	✓ 0	0	0	✓ 0	✓ 0	✗ 67%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 94%	✓ 50%	✓ 0	✓ 0	! 87%	✓ 98%	6.66	0	2
	Aldenham	NA	✓ 95%	✓ 95%	✓ 94%	✗ 1	0	0	! 4	✗ 1	✓ 100%	✓ 98%	✓ 0	✓ 0	✓ 0	✓ 95%	✓ 41%	✓ 0	✓ 0	✗ 65%	✓ 105%	7.19	2	1
	Bluebell	NA	✓ 98%	✓ 95%	✓ 95%	✗ 1	0	0	✗ 7	✗ 2	✓ 100%	✗ 63%	✓ 0	✓ 0	✓ 0	✓ 100%	! 30%	✓ 0	✓ 0	! 85%	✓ 98%	11.33	3	3
	Cassio	✓ 93%	✓ 100%	✓ 97%	✓ 96%	✓ 0	0	0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 94%	✓ 74%	✓ 0	✓ 0	✗ 65%	✓ 103%	5.39	1	1
	Croxley	✓ 96%	✓ 100%	✓ 91%	✓ 100%	✗ 3	0	0	! 3	✗ 1	✗ 50%	✓ 93%	✗ 1	✓ 0	✓ 0	! 78%	✗ 23%	✓ 0	✓ 0	! 83%	✓ 102%	6.55	4	3
	Heronsgate & Gade	✓ 94%	✓ 98%	✓ 95%	✓ 97%	✗ 1	0	0	✗ 8	✗ 2	✗ 50%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 99%	✓ 87%	✓ 0	✓ 0	✓ 96%	✓ 104%	6.43	3	1
	Oxhey	✓ 96%	✓ 100%	✓ 96%	✓ 98%	✓ 0	0	1	! 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✗ 2	✓ 0	✓ 100%	✓ 42%	✓ 0	✓ 0	✗ 74%	! 92%	5.87	1	2
	Red	! 86%	✓ 95%	✓ 96%	✓ 97%	✗ 1	0	1	! 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 20%	✓ 0	✓ 0	✗ 74%	✓ 102%	6.06	1	3
	Sarratt	✓ 94%	✓ 97%	✓ 98%	✓ 100%	✗ 1	0	1	✗ 7	✗ 2	✓ 100%	✓ 96%	✓ 0	✓ 0	✗ 1	✓ 96%	! 33%	✓ 0	✓ 0	✗ 61%	✓ 110%	7.37	4	2
	Simpson	NA	NA	✓ 100%	✓ 100%	✓ 0	0	0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	NA	NA	NA	0	0
	Stroke	✓ 99%	✓ 94%	✓ 93%	✓ 94%	✗ 2	0	0	! 2	✓ 0	✗ 67%	✓ 100%	✓ 0	✗ 2	✓ 0	! 89%	✓ 56%	✓ 0	✗ 1	✗ 17%	✓ 103%	8.11	3	2
	Tudor	✓ 96%	✓ 100%	✓ 92%	✓ 97%	✓ 0	0	0	✗ 5	✓ 0	✓ 100%	! 89%	✓ 0	✓ 0	✓ 0	✓ 99%	✓ 59%	✓ 0	✓ 0	✗ 52%	✓ 115%	7.56	1	2
	Winyard	✓ 96%	✓ 97%	! 86%	✓ 94%	✗ 1	0	2	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 90%	✓ 37%	✓ 0	✓ 0	✓ 100%	✓ 113%	6.60	1	1
Surgery	Cleves	✓ 92%	NA	✓ 100%	✓ 100%	✗ 1	0	0	! 2	✓ 0	✓ 100%	! 82%	✓ 0	✓ 0	✗ 1	✓ 98%	✓ 51%	✗ 1	✓ 0	! 85%	✓ 100%	6.16	3	2
	DLM	✓ 100%	✓ 100%	✓ 96%	✓ 100%	✓ 0	0	0	! 2	✗ 1	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 98%	✓ 52%	✓ 0	✓ 0	✓ 100%	✓ 99%	12.36	1	0
	Flaunden	✓ 93%	NA	✓ 97%	✓ 100%	✗ 1	0	2	! 1	✓ 0	✗ 0%	✓ 100%	✓ 0	✓ 0	✓ 0	! 87%	✓ 44%	✓ 0	✓ 0	✗ 70%	✓ 97%	6.66	2	2
	ICU	✓ 100%	✓ 91%	NA	NA	✗ 1	0	0	✓ 0	✓ 0	✗ 50%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 2%	✓ 0	✗ 2	✓ 100%	✓ 100%	18.25	1	3
	Langley	✓ 100%	NA	✓ 100%	✓ 100%	✓ 0	0	0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✗ 2	✓ 0	✓ 97%	✓ 65%	✓ 0	✓ 0	! 80%	✓ 130%	6.70	2	1
	Letchmore	! 81%	NA	NA	NA	✗ 2	0	0	! 2	✓ 0	✓ 100%	! 80%	✓ 0	✓ 0	✓ 0	✓ 92%	✓ 36%	✓ 0	✓ 0	✗ 51%	✓ 112%	6.68	1	3
	Ridge	! 80%	NA	✓ 97%	✓ 98%	✗ 2	0	0	! 1	✓ 0	✗ 50%	✓ 100%	✗ 1	✓ 0	✓ 0	! 84%	✓ 49%	✓ 0	✓ 0	✗ 70%	✓ 100%	6.11	3	3
	Elizabeth	✓ 98%	NA	✓ 96%	✗ 64%	✓ 0	0	0	✓ 0	✓ 0	✗ 67%	✓ 100%	✓ 0	✗ 2	✓ 0	✓ 98%	✗ 17%	✓ 0	✓ 0	✓ 90%	✓ 101%	5.61	1	3
Paeds	SCBU	✓ 98%	NA	✓ 99%	✓ 100%	✓ 0	0	0	NA	NA	NA	! 86%	✓ 0	✓ 0	✓ 0	✓ 96%	✓ 50%	✓ 0	✓ 0	✓ 100%	✓ 103%	12.62	0	1
	Starfish	NA	NA	NA	NA	✓ 0	0	0	NA	NA	✗ 0%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 4%	✓ 0	✓ 0	! 84%	✓ 98%	8.91	0	3
	CED	NA	NA	✓ 93%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 94%	✗ 2%	✓ 0	✓ 0	✓ 100%	NA	NA	0	1
	Safari	NA	NA	✓ 97%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 96%	! 21%	✓ 0	✓ 0	! 84%	NA	NA	0	2
Maternity	Delivery Suite	✓ 99%	NA	! 85%	NA	✓ 0	0	0	NA	NA	NA	✓ 94%	✓ 0	✗ 1	✓ 0	✓ 97%	✓ 52%	NA	NA	NA	! 94%	23.83	1	2
	Katherine	NA	NA	✓ 96%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 93%	NA	NA	NA	NA	✗ 84%	5.18	0	1
	ABC	✓ 99%	✓ 100%	NA	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 97%	✓ 52%	NA	NA	NA	! 91%	22.58	0	1
Green		>=90	>=90	>=90	>=90	0	n/a	n/a	0	0	>=90	>=90	0	0	0	>=90	IP 35%	0	0	>=90	>=95	n/a		
Amber		80-89	80-89	80-89	80-89	n/a	n/a	n/a	1-4	n/a	80-89	80-89	n/a	n/a	n/a	80-89	Paeds/	1	n/a	75-89	90-94	n/a		
Red		<=79	<=79	<=79	<=79	>=1	n/a	n/a	>=5	>=1	<=79	<=79	>=1	>=1	>=1	<=79	Mat 25%	>=2	>=1	<=74	<=89	n/a		

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West Hertfordshire Hospitals NHS Trust

Ward Scorecard (Other/ Non Adult Inpatient)

Ward Scorecard (Other/ Non Adult Inpatient) October 2019

Alert Trigger Point		<90%	<90%	<95% <92%	>8%	<95%	<95%	N/A	N/A	>0	<95%	>9%	<95%	<90%	<35%	Number of Alerts (WIP)	
Number of Alerts	Process	4 / 22	1 / 17	8 / 18	6 / 13	0 / 13	6 / 12	TBC	TBC	1 / 33	16 / 27	17 / 27	18 / 27		11 / 14		
	Safety													5 / 27			
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 IP 35% Paeds/Mat 25% ED 10%	Safety	Process
Unscheduled Care	A&E	✓ 90%	NA	✗ 75.0%	NA	NA	NA	319	0	✓ 0	! 90%	✗ 14%	! 92%	✓ 98%	✗ 1%	0	5
	MIU	NA	✓ 100%	✓ 100.0%	NA	NA	✓ 100%	21	0	✓ 0	! 94%	✗ 27%	✗ 80%	! 86%	! 6%	1	4
	UCC	✓ 95%	✓ 100%	✓ 99.7%	NA	NA	NA	21	0	✓ 0	✓ 97%	✓ 7%	✓ 100%	! 89%	✗ 5%	1	1
Paeds	SCBU	✓ 99%	! 86%	NA	NA	! 97%	✓ 97%	22	0	✓ 0	! 92%	✗ 33%	✓ 100%	✓ 96%	✓ 50%	0	3
	Starfish	NA	✓ 100%	NA	NA	! 98%	✗ 88%	13	0	✓ 0	✗ 86%	✗ 14%	! 91%	✓ 100%	✗ 4%	0	5
	CED	✓ 93%	✓ 100%	NA	NA	! 98%	NA	12	0	✓ 0	! 93%	✗ 20%	! 94%	✓ 94%	✗ 2%	0	4
	Safari	✓ 97%	✓ 100%	NA	NA	NA	NA	1	0	✓ 0	✗ 84%	✗ 14%	✓ 100%	✓ 96%	! 21%	0	3
Maternity	Delivery Suite	! 85%	✓ 94%	NA	NA	✓ 99%	✗ 83%	63	0	✓ 0	✓ 96%	✓ 8%	✗ 77%	✓ 97%	✓ 52%	0	3
	Katherine	✓ 96%	✓ 100%	NA	NA	NA	✗ 88%	16	0	✓ 0	! 90%	✗ 12%	✗ 85%	NA	NA	0	4
	Community	✗ 72%	NA	NA	NA	NA	NA	0	0	✓ 0	✓ 95%	✗ 15%	✗ 70%	✗ 60%	NA	1	3
	ABC	NA	✓ 100%	NA	NA	NA	✓ 100%	14	0	✓ 0	! 93%	✗ 20%	✗ 84%	✓ 97%	✓ 52%	0	3
clinical support	Radiology WGH	NA	NA	✓ 100%	✓ 4%	NA	NA	36	0	✓ 0	! 94%	✓ 9%	! 94%	! 89%	NA	1	2
	Radiology HHGH	NA	NA	✓ 100%	✓ 5%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 100%	NA	0	0
	Radiology SACH	NA	NA	✓ 100%	✓ 4%	NA	NA	0	0	✓ 0	✗ 89%	✗ 9%	✗ 0%	✓ 100%	NA	0	3
	Radiology AAU	NA	NA	NA	NA	NA	NA	0	0	✓ 0	NA	NA	NA	NA	NA	0	0
Medicine	Outpatient WGH	✓ 100%	✓ 100%	✓ 93%	✗ 9%	! 95%	NA	35	0	✗ 1	✓ 97%	✓ 5%	! 91%	✓ 100%	NA	0	3
	Outpatient HHGH	✓ 100%	✓ 100%	✓ 94%	✗ 9%	! 97%	✓ 97%	0	0	✓ 0	✓ 98%	✗ 18%	! 94%	✓ 91%	NA	0	3
	Outpatient SACH	NA	✓ 100%	✗ 92%	✗ 8%	✓ 99%	NA	0	0	✓ 0	✓ 98%	✓ -5%	✓ 100%	✓ 94%	NA	0	2
	Endoscopy HHGH	✓ 100%	✓ 100%	✓ 97%	NA	! 98%	✓ 97%	0	0	✓ 0	✓ 97%	✓ 7%	✓ 96%	✓ 100%	✗ 20%	0	1
	Endoscopy WGH	✓ 100%	✓ 95%	✓ 93%	NA	✓ 99%	✗ 87%	0	0	✓ 0	! 95%	✗ 12%	✓ 97%	✓ 92%	✗ 4%	0	4
	Cath lab WGH	✓ 100%	✓ 100%	NA	NA	! 98%	✗ 93%	7	0	✓ 0	✓ 98%	✗ 41%	✓ 100%	✓ 98%	✗ 21%	0	3
	Dermatology WGH	✓ 97%	NA	✓ 96%	✗ 8%	NA	NA	0	0	✓ 0	! 92%	✓ 5%	! 94%	✓ 93%	NA	0	3
	Dermatology SACH	✓ 95%	NA	✓ 98%	✓ 6%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 97%	NA	0	0
	Dermatology HHGH	✓ 100%	NA	✓ 96%	✗ 9%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 92%	NA	0	1
	Helen Donald WGH	✓ 100%	NA	NA	NA	NA	NA	0	0	✓ 0	! 92%	✓ 5%	✓ 100%	✓ 100%	✗ 3%	0	2
Surgery	Day surgery SACH	✓ 100%	✓ 100%	NA	NA	! 96%	NA	45	0	✓ 0	✓ 97%	✓ 6%	✗ 80%	✓ 99%	✗ 13%	0	2
	Opthalmology WGH	✓ 98%	NA	✓ 94%	✗ 9%	NA	NA	0	0	✓ 0	! 90%	✗ 9%	✗ 62%	✗ 67%	NA	1	4
	Pre Op WGH	NA	NA	✗ 89%	✓ 7%	NA	NA	4	0	✓ 0	✗ 90%	✗ 16%	✓ 100%	✓ 94%	NA	0	3
	Pre Op HHGH	NA	NA	✓ 100%	✓ 8%	NA	NA	0	0	✓ 0	✓ 95%	✓ 8%	! 94%	NA	NA	0	1
	Pre Op SACH	NA	NA	✓ 94%	✓ 6%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 92%	NA	0	0
	Theatres WGH	! 82%	ND	NA	NA	✓ 99%	✓ 100%	26	0	✓ 0	✗ 84%	✗ 25%	✗ 89%	NA	NA	0	4
	Theatres SACH	✓ 94%	✓ 95%	NA	NA	✓ 99%	✗ 91%	0	0	✓ 0	✓ 95%	✗ 24%	✗ 81%	NA	NA	0	3
	Theatres Delivery WGH	! 88%	NA	NA	NA	NA	NA	2	0	✓ 0	NA	NA	NA	NA	NA	0	1
Green		>=90	>=90	>=95	<=8	>=95	>=95			0	>=95	<=9	>=95	>=90	IP 35%		
Amber		80-89	80-89	85-94	TBC	85-94	85-94	TBC	TBC		85-94	TBC	85-94	80-89	Paeds/		
Red		<=79	<=79	<=84	>8	<=84	<=84			>0	<=84	>9	<=84	<=79	Mat 25%		

11

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

Safe Care & Improving Outcomes: Patient Safety

In this reporting period:

Never events

There were no Never Event incidents reported in October.

Serious Incidents

There were 4 serious incidents declared in October 2019 in the following divisions: 3 in Surgery and 1 in Corporate.

At the end of October the Trust had 14 open SIs. Of these, 3 investigations were complete and with commissioners, pending formal closure on StEIS. There were 11 ongoing SI investigations.

Learning from SIs

There were no completed reports submitted to the commissioners during October.

% of patient safety incidents which are harmful

7.9% of incidents reported in October 2019 were recorded as having caused harm to the patient, compared to 8.4% in September 2019.

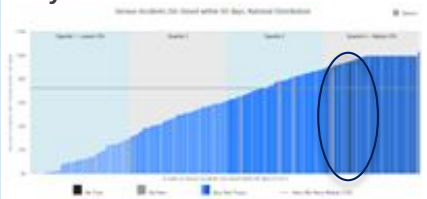
There were 20 incidents reported in October 2019 with a moderate or above level of harm.

There were no incidents reported in October 2019 with a harm level of Death/Catastrophic.

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL

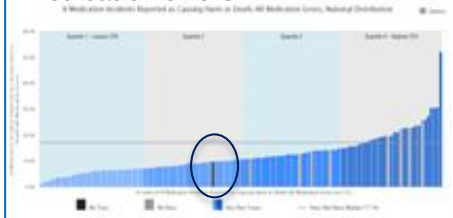
Serious Incidents closed within 60 days



Period: 2018/19
WHHT 95% **Peer: 72%**
National: 61%

Benchmarking: MODEL HOSPITAL

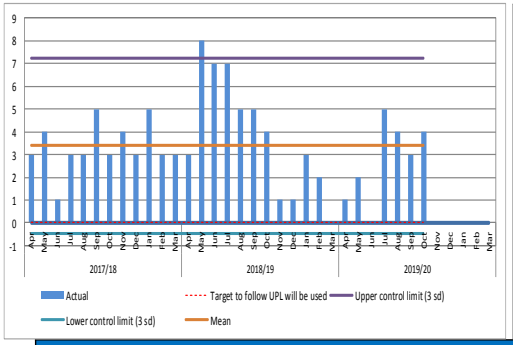
% medication incidents reported as causing harm or death/all medication errors



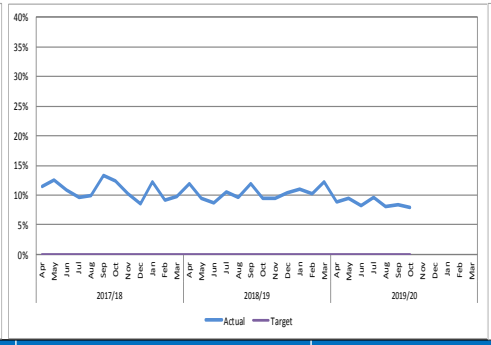
Period: 31/03/2019
WHHT 10.0% **Peer: 17.1%**
National: 10.7%

(Peers = Nightingale Group – acute multi-site trusts)

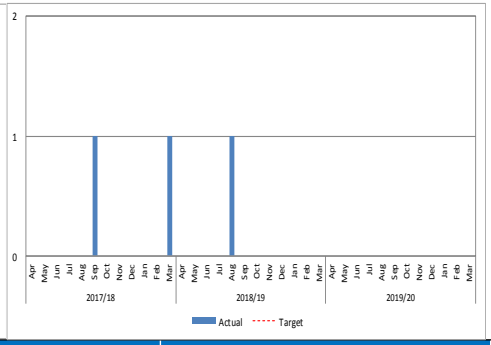
Serious Incidents



Safety incidents (% harmful)



Medication incidents causing serious harm



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee		

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

Safe Care & Improving Outcomes: Falls & Falls with harm

In this reporting period: In October there were 95 falls in total. 16 Falls with harm. 1 of which sustained severe harm.
Analysis of October's falls with harm data shows that 9 (56.3%) falls were not witnessed, 7 (43.7%) falls were witnessed , 5 incidents occurred during the day shift and 11 during the night shift, 11 (73.3%) incidents involved patients with cognitive impairment. Of these 3 patients were reported as having dementia. The majority of falls 10 (66.7%) occurred around the bed area. The fall with significant harm occurred during the night shift.

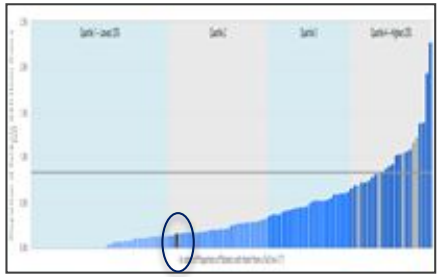
Falls with harm remain low in comparison to the number of falls reported locally and nationally. Of the 95 falls reported in October, 8 recurrent fallers accounted for (18.9%) 18 incidents. In October several clinical areas reported 7 or more falls, these included; AAU L3 Blue/Yellow – 8, Heronsgate/Gade – 8, Bluebells – 7,Sarratt – 7

Actions:

- All SI's and Divisional Learning Reviews are presented at the bi-monthly Patient Falls Review group where there is a focus around disseminating learning and what can be done differently.
- Using a QI approach- plan to measure impact on Heronsgate/Gade of swarming on post fall review for patients with significant harm and prevention of recurrent falls. Considerations to spread this to other clinical areas.
- Matrons have conducted a full survey and are evaluating the results regarding night lights and the appropriate use and working state within wards following findings from a night walk by senior staff . Ongoing trial of nightlights- review through Quality Information Forum (QIF)
- Meeting planned to explore how to take the NHSI falls collaborative work on reducing hypertensive medication in frail elderly patients forward
- Focusing on the CQUIN three high impact interventions to reduce falls and improve patient safety and outcomes. Audit showing a slight improvement in performance in Q2.
- Improved reporting on Datix to reflect how patients are transferred post fall and highlight areas that require additional support and training

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Proportion of patients with harm from a fall in care

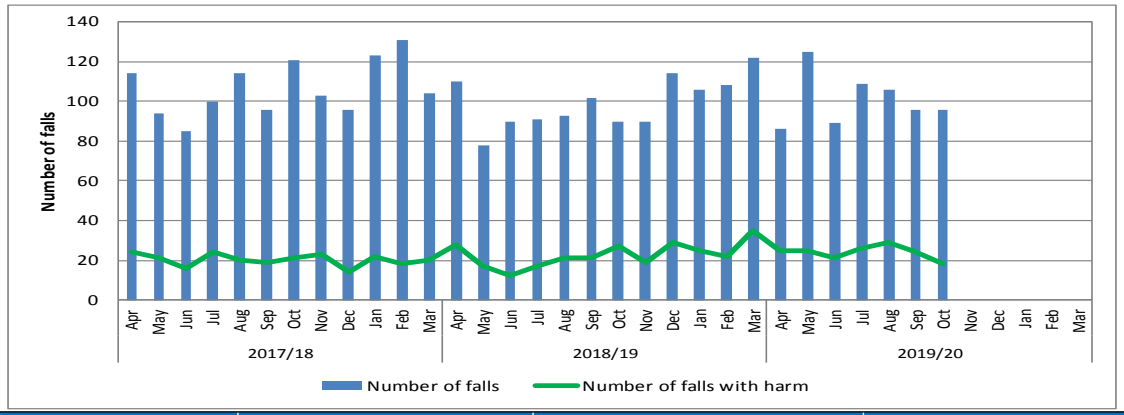


Period: April 2019

WHHT 0.2% **Peer: 0.8%**
National: 0.3%

(Peers = Nightingale Group – acute multi-site trusts)

Number of falls (total and with harm)



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee		

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Safe Care & Improving Outcomes: Harm free care

In this reporting period
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 during October is 98.2% compared to national average of 97.7%

September comparison with national data:

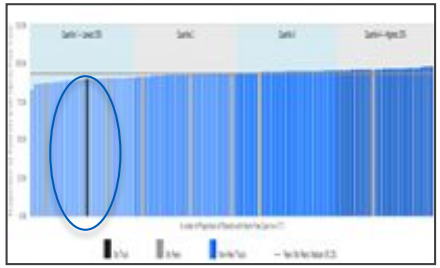
- New Pressure Ulcers 1.2% (an increase compared with September 0.8%) vs national figure 1%
- Falls with harm 0.3% vs national figure 0.5%
- New VTE 0.2 % vs national figure 0.6% This is an improvement on September when the Trust was above national data
- Patients with a urinary catheter 21.8% (an increase on September) vs national figure 13.9%. Patient with catheter and UTI 0.5%vs national figure 0.7% this is an improvement on September data.

Children and Young People's Services Safety Thermometer: The Children and Young People's Service 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 83.9% in October 2019, lower than the national average of 85.7%.

Maternity Safety Thermometer: The combined harm free care score was above the national average of 76.5% (85.2%).
On the day of review, 0% of women experienced a 3rd /4th degree tear in this audit, and remains below the national average of 1.1% .
The proportion of term babies born with an APGAR of 7 or less at 5 minutes was 0.0% which is lower than the national average of 3.1%.
The proportion of woman with a maternal infection from onset of labour to 10 days postnatal had increased to 7.4% in October with the national average being 6.2%. Our PPH rates (on the day of review) remain below national average for the 7th month running sitting at 3.7% compared to the national average of 11.3%.

Performance stable
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Proportion of patients with harm free care (including harm acquired outside the trust

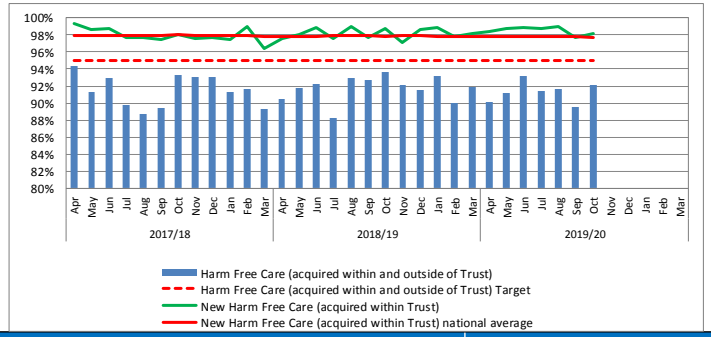


Period: April 2019

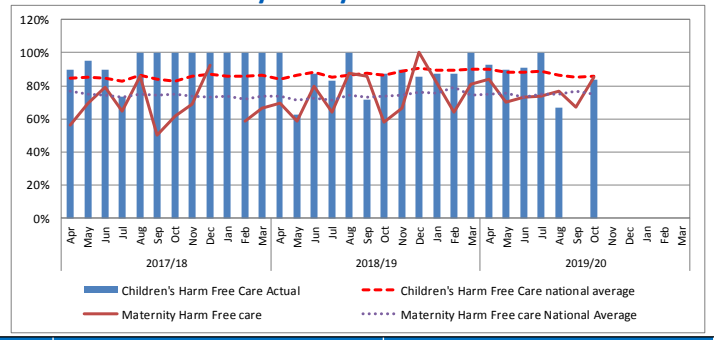
WHHT 90.1% **Peer 93.2%**
National 94%

(Peers = Nightingale Group – acute multi-site trusts)

Adult safety thermometer: Harm free care



Children & Maternity Safety thermometer: Harm free care



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee		

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Safe Care & Improving Outcomes: Pressure ulcers (HAPUs)

In this reporting period

In October there were 21 reportable HAPU's affecting 20patients. In addition there were 5 category 1 pressure sores affecting 3 patients and 9 cases of SDTI affecting 9 patients.
Category 4-0, Unstageable – 0, Category 3-1, Category 2-20, Category 1-5, SDTI -9

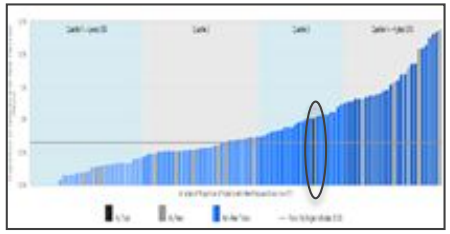
There has been a slight decrease in pressure ulcers reported in October. The majority of pressure damage remains in the medical division. Two thirds in medicine from (11 wards) and one third (5 wards) in surgery .
All but one patient with an SDTI were discharged with this damage and therefore unable to categorise. STDIs are still predominately occurring on the lower limbs.
Although the Trust incidence is lower in October our overall prevalence using the National Safety Thermometer is higher than the National average for the first time since February 2019 Trust Prevalence 1.2% National Prevalence 1%

Actions:

- Focus within the safety huddles patients with medical devices and heel offloading. Training external devices in relation to off-loading has taken place in October.
- Target work from the TVN team member working alongside HCA and clinical support workers to enable role modelling good patient care in relation to skin management. Focus was on Red suite, Ridge ward and Langley in October.
- Implementation programme for NHSI recommendations for defining and measuring pressure ulcers, published in June 2018
- Continued support to the matrons who validate Category 2 pressure ulcers for the clinical areas.
- The Trust has started participating in The National collaborative 'Stop the Pressure'. This is progressing on Croxley and Tudor ward.

Stable

Benchmarking: MODEL HOSPITAL
Proportion of patients with new pressure ulcers (grade 2-4)

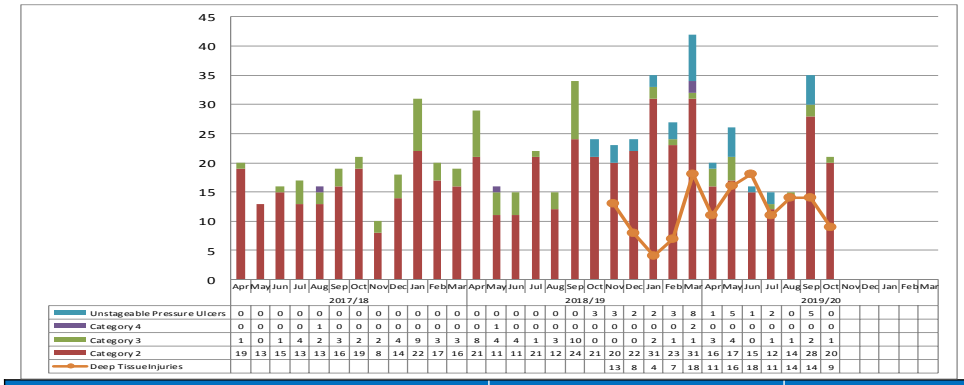


Period: April 2019

WHHT 1.0% **Peer 0.7%**
National 0.7%

(Peers = Nightingale Group – acute multi-site trusts)

Pressure Ulcers (HAPUs)



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee		

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Safe care & Improving Outcomes: VTE risk assessment

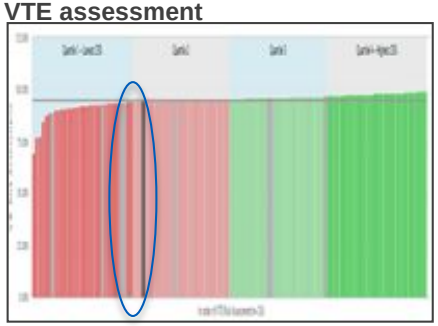
In this reporting period:
The current reported position is below target, but compliance is expected to improve as inpatient episodes are completed and then coded.

Factors / Themes:
Gaps in risk assessments in admitting areas.

Next steps:
- Focused awareness and training sessions in AAU Level 1. VTE prevention specialist nurse to target these areas and to visit Safety Huddles as well as liaise with senior sisters.
- VTE learning is part of Doctors' and nurses' mandatory training

Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
VTE assessment

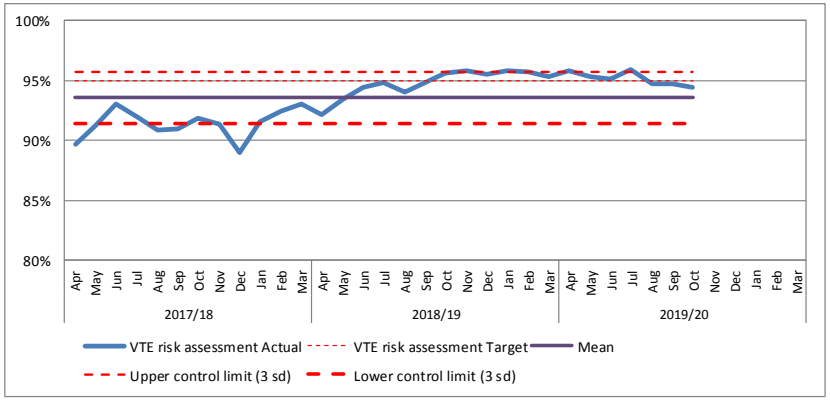


Period: Q1 2019/20

WHHT 94.73% Peer: 94.67%
National 95.92%

(Peers = Nightingale Group – acute multi-site trusts)

VTE risk assessment



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee		

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Safe Care & Improving Outcomes: Stroke

In this reporting period:

Stroke
Performance against the 4 hour target for admission to the stroke unit was 71%. Maintaining ring fenced beds on the stroke unit has not always been possible when the Trust experiences capacity constraints affecting "right bed" availability. However patients continue to receive stroke specialist care and input while they await transfer to the stroke unit.

90% stay on the Stroke Unit
92% of stroke patients in this reporting month spent 90% of their stay on the stroke unit which is above the 80% target.

Thrombolysis within one hours
56.3% of patients were thrombolysed within 1 hour (target is 50%)

Stable

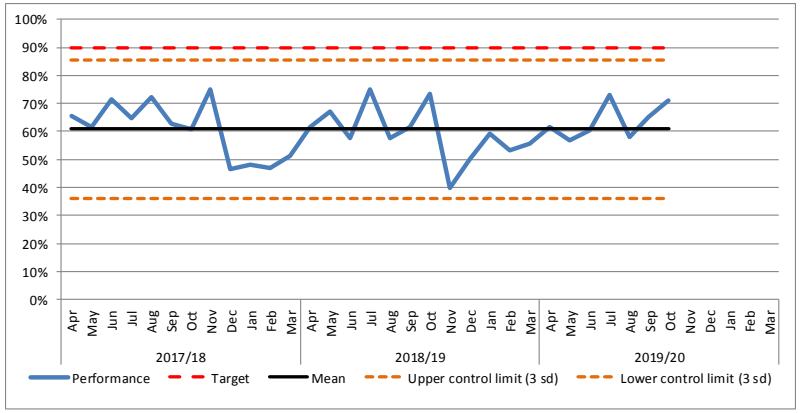
Benchmarking: SSNAP

Period: January to March 2019

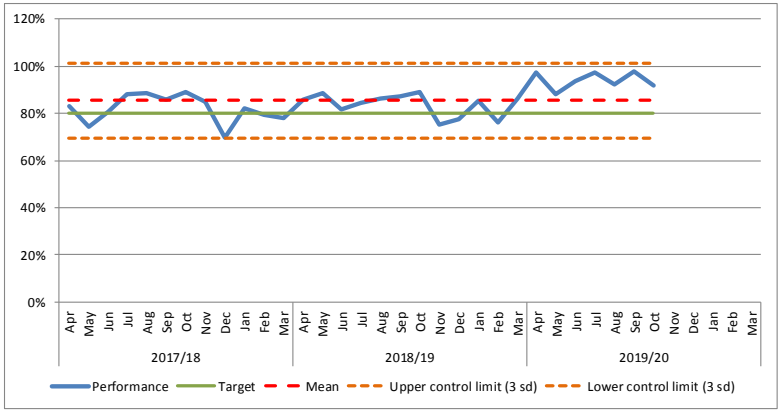
Admission within 4 hours: 55.5%

90% of admission on Stroke Unit: 83.3%

Stroke: Admission within 4 hours



Stroke: 90% of admission on Stroke Unit



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee		

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Caring & Responsive Services: Emergency Department

In this reporting period:

Overall performance against the 95% 4 hour standard has improved from 83.0% to 83.4%. Minors performance has improved from 94.7% to 97.3%. CED performance has also improved from 92.9% to 93.4%. Of note, both majors and admitted performance has improved to 58.8% and 61.1% respectively. HHGH UTC improved from 99.4% to 99.7% and MIU remained 100% compliant.

Factors/Themes:

Type 1 attendances were higher than in September at 9185 and the second highest month for the year. Ambulance attendances were higher in October than September, representing a 7% increase.

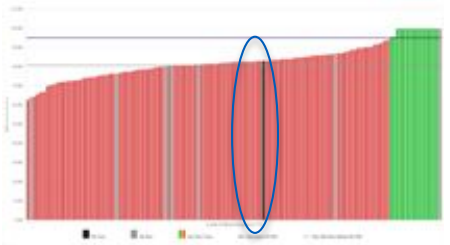
Next Steps:

- The regular check in meetings between the service team and Executive colleagues continue, together with the weekly access meetings. There is a robust framework for monitoring the improvement plan.
- Work continues with the expansion of the ambulatory care service with the service returning to full capacity mid December. This work will support an increase in patients being streamed away from the ED.
- Work with system partners is ongoing to develop the urgent care strategy which includes the development of Urgent Treatment Centres (UTCs) across all 3 trust sites.
- Work is required with EEAST to improve handover delays. The monthly programme board meetings oversee this work stream with a joint action plan being developed between EEAST and the Trust. The focus will be on improving the 15 minute off load times and no 60 minute delays by ensuring a robust STARRing SOP and escalation policy. Validation of activity is underway between EEAST and WHHT.
- A recruitment plan for medical staffing is in place, 4 Middle Grades have been recruited but await their visas, Consultant recruitment has not been as successful. The department is reviewing the possibility of joint posts and being supported by recruitment agencies.
- The new medical take model pilot is underway with regular review meetings being held. This has shown a reduction in LOS and conversion to admission.

Performance stable
Worse than target/threshold

Benchmarking: MODEL HOSPITAL

% of patients admitted or discharged within 4 hours of arrival

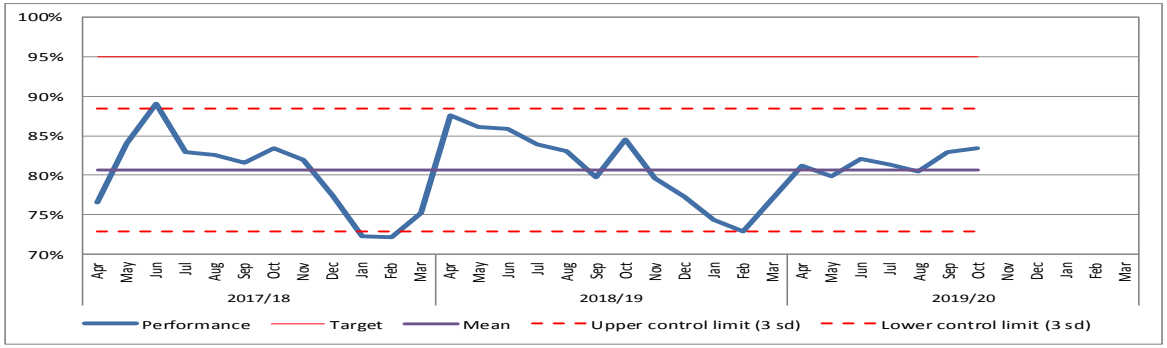


Period: October 2019

WHHT 83.1% **Peer: 80.6%**
National 95.0%

(Peers = Nightingale Group – acute multi-site trusts)

AE&: Attendances within 4 hours



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee		

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Caring & Responsive Services: Mixed sex accommodation breaches

In this reporting period:
Mixed sex accommodation (MSA)

There were no mixed sex accommodation breaches in October. For breaches in previous months, privacy and dignity was maintained at all times. Full length curtains are used and patients are offered the use of the toilet/shower if they are able.

Factors / Themes:
All historical breaches occurred in ITU and were due to pressures on the emergency care pathway.

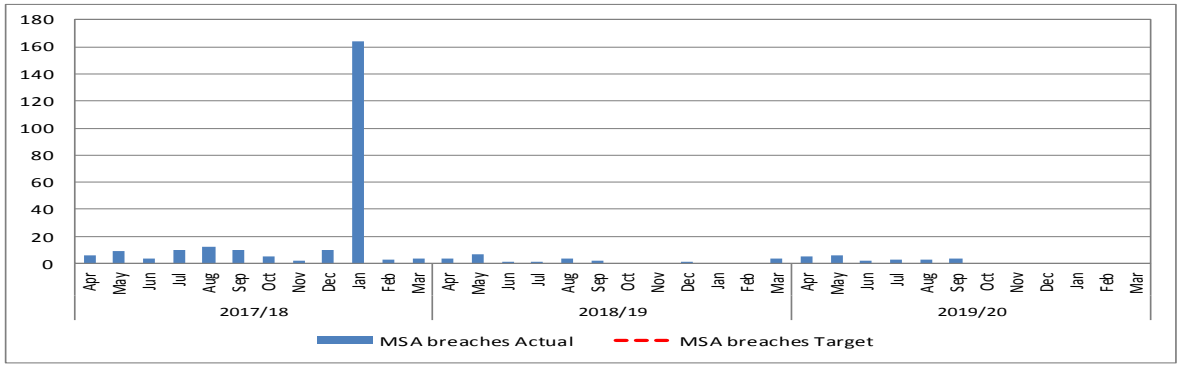
Next steps:
The monitoring and management of patients requiring step down from ITU is reviewed daily as part of the regular operational management meetings.

Performance stable
Better than target/threshold

Benchmarking:

Not currently available

Mixed sex accommodation breaches



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Effective	Chief Nurse	Quality Committee		

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Caring & Responsive Services: Delayed Transfers of Care

In this reporting period: Delayed Transfers of Care (DToC) patients represented 6.5% of occupied beds in October, higher than in the previous month's reported position of 6.3%. This is based on a snapshot of the number of patients waiting at a specific 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 1088 bed days, the equivalent of 35.1 beds.

In October IDT's performance deteriorated with 1081 (verified but unpublished data) bed days lost, a 30% increase in people occupying beds awaiting complex care to enable discharge. Whilst the number of bed days increased for all attributable reasons, the change for health delays was less and only contributed to 48% of bed days (524 bed days) lost compared to 55% in September 2019. People awaiting IMC or CHC beds for discharge accounted for 40% of health delays compared to 43% the previous month with 54% of health attributable delays accounted for by people who are self-funding their own care.

Social Care delays increased during October by 75% compared to September and in part can be accounted for by the transition of Simpson Ward and the high volume of people awaiting social care support. This is for people who have been through a CHC Pathway or have been flexed transfers from the acute setting. 63% of the 334 social care bed days lost (31% of the total delays compared to 23% last month) were accounted for by people awaiting a residential or nursing care placement, of which 76% were awaiting a residential care placement.

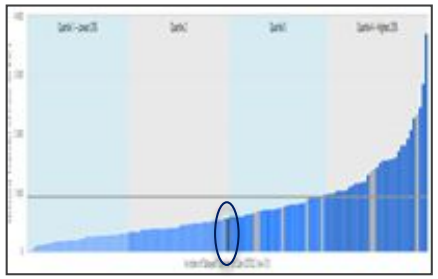
Across all health, social and joint delays, home care continues to remain a factor, accounting for 40% of the 1081 beds days lost, compared to 38% last month. Some of the long term care issues link to availability of support within the care market, as well as the added competition of the private market. Other considerations for the deterioration in performance relate to the transfer of HCT to CLCH – evidenced in challenges in 3 areas:

1. The transfer of Simpson and the incorporation of their performance figures
2. The flow of people classed as 'Joint Delays' which increased by 18% during October 19, albeit a smaller % of the overall delays.
3. The flow through IMC beds whilst transition took place.

Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL

Total number of bed days lost due to patients not being transferred to a more appropriate care setting

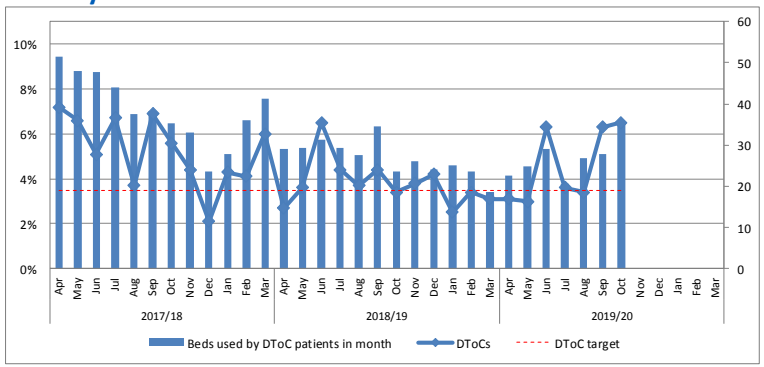


Period: March 2019

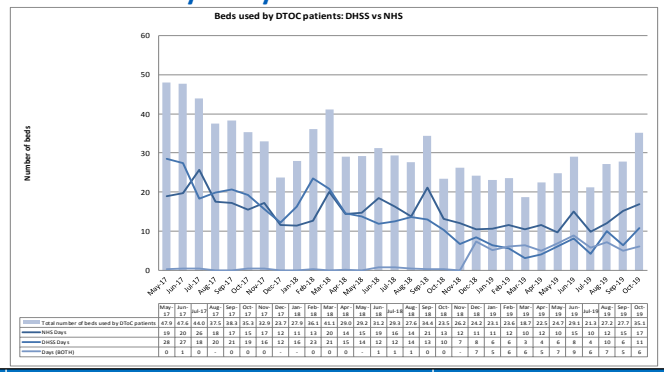
WHHT: 579 **Peer: 928**
National: 579

(Peers = Nightingale Group – acute multi-site trusts)

Delayed Transfers of Care



Beds used by Delayed Transfers of Care Patients



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Effective	Chief Operating Officer	Finance & Performance Committee		

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Caring & Responsive Services: Friends & Family Test (1 of 2)

In this reporting period:

Inpatients

17 of the 24 adult inpatient wards achieved the internal response rate target of 30% and 14 also achieved the CCG target of 35%.
Overall there were 4 low scoring inpatient wards (Croxley, Red Suite, Starfish & Elizabeth). The remaining areas with low scores were AAU Level 1, Ambulatory Care, Cath Lab, Helen Donald, Endoscopy, ESAU, DSU, Safari and ITU.

A total of 978 comments were received from inpatients, of which 903 were positive and 15 were negative. The two main areas of concern from five of the 15 patients were cancelled surgery at SACH and length of time waiting to be discharged from the patient lounge and the ward.

The positive comments from Transitional Care described staff as "*Professional caring staff, calm environment and great care all round. Facilities are good and respect towards both birthing partners appreciated*". DSU, SACH "*Really helpful, friendly, professional staff. Courteous and caring too*" and AAU L1 Yellow *"I have been treated with the utmost respect; excellent care and understanding by all the staff. "*

A&E

The response rate has slightly improved from 2.7% to 3.3% and the number of patients not recommending has improved by 1.3% .
The reason given by those not recommending was due to the length of time spent waiting to be seen and a rude member of staff; there were 6 negative comments. The recommendation rate is 90.6% in comparison to the national rate for September of 85%.The 223 (out of a total of 260) positive comments identified "*seen in good time, staff were friendly and doctor was clear and helpful"* ED, WGH. In CED the feedback was *"really good with patients, make sure they do whatever they can to help you"* and staff in UTC at HHGH were described as *"fantastic staff from start to finish".*

A review of the data for ED rates nationally indicates that the average response rate remains at 12%.

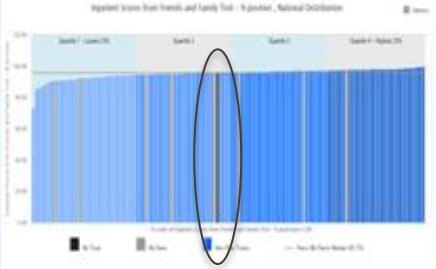
Next steps:

A review of the inclusion of Endoscopy and other non in patient areas that use alternative methods to capture patient feedback will be completed as part of the FFT changes being implemented in April 2020.

Performance stable
Better than target/threshold

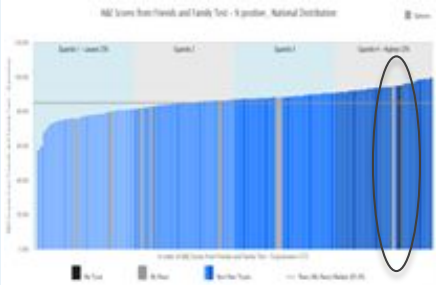
Benchmarking: MODEL HOSPITAL

Inpatient FFT scores % positive



WHHT: 96.0% Peer: 95.7%
National: 96.2%

A&E scores - % positive

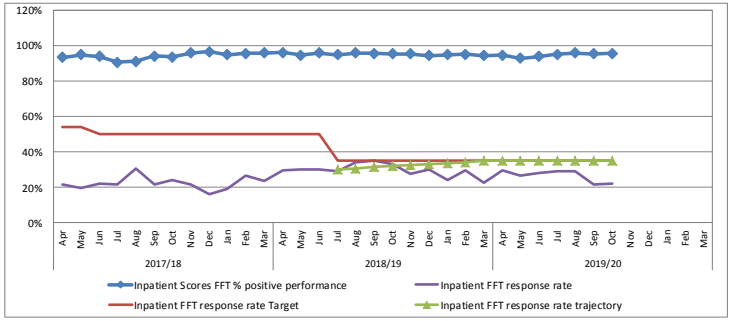


Period: August 2019

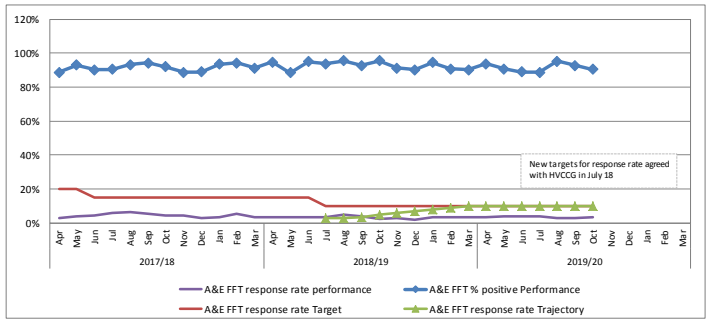
WHHT 95.4% Region 85.0%
National 87.2%

(Peers = Nightingale Group – acute multi-site trusts)

Inpatient FFT: responses and % positive



A&E FFT: responses and % positive



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee		

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Caring & Responsive Services: Friends & Family Test (2 of 2)

Day Case
The average response rate within day surgery is 10.5%; St Albans is 12.6% and Watford is 7.9%.; the recommendation rate is 99%. A review of the response rate within day case surgery is being discussed with the Senior Sister to understand and improve the low level of response rate – discussions with other organisations is being explored to understand further.

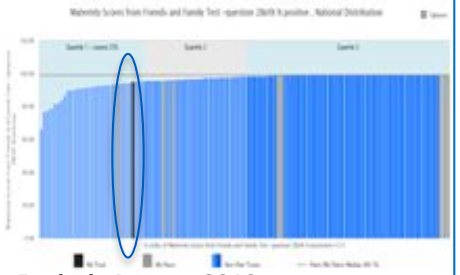
Outpatients
The recommendation rate was unchanged at 94.6% and 0.8% not recommending the service. A review of the responses, 2576 of which included a free text comment, has identified a small number (72) of negative comments Trust wide. The comments related to the length of time it had taken to receive an appointment followed by the long delays in the outpatient department waiting to be seen. The 2313 positive comments included "*all questions were answered swiftly and ongoing support offered. Brilliant experience*" Parkinson's Nurse clinic

Maternity
The response rate has increased this month (52.5%) demonstrating a sustained improvement over a 5 month period. The National response rate for September was 20%.There were 159 comments from ABC & Delivery Suite; 5 were negative and 148 were positive including the following: *"we had a very positive experience-the midwife and student were both lovely and very caring. They both made sure everything went smoothly and were very attentive and their aftercare was very reassuring. We felt very confident in their care". Alexander Birthing Centre.*

Next steps:
A review of the inclusion of non inpatient areas that use alternative methods to capture patient feedback will be completed as part of the FFT changes being implemented in April 2020.

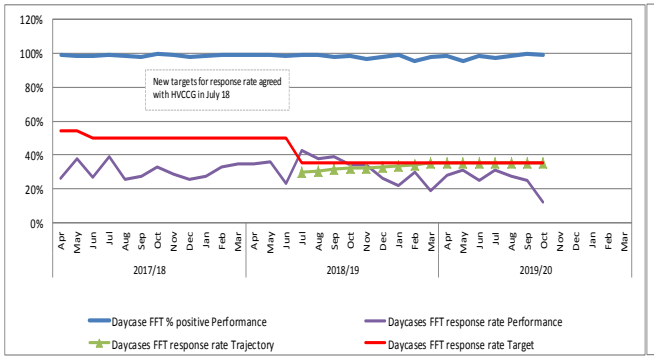
Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Maternity scores from FFT – Q2
Birth % positive

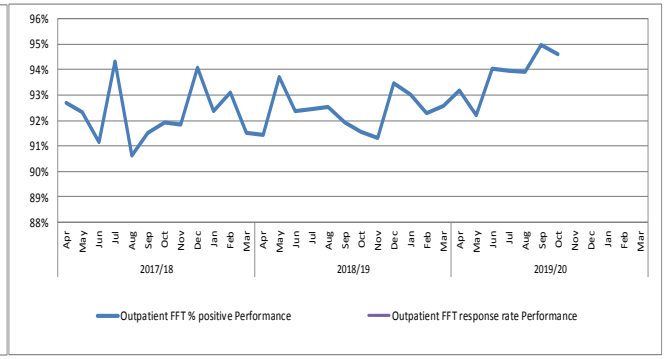


Period: August 2019
WHHT: 95.2% Peer: 99.1%
National: 98.4%
(Peers = Nightingale Group – acute multi-site trusts)

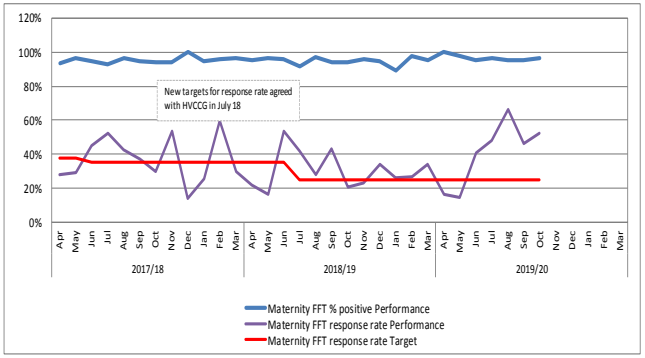
Daycase FFT: responses and % positive



Outpatient FFT: responses and % positive



Maternity FFT: responses and % positive



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee		

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Caring & Responsive Services: Complaints

In this reporting period:
October's response rate, at 78.6% was just below the 80% target. 39 new complaints were received in October 2019.

- 36% (14) relate to Surgery, Anaesthetics and Cancer (SAC)
- 26% (10 Medicine
- 23% (9) Emergency Medicine/USC
- 9% (4) Women's & Children's (WACs)
- 3% (1) Corporate
- 3% (1) Clinical Support Service.

At month end there were a total of 55 live complaints. 39 complaints were closed in the month. 3 complaints were reopened, 4 less than the previous month:

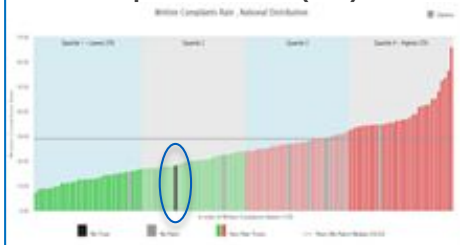
- 2 for Medicine
- 1 for Emergency Medicine.

Improvement plan: Currently SAC have the most complaints (38) and response performance is at 50% which impacts upon overall performance. There is an agreed plan to address the backlog and improve performance. Twice weekly meetings are held with the SAC Divisional Manager and senior staff to review all complaints and progress going forward to improve the response rate.

Factors/Themes: Trust wide, common themes remain all aspects of clinical care (incl clinical care and treatment) 72% (28); attitude of staff and communication at 15% (6), 5% (2) around admission and delays in appointments. The remaining complaints 8% (3) are single incidents that do not have any underlying trend or pattern. Of note is that the rise in complaints relating to staff attitude seen in previous months has shown a significant reduction with only 2 complaints received this month. However this will be monitored over the coming months to identify if there is a reoccurrence.

Performance improved
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Number of written complaints received per 1000 staff (wte)

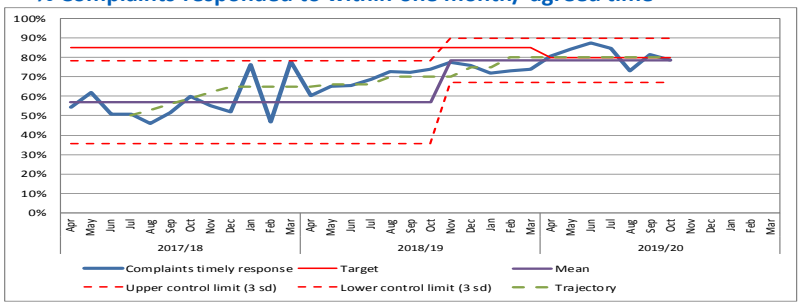


Period: Q1 2019/20

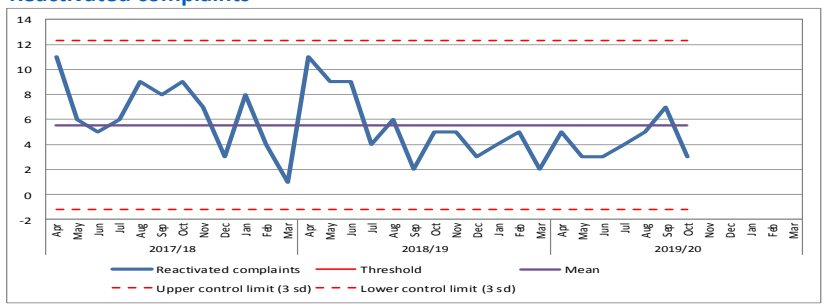
WHHT 18.38 Peer 29.03
National 24.27

(Peers = Nightingale Group – acute multi-site trusts)

% Complaints responded to within one month/ agreed time



Reactivated complaints



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee		

11

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Caring & Responsive Services: End of life care

In this reporting period:

The NHS End of Life Care Strategy (2008) emphasised that improved end of life care provision in acute hospitals was crucial; this is where more than half of all deaths take place.

Referrals to Specialist Palliative Care

The End of Life Care Strategy identified 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. There continues to be 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 October, 98 referrals were made to the Trust Specialist Palliative Care Team. Of the patients with capacity to make decisions about PPD, 100% had an identified PPD.

Patients who died at WGH where their identified preferred place of death was not achieved

There were 4 patients who died in a setting that was not their preferred place of death (PPD). In in 2 cases the reason was due to a delay in the C/C Process (Hospice Bed), and in 2 cases this was due to the patients' physical symptoms not permitting their transfer.

Patients on an Individualised Plan of Care for the Dying Person (IPCD)

Of the 11 patients whose death was reviewed in October, there were 7 patients who did not have an IPCD and it was deemed that for 4 of these patients, it would not have been appropriate. Learning from the audit will be fed back to ward areas to support the identification of patients appropriate for an IPCD.

Treatment Escalation Plans (TEP)

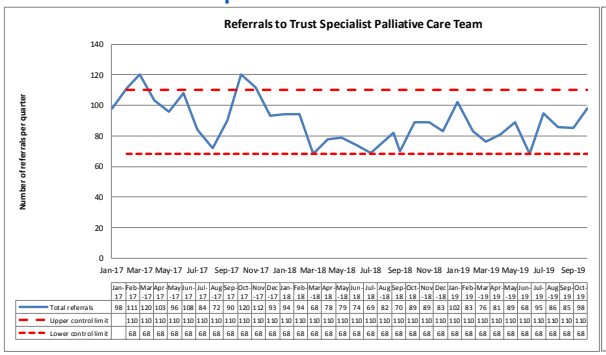
Treatment Escalation Plans ensure that every patient's care is reviewed, individualised and their levels of care are considered, in line with the Trust's guidelines. In October 2019, of the 11 deceased patients reviewed 9 had a TEP in place. In all 9 of those patients, the TEP had been reviewed as needed and was appropriate. There were two patients without a TEP.

Stable

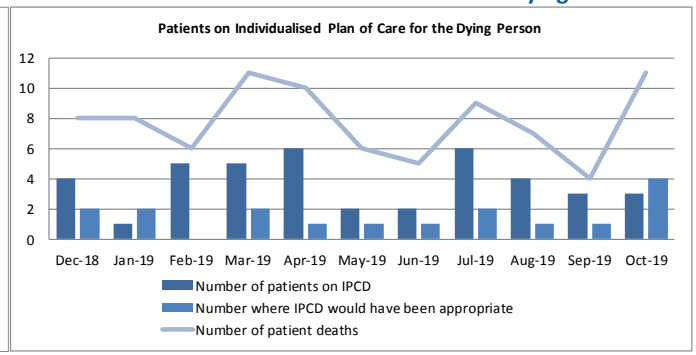
Benchmarking:

Not currently available

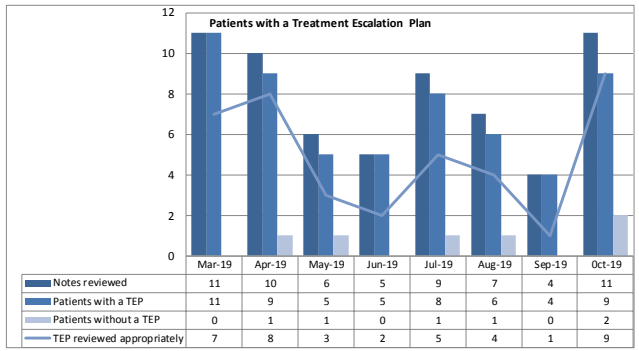
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Notes reviewed	11	10	6	5	9	7	4	11
Patients with a TEP	11	9	5	5	8	6	4	9
Patients without a TEP	0	1	1	0	1	1	0	2
TEP reviewed appropriately	7	8	3	2	5	4	1	9

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee		

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Caring & Responsive Services: RTT Open pathways

In this reporting period:
Performance against the 92% open pathway standard continues to improve, with a 1% increase this month to 86.8%. The most recent national data available (September 2019) shows that WHHT performance that month was better than the national average (84.8%).

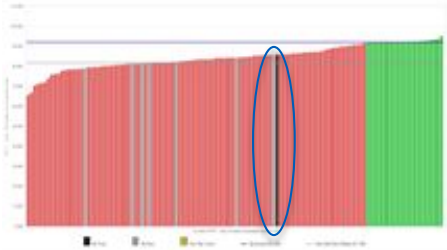
The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was better than the national position (7.2 vs 8.0 weeks) and the 92nd percentile wait time (23.3 vs 23.9 weeks). The overall PTL size remains lower than the March 2019 position and is on track to meet national expectations. The 18 week plus backlog continues to decrease.

At the end of the month there were no patients whose waiting time exceeded 52 weeks.

Next steps:
Good progress is being made against the improvement plan, supported by waiting list initiatives, outsourcing and focused validation.

Performance improved
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

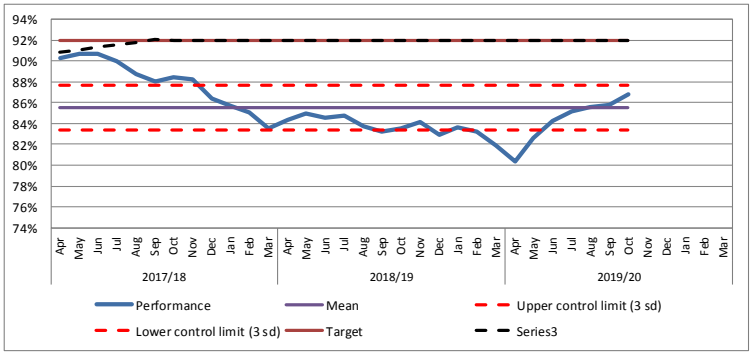


Period: September 2019

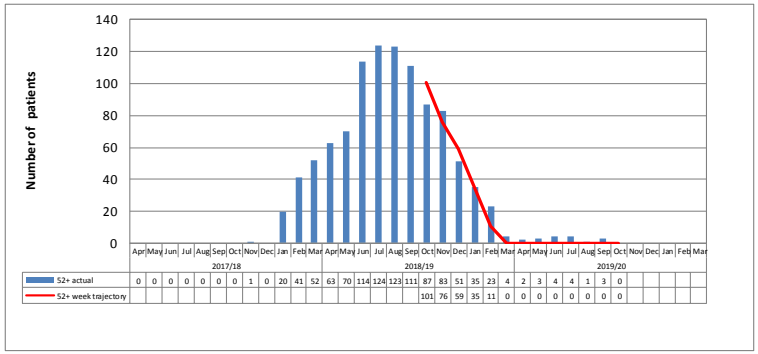
WHHT: 85.8% **Peer: 81.8%**
National: 92.0%

(Peers = Nightingale Group – acute multi-site trusts)

RTT - % within 18 weeks



Number of 52 week waits



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee		

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:
2 week wait: The provisional position for October is compliant at 94.2% with 1732 referrals, of which 100 were seen beyond 14 days.

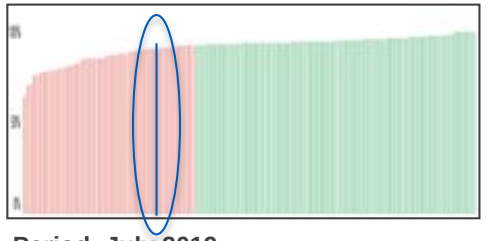
Breast symptomatic: The provisional position for October is compliant at 100%. There were 158, referrals all patient were seen within 14 days.

Factors / Themes:
The referral numbers are higher than the average. (Average since April 2019 is 1617 referrals/month)
The areas with the highest number of breaches were: Skin with 29 and LGI with 30.
Improvements in the Trust's performance against the 2ww standard continues with the best performance since January 2019. This has been achieved following work in all services on bringing the activity from the second to first week. The current percentage in the second week is 47% (74% in June 2019)

Next steps:
Continue the work aiming to offer the date first seen by day 8
Continue the work to strengthen the TAS pathway

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

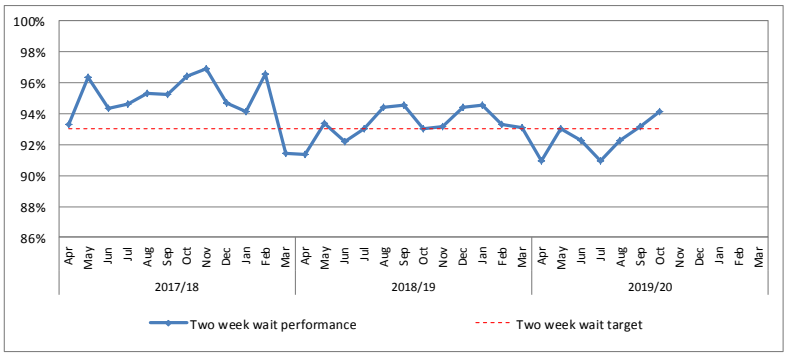


Period: July 2019

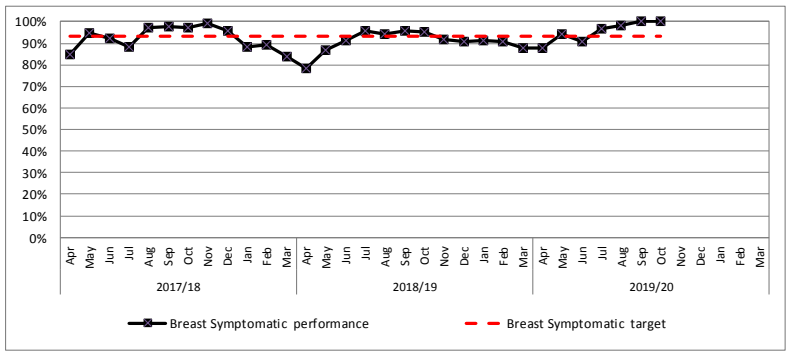
WHHT: 91.1% **Peer: 92.7%**
National: 90.0%

(Peers = Nightingale Group – acute multi-site trusts

Two week waits: % within target time



Breast symptomatic patients: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Responsive	Chief Operating Officer	Quality Committee		

11

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Caring & Responsive Services: Cancer 31 day

In this reporting period:
31 day first: The position for October is provisionally non-compliant at 94.7% with 171 pathways with 9 breaches (colorectal x 4, urology x 3 and breast x 2).

31 day subsequent Surgery: The position for October is provisionally non-compliant at 88.2%, with 17 pathways and 2 breaches (colorectal and urology).

31 day subsequent Drug: The position for October is provisionally compliant with 100% . There were 9 pathways, all in target

31 day subsequent Palliative: The provisional position for October is compliant at 100 %

Factors / Themes:
Escalations are happening but further work is required to increase their effectiveness

Next steps:
Work on escalation processes and communication between services is vital and ongoing
Work with POA to reduce delays

Performance deteriorated
Worse than target/threshold

Benchmarking: NHS England

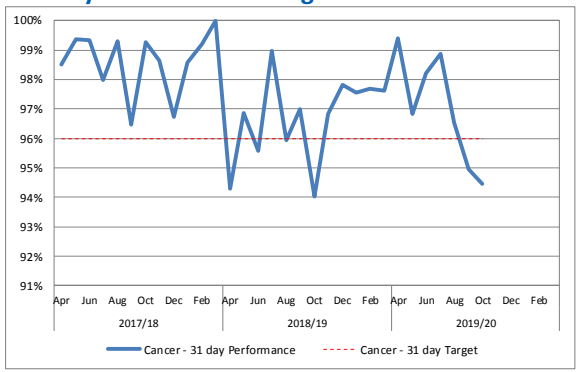
April to June 2019

31 day first: 96.1%

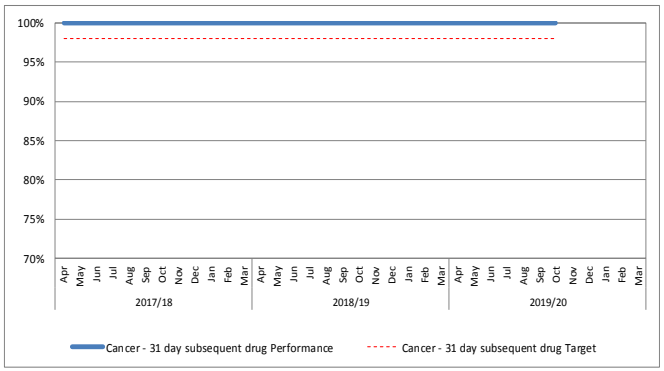
31 day subsequent (surgery): 91.6%

31 day subsequent (drug): 99.2%

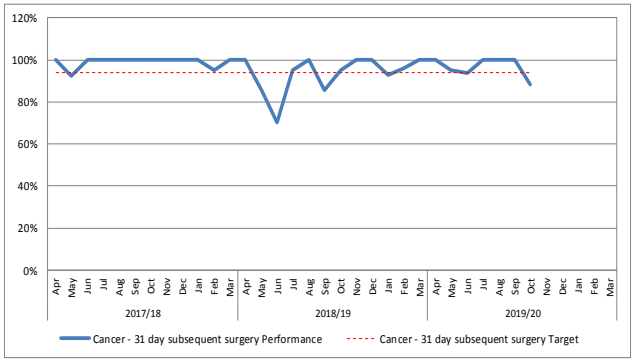
31 day first: % within target time



31 day subsequent drug: % within target time



31 day subsequent surgery: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services : Responsive	Chief Operating Officer	Quality Committee		

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Caring & Responsive Services: Cancer 62 day urgent GP referral

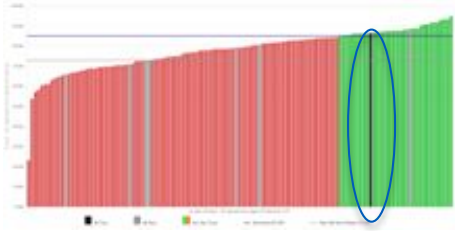
In this reporting period:
The provisional position for October is non- compliant at 78.6% Currently there are 91 treatments with 19.5 breaches :
Lung x 4 H&N x 1 Gynae x 1 UGI x 3 Urology x 10 LGI x5 Breast x 1 Haematology x 3
Delay reasons: waiting for >7 days for diagnostics and/or OPAs, some ineffective escalations, patient choice with holidays, delays for oncology OPA (lung), PET CT scans, elective capacity and being unable to treat within target. There were delays waiting for POA and outscourced MRIs (urology)

These breaches have not yet been validated and it is possible that more treatments will be added before submission on the 3rd December

Pathways >104 days
Open pathways: In October's submission there were 20 patients on an open pathway that was longer than 104 days.
These were 8 x LGI, 3 x Haem, 1 x H&N, 1 x UGI and 7 x urology
Breach reasons: There is significant amount of patient DNA and cancelling/rebooking. Several delays waiting for virtual clinics, some patients are on complex pathways, some requiring re-procedure for diagnostics, two patients swapped tumour-site part way through pathway, one patient booked for diagnostic as routine as low suspicion pathway, one patient thinking time.
Closed pathways – Provisionally the Trust has closed 14 pathways over 104 days (including consultant upgrades and screening) : 1 x breast, 2 x haem, 2 x lung, 2 x UGI, 2 x LGI and 5 urology
Next Steps:
Continue working with services to implement the Cancer Improvement Plan and monitor progress in each area.

Performance improved
Better than target/threshold

Benchmarking: MODEL HOSPITAL
62 day wait from urgent GP referral

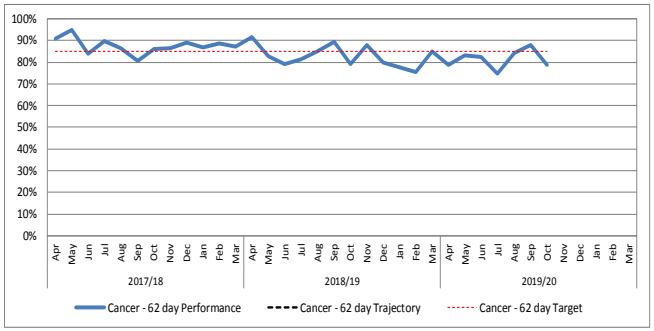


Period: September 2019

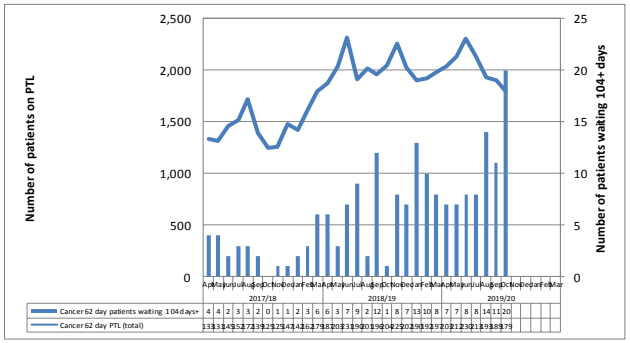
WHHT: 86.55% Peer: 72.95%
National: 85.0%

(Peers = Nightingale Group – acute multi-site trusts

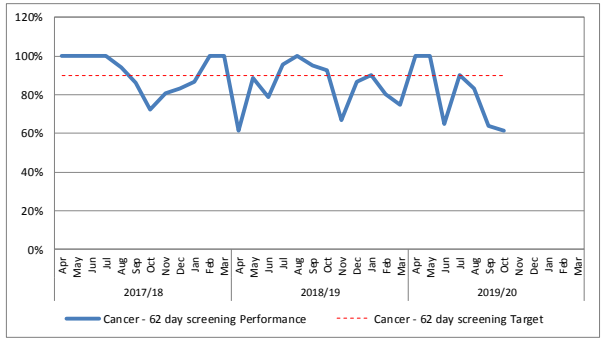
62 day GP: % within target time



62 day GP: patients waiting 104 days and over



62 day screening: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Caring	Chief Operating Officer	Finance & Performance Committee		

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Caring & Responsive Services: Outpatients

In this reporting period:
Short notice, hospital initiated cancellation rates increased at 5.4% (target 5%) this month (excluding valid cancellations and patient initiated cancellations) . Services with a high rate (over 10%) this month include Vascular Surgery, Urology (adult & paediatric), ENT, Paediatric Diabetic medicine, Paediatric Cystic Fibrosis

It should be noted that the total cancellation rate does not equate to unfilled capacity as vacated appointment slots are often re-filled.

The DNA rate has also risen, to 9.1% (from 8.7%). Specialties with high DNA rates include ENT, Oral Surgery, Gastroenterology, Thoracic (Respiratory) Medicine, Cardiology and Neurology.

Next steps:
The Outpatient Users Group, overseen by the Outpatient Transformation Board works with services to address these and other issues relating to outpatients. Focused work on reducing DNA rates is ongoing, with pre-appointment calls in some areas, which have been successful in reducing DNAs where this has been trialled.

Total cancellations: 25.1%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
12.7%	5.4%	12.4%	9.8%

Performance stable
Better than target/threshold

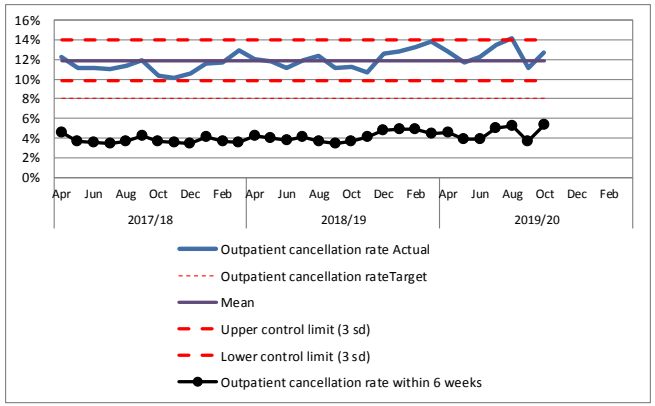
Benchmarking: MODEL HOSPITAL
Did not attend rate

Period: Q2 2019/20

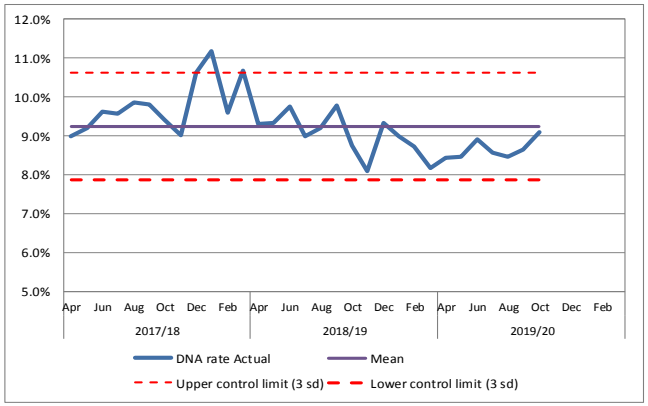
WHHT 7.63% **Peer: 6.72%**
National: 7.14%

(Peers = Nightingale Group – acute multi-site trusts

Outpatient cancellation rate



DNA rate



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee		

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Workforce & Finance: Recruitment & Retention

In this reporting period: Staff in Post and Vacancies

The number of staff in post increased to 4,524wte in October. This is an increase of 148wte over the last 12 months. This month's staff in post figure reflects the TUPE transfer of staff from Simpson Ward. The funded establishment has increased by 137wte over the same period. The funded establishment increases were due to the TEC approval of a business case for Emergency Medicine, (focussing particularly on A&E, theatres, Endoscopy later and Simpson ward. The Trusts workforce establishment is now 5088wte.

'The number of vacancies is currently 546wte, and in percentage terms,10.7%. This compares to 601wte in Sept 2018. For Band 5 nurses the vacancy rate is maintained at 0 in comparison with 123wte or 17.2% in March 2018. NB – the Band 5 Nurse vacancy wte figure includes approx. 30 overseas transitional nurses who are currently working towards their NMC registration. There are plans to recruit both in the UK and abroad to reduce these vacancies over 19/20 to maintain the vacancy rate at under 5%. Current projections show that recruitment plans will maintain the current Band 5 staffing levels

Sickness Rate :

- October sickness absence is currently 3.9%, above the 3.5% target. The Trust is ranked 6 / 16 in terms of the lowest sickness scores as at Q2 for local NHS benchmarking organisations

Labour Turnover and Number of staff leaving within first year

- Turnover based on a rolling 12 month period is currently 14.7%, the lowest rate for several years, and significantly lower than 17% as at last year. The Trust also measures 3 monthly turnover rates which help identify more immediate changes in trends, and the rate is currently 17%. The percentage of staff who leave their post before serving 1 year is currently 16,7%. This rate is significantly less than 22.6% where it was a year ago. Nursing Band 5 turnover has now been below the 16% target for two months, but has increased slightly to 17.0% in October.

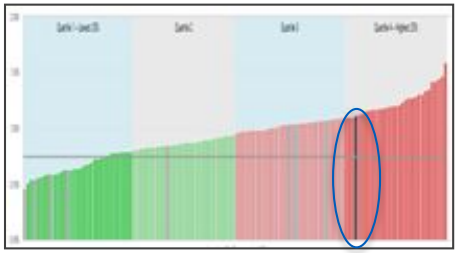
Next steps:

The on-boarding and retention project continues to implement a number of initiatives:

- Improving organisation and local inductions
- Development of a staff handbook / welcome booklet
- Implementation of a buddy system for new starters
- Raising awareness of development opportunities
- Improvements to website and intranet and Acorn system
- On boarding clinics and reconnect sessions

Performance stable
Worse than target/threshold

Model Hospital benchmarking:
Proportion of staff leaving each month

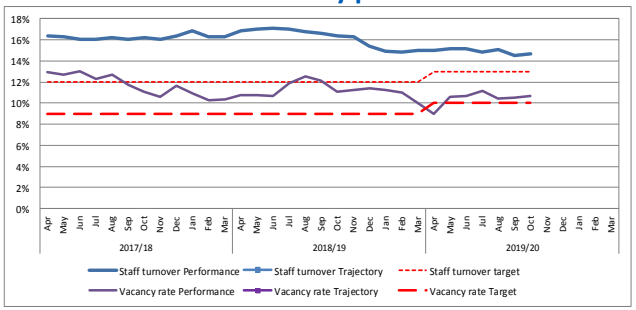


Period: July 2019

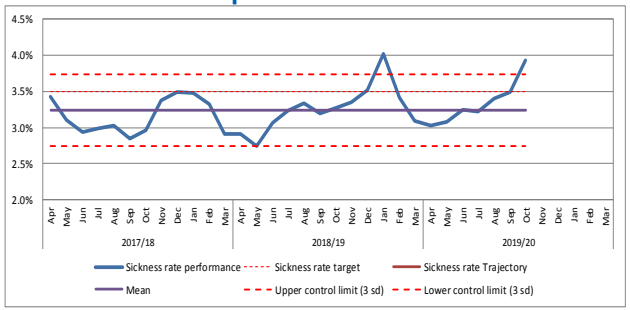
WHHT: 1.11% Peer: 0.74%
National: 0.96%

Peers = Nightingale Group – acute multi-site trusts)

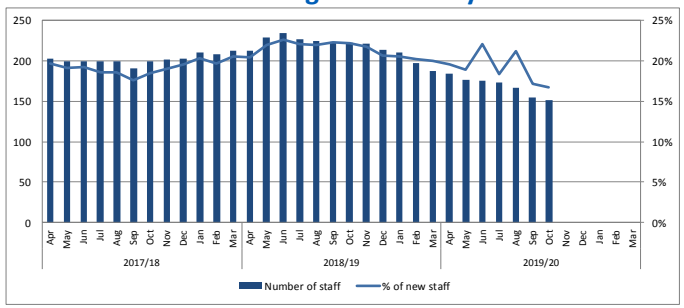
Staff turnover and vacancy performance



Sickness absence performance



Number of staff leaving within first year



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Workforce & Finance: Well Led	Chief People Officer	People, Education & Research Committee		

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Workforce & Finance – Developing Staff

In this reporting period:

Appraisals

There has been an improvement in compliance with 90.2% (target 90%) of staff with an in date appraisal. This rate includes medical staff. Not all Divisions are compliant with the target however, and work is ongoing in all areas.. The OLM core training compliance is currently 93% and above target, and the rate for essential training is 90%. The Trust is now compliant in terms of its internal targets for all 3 above areas.

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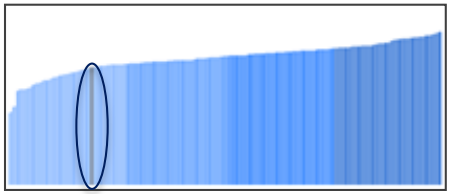
Mandatory training

- The all Trust mandatory training rate remains above target at 93%, an increase compared to last month. Compliance has now been consistently maintained since November of 2018
- With the all-Trust target is met, attention is now focussed on any subject, department or staff group where specific help will support the achievement of compliance, and the Education Service will continue to liaise with the HR Business Partners, Divisional Performance Reviews and Trust management as necessary to ensure that any outstanding areas receive appropriate support.

Performance stable
Worse than target/threshold

Benchmarking: Model Hospital

Trust staff with appraisal completed by the required date

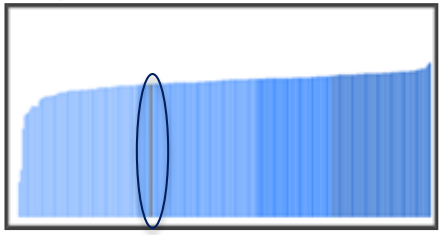


Period: 2017/18
WHHT: 76% **Peer: 83%**
National: 93%

Performance stable
Better than target/threshold

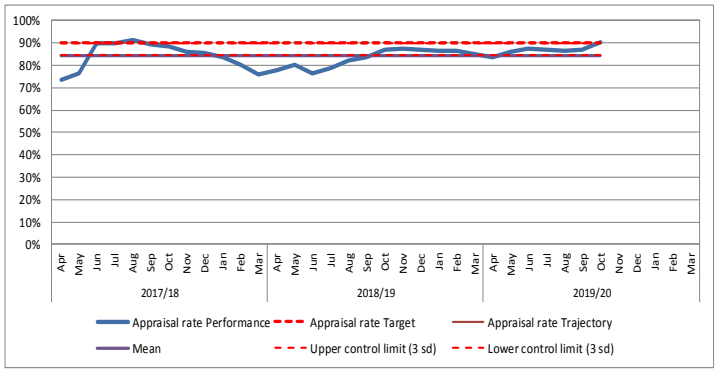
Benchmarking: Model Hospital

Statutory & Mandatory training compliance rate

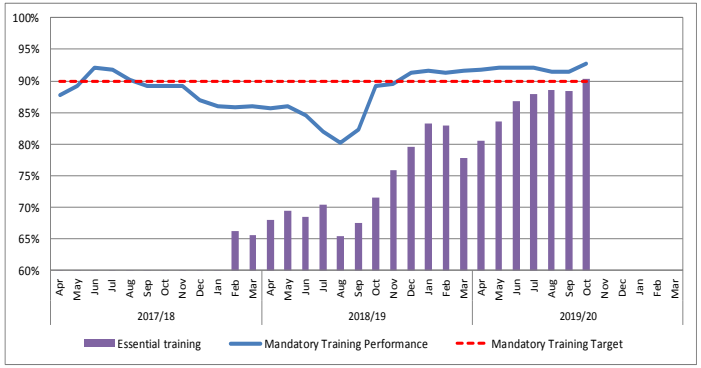


Period: 2017/18
WHHT 86% **Region 87%**
National 89%
Peers = Nightingale Group – acute multi-site trusts)

Appraisal performance



Essential training and mandatory training performance



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref	Regulator
Workforce & Finance: Well Led	Chief People Officer	People, Education & Research Committee		

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Workforce & Finance: Workforce BAF scorecard

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 we are monitoring. These include B5 nurse vacancies and turnover, reflecting the focus on recruitment and retention of these staff in conjunction with NHSI. These areas are identified as the Trust's highest workforce risk factors. B5 Nurse Turnover rates are 17.2% currently. The Trust is just above its 16% target, and the reduction is significant compared to the 29% rate at the start of May 2017. For B5 Nurse vacancies, the rate is currently 0% overall and means the Trust is now achieving its target. The indicator is now rated green. The Trust is proceeding with plans to recruit overseas to ensure a continuous supply of nurses and ensure the vacancy target is maintained, as nationally there are still significant shortages of these staff. NB - The figure includes 34 transitional nurses awaiting PIN numbers, when these staff are excluded, the rate is circa 5%.. Recruitment forecasts indicate that the rate will remain close to 0% for the next 12 months.

Combined appraisals rates are now compliant against the 90% target.. The overall rate for medical staff (97%) includes all medics apart from Deanery posts. Mandatory training compliance is 93%, and is now consistently above the 90% target.. It should be noted that results are now taken from the Acorn system to ensure improved reporting accuracy.

The October monthly Trust sickness rate is 3.9% against a 3.5% target, and so is above target. The 12 month sickness figure is 3.4%, below target. It is anticipated that sickness will rise over Winter months.

The current agency pay bill percentage is 5.1%. The overall target rate for 2019/20 is 5%, reflecting the reduced agency cost target envelope.

The 12 month turnover rate is 14.7%, amongst the lowest rates we have recorded. The Trust is ranked 7 / 13 nearby NHS organisations.

The latest FFT score (52.2%) shows an increase compared to 3 months ago . Although slightly lower than a year ago.

Workforce Indictors - Progress Table

Progress against target -Oct 2019

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	11.7%	11.0%	11.2%	10.7%	10.0%	0.7%	↘	7%
Band 5 Nurse Vacancy		17.3%	1.0%	0.0%	9.0%	-9.0%	↘	-100%
Headline Turnover	13.9%	16.4%	14.9%	14.7%	13.0%	1.7%	↘	13%
Band 5 Nurse Turnover		20.3%	15.5%	17.0%	16.0%	1.0%	↗	6%
Total Sickness	3.9%	3.3%	3.2%	3.9%	3.5%	0.4%	↗	11%
Non-Medical Appraisal	80%	87.0%	87.0%	90.2%	90.0%	0.2%	↗	0%
Medical Appraisal		99.0%	99.0%	97.1%	90.0%	7.1%	↗	-8%
Core Skills Framework	92%	89.0%	92.0%	93.0%	90.0%	3.0%	↗	-3%
Agency as a % of Paybill	7.0%	6.6%	5.7%	5.1%	5.0%	0.1%	↘	2%
Friends and Family Test (Work)		53.9%	47.4%	52.2%	66.0%	-13.8%	↗	21%
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 Q2 19/20 - Local Survey
Turnover	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q2 19/20 - Local Survey
Sickness	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q2 19/20 - Local Survey
Appraisal	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q2 19/20 - Local Survey
Core Skills Framework	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q2 19/20 - Local Survey
Friends and Family Test	Based on FFT Survey

Data sources

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Source	Executive lead	Lead	Board IPR	Quality IPR	Patient Experience IPR	Divisional IPRs
Safe care & Improving Outcomes	Safe	**Quality of Care: Mortality Indicators**							
		SHMI (Rolling 12 months)	Dr Foster	MD		✓	✓	✗	✓
		HSMR - Total (Rolling three months)	Dr Foster	MD		✓	✓	✗	✓
		HSMR - Crude mortalilty %	Dr Foster	MD		✓	✓	✗	✓
		Quality of Care: Infection Control							
		Clostridioides Difficile - Hospital associated (Cat 1)	WHHT	CN		✓	✓	✗	✓
		Clostridioides Difficile - Healthcare associated (Cat 2)	WHHT	CN		✓	✓	✗	✓
		Clostridioides Difficile - Hospital and Healthcare associated Total	WHHT	CN		✓	✓	✗	✓
		Hand Hygiene Compliance		CN		✓	✓	✗	✓
		Quality of Care: Emergency Readmissions							
		30 Day Emergency Readmissions - Elective *	Dr Foster	MD		✓	✗	✗	✓
		30 Day Emergency Readmissions - Emerg *	Dr Foster	MD		✓	✗	✗	✓
		Quality of Care: Caesarean Section rates							
		Caesarean Section rate - Combined*	WHHT	MD		✓	✓	✗	✓
		Caesarean Section rate - Emergency*	WHHT	MD		✓	✓	✗	✓
		Caesarean Section rate - Elective*	WHHT	MD		✓	✓	✗	✓
		Patient Safety							
		% nursing hours (shift fill rate)	WHHT	CN		✓	✓	✗	✓
		Serious incidents - number*	WHHT	MD		✓	✓	✗	✓
		Serious incidents - % that are harmful*	WHHT	MD		✓	✓	✗	✓
		% of patients safety incidents which are harmful*	WHHT	MD		✓	✓	✗	✓
		Never events	WHHT	MD		✓	✓	✗	✓
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	WHHT	CN		✓	✓	✗	✓
		Safety Thermometer % New Harm Free Care (acquired within Trust)	WHHT	CN		✓	✓	✗	✓
		Category 4 pressure ulcers - New (Hospital acquired)	WHHT	CN		✓	✓	✗	✓
		Category 3 pressure ulcers - New (Hospital acquired)	WHHT	CN		✓	✓	✗	✓
		VTE risk assessment*	WHHT	MD		✓	✓	✗	✓
		Patients admitted to stroke unit within 4 hours of hospital arrival	SSNAP	MD		✓	✓	✗	✓
		Stroke patients spending 90% of their time on stroke unit	SSNAP	MD		✓	✓	✗	✓

Data sources

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Source	Executive lead	Lead	Board IPR	Quality IPR	Patient Experience IPR	Divisional IPRs
Caring & Responsive Services	Effective	**Patient Flow: Emergency Department**							
		Ambulance turnaround time between 30 and 60 mins	East of England Ambulance Service	COO		✓	✗	✗	✓
		Ambulance turnaround time > 60 mins	East of England Ambulance Service	COO		✓	✗	✗	✓
		% Patients admitted through A&E - 0 day LOS	WHHT	COO		✓	✗	✗	✓
		Patient Flow: In hospital flow							
		% Discharges before 12am	WHHT	COO		✓	✗	✗	✓
		Mixed sex accommodation breaches	WHHT	COO		✓	✗	✗	✓
		LOS > 21 days	WHHT	COO		✓	✗	✗	✓
		Delayed Transfers of Care (DToC)*	Integrated Discharge Team	COO		✓	✗	✗	✓
		Delayed Tranfers of Care (DToC) beddays used in month	Integrated Discharge Team	COO		✓	✗	✗	✓
		Delayed Tranfers of Care (DToC) beds used in month	Integrated Discharge Team	COO		✓	✗	✗	✓
	Caring	**Patient Experience: Friends & Family Test**							
		A&E FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Inpatient Scores FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Daycase FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Maternity FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Patient Experience: Complaints							
		Complaints responded to within target/agreed timescale	WHHT	CN		✓	✓	✓	✓
		Reactivated complaints	WHHT	CN		✓	✓	✓	✓
		Patient Experience: End of life care							
		New indicators to be included in Q3	WHHT	CN		✓	✓	✓	✓
		New indicators to be included in Q3	WHHT	CN		✓	✓	✓	✓
	Responsive	**Access to Services**							
		ED 4hr waits (Type 1, 2 & 3)	WHHT	COO		✓	✗	✗	✓
		Referral to Treatment - Incomplete*	WHHT	COO		✓	✗	✗	✓
		Referral to Treatment - 52 week waits - Incompletes	WHHT	COO		✓	✗	✗	✓
		Cancer							
		Cancer - Two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - Breast Symptomatic two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent drug *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent surgery *	WHHT	COO		✓	✗	✗	✓
		31 Day - Subsequent Treatment at WHHT - Palliative Treatments	WHHT	COO		✓	✗	✗	✓
		31 Day - Subsequent Treatment at WHHT - Other Treatments	WHHT	COO		✓	✗	✗	✓
		Cancer - 62 day *	WHHT	COO		✓	✗	✗	✓
		Cancer - 62 day screening *	WHHT	COO		✓	✗	✗	✓
		Access to Services: Outpatients							
		Outpatient cancellation rate within 6 weeks^	WHHT	COO		✓	✗	✗	✓
		DNA rate	WHHT	COO		✓	✗	✗	✓

Data sources

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Source	Executive lead	Lead	Board IPR	Quality IPR	Patient Experience IPR	Divisional IPRs
Workforce and finance	Well led	**Recruitment & Retention**							
		Staff turnover rate (rolling 12 months)	WHHT	CPO		✓	✗	✗	✓
		% staff leaving within first year (excluding medics and fixed term contracts)	WHHT	CPO		✓	✗	✗	✓
		Vacancy rate	WHHT	CPO		✓	✗	✗	✓
		Sickness rate	WHHT	CPO		✓	✗	✗	✓
		Developing Staff							
		Appraisal rate (Total)	WHHT	CPO		✓	✗	✗	✓
		Mandatory Training	WHHT	CPO		✓	✗	✗	✓
		Essential Training	WHHT	CPO		✓	✗	✗	✓
		Finance overview							
		Financial Risk Rating	WHHT	CFO		✓	✗	✗	✓
		Income & Expenditure Actual vs Plan	WHHT	CFO		✓	✗	✗	✓
		Income & Expenditure forecast	WHHT	CFO		✓	✗	✗	✓
		Cash balance at the end of the month	WHHT	CFO		✓	✗	✗	✓
		Capital expenditure	WHHT	CFO		✓	✗	✗	✓
		CIP delivery against plan	WHHT	CFO		✓	✗	✗	✓
		% Bank Pay**	WHHT	CFO		✓	✗	✗	✓
		% Agency Pay**	WHHT	CFO		✓	✗	✗	✓
		Activity (chargeable)							
		GP referrals	WHHT	CFO		✓	✗	✗	✓
		A&E attendances	WHHT	CFO		✓	✗	✗	✓
		Elective spells (overnight)	WHHT	CFO		✓	✗	✗	✓
		Elective daycase	WHHT	CFO		✓	✗	✗	✓
		Total elective spells	WHHT	CFO		✓	✗	✗	✓
		Non-elective spells	WHHT	CFO		✓	✗	✗	✓
		Births	WHHT	CFO		✓	✗	✗	✓
		Outpatient attendances	WHHT	CFO		✓	✗	✗	✓

TRUST BOARD
05 December 2019

Title of the paper	**Annual Report on infection prevention and control**
Agenda Item	**12/77**
Owner	**Tracey Carter, Chief Nurse & Directors of Infection Prevention & Control**
Author(s)	**Annesha Archyangelio & Glynis Bennett, Deputy Directors of Infection Prevention & Control** **Dr Prema Singh, Infection Control Doctor, Consultant Microbiologist**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: *X*
Executive Summary	This annual report is a summary of the Trust's performance in relation to Infection Prevention and Control (IP&C) for April 2018 to March 2019. The information provided is in relation to evidence and assurance on the Trusts compliance with the Hygiene code. It also includes information on incidents and actions undertaken to address these. This demonstrates that the Trust is providing a clean and safe environment and infection prevention and control is everybody's business. The report has been fully discussed at the infection, prevention control panel and the quality committee and the Trust Board was updated through the committee assurance report. In 2018-19 the Trust performed well against the set Healthcare associated infections trajectories and continued to build upon achievements of previous years. The following summary outlines the achievements and continued work: The rate of Clostridioides (formerly clostridium) difficile infection (CDI) continues to be lower than the national and regional average. There were 15 cases of Trust apportioned CDI from April 2018 to March 2019 against a trajectory of 22 for the year, representing 45% reduction on the previous year. Following the appeal process with the CCG 5 cases were approved which means that were no lapses in care for these cases. There were 3 cases of MRSAb identified post-48 hours and were trust apportioned, a full PIR was undertaken for each case. No lapses in care were identified by WHHT. Cases of MRSAb regionally were higher than average, although no formal trajectory is set for the trust mandatory, reporting is still required and continues. There has been an increased focus on Escherichia coli bacteraemia (E. colib) and methicillin sensitive staphylococcus aureus bacteraemia (MSSAb) strategies to ensure their reduction. The Trust IP&C team continues to work closely with the community colleagues to reduce the numbers and implement measures to reduce transmission.

	There have been key investigations and discussions regarding Carbapenemase Producing Enterobacteriaceae (CPE) management in the Trust. The Trust continues to embed the CPE toolkit to ensure effective management of CPE cases. Surgical site infection (SSIs) rates are below the average for local Trusts and have shown improvement on the previous year's data for the Trust. Work to improve compliance with key interventions such as hand hygiene and compliance with Personal Protective Equipment (PPE) continues and audit data illustrates improved compliance. High numbers of cases of Influenza were admitted to the trust over the winter months, leading to added operational pressures. However, no evidence of internal transmission has been identified and good management including isolation of patients has been evident throughout the winter period. A successful Flu vaccination campaign of frontline staff meant the trust reached the 75% target, improving and protecting staff wellbeing. Antibiotic stewardship is robust and the trust achieved its CQUIN target this year and has seen a reduction in the total consumption of antibiotics. The limited numbers of single rooms (isolation facilities) continues to be an operational challenge for patient flow in the trust while managing infectious patients, the IP&C team work closely with operational teams to risk assess patients enabling efficient use of the facilities available. The IP&C Team currently do not have an electronic surveillance system but use a paper-based system working closely with Microbiology colleagues to ensure systems are in place to identify infectious patients as well as identifying any transmission. 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 and has mitigation in place to manage the risks to compliance.
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

<table>
<tr><td></td><td>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>IPC Panel</td><td>September 2019</td></tr><tr><td>Quality Committee</td><td>October 2019</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Trust Board is asked to receive this report for information and assurance of the compliance with the Health & Social Care Act which contains the ‘Hygiene Code’.</td></tr>
</table>

Agenda Item: 12/77

Trust Board meeting – 05 December 2019

Annual report on infection prevention and control

Presented by: Tracey Carter, Chief Nurse & DIPC

1.0 INTRODUCTION

Preventing infections is a key priority for the Trust. The objective and strategy for IP&C are based on the criteria within the H&SC Act 2008 code of practice on the prevention and control of infections and related guidance (DoH 2015) ensuring compliance with the Hygiene Code (appendix 1).

Criteria 1 – Management and Structure for Infection Prevention and Control

The Chief Executive has overall responsibility for IP&C. The post of Director of Infection prevention and Control (DIPC) is held by the Chief Nurse who is also the executive lead for IP&C.

The Infection Prevention and Control Panel is chaired by the DIPC and meets bi-monthly. The Panel includes divisional, estates, facilities, medical, nursing, occupational health, pharmacy and patient lead representation.

The day to day coordination of the IP&C nurses is managed by the Deputy DIPC. The IP&C Team consists of a Deputy CIPC, Clinical Lead Nurse, and one WTE IP&C Specialist Nurse supported by 3 part time IP&C Nurses. There is also a vascular access specialist Nurse and Surgical Site surveillance Nurse. One support worker, responsible for auditing and support for the IP&C Nurses and the team is supported by a Data analysis and an administration coordinator.

There are three consultant microbiologists one of which takes the role of Infection Control Doctor. A designated antibiotic pharmacist post supports the Microbiologist and IP&C Team.

The IP&C Nurses in the team manage new results of alert organisms, providing advice and support in the management of identified patients when results are received from the microbiology laboratory.

The IPC nursing team also monitor for evidence of outbreaks and Periods of Increased Incidence (PIIs) to provide data to aid mandatory reporting to the Public Health England (PHE) national Data Capture System (DCS).

In addition to managing results, the team provides support and advice to clinical staff in the identification and management of infections. The team liaises with both the operational team and the management teams to enable the management of individual patients and outbreaks of infections within wards and clinical areas.

There is currently no dedicated electronic infection control surveillance software. The IPCT use a manual system which is resource intensive. The need for a surveillance system would allow the IPCT to identify and assess all the infected patients in the hospital. The IPC team are working on a business case for a system that would provide comprehensive data, ensuring that data capture is less resource intensive.

2.0 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 as an indicator of standards.

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

- *Methicillin resistant staphylococcus aureus (MRSA) bacteraemia (MRSAb)*
- *Clostridioides 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 national Data Capture System (DCS).

2.1 Trust Assigned *Methicillin Resistant Staphylococcus Aureus* Bacteraemia

Trajectory = none set

The DH began mandatory surveillance of MRSAb in April 2004. No formal trajectory was set for the current year for on MRSAb although a full Post Infection Review (PIR) is carried out and cases are still required to be reported. The purpose of the PIR is to investigate how a case of MRSAb occurred and to identify actions that will prevent it reoccurring.

For the year 2018/19, the Trust reported 3 post 48-hour and 9 pre-48 hours cases of MRSAb. PIRs were undertaken on all cases and 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. No lapses in care were identified for the Trust.

Figure 1a: This illustrates the MRSA bacteraemia from April 2001 to March 2019, identifying the number of WHHT cases per year since 2001.

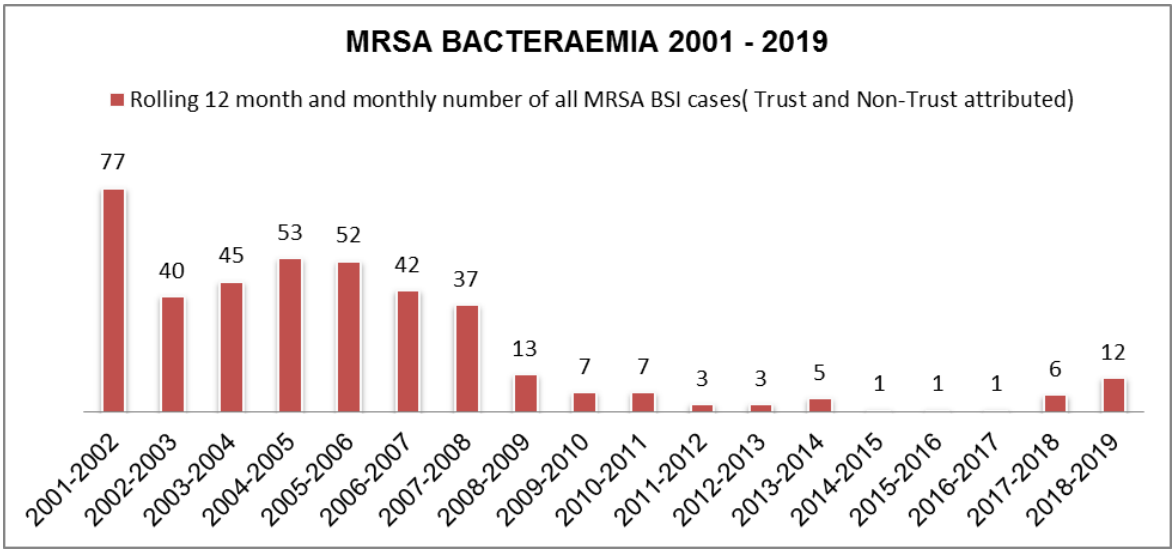
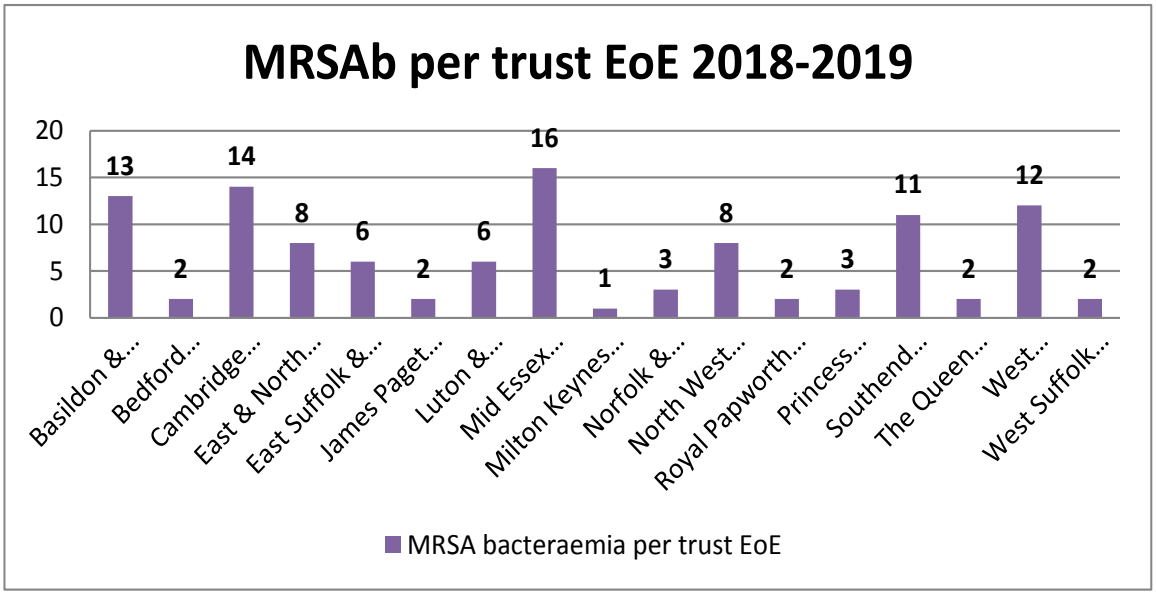


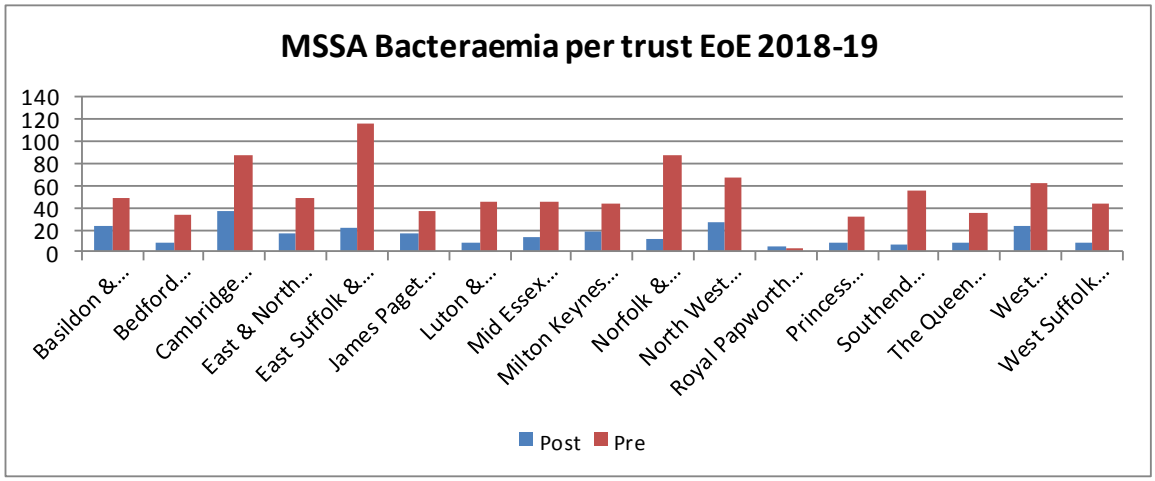
Figure 1b: This illustrates the number of MRSAb per trust in East of England (Apr 2018 to March 2019). Regionally, the numbers of MRSAb were high. The cases recorded under WHHT refers to the cases identified while patients were in the Trust (either ED or inpatient areas). Of 12 cases for 2018-19, 3 cases were trust apportioned and 9 cases were community apportioned. There is currently no set trajectory for number of cases for WHHT.



2.2 *Methicillin Sensitive Staphylococcus Aureus Bacteraemia* (MSSAb)

Reporting of MSSAb has been mandatory since January 2011. As with MRSAb, no trajectory is set for MSSAb. For the year 2018/19 there were 23 post-48 hours cases of MSSAb and 62 pre 48-hours cases, regionally numbers were high (see figure 2). Each case of MSSA is reviewed and findings from thematic analysis such as the presence of an invasive device were addressed.

Figure 2: MSSAb Pre and post 48-hours cases:



The graph above illustrates the number of MSSAb per Trust in Midlands & East of England, 2018/19. There has been collaboration with the Head of IPC for the Herts Valley CCG to address the findings from review of MSSA.

12

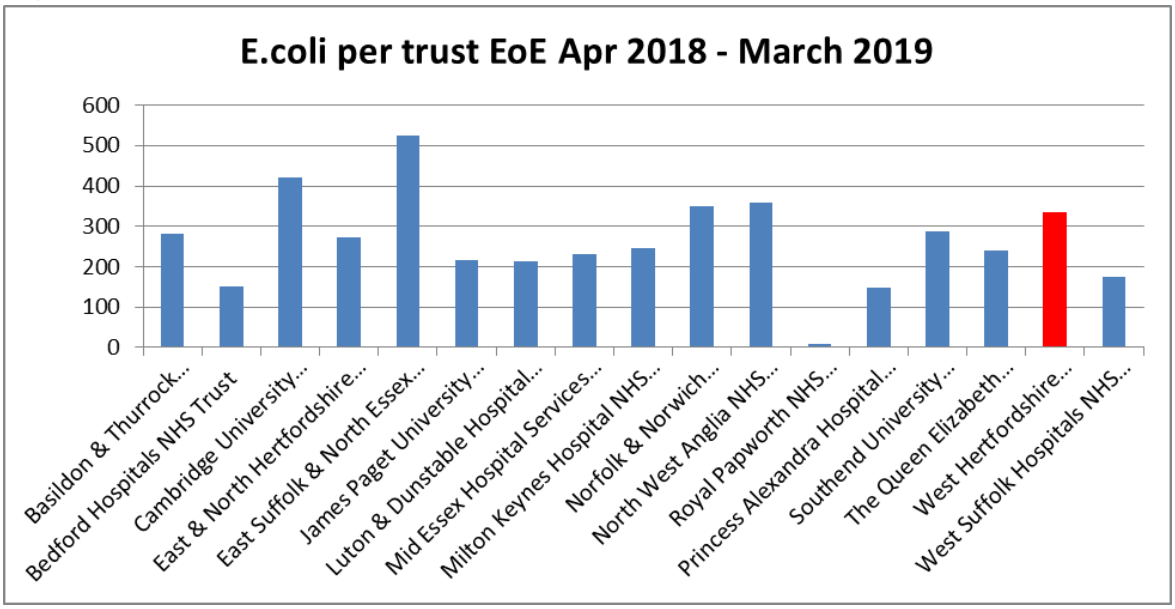
2.3 *Escherichia Coli* Bacteraemia (E. colib)

The reporting of E. colib became mandatory in June 2011. For the year 2018/19 no targets were set. A quality premium set for CCG, (a reduction in number of cases across both Hospital and Community) of 20% reduction was implemented. The majority of cases being community associated with 40 E. colib post-48 hours' cases and 301 pre 48 hours cases. The WHHT cases were lower than the previous year, with 40 cases in 2018-19, compared to 43 cases in 2017-18.

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.

The common theme for E. colib is the presence of a catheter associated urinary tract infection (UTI). Collaborative work is in progress with the CCG to address this including a 90-day UTI Collaborative and an RCA is completed for each case of E. colib, the findings of which is fed back at the divisional governance meeting.

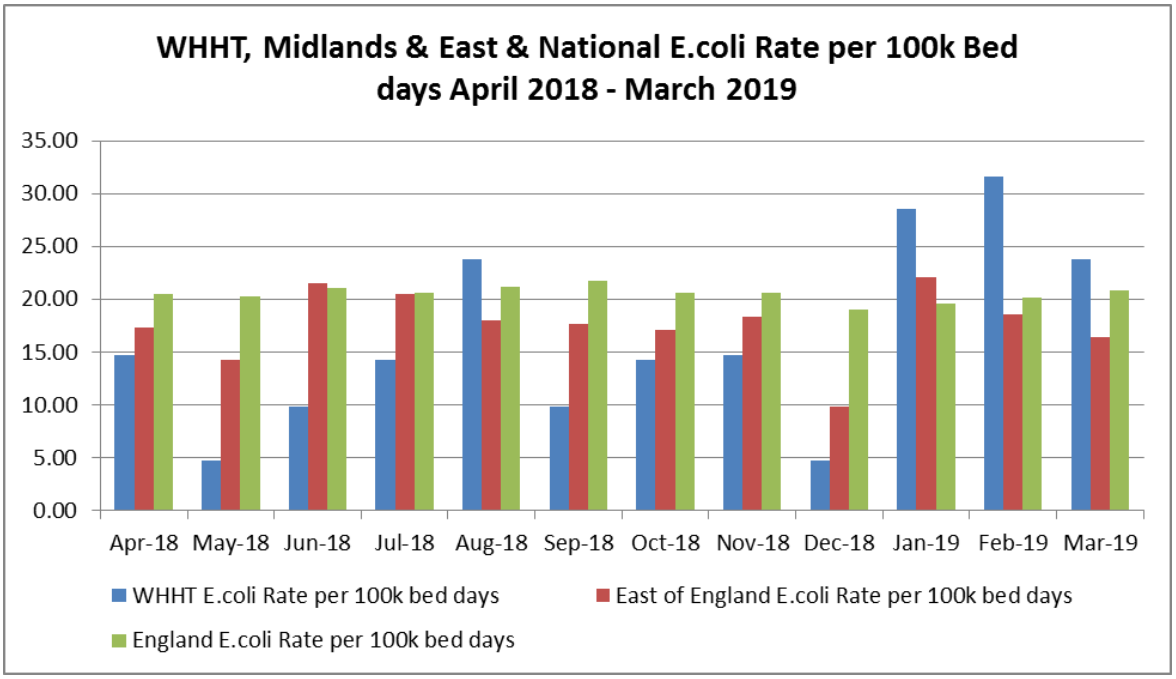
Figure 3a:



The increase in Escherichia *coli* bacteraemia is reflected regionally and on a national level, hence the continued collaborative work nationally and regionally to address this.

12

Figure 3b:



The above graphs and figures show the comparison of West Hertfordshire Hospitals NHS Trust (WHHT) 2018/19 E. coli number and rate per 100,000 bed days against that of Midlands and East (M&E) and the national data.

The E. coli rate has been increasing by 6% per year, which is the reason for the national, regional and local drive regarding E. coli reduction. There are a number of activities which are underway to reduce E. coli figures nationally, regionally and trust-wide.

The trust is currently, collecting and reporting E. coli figures, undertaking RCA's for each case, and planning other strategies through the Continence group and Best Practice Catheter and Urinary Tract Infection (UTI) group. This involves WHHT being part of a wider group with CCG and other Health Care organisations to identify areas of improvement to reduce the number of E Coli infection. Initial work is related to the management of patients with UTIs and Urinary catheter care. This includes the trust participation in a 90-day QI programme looking to increase oral hydration.

The IPCT has commenced an E. coli management group with action plan. This includes looking at the use of catheter passport and communication between organisations. The key focus also 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 /management and display of E. coli figures on the ward IPC board. Findings from E. coli review will now be feed into the Quality Improvement Forum.

2.4 WHHT apportioned CDI cases 2018/19

The trust trajectory for this financial year was 22, and Root Cause Analysis (RCA) are completed for all cases.

All cases of CDI of day 3 of admission or after (WHHT apportioned CDI cases) were investigated using the RCA process. The expectation was that the RCAs were completed within fourteen working days of the notification.

The RCAs process involves; the IPCT (Deputy Director of IPC, IPC nurse, 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 and shared as part of the CCG appeal process. 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 attend the Divisional Clinical Governance meeting. IPC is a standing item on the agenda of these meetings. The CDI RCA and action plan are also feedback at the IPC Panel for assurance and compliance through the divisional infection prevention and control exceptional reports.

2.5 Summary of Trends of the Finding from CDI RCA for 2018/19

- Incomplete stool chart documentation
- Improvement in equipment decontamination score
- Improvement in compliance with IPC training uptake
- Delay in sending stool specimen and identification of possible infectious cause

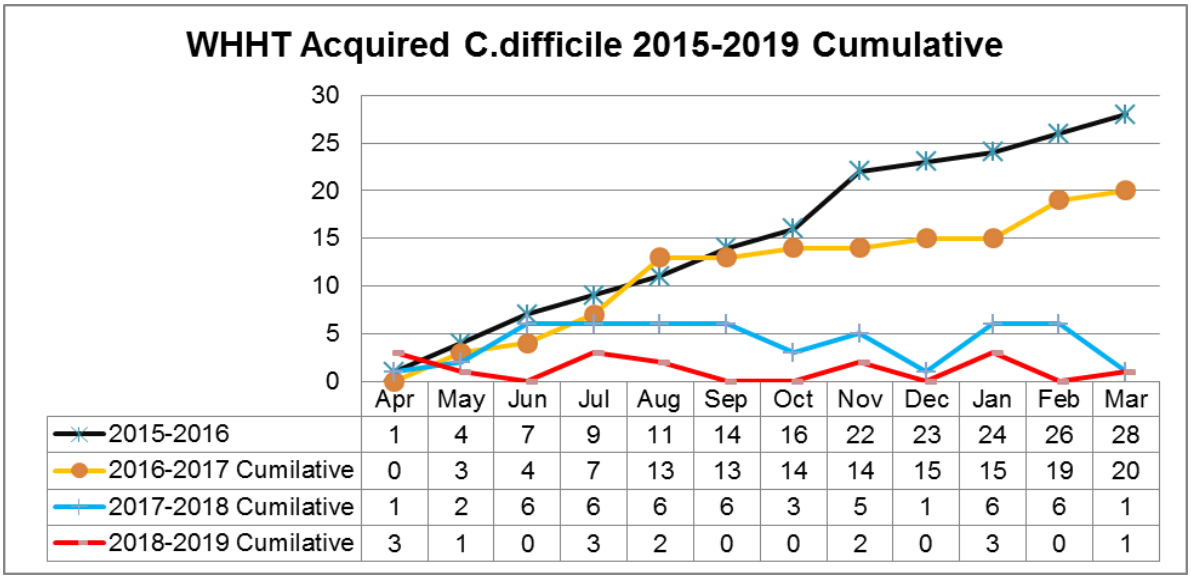
These trends have been addressed using various measures including; a CDI action plan in place which has been implemented to improve CDI management and strategies in the Trust and it is feedback regularly to the Herts Valley CCG for assurance purposes. The IPC team continued to deliver C. diff power training on wards, at governance meetings and training days to raise awareness of C. diff management. Communications were distributed to increase C. diff awareness at all levels, particularly relating to early sampling and isolation. The IPCT antimicrobial rounds and weekly MDT C. diff rounds continued in 2018-19, along with increased targeted IPC support for audit and commode training in key clinical areas.

2.6 Exclusion from Lapses of Care for CDI cases

Negotiation is allowed with the CCG 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, 5 cases have been submitted, where we demonstrated that the acquisition of CDI was unavoidable, indicating that there were no lapses in care in these cases.

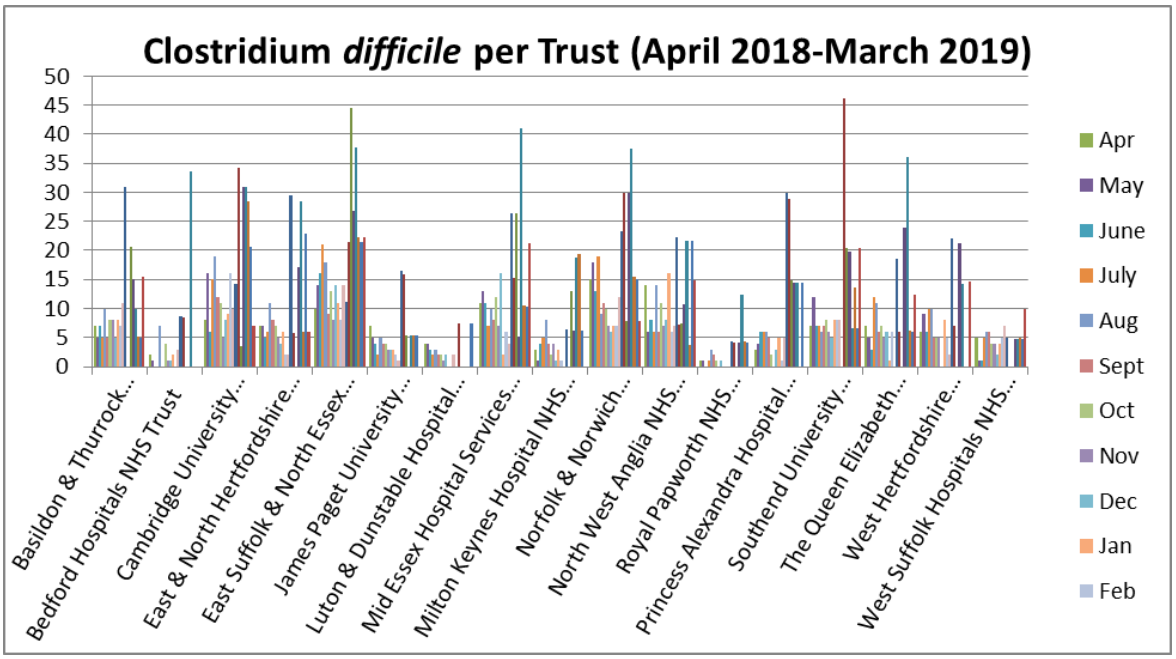
The below C. diff graph compares the last four financial years, identifying 2018-19 with the lowest figures, compared to the previous years.

Figure 4: C. diff rates for the last four years April 2015 to March 2019:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	1	4	7	9	11	14	16	22	23	24	26	28
2016-2017 Cumilative	0	3	4	7	13	13	14	14	15	15	19	20
2017-2018 Cumilative	1	2	6	6	6	6	3	5	1	6	6	1
2018-2019 Cumilative	3	1	0	3	2	0	0	2	0	3	0	1

Figure 5: WHHT C. diff compared with other trusts in East of England in 2018/19:



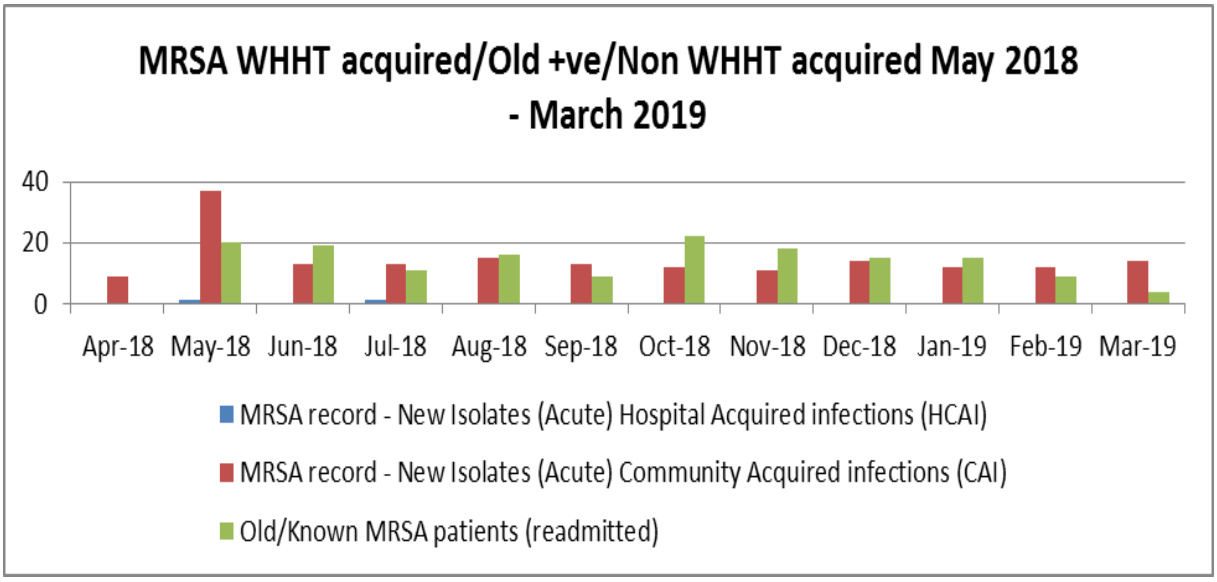
2.7 MRSA Isolates

2.7.1 MRSA isolates for April 2018 – March 2019

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

12

Figure 6:



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

2.8 Carbapenemase-Producing Enterobacteriaceae (CPE)

WHHT has adopted a strict policy for the control of CPE 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).

2.8.1 CPE Endoscopy - SI

Two patients were identified in May 2018 with CPE, having the same strain following bronchoscopy, same scope used on both patients was scope 56. This was declared as a SI in line with the SI investigation process and following a full SI investigation and implementation of an action plan, the SI was de-escalated. The actions required have now been completed and final sign off with evidence of completion of all actions is monitored by the Infection Control Panel.

The SI investigation highlighted a number of areas for improvement regarding the processing of scopes. As a result of this investigation, recommendations were made and an action plan was put in place and a report written by members of IPCT and SI review panel which was shared with the HVCCG and presented at the Infection Prevention and Control Panel.

As a result of this investigation, the following recommendations have been made:

- Electronic tracking is being implemented across all areas of the decontamination unit, including the treatment room in endoscopy. This will highlight any errors or delays in the processes. A system called T-DOC is implemented in the decontamination unit for electronic tracking of scopes.
- A bid is to be submitted so that electronic tracking can also be installed in ITU and theatres, where scopes are also in use.
- A maximum six-hour delay between the decontamination processes has been recommended and updated in the standard operating procedure (SOP) as advised by Public Health England. This is being complied with by the decontamination unit.
- Vacuum packing of scopes has been introduced to the decontamination department which means that scopes can be stored for up to 30 days. Public Health England's current recommendation is that there is a 12-hour drying time for scopes prior to vacuum packing.
- An audit of all scopes (including upper and lower GI) processing was undertaken, covering a one-month period, which provided assurance that there were no other areas for improvement identified in the decontamination process.

These recommendations are monitored via the Trust decontamination committee, and progress reports submitted to IPC panel.

2.8.2 CPE Flaunden Ward

June 2018 - Two patients from the bay were identified as CPE +ve. Two cases were investigated which identified that the cases each had a unique profile supporting that there was no evidence of transmission between the 2 cases.

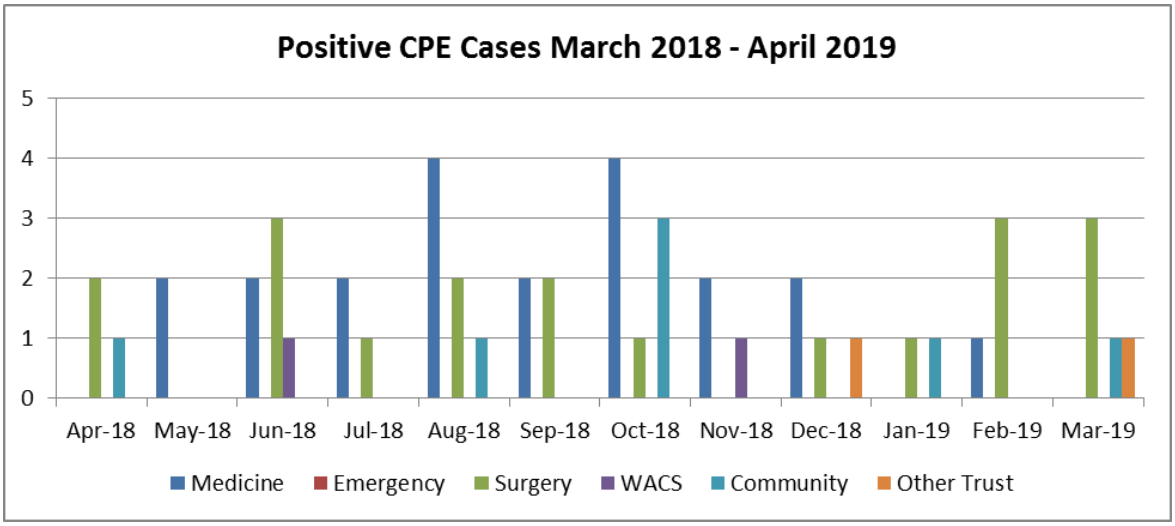
2.8.3 CPE Ridge Ward

September 2018 - Two cases of CPE were identified on Ridge Ward, the typing were similar and therefore it was not possible to rule of cross transmission between both patients, who were in same bay whilst on the ward. It was identified that the index case was unable to be isolated when transferred to Ridge Ward as no single room available. Patients shared toilet facilities and were in same bay for 7 hours. The actions taken are outlined below.

Actions undertaken:

- Full deep clean of bay
- Screening of all contacts
- Training for ward staff
- PIR meetings including outside agencies
- Enhanced cleaning of area including drain decontamination

A full investigation into CPE transmission during 2018-19 in these areas led to the development of the monthly CPE management meetings and weekly CPE ward rounds, an action plan to address issues identified and monitor progress on actions required. The actions are monitored at the CPE management meetings, discussed at the divisional governance meetings and reported to IPC Panel. The evidence for assurance of improved management and practice in relation to CPE includes a reduction in the number of positive CPE organisms identified and the level of screening remains is in line with the Trust policy, improved awareness among staff regarding the management of patients with CPE and no recent clusters of CPE organisms in our wards and departments.



2.8.4 Pseudomonas Special Care Baby Unit (SCBU)

Between August and October 2018 5 cases of pseudomonas were identified as a result of routine screening of babies. This was placed on the risk register for the division. A period of increased incidence (PII) investigation meeting was held to review the cases. None of the babies were clinically infected with the organisms. The investigation identified that none of the babies were in the same clinical areas on the unit at the same time, so transmission was thought to be unlikely. This was further corroborated by the typing profile of the 5 isolates which showed 3 of those to have different VNTR profiles. Two of the remaining isolates which had similar profile did not appear to have been linked when reviewed in the context of the time line. There are current constraints in particular with regards to space on the unit which has been identified as an issue and is on the risk register. A redesign of the unit is now in progress to improve the spacing and layout of the unit. Routine water testing is regularly undertaken on the unit and extra testing demonstrated negative results for pseudomonas which provides assurance that the source was not from the water supply or any contaminated water outlets.

The following additional actions were taken:

- Training of cleaning staff
- Maintaining a clutter free environment and storage
- Evidence of compliance with standards of cleaning
- Hand hygiene and COP auditing to ensure practice compliance

Following a second review meeting the case was closed as there were no outstanding actions or new findings.

3.0 CRITERIA 2 ENVIRONMENTAL CLEANING AND DECONTAMINATION

3.1 Environmental Cleanliness Joint Monitoring

Since April 2018, the cleaning service is provided by Mitie and the contract is monitored by the Facilities team. The Standards audited monthly and are monitored through an auditing system undertaken by Mitie and overseen by the Trust monitoring officers. Input from clinical staff including Ward Managers, Matrons and Housekeeping staff is encouraged throughout the audit process. Scores are divided into responsibilities including estates, domestic and clinical issues to identify the areas where the improvement required.

Trust cleaning compliance is discussed at the site management group for all 3 sites. The IP&C Team, cleaning contractors, facilities and clinical staff are all in attendance at these meetings.

The IP&C Team also meets with Mitie regularly to improve the standards and auditing process, this has included training from the IP&C Team for domestic staff. Monthly areas of concern are raised and this has led to clear improvements in assurance around standards of cleaning.

The cleaning audit scores are reported on the IP&C dashboard and shared with ward managers on a monthly basis. They are discussed at IPCP also.

3.2 Informal Monitoring of Cleaning

The Trust has a programme of regular walk-about including with the Director of Infection Control (DIPC), Deputy DIPC/IPC Lead Nurse and the environment and facilities teams. These visits assess, amongst other things, cleaning standards, reporting back to clinical areas and ensuring actions are taken to address the findings. The IP&C Team ensure that oversight over findings is raised at the time of the review and risk assessments are in place for any outstanding works and actions identified.

3.3 Clinical Cleaning Responsibilities

Cleaning of clinical items and patient equipment is undertaken by both the nursing and housekeeping staff with oversight by the matrons. Compliance with policy is monitored through the environmental and COP audits which are reported on the IP&C Dashboard. COP audit themes have included the cleaning of equipment and in particular the cleaning of chairs, clinical equipment and estates items. Action plans are completed and progress reported via IPC Panel. New cleaning wipes were introduced in March 2019 following a review of products used; detergent wipes were replaced with disinfectant wipes to provide assurance of standards and effectiveness. Training has been undertaken to support the implementation.

3.4 Estates

The Estates team report to the Director of Environment. The aging estate presents challenges for IP&C and a continuous maintenance programme is required. Findings regarding the infrastructure are escalated through the auditing process and Senior Team Walk-about, and risk assessments are undertaken to prioritise the work. This year has seen some work undertaken to improve environment in Winter Ward, theatres and Accident and Emergency department.

3.4.1 Water safety

The water management group meets bi-monthly and comprises of a multi-discipline group of staff. The group advises on actions required to maintain the quality of water system in the organisation. An external water safety engineer also provides advises and oversight of water management.

In accordance with HTM 04-01, the Trust is required to check for the presence of pseudomonas aeruginosa in augmented clinical care areas, including WAC including SCBU, Oncology/Haematology and ITU/HDU.

Electronic systems are in place to ensure the regular tap flushing in the WAC areas and a manual record is available for other areas in the organisation, which is also monitored as part of the “Trust Test Your Care” audits.

The trust also has a statutory responsibility to take appropriate measures for the control of all water-borne microorganisms including Legionella and pseudomonas. Regular temperature checks and surveillance is in place to monitor the water systems.

3.4.2 Ventilation.

The ventilation is managed by the estates team with oversight from an authorising engineer, the Trust Ventilation group aims to meets quarterly and includes multi-disciplinary members.

A programme of maintenance and checking is undertaken in all high-risk areas including the Theatres and ITU. Vents in all areas are cleaned as part of the deep cleaning schedule undertaken by Mitie as part of the cleaning contract.

3.4.3 Decontamination

The Trust decontamination committee reports to IPC Panel, an Authorising engineer for decontamination oversees practices. Following an investigation in Endoscopy related to CPE earlier in the year the decontamination process of endoscopes has been reviewed and improvements made.

Following the decommissioning of a washer for decontamination of nasal scopes the trust has reviewed process for decontamination of some probes, which is undertaken with a 3-stage wipe process, and a log of evidence of the process is completed. Further options are currently being investigated including the decontamination of USS probes.

4.0 ANTIBIOTIC USAGE

Antimicrobial Stewardship April 2018 - March 2019

Establishing an antimicrobial stewardship programme is crucial to the reduction of healthcare associated infections (HCAI) and contributes to slowing the development of antimicrobial resistance. The 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, particularly, 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 and monthly audit report feedback at the IPC Panel.

WHHT’s antimicrobial strategy 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 an annual point prevalence survey of antimicrobials. Junior doctors participated in antimicrobial stewardship audits as part of junior engagement plan.

Several interventions were put in place to achieve the National CQUIN target including regular antimicrobial stewardship review ward rounds, audits to monitor broad spectrum antibiotics (carbapenems), setting up a real time database for carbapenem use and monitoring antibiotic consumption. Antibiotic consumption and other relevant data have been submitted to CCG and PHE for part 2c and 2d targets for the year 2018/19. (Results below):

2c: Indicator 2c Antibiotic review

Month	Numerator	Denominator	% reviewed at 24-72hours	Target 2018/19
QTR1	18	51	35%	QTR 1= 25%
QTR2	40	68	59%	QTR 2= 50%
QTR3	57	62	92%	QTR 3= 75%
QTR4	51	53	96%	QTR 4= 90%

2d: Reduction in antibiotic consumption per 1,000 admissions

Reduction of 1% or more in total antibiotic consumption against 2017/18 target:

Date	Baseline 2017/18 target DDD/admission	DDD/1000 admission (PHE data)	Variation % from baseline 2017/18 target	YTD %
QTR 1	4235.35	3727 (3799)	-12	-12 (-10.3)
QTR 2	4235.35	3810 (3891)	-10	-11 (-9.2)
QTR 3	4235.35	4130 (4022)	-2.5	-8.2 (-7.8)
QTR 4	4235.35	3678 (4006)	-13.2	-9.4 (-7.2)

Reduction of 3% or more in carbapenem against the 2017/18 target:

Date	Baseline 2017/18 target DDD/1000 admission	DDD/1000 admission (PHE data)	Variation % from baseline 2017/18 target	YTD %
QTR 1	65.7	75 (74.6)	+14.2	+14.2 (+13.5)
QTR 2	65.7	64 (75.7)	-2.6	+5.8 (+14.4)
QTR 3	65.7	56 (68.2)	-14.8	-1.1 (+10.9)
QTR 4	65.7	46 (68.3)	-30	-8.3 (+9.1)

Increase of 3% from baseline 2016 of Access group antibiotics:

Date	Baseline 2016	Total antibiotic DDD/1000 admission	Access Antibiotic DDD/1000 admissions	Access group % of total antibiotic (PHE data)
2016	40.66 %			
QTR 1	40.66 %	3644	1392	38.12% (43%)

QTR 2	40.66 %	3810	1445	37.93% (38.6%)
QTR 3	40.66 %	4130	1560	37.77% (37.1%)
QTR 4	40.66 %	3561	1418	39.82% (34.1%)

The antimicrobial stewardship activities in the Trust were presented as posters at different international and national conferences. Junior doctors participated in some of these audits. Posters of these audits were presented at ECCMID 2018; Madrid were:

- Empirical use of temocillin in hospitalised patients: a retrospective study on clinical effectiveness, outcome, associated cost and mortality rates at a large district hospital, East of England, UK
- Piperacillin/tazobactam (piptaz) shortage: consequences and experience at a large district hospital in East of England, UK
- Appropriateness of antibiotic treatment for the community-acquired pneumonia (CAP): a retrospective study at a large district hospital, East of England, UK.

Five posters and one workshop on “A year in antimicrobial stewardship workshop” were presented at Federation of Infectious Societies (FIS) in Newcastle in November 2018. Posters for the antimicrobial stewardship and case studies presented were:

- Appropriateness of antibiotic use in hospitalised patients: a retrospective study at a large district hospital, East of England, UK
- On-the-go” real time Meropenem Database: Innovative Approach to Microbiologist Advising with a positive impact on meropenem stewardship
- Drivers of Meropenem Prescription: A retrospective study at a large district general hospital, East of England, UK
- Poor sensitivity of the qSOFA assessment when deployed as a stand-alone screening tool for sepsis in adult inpatients at a large District General Hospital
- Fatal Septic Shock in 50-Year Old with Unusual Organism isolated from the Blood

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 Antimicrobial Stewardship team was very proud to receive the antibiotic guardian award organised by PHE in recognition of achievements in antimicrobial stewardship for prescribing and stewardship in the Trust. The award was presented by Dame Sally Davies CMO at an international ceremony in June 2018.

The antimicrobial stewardship team was also interviewed by hospital pharmacy Europe about how our hospital is tackling antimicrobial resistance. This case study was published online on hospital pharmacy Europe in September 2018.

4.1 Current Actions and Recommendations:

- Assess appropriateness of antimicrobial prescribing for treatment and prophylaxis.
- Complete the annual point prevalence audit in November 2019
- 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
- Expansion of OPAT service
- Introduction of innovation to improve antibiotic prescribing and ensure appropriate antibiotic use for example rapid diagnostics

5.0 CRITERIA 4 – PROVIDING INFORMATION TO SERVICE USERS

The Trust provides regular updates on performance related to IP&C and mandatory reporting of alert organisms is completed and shared with the wider community. The Trust provides infection rates on Ward information boards which are updated on a monthly basis.

Patient information leaflets are available on the Trust intranet and web site and include MRSA, C diff, CPE, Influenza and Norovirus.

In addition, the Trust responds to rises in cases of communicable disease and seasonal peaks of viruses such as Influenza and Norovirus, providing advice on visiting the Trust and measures to reduce spread.

The IP&C Team also work with clinicians and GPs to alert individual patients to their infectious status and support with advice re-treatment and management of these conditions. Where applicable, Duty of Candour is undertaken with patients that acquire avoidable Health Care Associated Infections.

6.0 CRITERIA 5 - PROMPT IDENTIFICATION OF PEOPLE WITH INFECTIONS AND PREVENTION OF SPREAD

6.1 Identification of patients with infections

The IP&C team usual a manual system of managing microbiological results, ensuring effective communication with the Laboratory to act on results promptly. In addition, the Team use an electronic admission system to identify patients already flagged with alert organisms such as MRSA, CPE and C. *diff* to identify isolation precautions and give advice on the management of these patients. Manual records are used to identify any possible transmission, and identify PII or outbreaks. The possibility of an electronic surveillance system for the Team is being investigated in order to formulate a business case.

6.2 Assessment of patients with risk factors for infections

6.2.1 Diarrhoea & Vomiting (D&V) risk assessment

A D&V risk assessment is used across the Trust to assist in the management of patients that develop or are admitted with diarrhoea and/or vomiting. The assessment assists to identify risk factors for infections such as *C. difficile* and viral gastroenteritis (including Norovirus). This assessment assists with the ongoing management of patients and allows the effective use of isolation rooms by identifying patients that are at a higher risk. The documentation forms part of the individual's plan of care. Where single rooms are not available to isolate patients, staff are advised to escalate to the site management team for an available single room.

6.2.2 Admission IP&C assessment

A SOP is now in place for both Hemel Hempstead UTC and St Albans MIU, to determine patients that are of a high risk related to IP&C. Isolation facilities are available at both sites to manage these patients. The process of assessment includes the electronic checking of alerts for previous/current infections, and asking patients a series of questions related to IP&C risk. This includes PHE guidance on CPE and other infectious illnesses. All staff have been trained in use of the SOP.

In addition to these 2 areas, Watford ED also have a system of identifying high risk patients and a process for isolation of these patients. The IP&C team work closely with operational colleagues to identify isolation facilities for patients requiring admission.

6.3 WHHT Surgical Site Infection Surveillance Programme 2018-2019.

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

6.3.1 Orthopaedic SSIS Results Published Data

In 2018/19 WHHT has continued to participate in continuous THR + TKR SSI surveillance across both WGH + SACH, in line with the mandatory requirement. Additional SSI Surveillance has also been undertaken on Spinal Surgery (SACH, Jul-Sep 18), Breast Surgery (SACH, Oct-Dec 18) and Repair of #NOF (WGH, Jan-Mar 19).

The Trust undertakes Surgical Site Surveillance in a number of areas, with Orthopaedic being one of the biggest areas. Ongoing surveillance of THR and TKR is reported quarterly, with Neck of femur fractures and spinal surgery reviewed on an annual basis. All patients are monitored for signs of infection at the time of surgery and at follow up appointments.

The data below covers all sites for WHHT and shows SSI rates for the last 6 months, and cases reported in the previous 4 quarters.

There has been an improvement in SSI numbers in 2018-19 as outlined in the tables below.

Figure 15: Orthopaedic SSIS results:

Q4. October-December 2019 (Published PHE data)

SACH Total Hip Replacement (THR)	**Oct-Dec 18**	**Last 4 periods**
Study population (number of operations)	63	295
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
SACH Total Knee Replacement (TKR)	**Oct-Dec 18**	**Last 4 periods**
Study population (number of operations)	103	382
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%
SACH Breast Surgery	**Oct-Dec 18**	**Last 4 periods**
Study population (number of operations)	96	N/A
Number of inpatient/readmission SSIs	1	
% infected	1%	
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		1.3%
SSI details: • **Operation:** Right sentinel lymph node biopsy • **Date of Operation:** 18.10.18 • **Date of SSI:** 17.11.18 • **Detection:** Readmission • **Depth:** Deep Incisional • **Organism 1:** MSSA		
WGH Total Hip Replacement (THR)	**Oct-Dec 18**	**Last 4 periods**
Study population (number of operations)	29	83
Number of inpatient/readmission SSIs	0	0

% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Knee Replacement (TKR)	**Oct-Dec 18**	**Last 4 periods**
Study population (number of operations)	36	82
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%

Q3. January-March 2019 (Prospective results, PHE upload due 30.06.19)

SACH Total Hip Replacement (THR)	**Jan-Mar 19**	**Last 4 periods**
Study population (number of operations)	74	291
Number of inpatient/readmission SSIs	1	1
% infected	1.35%	0.3%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		Awaiting PHE report
SSI details: • **Operation:** Left Total Hip Replacement • **Date of operation**: 04.01.18 • **Date of SSI:** 28.01.19 • **Detection**: Readmission • **Depth:** Superficial • **Organism 1:** Proteus Mirabilis.		
SACH Total Knee Replacement (TKR)	**Jan-Mar 19**	**Last 4 periods**
Study population (number of operations)	97	388
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		Awaiting PHE report
WGH Total Hip Replacement (THR)	**Jan-Mar 19**	**Last 4 periods**
Study population (number of operations)	32	107
Number of inpatient/readmission SSIs	0	0
% infected	0	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		Awaiting PHE report
WGH Total Knee Replacement (TKR)	**Jan-Mar 19**	**Last 4 periods**
Study population (number of operations)	22	103
Number of inpatient/readmission SSIs	0	0
% infected	0	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		Awaiting PHE report
WGH Repair of Fractured Neck of Femur	**Jan-Mar 19**	**Last 4 periods**

(#NOF)		
Study population (number of operations)	80	N/A
Number of inpatient/readmission SSIs	0	
% infected	0	
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		Awaiting PHE report

6.4 Vascular Access

6.4.1 Clinical Nurse Specialist (CNS) Vascular Access (VA) main responsibilities

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, trust-wide training including competency assessment and completion and CVAD guidelines.

6.4.2 Vascular Access Service - Insertions

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 referrals automatically link to the Vascular Access database. The VAN reviews all referrals and prioritises according to clinical and discharge needs. Furthermore, the CNS Nutrition and the nutrition support nurse undertake the insertion PICC and midlines to support the VAN.

Figure 1.0 shows PICC/ midline insertions (May 2018 – May 2019)

REASON FOR INSERTION	PICC	MIDLINES
Intravenous antibiotics	113	119
Parenteral Nutrition	25	-
Chemotherapy	12	-
Access	18	11
TOTAL	168	129

Figure 1.1 shows average waiting time for insertion since referral (May 2018 – May 2019)

Average waiting days from referral to insertion	PICC	MIDLINE
Intravenous Antibiotics	2.5	2
Parenteral Nutrition	1.04	-
Chemotherapy	3.3	-
Access	1.5	0.75

Figure 1.2 shows the reason of delayed insertion and the average waiting day (May 2018 – 2019)

Reason of delayed insertion	No. of patients	Average waiting days
ACU room availability	14	4.4
A/W microbiologist plan	9	7
Interim arrangements	6	6

6.4.3 PICC/ Midline removals

The information is based on 88 removals for this period.

Figure 2.0 shows the reason of removal of lines (May 2018 – May 2019)

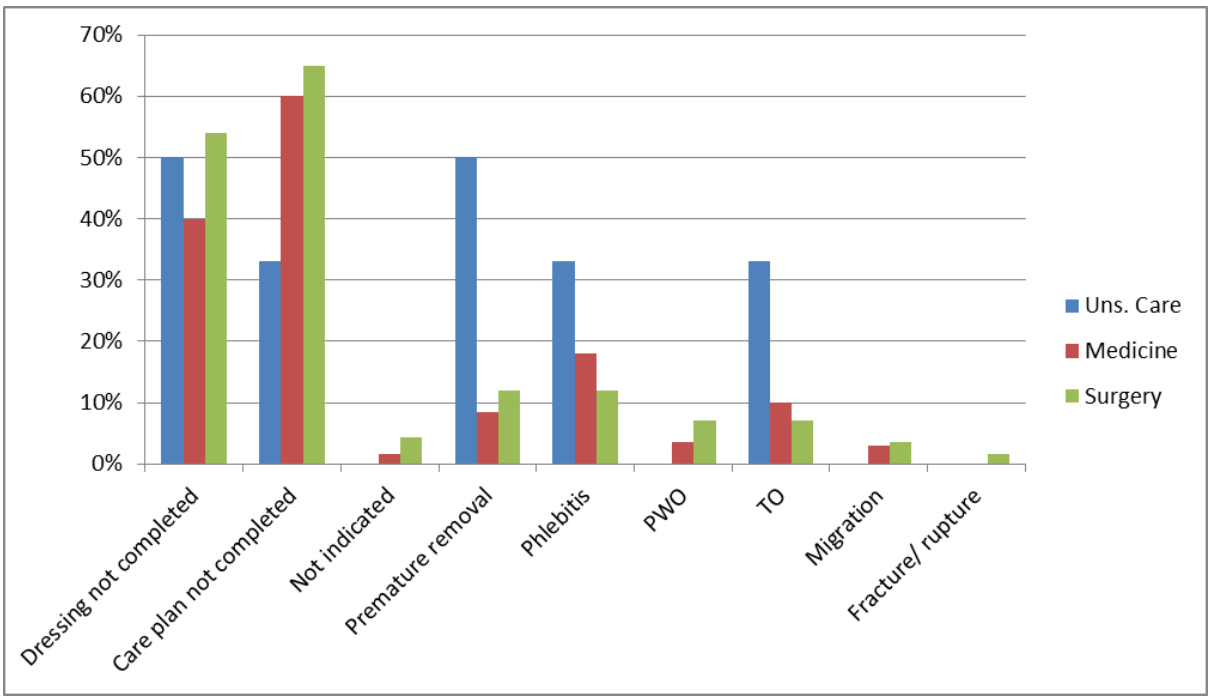
Reason of removal:	PICC	Midline
Treatment finished:	25	29
Infection (suspected):	4 *(Negative tip)*	2 *(Negative tip)*
Malposition:	11	N/A
Migration:	4 *(before December 2018)*	2 *(before December 2018)*
Accidental removal:	1	1
Occlusion:	1	1
RIP:	3	4

- The Healthcare @ Home team provide PICC/Midline removal information on all relevant patients.
- Notification of line removal is vital in providing safe care to the patients especially once the patient is discharged into the community. There is partnership working with commissioners to improve communication in this regard.
- Secur-A-cath has been introduced to keep lines in place which has seen the migration rates have drop to 0%.
- PICC positioning monitored with a chest x-rays at the end of the insertion. This is costly and time consuming. Other methods such as an intraluminal ECG tip placement process are being looked into.

6.4.4 Care and Management - AUDIT

The VAN carries out an audit of CVC lines, which covers both those inserted internally by the vascular access service and those externally inserted by other organisations. The collected data includes: indwelling days, PIVD presence, observations, signs/ symptoms, indication, care plan and dressing compliance, complication rates. The devices audit includes: PICC lines, Hickman lines and midlines. From August 2018 – May 2019, 129 lines were audited across unscheduled care, Medicine and Surgery. Two CVCs were observed in unscheduled care, 69 CVCs were observed in Medicine and 58 CVCs were observed in Surgery.

Figure 3.0 shows results of the audit August – May 2019:



Based on findings of each individual review and audit, the VAN provided recommendations regarding clinical care and areas for improvement in the divisions.

There is a focus on teaching in the wards or divisions to reduce the complication rates as well as clinical care of CVCs.

This year:

1. Securacath devices have been implemented (January 2019) for PICC and midline insertions, so as to reduce migration and mechanical phlebitis. None of these complications has been noted since then.

2. Compliance regarding dressing changes has been the main focus in Medicine, so as to reduce the risk of phlebitis. Band 5s and 4s staff are also being trained. Since March, a big reduction in missed dressing changes has been notes as well as phlebitis reduction.

3. There has been daily advice on VIP scoring and maintaining the care plan as per policy and there has been an increase in the number of staff trained on vascular access care. Individual wards are now taking charge of this and updating staff at their daily huddles.

There was an observation of an increase in total occlusions rates, which was possibly due to inadequate flushing. To address this there was an increase in staff training, which focused on the correct maintenance of CVC as per policy. Also, with the assistance of TELEFLEX (PICC procurement), the Vascular Access champions and link role was created to embed compliance with Vascular access care across the Trust.

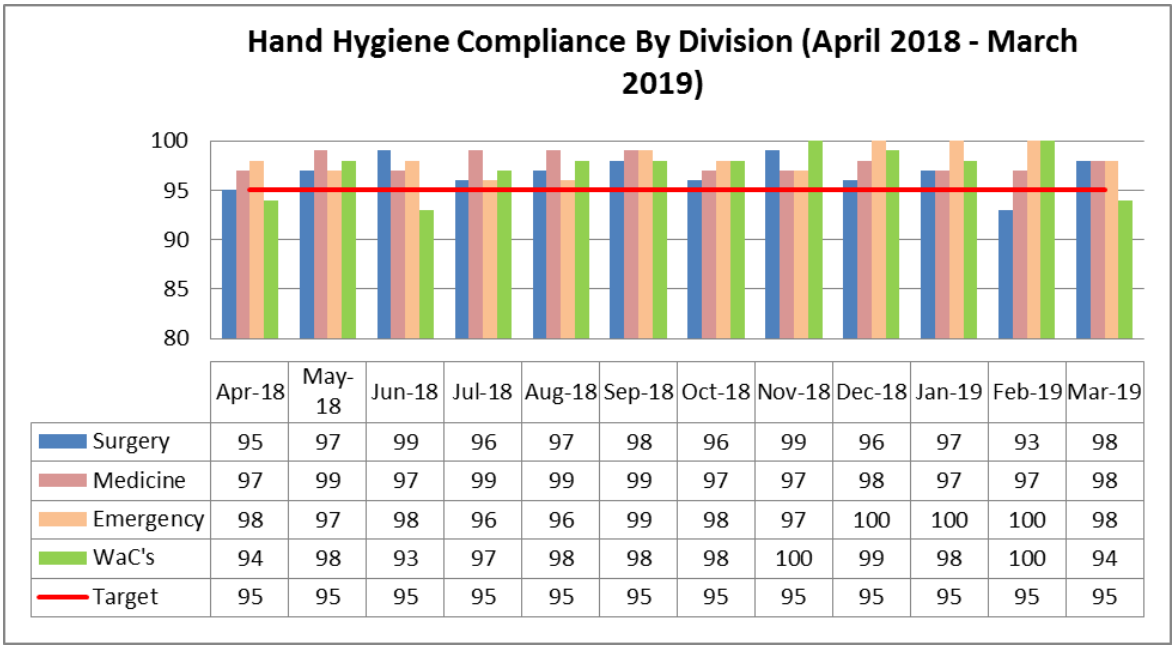
7.0 CRITERIA 6 - SYSTEMS TO ENSURE ALL CARE WORKERS ARE AWARE AND UNDERTAKE RESPONSIBILITIES FOR IP&C

7.1. 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.

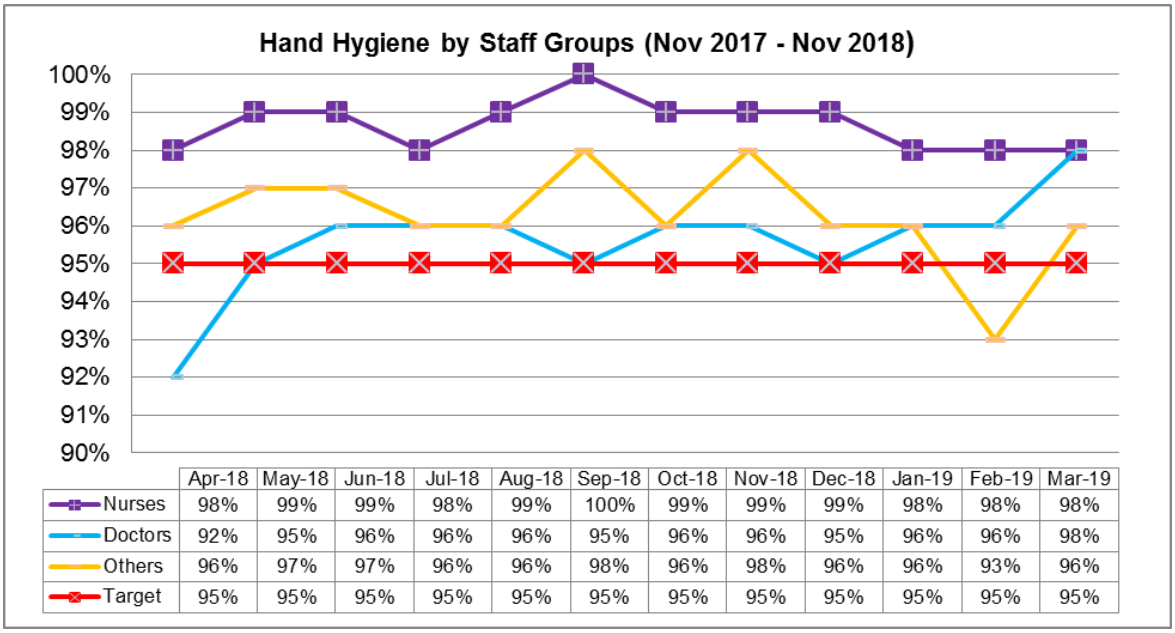
All auditors are trained in undertaking the hand hygiene audits to ensure that there are no variations.

Figure 15a:



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Surgery	95	97	99	96	97	98	96	99	96	97	93	98
Medicine	97	99	97	99	99	99	97	97	98	97	97	98
Emergency	98	97	98	96	96	99	98	97	100	100	100	98
WaC's	94	98	93	97	98	98	98	100	99	98	100	94
Target	95	95	95	95	95	95	95	95	95	95	95	95

Figure 19b:



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Nurses	98%	99%	99%	98%	99%	100%	99%	99%	99%	98%	98%	98%
Doctors	92%	95%	96%	96%	96%	95%	96%	96%	95%	96%	96%	98%
Others	96%	97%	97%	96%	96%	98%	96%	98%	96%	96%	93%	96%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

12

7.2 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.

7.2.1 Code of Practice (CoP) audits

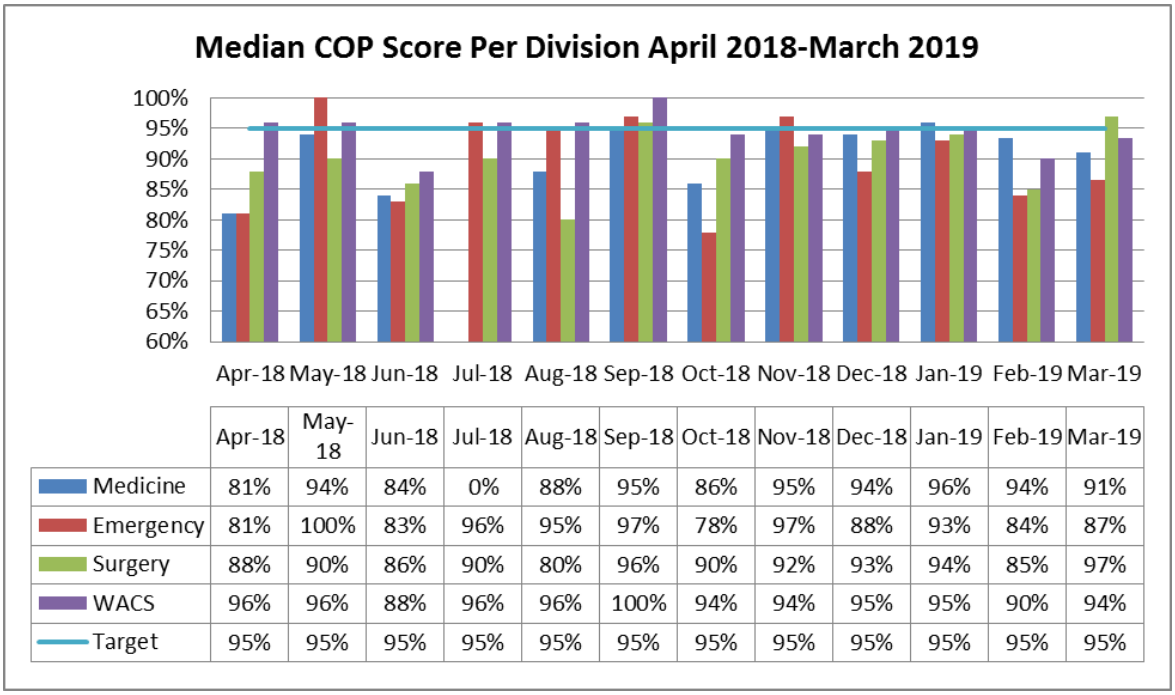
CoP audits are undertaken monthly, with the IPCNs and the clinical areas are required to complete them on alternate months.

The key themes are:

- Cleanliness of equipment – patient chairs have been highlighted as a particular area for improvement
- PPE usage and compliance with policy
- Cleaning of the environment to remove high- and low-level dust

There are followed up with the facilities, Mitie and clinical leads. Feedback is provided at the matrons meeting, where actions for improvement are agreed and taken forward.

Table 16:



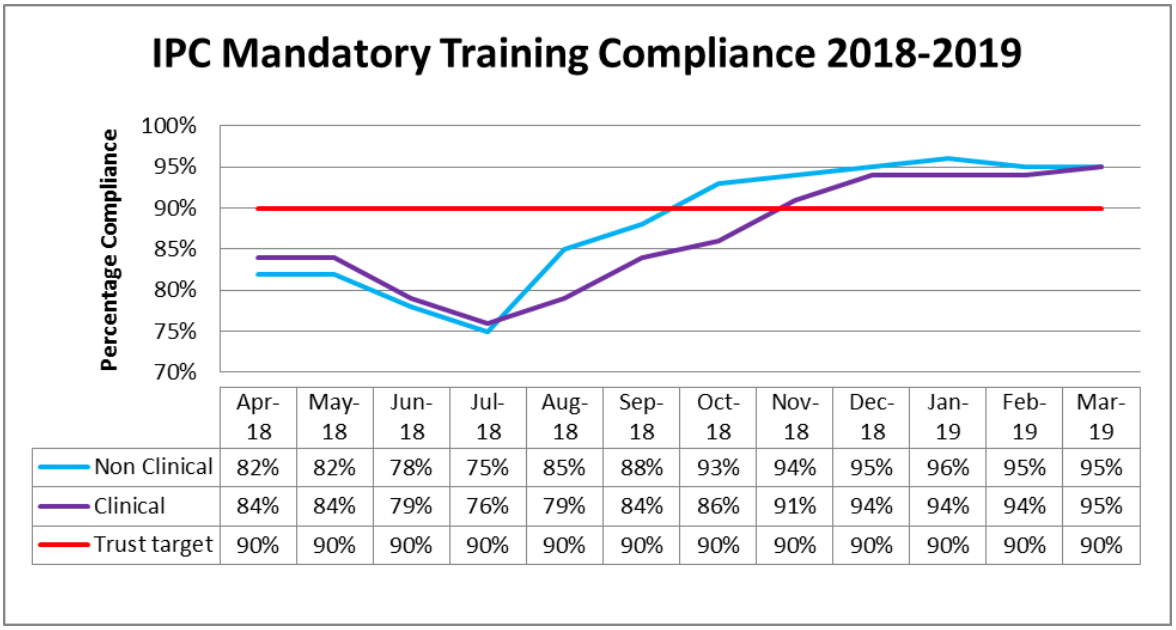
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medicine	81%	94%	84%	0%	88%	95%	86%	95%	94%	96%	94%	91%
Emergency	81%	100%	83%	96%	95%	97%	78%	97%	88%	93%	84%	87%
Surgery	88%	90%	86%	90%	80%	96%	90%	92%	93%	94%	85%	97%
WACS	96%	96%	88%	96%	96%	100%	94%	94%	95%	95%	90%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Action plans are completed by clinical areas for any identified areas of concern, the IP&C team support with Power training on areas such as PPE usage, hand hygiene. C *difficile awareness* and other identified needs.

7.3 IPC ACTIVITIES

Figure 17: Infection Prevention and Control Training Compliance

The Trust target for IPC mandatory training is 90% for clinical staff. Compliance is monitored at the meeting



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Non Clinical	82%	82%	78%	75%	85%	88%	93%	94%	95%	96%	95%	95%
Clinical	84%	84%	79%	76%	79%	84%	86%	91%	94%	94%	94%	95%
Trust target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

The IP&C Team also offer education in the form of formal study days, awareness days and ad-hoc ward power training. Example of this include areas where PII have been identified and support is required to raise awareness and focus on areas of non-compliance as well as areas with new/junior staff and support is required to ensure that standards are understood and maintained. The IPC team has worked alongside clinical educators in Medical division to provide a general understanding of IP&C Practice and management. Tudor and castle wards have particularly benefited from this with sustained improvements now ween in audit data for the area.

7.4 IP&C Dashboard Data

An IP&C monthly dashboard is updated at the start of each month and the data forms part of the monthly board report and is shared with all managers. Each ward area has its own separate dashboard with information to share with ward staff. This data is reviewed at IP&C Panel, and divisional reports received.

WEST HERTFORDSHIRE HOSPITALS INFECTION CONTROL DASHBOARD March 2019

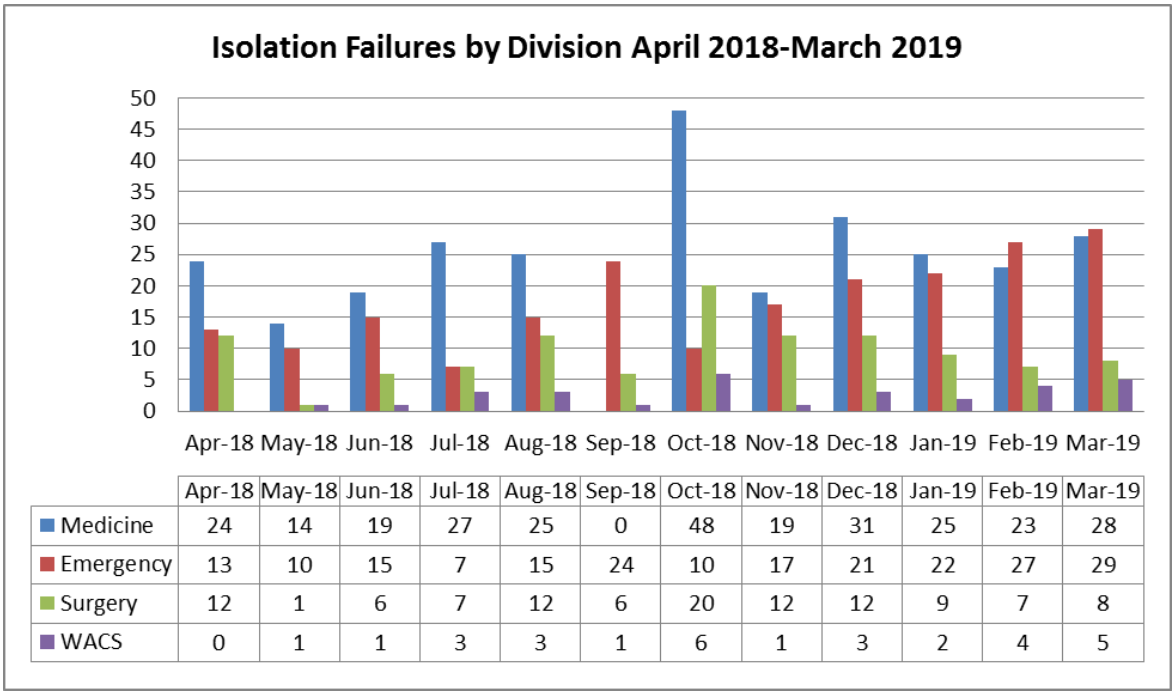
Data Entry by	Reponsible Matron	Ward	IPC	IPC	IPC	IPC	IPC	IPC	IPC				IPC	Ward	IPC		V
WARDS/DEPARTMENTS		IPC Mandatory Training compliance	Hospital acquired MRSA Blood	Hospital acquired MRSA Other sites	Hospital acquired C. diff	E.coli BSI	CPE Positives	Time to Isolate Diarrhoea	Hand Hygiene Compliance in %				Commode Cleanliness	Joint Mitie & Vard Staff Cleaning Scores	Enviromental Report		Co
COLOUR MATRIX SCORE AS %	Matron in Charge of the Vard/Area	≥90%= Green Amber = 75 - 89% <74%= Red	≥1 = Red 0= Green	≥ 1 = Red 0= Green	≥ 1 = Red 0= Green		New Cases	≥1 = Red 0= Green (Number of failures)	≥95%= Green 80-94%= Amber <80%= Red				100%= Green 95-99%= Amber <95%= Red	95-100% = Green <95% = Red High Risk Areas (e.g ITU, SCBU, Theatres) 98%= Green <98%=Red)	44 Page Completed	16 Page Completed	95-100% = Green < 95% = Red
KEY INDICATORS		% of staff trained	Number of infections	Number of infections	Number of infections		CPE Positive Numbers	Time to Isolate	Nurse/HCA	Doctor	Others	Overall	% Clean	Cleaning Score	Received by IPC	Received by IPC	%Facilities/Equipment
MEDICINE DIVISION (Head of Area Angela Wellman)																	
Bluebell Ward	Emma Pope	100%	0	1	0	1	0	0	100%	100%	100%	100%	100%	97%			93%
Frailty Unit	Emma Pope	89%	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A			N/A
Red Suite	Emma Pope	91%	0	0	0	0	0	4	100%	100%	100%	100%	100%	95%			N/A
Oxhey Ward	Jo Cartwright	100%	0	0	0	0	0	1	100%	100%	100%	100%	100%	98%			N/A
Patient Lounge	Jo Cartwright	100%	0	0	0	0	0	0	100%	NO	100%	100%	N/A	95%			100%
Tudor	Jo Cartwright	98%	0	0	0	0	0	6	100%	71%	100%	90%	100%	96%		Yes	N/A
Castle	Jo Cartwright	98%	0	0	0	0	0	0	100%	71%	100%	90%	100%	97%			N/A
Winyard Ward	Emma Purkis	96%	0	0	0	0	0	4	100%	NO	NO	100%	100%	95%			N/A
Helen Donald Unit	Marisa Ruppersburg	100%	0	0	0	0	0	1	100%	NO	NO	100%	100%	98%			100%
OPD HHGH	Marisa Ruppersburg	100%	0	0	0	0	0	0	ND	ND	ND	ND	N/A	97%			75%
OPD SACH	Marisa Ruppersburg	100%	0	0	0	0	0	0	100%	100%	NO	100%	N/A	97%			82%
Dermatology WGH	Marisa Ruppersburg	100%	0	0	0	0	0	0	ND	ND	ND	ND	N/A	95%			N/A
Dermatology HHGH		100%	0	0	0	0	0	0	ND	ND	ND	ND	N/A	99%			91%
AAU Level-3 Isolation	Kirsty Spazzolino	88%	0	0	0	0	0	0	89%	100%	71%	85%	100%	96%			N/A
AAU Level-3 Blue/Yellow	Kirsty Spazzolino	88%	0	0	1	1	0	2	89%	100%	71%	85%	100%	96%			70%
Sarratt Ward	Jo Cartwright	93%	0	0	0	0	0	1	100%	93%	100%	99%	100%	95%			74%
Cassio Ward	Jo Cartwright	100%	0	0	0	0	0	4	100%	100%	100%	100%	100%	97%			N/A
CCU	Kirsty Spazzolino	100%	0	0	0	0	0	1	100%	100%	100%	100%	100%	96%			86%
Heronsgate	Kirsty Spazzolino	98%	0	0	0	0	0	0	ND	ND	ND	ND	100%	96%			77%
Gade	Kirsty Spazzolino	98%	0	0	0	0	0	2	ND	ND	ND	ND	100%	95%			77%
Stroke Unit	Emma Pope	96%	0	0	0	0	0	0	100%	100%	100%	100%	100%				91%
Aldenham	Kirsty Spazzolino	100%	0	0	0	0	1	1	100%	86%	100%	95%	100%	95%			89%
Croxley	Kirsty Spazzolino	90%	0	0	0	1	0	1	100%	95%	85%	92%	100%	99%			79%

June 2018 | July 2018 | August 2018 | September 2018 | October 2018 | November 2018 | December 2018 | January 2019 | February 2019 | March 2019 | Marc

8.0 Criteria 7 - Provide adequate isolation facilities

There are challenges in isolating patients with the limited availability of side rooms in the Trust as well as competing priorities. 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. IPC and the site team review the use of the side rooms regularly and allocate them to patient who requires isolation.

Figure 14: Percentage for time unable to isolate for 2018-19:



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medicine	24	14	19	27	25	0	48	19	31	25	23	28
Emergency	13	10	15	7	15	24	10	17	21	22	27	29
Surgery	12	1	6	7	12	6	20	12	12	9	7	8
WACS	0	1	1	3	3	1	6	1	3	2	4	5

Figure 14 shows the percentage for failure to isolate. Failure to isolate within two hours is recorded on Datix as an incident and discussed at the bi-monthly IPC Panel. 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.

9.0 Criteria 8 – Microbiology Laboratory Support

Laboratory services for the Trust are provided by a fully UKAS accredited on-site laboratory. The Clinical advisory component of the Microbiology service is provided by three Consultant Microbiologists, one of whom is the Clinical Lead and Lead Infection Control Doctor, one is the Antimicrobial lead and the other is the TB and C. difficile ward round lead. The Microbiologists also provide input on various clinical and IPC activities including Joint IP&C & Microbiology ward rounds for C. diff, CPE, TB, Orthopaedic, and Diabetic Foot Infection MDT and other high risk and complex patients.

The IP&C team and Microbiology team work closely together to provide a comprehensive and cohesive IPC service to the Trust and meet regularly to discuss issues and future plans and initiatives.

Recent National UKAS review on 18th June:

The laboratory was inspected as part of its Annual Surveillance Programme by UKAS (UK Accreditation Service) to assess compliance against a set of National Laboratory

Standards. The feedback was really positive. The assessors described the medical component as “Clinical Excellence-Patient focused and High quality”. Comments included: “Competencies assessment well embedded within the Quality management culture, putting patient first is of foremost importance and a priority, broad array of specialist clinical activities, very good mix of leadership and team work, gaining recognition/winning National awards is a reflection of the Clinical Excellence and working to high standards, very good documentation and supporting evidence” They added that “they had faith in the excellent service that we provide”.

National Award Recognition on the 12th June

The Lead Infection Control Doctor also received a prestigious National Award, the RCPath Excellence Award in recognition for the significant contribution she has made to microbiology both nationally in providing leadership as Chair of the Microbiology Specialty Advisory Committee and locally in combining dedication and commitment and going beyond the day-to-day to improve the health and care of patients and the welfare of trainees. The award was presented by Professor Jo Martin, President of the Royal College of Pathologists on the 12th June at an award ceremony at the Royal College in London.

10.0 Criteria 9 - IP&C Polices

10.1 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.

10.2 Risks

Current risks on the register are all scored 12 or below.

The key risks relating to IPC are outlined below with the mitigatory actions in place:

- No 2883: Estates issues due to the age and fabric of building.

  Mitigation: IPC works closely with Estates and Facilities to address these, prioritising the highest risk items which require addressing.

- No 4044: Vascular access provision for insertion of PICC lines.

  Mitigation: a CNS for VA is now in post, and service development process is in progress.

- No 2199: Inadequate isolation facilities in the Trust.

  Mitigation: Out of hours and weekends there is a senior nurse to support ward staff in prioritising the side rooms and during the week IPC Nurses support this. IPC and the operational site team review the use of the side rooms regularly and allocate them to patient who requires isolation.

- No 3935: SSI in orthopaedic surgery with previous high rates of SSI identified is elective arthroplasty surgery at Watford site.

  Mitigation: this has since been addressed, which all categories showing a low SSI rate. Actions implemented included a ring-fenced elective orthopaedic self-contained unit at the Watford period on a trial basis. There is also recent implementation of pre-operative decolonisation washes for high risk orthopaedic patients.

- No 3671: Deep clean programme delayed due to operational pressures over winter months.

  Mitigation: this is now monitored very closely with the facilities team to ensure that staff are provided as required to undertake the required deep cleans. We now also have a decant area of 'winter ward' due to reconfiguration of the site.

- No 4078: there is no electronic surveillance system for IP&C Team to manage alert organisms and infection rates.

  Mitigation: the IPCT continues to monitor infections manually and the development of a business case for an IPC software is in progress.

11. CRITERIA 10 - OCCUPATIONAL HEALTH 2018/19

Occupational health provides services to the Trust that are designed to protect and enhance staff health through risk management, health assessment, immunisation and the provision of specialist advice including rehabilitation and fast track physiotherapy. Occupational health supports the control and management of infectious disease through the screening and immunising of new employees, staff exposed to infectious disease as part of their work duties including exposure through needle stick injury and splash incidents and by undertaking staff contact tracing.

Seasonal influenza 2018/19

The 2018/19 seasonal influenza campaign commenced on the 10th October 2018 and ended on the 28th February 2019. Following a significant communications and advertising campaign focusing on informing and educating staff - this year's seasonal Influenza uptake improved resulting in 76.0% of frontline clinical staff being vaccinated.

NHS England and NHS Improvement have published their Commissioning for Quality and Innovation (CQUIN) guidance for 2019/20. Improving the uptake of flu vaccinations for front line staff in providers – this indicator remains in the 2019/20 CQUIN and the payment threshold has been increased to 80 per cent.

Tuberculosis Screening

Healthcare workers (HCWs) are at occupational risk of contracting and transmitting tuberculosis (TB). Occupational Health routinely screens healthcare workers as per the Collaborative TB strategy for England 2015/2020. This strategy recommends latent

tuberculosis testing and treatment for 16 – 35yrs olds who have recently arrived in the UK from high incidence countries (World Health Organisation TB rates of 150/100,000 or over and Sub-Saharan Africa).

All staff new to the NHS go through a process of being paper screened for signs/symptoms of active Tuberculosis. During April 2018 – Mar 2019, 65 Interferon-Gamma Release Assays (IGRAs) blood tests were undertaken in Occupational Health. Staff with a positive latent TB result was referred for further investigations, such as blood test and Chest X-ray and followed up by TB Nurse Specialist and WHHT Respiratory services.

Contact Tracing

Measles Mumps and Rubella

The protection of healthcare workers is especially important in the context of their ability to transmit Measles, Rubella or Mumps infections to vulnerable groups.

New figures From Public Health England (2019) indicates 231 confirmed cases of measles nationally in the first three months of this year—slightly less than in the same period last year but still a large increase since 2017. From 1 January to 31 October 2018 England had 913 laboratory confirmed measles cases, up from 259 reported in the whole of 2017.

At WHHT there has been one suspected case of measles (March 2019) and one confirmed case (July 2019) both admitted via the Children's Emergency Department.

Mumps

No new cases of mumps were reported this year – although PHE (2019) have reported a significant increase in outbreaks in some universities.

Rubella

No new cases of rubella were reported this year.

Pertussis - (whooping cough) - is an acute bacterial infection caused by Bordetella Pertussis, an exclusively human pathogen that can affect people of all ages

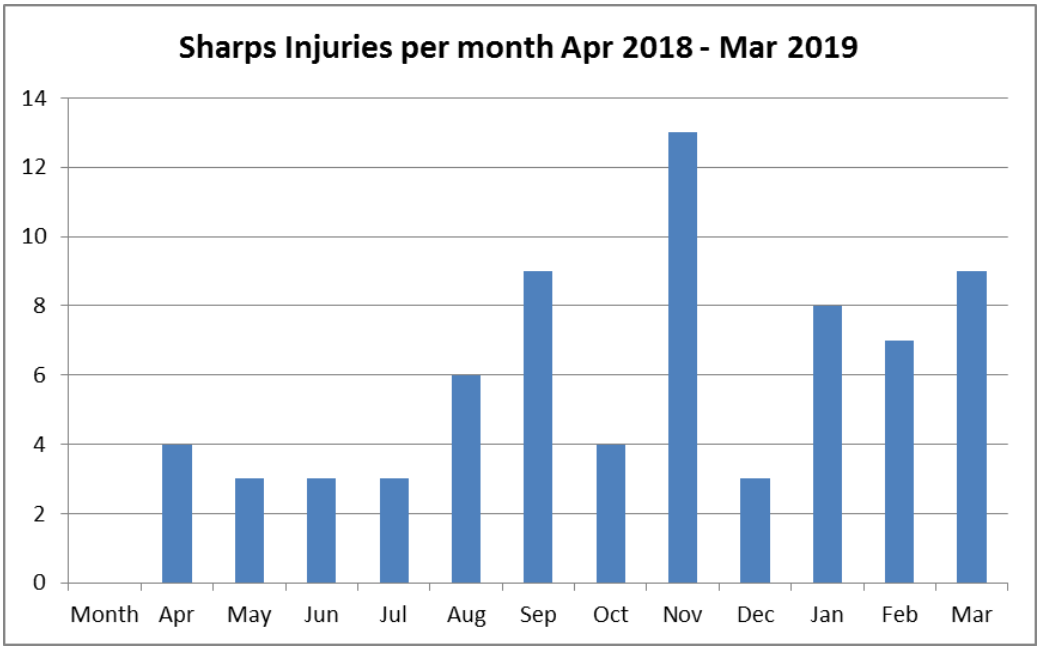
Occupational Health carried out contact tracing in February and March 2019 and also in May 2019 for positive cases of Pertussis. Contact tracing was initiated for A/E, AAU purple and Aldenham ward, AAU Green level 1, Red suite and Starfish ward.

In total 88 members of staff were provided with the Pertussis fact sheet in regard to signs and symptoms. All pregnant staff were advised to contact their General Practitioner to discuss the risk and benefits of antibiotic therapy.

There have been no reports to Occupational Health of staff presenting with symptoms.

Needle Stick Sharps Injuries and Splash incidents

In 2018/19 there were 72 reported sharps incidents. The cause of sharps injury according to the latest Health and Safety Report was due to staff taking blood 26.6%, subcutaneous needles 21%, and needles left unattended 9.5%.



Issues over the current year have been non-reporting on Datix. It has been identified where there have been proactive health and safety sessions there were a drop in the number of incidents reported. The highest professions affected by NSI remain nursing and medical staff. Over the last year there have been 2 incidents reported to HSE, in compliance with RIDDOR.

The service does not have an electronic system to accurately gather data in relation to Infection Prevention & Control. The service is Added to this is the complexity of staff records (stored at Hemel Hospital) which impedes the ability of Occupational Health to respond promptly to potential infection control issues.

12 PRIORITIES FOR COMING YEAR

- Strengthen IP&C team infrastructure to undertake surveillance and analysis within the IP&C Team. Possible business case for ICNET
- Sustain standards, methods and assurance around all aspects of cleaning working with cleaning contractors to provide assurance on standards in all three sites.
- Continue work to improve and sustain clinical standards of IP&C across the Trust to ensure consistency in all areas.
- Manage current estate including plans for refurbishment and updating. Continue with risk assessment for management of water, ventilation and decontamination, including the implementation of 2 negative pressure rooms on ITU.

- Undertake collaborative work with the CCG to reduce numbers of gram-negative BSIs across the region, including a collaborative QI programme across the whole region to improve patient hydration
- Continue to review of current isolation facilities and requirements for WHHT, managing the risks alongside the operational team.
- Collaboratively work with PHE and other partners to manage the CPE risk within the Trust and wider community
- Ensure robust winter plan for viral illness including influenza and norovirus
- Contribute to the design and planning of the proposed newly refurbished hospital to design out infections

13. RECOMMENDATION

The Trust Board is asked to receive this report for information and assurance of the compliance with the Health & Social Care Act which contains the 'Hygiene Code'.

Tracey Carter, Chief Nurse and Director of Infection Prevention & Control Team

October 2019

APPENDIX 1

The Hygiene Code: 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.

Compliance Criteria	What the registered provider is required to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse effects and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have, or are at risk of developing, an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for individual's care and provider organisations that will help control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Trust Board
05 December 2019

Title of the paper	**Annual Report on Complaints and Patient Advice and Liaison Service**
Agenda Item	**13/77**
Presenter	**Tracey Carter, Chief Nurse**
Author(s)	**Beverley Taylor, Complaints Manager** **Jackie Dick, Senior Nurse Resolution & PALS** **Marsha Jones, Associate Chief Nurse Quality**
Purpose	*For approval*: *For discussion*: *For information*: ✓

Executive Summary	In accordance with the NHS complaints Regulations (2017) this report sets out an analysis of the number and nature of complaints received by the Trust.
	The annual Complaints and Patient Advice and Liaison Service (PALS) report has been discussed at the Quality Committee and reported to Trust Board through the assurance report.
	
	This report provides a summary of patient complaints, concerns and compliments received in 2018/2019. It includes details of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman's investigations and actions taken by the Trust in response to complaints.
	
	Complaints Key points to note:
	
	• In 2018/19, 432 complaints were received by the Trust during 2017/18 giving an average of 36 complaints per month. This is a significant decrease when compared to 750 in 2017/2018 and 841 in 2016/17.
	• Acknowledgments were sent within the national target of 3 working days 100% of the time.
	• The Trust responded to 71% of all complaints within the time agreed with the complainant an improvement from 56.4% in 2017/2018 and 42% in 2016/2017.
	• There was only one complaint over 6 months old a significant drop from the same period last year (this is now closed)
	• Complaint learning events were held three times during this reporting period.
	• A number of improvements have been identified for development and implementation, a consistent way in which to share lessons learnt and feedback within the divisions and specialties. These include:
	  • Work with the Divisions and Quality Governance Facilitators to ensure where identified that learning/action plans are completed for all complaints.
	  • Further work to consolidate the response time improvements and to achieve the Trusts 80% target.

	PALS Key points to note • Development of a weekly tracker to monitor all concerns at a Divisional level using a RAG rating system (RED for breach, AMBER for nearing breach and GREEN for under investigation). • Standard Operating Procedure (SOP) was developed by PALS in February 2019; the target is to respond to all queries within 5 working days of contact. • Quality of data collection has improved due to robust management of individual members of staff recording concerns accurately. • The team have developed their own system of triaging the concerns raised and discussions are held as a team to establish the best course of action. • Updated Complaints Handling Policy
Trust strategic aims	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: Quality & Safety Group; Quality Committee Date: 20 August 2019; 26 September 2019
Action required	The Trust Board is asked to receive this report for information and assurance that the Trust is compliant with NHS England Complaints Policy.

13

Agenda Item: 13/77

Trust Board meeting – 05 December 2019

Annual Report on Complaints and Patient Advice and Liaison Service

Presented by: Tracey Carter, Chief Nurse

1 Introduction

1.1 In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and service they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or, if failings have occurred, ensure that learning and improvements take place.

1.2 Complaints, feedback forms and Patient Advice and Liaison Service (PALS) contacts are some of the useful feedback tools West Hertfordshire NHS Trust utilises to capture feedback about the care and treatment provided to patients.

2 Purpose

2.1 This report provides assurance that complaints handling and management is compliant with our Trust Policy. It presents the findings on complaints and PALS activity, and identifies the trends and learning from 1 April 2018 to 31 March 2019.

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

2.3 This annual report will also be used to assist in learning lessons and to improve the quality of patient care during the year. The report also sets out recommendations where further improvements could be made to the complaints process. This includes how the Trust learns from formal complaints received from patients, their families/carers and members of the public.

3 Background

3.1 The Department of Health published the Local Authority Social Services and NHS Complaint Regulations, which was updated in 2017. The policy contains up to date information relating safeguarding in terms of patients, complainants and staff. Further minor amendments have been made, with the aim to improve the service provided to complainants. These include making specific regulatory requirements more clear within the policy and also improving the quality of communication with complainants. This document outlines NHS England's commitment to dealing with complaints about the service provided by them and the services they commission. In doing so, it meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) updated June 2017, conforms to the NHS Constitution and reflects the recommendations from the

Francis report (2013).

3.2 The Trust's Complaints Handling Policy 2018 to 2021 outlines the process the Trust will undertake to manage complaints. Complaints can be received in writing, via email, verbally, or in person. There is information about how to raise a concern or make a complaint on the Trust's website. Posters and leaflets are also available around the Trust advising patients and their families how they can raise concerns and who to contact. All complaints received are reviewed by the Chief Nurse and signed off by the Chief Executive or their deputy. The Divisional Manager and/or relevant clinician are asked to investigate and collate the information relating to the complaint. This information has to be provided within a specific timeframe.

3.3 Over the last year staff has demonstrated good engagement and co-operation during complaints investigations. A small number had to be renegotiated due to delays in receiving responses from the divisions and/or when the complaint proved complex, requiring further investigation or input from other disciplines.

4 Analysis/Discussion

4.1 In 2018/2019 there continued to be a large focus on quality of data recorded and improving how data is recorded to provide more robust assurances to the Board, commissioners and regulators. This includes continuing to validate and ensure new data is quality checked on a weekly basis. We introduced new data sets to improve our assurance processes to the Board and equally having access to information in real time. This enables staff to act decisively and manage risks to the service.

4.2 Quality of data recorded also relies on the individual members of staff recording the correct information in the correct place. Correctly recorded data is necessary to ensure an accurate analysis of the information. An audit in 2016/2017 highlighted that Datix was not effectively used as the repository for all action plans and correspondences. This is now fully implemented in the complaints management process.

5 Summary

5.1 In 2018/19, **432** complaints were received at West Hertfordshire NHS Trust (750 in previous year 2017/2018). In total **555** complaints were responded to. The additional responses were as a result of outstanding complaints from 2017/2018.

5.2 The Trust responded to 71% of all complaints within the timeframe agreed with the complainant an increase from 56.4% in the previous year. Of the complaints we responded to, 53% of complaints were upheld or partially upheld. A reduction from 72% in the previous year.

5.3 The Trust recognises the value of having an independent body that patients, relatives and carers can refer their complaint to should the Trust not be able to resolve their concern to their satisfaction. In such instances and in accordance with the regulatory requirements, the Trust advises patients, relatives and carers of their option to refer their complaint to the Parliamentary Health Service Ombudsman (PHSO). The Trust embraces the PHSO's scrutiny of its complaint handling and uses findings as an opportunity to learn and improve. In addition to the PHSO's case work, the Trust review and seek to learn from the various reports that the PHSO produce throughout the year.

5.4 The Trust experienced a spike in the volume of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). There were 17 complaints referred to the PHSO during

the year (an increase of 14 from the previous year). The complaints team analysed these but identified no clear theme in the subject matter. A full update is available in section 19.

5.5 All lessons learnt are uploaded onto Datix. There are good examples of specific learning throughout the Trust and these are further discussed in section 20 'Learning and Improvement from Complaints' in this report.

5.6 The End of Life Compassionate Care Group continues to receive a bi monthly report from the Complaints team which details all complaints concerning end of life care. The complaints are reviewed and discussed at the meeting and learning is shared with the wider team and used to inform policy and practice as appropriate.

5.7 The Complaints team attend and provide reports for the Patient Experience Group meeting. The aim of the report is to provide an update to the Patient and Carer Experience Group on the delivery of four priorities with the Patient Experience and Care Strategy at a divisional department's level and to provide evidence of achievement against key performance indicators agreed 2018/2019.

6 Risks

6.1 Risk register number 3773 (closed). In 2016 it was identified that there was a risk that complaints were not captured, recorded, investigated and learned from in a timely manner. This was an area of ongoing improvement for the Trust. As contact could potentially happen anywhere and with anyone who works on one of the Trust sites, the risk that cannot be eliminated. This risk is mitigated through a combination of defining clear responsibilities, having clear systems and processes and education among front line staff and support services Trust wide. The central complaints and PALS teams also work collaboratively under a new leadership structure to ensure contacts are classified correctly and directed along the correct pathway.

6.2 The above risk is now closed and has been fully mitigated due to the processes and systems now in place to provide corrective action.

7 Overview of compliance with Complaints Policy

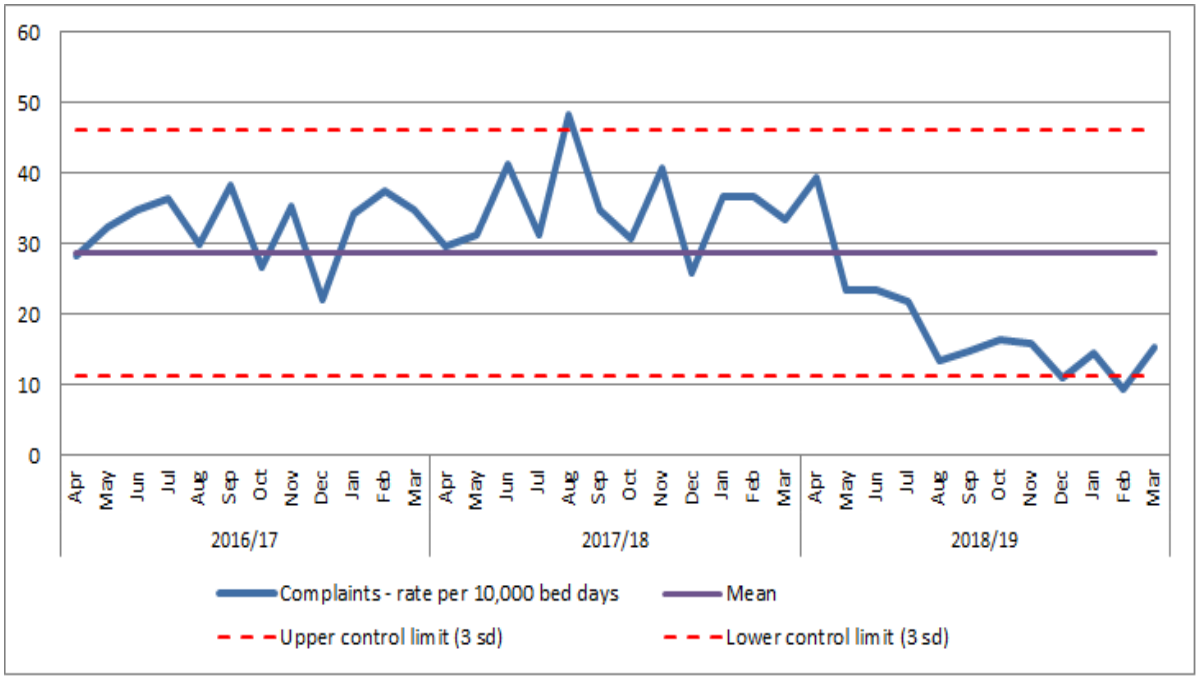
7.1 Complaints performance, themes and trends are monitored through the Patient Experience Group, chaired by the Chief Nurse. Complaints performance is also monitored monthly by the Trust Board and discussed bi-monthly at the Quality Committee, a subcommittee of the Board.

7.2 Themes and trends are monitored and shared at the Quality Committee, chaired by the Chief Nurse and complaints performance is monitored in Divisional Governance Meetings and the Divisional Performance Meetings, chaired by the Chief Operating Officer. The Trust process is compliant with the Complaints Handling Policy.

8 Analysis of Complaints Received in 2018/19
(Extracted from Datix Database)

8.1 The chart below records complaints per 10,000 bed days. This is reported monthly via the Integrated Performance report and bi monthly to the then Safety and Compliance Committee. The Complaints Team have been working with the divisions and supporting them to reduce the overdue complaints. As you can see from the graph the number of complaints the Trust received has reduced significantly this year.

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



8.2 The Trust received a total of 432 complaints (down from 750 the previous year) a decrease of 318 complaints from 2017/2018.

8.3 There are a number of reasons as to why the numbers of complaints the Trust receive have decreased, these are:

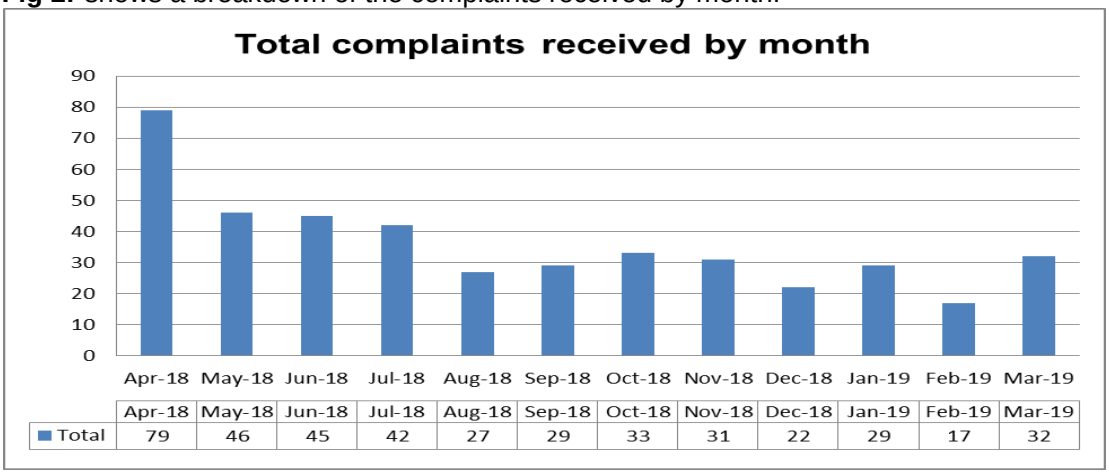
8.4 Complaints continue to be triaged on a daily basis by the Complaints team and the Lead Nurse for Resolution/PALS Manager and at this point a decision is made as to whether the concern can be dealt with by the PALS team or Complaints team. This ensures the concern is appropriately registered on Datix.

8.5 Divisions are learning from complaints and if, as a result of a complaint, any learning or action is identified, these are put into place to avoid something similar happening in the future. As a result of this fewer complaints are being made.

8.6 Ward staff are also being more proactive and resolving concerns before they escalate to become formal complaints.

9 Number of new complaints opened per month

9.1 **Fig 2:** shows a breakdown of the complaints received by month.



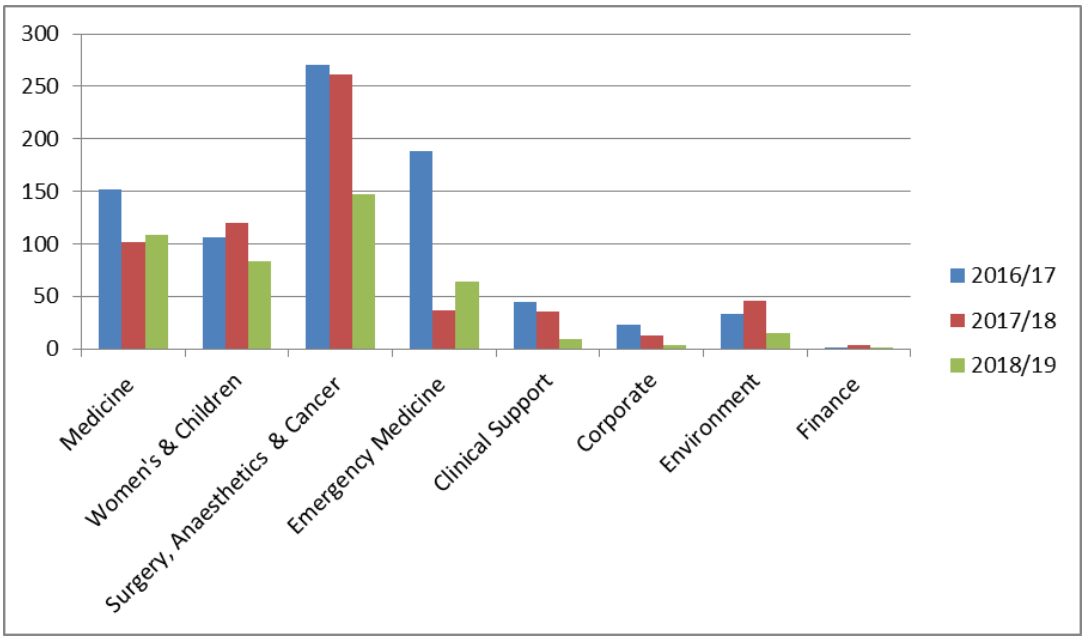
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total	79	46	45	42	27	29	33	31	22	29	17	32

10 Complaints acknowledged within 3 working days

100% of complaints are acknowledged within 3 working days. This is compliant with NHS England complaints process.

11 Complaints received by Division by year

Fig 3: shows show complaints broken down by division from 2016 to 2019.



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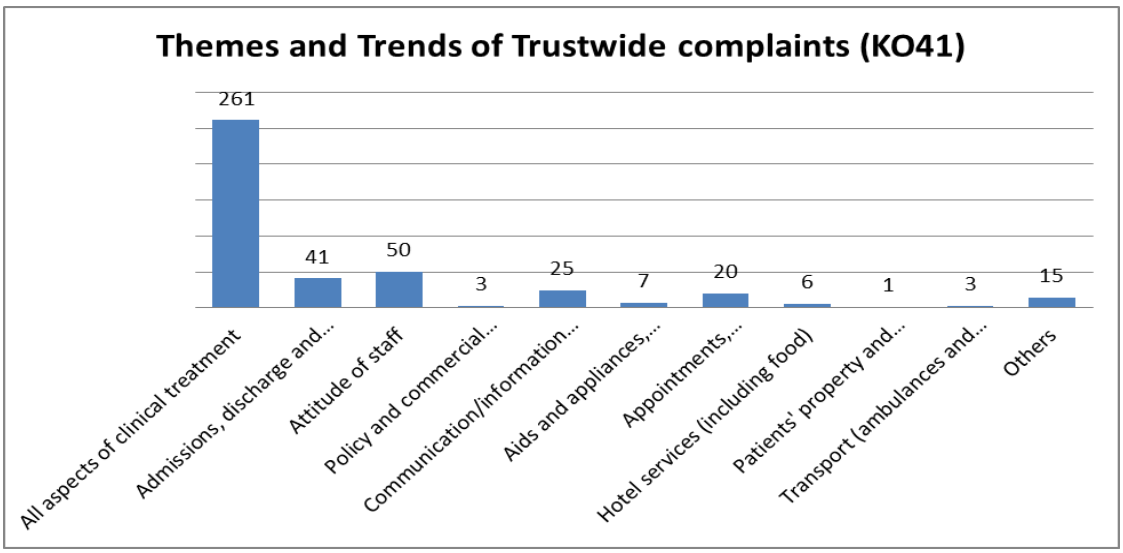
11.1 Surgery, Anaesthetics and Cancer in both 2016/2017 and 2017/2018 had the most reported complaints. However it is of note that the number of complaints they received in 2018/2019 has decreased by 44% (107). The division of Women's and Children have also decreased by 31% (37) and Medicine has stayed about the same.

12 Breakdown of complaints – Themes and Trends (KO41)

12.1 The Trust uses nationally reported subjects (KO41's) to analyse the main reasons for patients complaining. The Trust also uses a separate subject matter list of reasons in providing clarity in understanding the themes from the concerns raised. Each complaint the Trust receive can have a number of issues raised in each complaint received this can be from the cleanliness of the ward to concerns over care. The issues identified below are not an exhaustive list and most divisions have had similar issues raised. No trends have been identified.

12.2 **Fig 4:** shows themes and trends of Trust wide complaints' (KO41).



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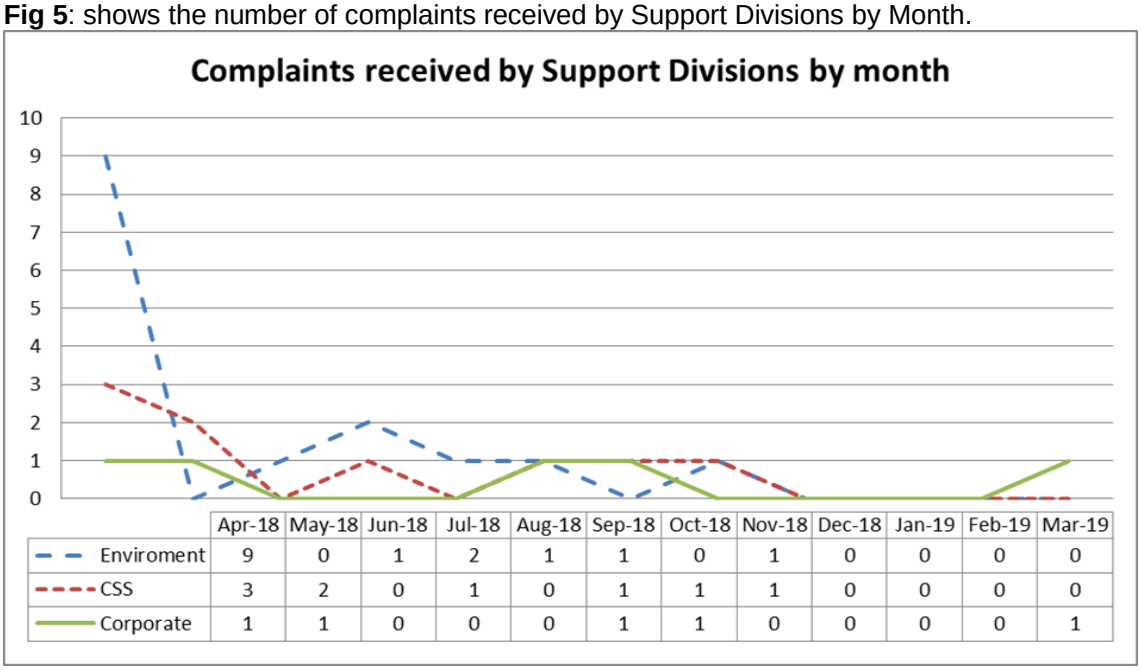
12.3 **Complaints received by Support Divisions by month**

12.4 **Fig 5**: shows the number of complaints received by Support Divisions by Month.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Enviroment	9	0	1	2	1	1	0	1	0	0	0	0
CSS	3	2	0	1	0	1	1	1	0	0	0	0
Corporate	1	1	0	0	0	1	1	0	0	0	0	1

12.5 **Themes of complaints received by the Environment Division**
Complaints received were about the cost of car parking, location of car park and issues resulting to delays being taken to a ward by Portering staff.

Particular issues raised: lack of china cups in coffee shop, pot holes and the state of the car parks at both Hemel and Watford General Hospital, lack of blue badge parking and welfare of staff during extremely hot weather.

12.6 **Themes of complaints received by Clinical Support Services**
The complaints received related to Physiotherapy, Phlebotomy and Radiology. There were no themes identified due to the few complaints received.

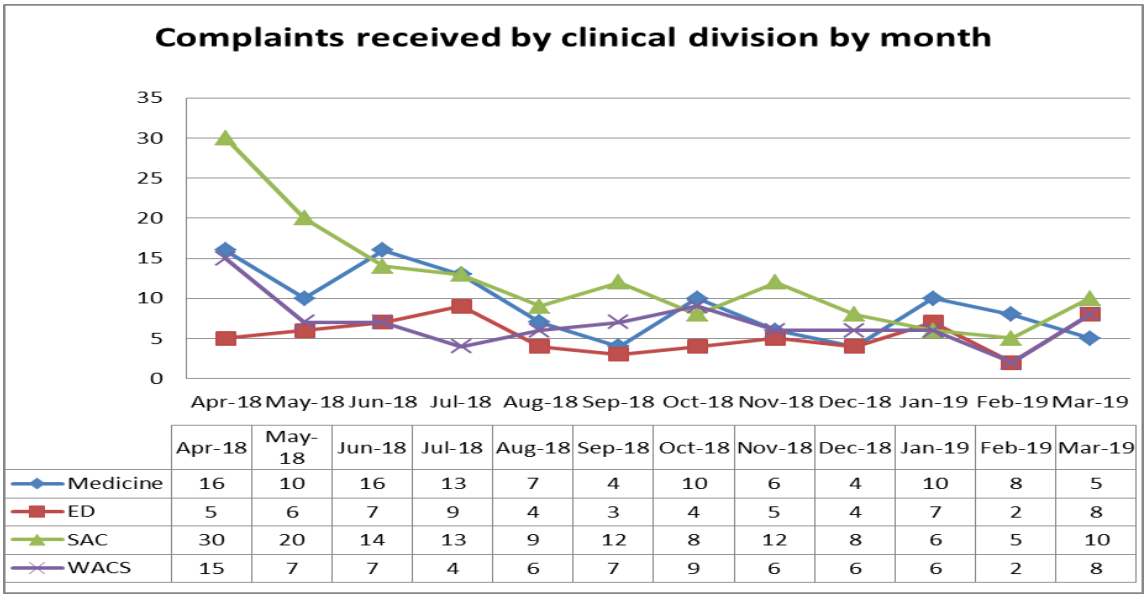
Particular issues raised: bruising on the patients arm after bloods being taken, concerns regarding the lack of physiotherapy appointments/referrals and general feedback.

12.7 **Themes of complaints received by the Corporate Division**
Complaints were around discharge planning, mishandling of patients records and regarding the loss of a deceased patient's jewellery.

Particular issues raised: lost jewellery, mishandling of complaints records and the proposed revamp of Watford General Hospital.

12.8 **Complaints received by Clinical Divisions by Month**

Fig 6: shows the number of complaints received by the Clinical Divisions by Month



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medicine	16	10	16	13	7	4	10	6	4	10	8	5
ED	5	6	7	9	4	3	4	5	4	7	2	8
SAC	30	20	14	13	9	12	8	12	8	6	5	10
WACS	15	7	7	4	6	7	9	6	6	6	2	8

12.9 **Themes of complaints received by the Division of Surgery Anaesthetics and Cancer**
Trauma and Orthopaedics received the highest number of complaints, 64 (44%) followed by General Surgery, 46 (31%). Complaints were related to all aspects of clinical care, including: lack of pain relief, poor treatment, incorrect diagnosis, failure to diagnose, missed fractures and delays in treatment and care, cancellations of operations, continuity of care and attitude/communication from staff.

12.10 **Themes of complaints received by the Division of Medicine.**
General medicine received the highest number of complaints, 27 (25%) followed by Care of the Elderly, 24 (22%). Complaints were related to the cancelation of procedures, poor care and treatment, missed diagnosis, delay in catheterisation, missed lunch, ward cleanliness, communication and attitude of staff, missed appointments, end of life care and lack of nursing care.

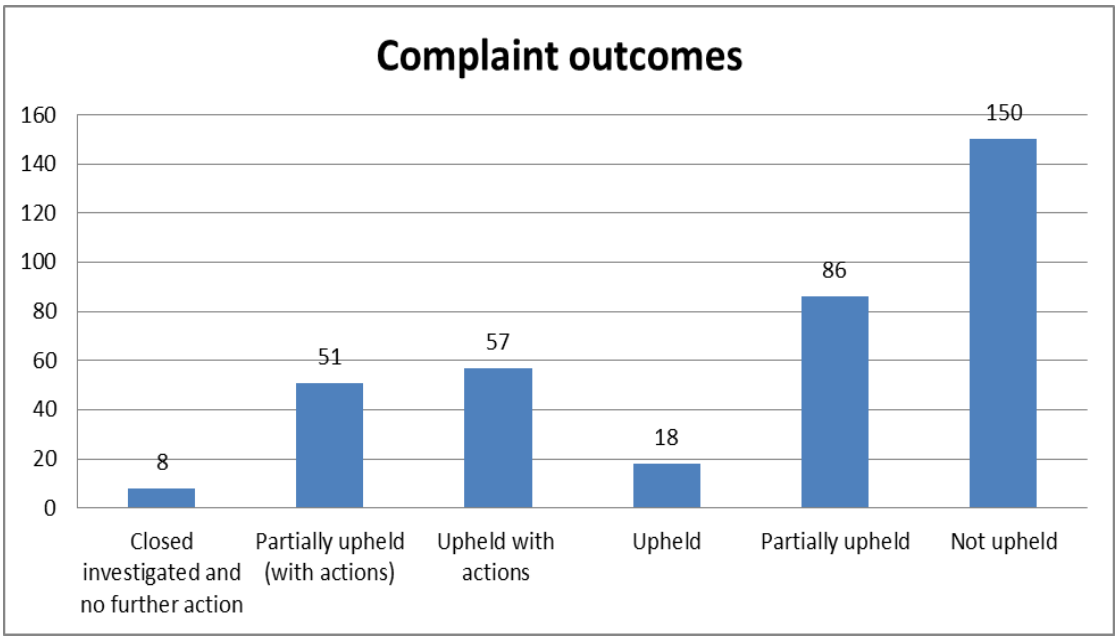
12.11 **Themes of complaints received by the Emergency Department.**
Issues raised included, waiting time in ED, delay in providing appropriate pain relief, diagnosis, lack of communication, attitude of staff, patient inappropriately sent home and delays in being reviewed.

12.12 **Themes of complaints received by the Division of Women's and Children's**
Midwifery received the highest number of complaints 39 (47%) followed by Gynaecology 25 (30%). The complaints related to retained products, not being informed of the risks of surgery, lack of post-operative care, lack of empathy from Consultant, not being kept fully informed about the procedure, experience in the delivery suite, ultrasound appointments not having been received, request for funding for private surgery following birth mismanagement, staff attitude and general lack of care.

13 Complaint Outcomes

13.1 In line with the PHSO approach to categorising the outcome of complaints, a complaint is recorded as being fully upheld if WHHT made mistakes or provided a poor service that amounted to maladministration or service failure and this had a negative impact on an individual. A complaint is partially upheld if WHHT got some things wrong, but not all the issues that were complained about or the mistakes made did not have a negative impact on anyone. If a complaint is not upheld if we find that we acted correctly. Finally the PHSO assess cases referred to them and they made the decision not to investigate as WHHT acted accordingly.

13.2 **Fig 7:** shows the number of complaint outcomes by Division.



13.3 **The divisions with the highest number of upheld or partially upheld are as follows:**

Surgery, Anaesthetics and Cancer – 61
Emergency Department – 35
Women's and Children's – 50
Medicine – 52
Environment – 9
CSS - 5

14 Reopened/Reactivated complaints

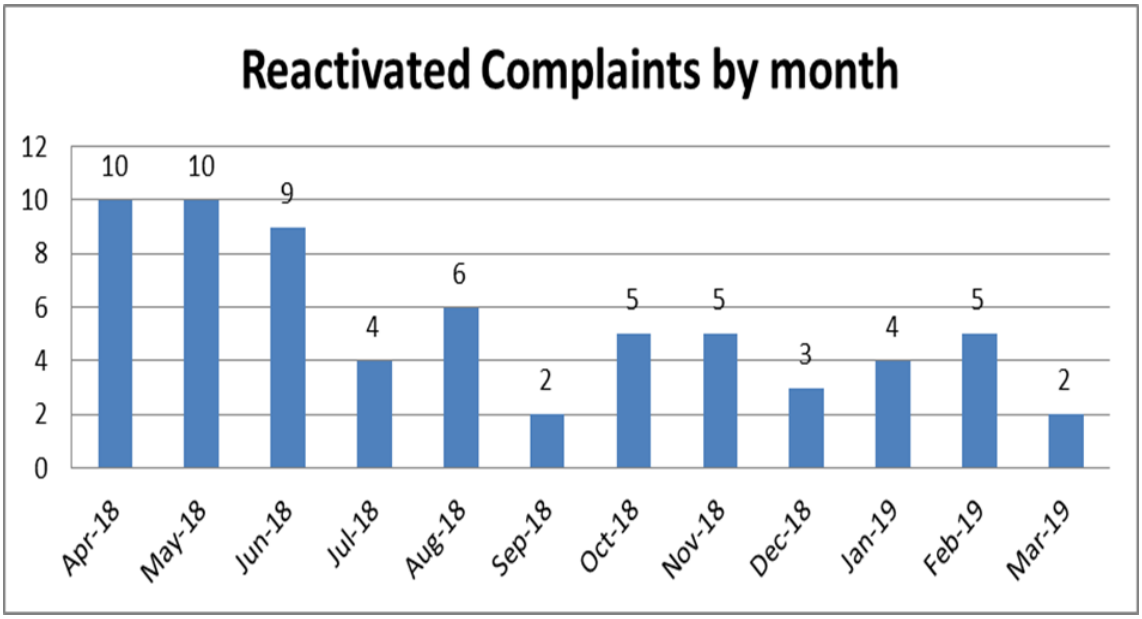
14.1 A complaint is categorised as "further local resolution" if the complainant is not satisfied with the Trust's first response, and requests a further response to the issues raised. A total of 65 (15%) of the 432 complaints received in 2018/2019 were returned for further local resolution.

14.2 The Trust is committed to understanding why complaints are returned for further local resolution and is constantly seeking to improve the way complaints are investigated and handled to improve complainant satisfaction. A review of this years reactivated complaints

has shown that the main reason for complainants reactivating their complaint is because not all of their questions have been responded to fully; they raise additional issues having received the response to the original complaint and/or they do not accept the information in the complaint response.

14.3 The reduction in the number of reactivated complaints had reduced since 2017/2018. This has been attributed to improved investigation, comprehensive complaint responses compliance with agreed timeframes and the allocation and the correct recording of concerns received on Datix to go in reactivated section.

14.4 **Fig 8:** shows the number of reopened complaints**.**



15 Local Resolution Meetings

15.1 Local resolution is a way of handling complaints by resolving or clarifying the matter directly with the complainant through discussion, generally in a meeting arranged for this purpose. This can be a proportionate, flexible and timelier way for the complainant and the service to resolve complaints. A record is kept of the outcome and complainants are advised of the next stage of the complaints process should this be required. The Trust continues to promote early face to face meetings with complainants to allay their concerns and establish early local resolution.

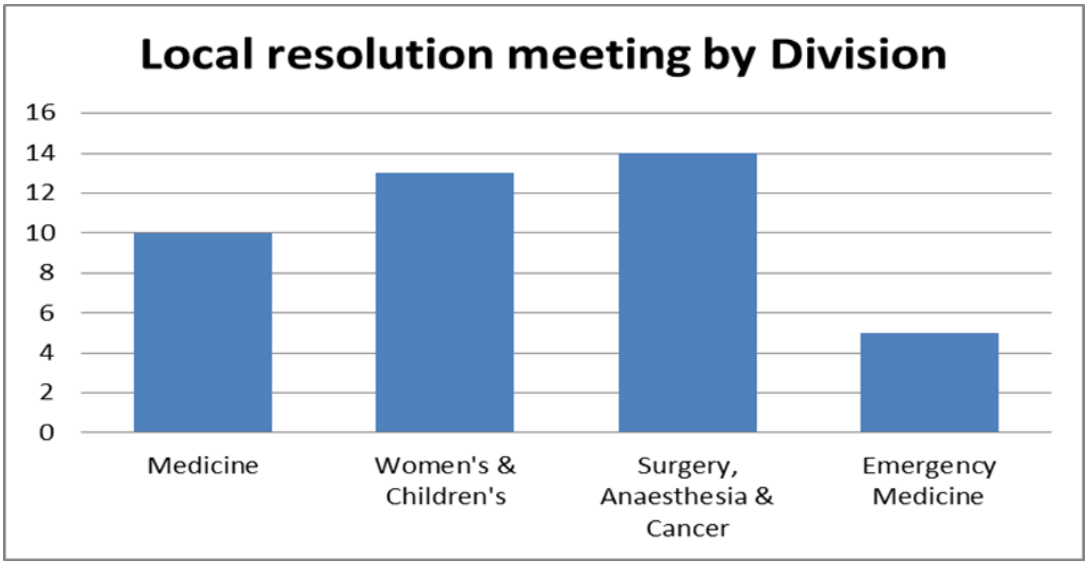
15.2 During 2018/19 we dealt with 42 complaints by way of local resolution meetings (LRM). Face to face resolution of concerns is considered the most effective way to resolve concerns and with the most positive outcome. A majority of the issues were fully resolved at this stage.

15.3 Of the LRM's which took place, 28 were resolved by way of a meeting first rather than a written response and 5 were in the process of being arranged, at the end of March 2019.

15.4 6 complainants received a response first and then requested or were offered a meeting. Of these 1 has approached the PHSO. The PHSO have confirmed they will not be investigating.

15.5 2 further complainants requested a meeting rather than a written response and both of these have approached the PHSO. At the time of writing this report, no decision had been made by the PHSO.

15.6 **Fig 9:** shows the local resolution meetings held by Division

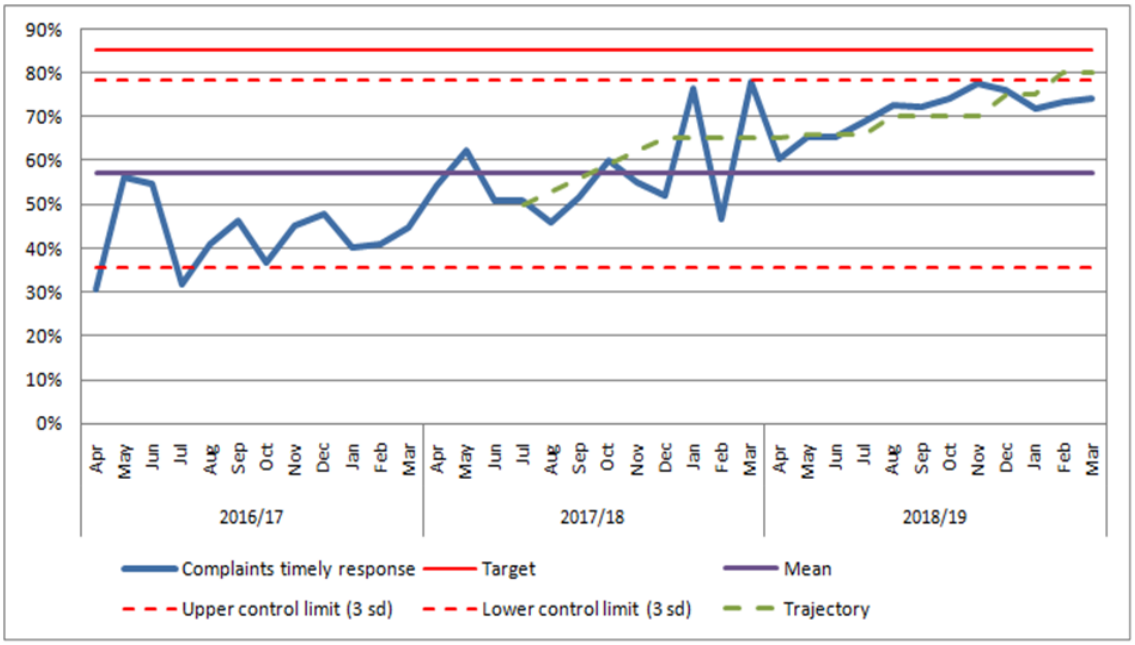


16 Complaints Performance

16.1 The Trust is committed to providing timely responses to any complaints received and all complaints are managed in accordance with the Trust complaint policy. The Trust set deadlines of 30 working days for standard complaints, 40 working days for complex complaints and 60 working days for local resolution meetings to be organised and held.

16.2 The Trust's target is to respond to 80% of all complaints within agreed timescales. Over the course of the year the number of complaints responded to within the agreed timescale steadily improved and was sustained.

Fig 10: Complaint response compliance over the past 3 years 2016 through to 2019



16.3 Divisional complaints performance is monitored weekly using a RAG tracker. The tracker is cascaded throughout the Trust to the Divisional Managers, Assistant Divisional Managers, Heads of Nursing, Matron and other key staff within the organisation. The document provides the Divisional leads with a 'live' picture of their complaints and an overview of all open complaints within the organisation. It indicates performance by way of 'Red' to highlight complaints which have breached an agreed response timeframe, 'Amber' for those complaints which are due within 14 days of the tracker being generated and 'Green' for complaints which are under investigation but still in time. The tracker also shows which complaints have been scheduled for an LRM following agreement with the complainant.

16.4 The Corporate Complaint advisors, who are each assigned responsibility over particular divisions, meet on a weekly or fortnightly basis with their divisional colleagues to address the performance of complaint investigations. The Corporate Complaints team also continue to support the divisions to help with reducing their delayed responses.

16.5 The Corporate Complaints team triage all complaints and decide whether it should be dealt with within 30 days or is more complex and requires 40 days. The complainant is contacted by telephone and a conversation takes place identifying the best course of action and agreed deadline for responding. The Complaint Administrator logs the complaint and the agreed date for responding. Should the divisions require a longer period of time the dates are adjusted if possible, with agreement of the complainant.

17 Members of Parliament (MP), Clinical Commissioning Group (CCG), Care Quality Commission (CQC) and Media contact

17.1 There were a total of 37 complaints in which the complainant involved any of the above group. A majority of these cases, the complainant copied one or more of the MP, CQC or

CCG into their complaint and if the complainant consented a copy was sent to the appropriate person.

17.2 Ten of the complainants contacted their local MP to support them and the complaints were received directly from the MP. These covered areas such as delay and cancellation of operations, travel time to appointments and lack of care provided to the patient. A response to these complaints was sent directly to the MP.

17.3 Fourteen of the complaints were copied to the Care Quality Commission (CQC) and in twelve complaints the Clinical Commissioning Group (CCG) was copied in. The types of complaints were to do with all aspect of clinical care, such as delays and errors in diagnosis which the complainant believes led to emergency surgery, lost jewellery from deceased patient, concerns about general treatment and care and issues around pain relief.

17.4 We had only one complaint in which the media had been contacted and was regarding a patient's lost property.

18 Complaints that are serious incidents

18.1 There were 5 complaints investigated as part of the serious incidents framework and process. In streamlining the process, a complaint received alongside a serious incident forms part of the terms of reference (TOR) and is investigated generating one report. If there are any outstanding issues the complaint can be re-opened to address these.

19 Parliamentary and Health Service Ombudsman (PHSO)

19.1 There were 17 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) during the year. Of the 17 requests received from the PHSO:

19.2 5 of the complaints the PHSO are currently in the process of assessing the complaint. However, a decision has not been made at the time of writing this report as to whether they are going to investigate the complaints.

19.3 7 of the complaints have been assessed by the PHSO and they have confirmed that they do not intend to investigate the complaint.

19.4 2 of the complaints were investigated and not upheld.

19.5 1 complaint the PHSO is intending to investigate and at the time of writing this report is currently ongoing.

19.6 The remaining 2 were partially upheld.

Fig 11: The table below provides details of those cases that were upheld, whether fully or partially and a description of the action taken to learn and improve.

Complaint	Outcome	Recommendation	Organisational Learning
Complaint regarding not establishing patient's capacity before putting a password on the patient's records and the subsequent distress caused by daughter being denied information.	Partially upheld.	The PHSO recommended the Trust provide a suitable apology with £450 in compensation in recognition of the distress caused and to take action to reduce the likelihood of reoccurrence.	• Safeguarding training assessment undertaken - all ward staffs have completed the requirements including mental capacity assessments, best interest's forms and Deprivation of Liberty Safeguards (DoLS) training. • Update and refresh of the Complaints Handling policy to include the systems in place to effectively manage all complaints in accordance with NHS complaints regulations. • Availability of the Trust Mandatory e-Learning package for MCA/DoLS for all staff via the ACORN training page. • All clinical areas issued with an NHS England book on safeguarding which has a specific section on MCA/DoLS
Complaint regarding fall whilst in hospital which resulted in 2 fractures of the left femur.	Partially Upheld.	Explain how the Trust plans to use information in our database to improve record keeping. Explain the action we will take where appropriate to ensure Serious Incidents reports are completed and to provide a suitable apology.	• Reiteration to staff that all patient records must not contain loose paper work, but must be filed in accordance with the Trust's Health Records Management Policy. • A programme of training in the management of health records is included in the Trust's mandatory information governance training, which is attended by all staff annually. • The Trust is reviewing its approach to make all patient records digital in the near future to eliminate loss of paperwork. • The SI process was fully implemented..

20 Improvements to Managing Complaints and Organisational Learning

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

20.2 The action plans are reviewed at the divisional monthly quality and governance meeting and actions are tracked and monitored. Divisions are responsible for ensuring that the learning from complaints and incidents is shared widely with front line staff. All Divisions have

implemented local communication approaches, which have included the review of how shared learning can be achieved across the organisation utilising good practice for established areas. In addition to circulation within the Division, action plans are presented monthly to the Quality and Safety Group.

20.3 Complaint learning events were held three times during this reporting period with aspirations to hold these quarterly every year going forward. At these events, divisions are invited to share examples where direct learning has originated from a complaint. Also as a result of a number of complaints, patients have been actively encouraged to share their experiences with staff. This has been a valued engagement piece for staff to meet with patients and to understand how they experienced their care and treatment.

20.4 A member of the complaints team also attends the Band 7 development programme and presents information on dealing with complaints. For staff to gain a better understanding of complaints handling and resolution. The importance of good record keeping and how to deal effectively with concerns and complaints and finally the need to ensure that lessons are learned from complaints to ensure that service quality is improved.

20.5 Figure 12 provides a number of examples of organisational learning set against a selected set of themes. The number of themes will be expanded and reported on within the next annual report.

Fig. 12 Organisational learning from complaints

Complaint theme: **Communication**	Organisational Learning
Following a miscarriage a woman attended Watford GDU where she was exposed to a number of pregnant women. This she found very distressing.	Review of the clinic arrangements took place to establish what could be done differently. Introduction of this scenario within maternity training packages to illustrate the importance of communicating with vulnerable women at times of distress and what techniques are available to safeguard the emotions of these women.
Requirement to improve the availability of patient and relative ward information to facilitate the discharging of a patient.	Ward leaflet has been reviewed and up-dated to include specific information to facilitate the safe discharge of a patient including appropriate available clothing. Communications department have been involved to ensure correct language and clear messages. All staff made aware of the importance of patients being appropriately dressed for discharge.
Delay in the reporting of a MRI scan which left the patient extremely anxious and worried. Delay in the review of X rays	The Trust has reviewed its approach to managing consultant leave to ensure that provision is in place with alternative arrangements to review and feedback results to patients in a timely manner. A change in process has been implemented which now ensures that any doctor requesting an x-ray must discuss and review the x-ray at the daily trauma meeting. An additional field has been included in the e-trauma documentation to confirm the review of an x-ray.

Complaint theme: **Communication**	Organisational Learning
A patient attending MIU having sustained a hand injury did not receive the care and treatment required as the area was undergoing a deep clean following contamination from a sewage leak. No alternative provision was advised.	A full review of existing business continuity has taken place to ensure that patient's safety is maintained and that there is provision for access to the necessary care on and off site should the area require closing for any other emergency situation.
Complaint theme: **Care and treatment**	Organisational Learning
The provision of appropriate footwear to prevent a patient from slipping and falling whist in hospital.	In response the Trust continues to ensure the use of slipper socks for all inpatients across the Trust where they are not in receipt of appropriate footwear.
Recognising the importance of when to move a patient from A&E to a bed when in the last stages of life. The patient was moved which did not allow the family the opportunity to be with their mother at the point the patient died.	The decision was not the right decision in these circumstances. The scenario was used within A&E to explore what mechanisms and observations could be improved on and how to engage with the family of patients should this situation arise again.
Complication following a 'subtotal hysterectomy, removal of both ovaries and a rare complication following prolapse surgery and repair.	This case was used as a case study with an acknowledgement that procedure specific consent forms would be reviewed by the division to ensure all the risks associate with this type of surgery were given in full.
Review of the toileting arrangements and management of patients requiring assistance in toileting following concerns raised by a family and the use of incontinence aids.	The family was invited to share their experience with the ward staff and the impact this had on the patient as well as seeking permission to share the local resolution CD recording with the ward staff. A full review of the ward and toileting arrangements was undertaken.
Complaint theme: Information Governance	Organisational Learning
Concern was raised by a patient that the name of the clinic was visible through the window of the appointment letter as sent.	The template letter presents the title of the clinic on the left hand side which is visible through the envelope window. The template for clinic letters has now been amended; the specialist clinic title has now been moved to the right hand side to maintain confidentiality and data protection. This new template has also been shared with the secretarial team so they are aware of the change and why it has been made.

21 Key Achievements of 2018 – 2019

21.1 **Visit by Healthwatch and Herts Valley Clinical Commissioning Group**

Prior to the Care Quality Commission inspection (CQC) to West Herts Hospitals Trust (WHHT) in 2017, the Trust commissioned Healthwatch Hertfordshire (HwH) to undertake an 'Enter and View' inspection see and hear for them on how services were provided. In order to understand the patient experience at WHHT (St Albans and Watford General Hospital sites) a qualitative review of the Trust's complaints handling process was undertaken. The period covered by the report was 01/01/2017- 30/09/17 and assessed Divisions against the good practice highlighted by the Parliamentary and Health Service Ombudsman (PHSO). The report underlined areas of good practice and improvement, such as 'governance', 'honesty and transparency' and 'remedies', as well as areas that could be improved further.

The recommendations which came of this report were used as an assessment framework for the Complaints table top exercise.

The focus of the Quality Assurance Visit (QAV) was to undertake a table top exercise for all stakeholders in the room to understand the progress WHHT had made in terms of learning from patient complaints to the Trust on the back of the HwH recommendations, 2017. HVCCG and HwH in liaison West Herts Hospitals wanted to ensure that all opinions and discussions were openly tabled in order to understand how the Trust had reacted to implement the 7 recommendations of the report. The Trust carried out a random selection of 20 complaints from 5 divisions. These were reviewed in 2 parts, the initial contact from the complainant and the final response by the Trust to the complainant. A total of 5 random complaints were reviewed for a drill down and outcomes scored against the 7 recommendations from the HwH 2017 report. The reviewers consisted of a group of 6 people from HVCCG and HwH. This group was tasked with reading the individual complaints reviewed, feeding back and scoring against the HwH recommendation score sheet. The Trust was represented by Divisional Leads and other Senior Managers.

21.2 **Outcome:**
The complaints responses were well written and there was evidence to demonstrate that the Healthwatch recommendations had been taken on board. Most responses reviewed captured the core essence of the 7 HwH recommendations. For example, the complainant response from the Medical Division was patient centric, personalised and answers given were explained in detail.

The Medical Division demonstrated a robust process in their operational management of complaints through multidisciplinary team approach and responding to complainants in a timely manner as compared to other divisions.

The visiting team were assured that based on the recommendations from the Healthwatch report that the learning has been embedded into the process of managing complaints by the Trust.

21.3 **Recommendations:**
A revisit to be scheduled for 12 months' time to see how the learning from the Bond Solon training has been embedded into new process

WHHT was to consider whether a timeline could be appended to a complaint as currently the chronology of events is a prominent feature throughout a response and can detract from the original complaint issue. This will be reviewed on a case by case basis.

WHHT was to consider the introduction of an initial template which allows complainants to complete. This may provide WHHT with more detail during first contact which may mitigate any misinterpretation of issues raised.

21.4 **Investigation/action plan Module**

The Complaints team piloted using the Actions/Investigation plan Module within Datix (Trust's Incident Management Software) with all divisions and Parliamentary and Health Service Ombudsman cases to record and track actions resulting from complaints through to completion. This had previously been carried out at a divisional level but it was considered that capturing and managing this centrally would be more robust and provide greater assurance that learning and improvements result from complaints. This was a success with individual actions being recorded and shared with the Safety and Quality Committee and with the Board on a monthly basis.

21.5 **New Complaints and PALS leaflet developed**

The Complaints and PALS leaflet has been revised and updated and is now on the Trust internet page. The leaflet is now called 'Do you have any compliments, suggestions and concerns about the service you have received?' and has been distributed around the Trust.

21.6 **Complaints Handling Policy revised and ratified**

The Complaints Handling Policy has been updated to reflect the RSM Complaints Audit published May 2018 who recommended that the Complaints Handling Policy which was due for review in November 2018 was revised to reflect the implemented initiatives and improvements. In addition, the audit identified that the Complaints Handling Policy is not reflective of current practice. The Policy has now been reviewed and is now reflective of current practice and is on the Trust internet site.

21.7 **Professional training in complaints handling and investigations completed**

16 members of staff, including the complaints team have undertaken professional complaints handling training undertaken by Bond Solon. This included:

- Process, Procedure and Information gathering this enables staff plan and conduct and investigation in accordance with the relevant legislation, procedures and Policies and to recognise, analyse and evaluate the different types of evidence.

- Questioning and Communication techniques this enables staff to plan, structure and conduct interviews using the appropriate interview models and to explore and evaluate questioning techniques that are effective in establishing the facts and obtaining all available evidence.

- Responding to Complaints and how to create maintain and enhance best practice in writing response letters to complainants.

21.8 **Updating of template letters in Datix and consent forms to reflect GDPR**

- All complaint templates letters have been updated and added to the Datix database.
- All consent forms have been reviewed and updated to reflect GDPR.

21.9 **Datix subject codes**

With the support of Datix we have coordinated our subject codes with the Friends and Family test and PALS to enable comparison of data between the entire patient experience functions.

22 The Complaints team work plan can be found in Appendix 1.

23 Patient Advice and Liaison Service (PALS) and Interpreting Service

23.1 PALS are a first point of contact helping patients and visitors with questions, concerns and suggestions about our Trust services. They provide a professional, friendly, confidential service and on the spot support to help resolve problems. PALS are an integral part of the service we provide to our patients, relatives and carers, acting as a vital channel for feedback.

23.2 The PALS Team have developed a weekly tracker to monitor all concerns at a Divisional level using a RAG rating system (RED for breach, AMBER for nearing breach and GREEN for under investigation). Feedback from the Divisions has been very positive with the Tracker being used to help identify which concerns are for LRM and also 'waiting for surgery approval'.

23.3 Following the introduction of the Tracker a Standard Operating Procedure (SOP) was developed by PALS in February 2019; the target is to respond to all queries within 5 working days of contact.

23.4 Quality of data collection has improved due to robust management of individual members of staff recording concerns accurately. The team have developed their own system of triaging the concerns raised and discussions are held as a team to establish the best course of action. A small number of concerns are escalated to the formal complaints team or forwarded to the SI team for investigation and discussion as appropriate.

23.5 An improvement in the closure of concerns following the introduction of the SOP is evident in the first two months of data available as detailed below:

Month	**Percentage of concerns closed within 5 working days**
February	86%
March	94%

23.6 **PALS activity Trust wide**

For the period year ending 31 March 2019 the number of contacts/concerns received was 3265; an increase of 400 when compared to 2017/18.

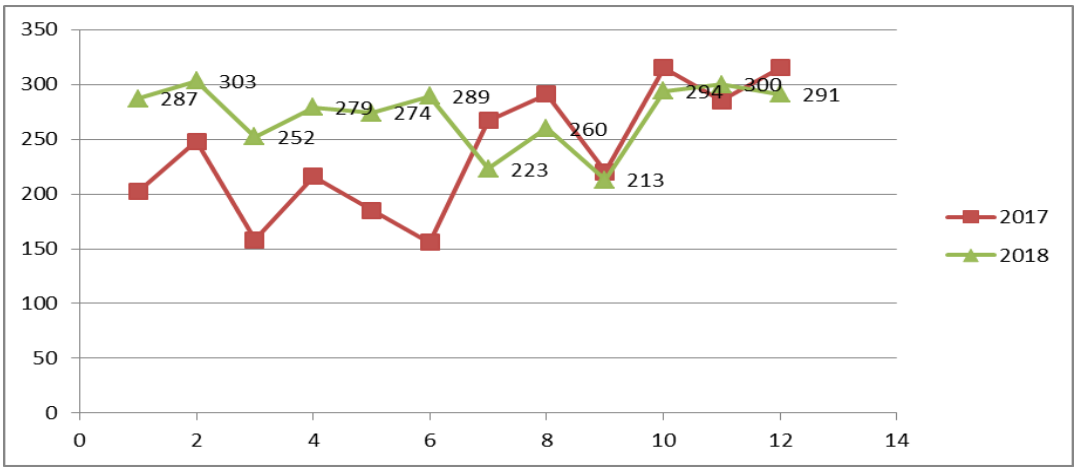
Historically complex concerns were escalated to formal complaints but the PALS Team have evolved and now plan and organise Local Resolution Meetings to address a number of

complex concerns. The use of LRM's negates the need to involve formal complaints or provide a written response.

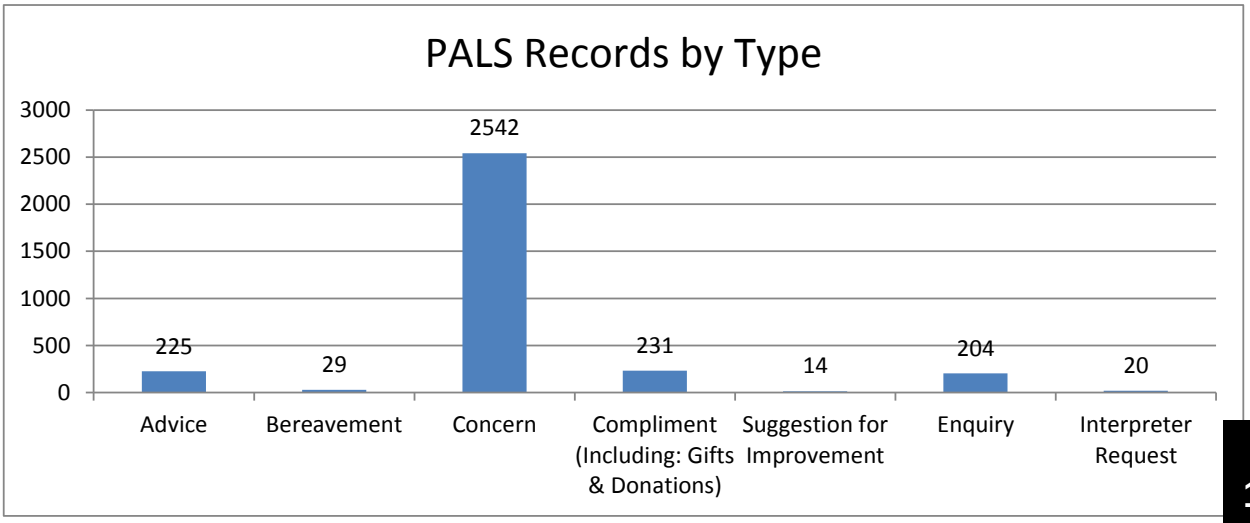
The LRM also provides opportunity for face to face discussion between the person raising the concern and staff involved in the care and treatment; raising awareness and learning through action.

23.7 The following graphs detail the PALS activity for 2018/19 compared to 2017/18 followed by a breakdown of the concerns by type, division and subject and the conversion of PALS concerns to formal complaints.

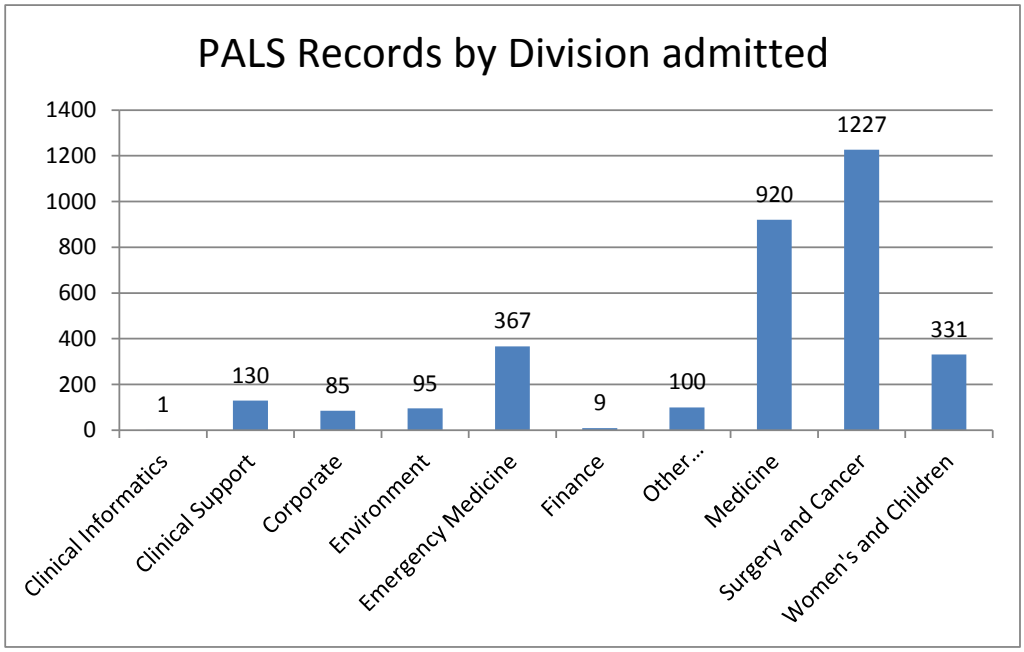
23.8 PALS Activity graph Trust wide 2017/18 & 2018/19



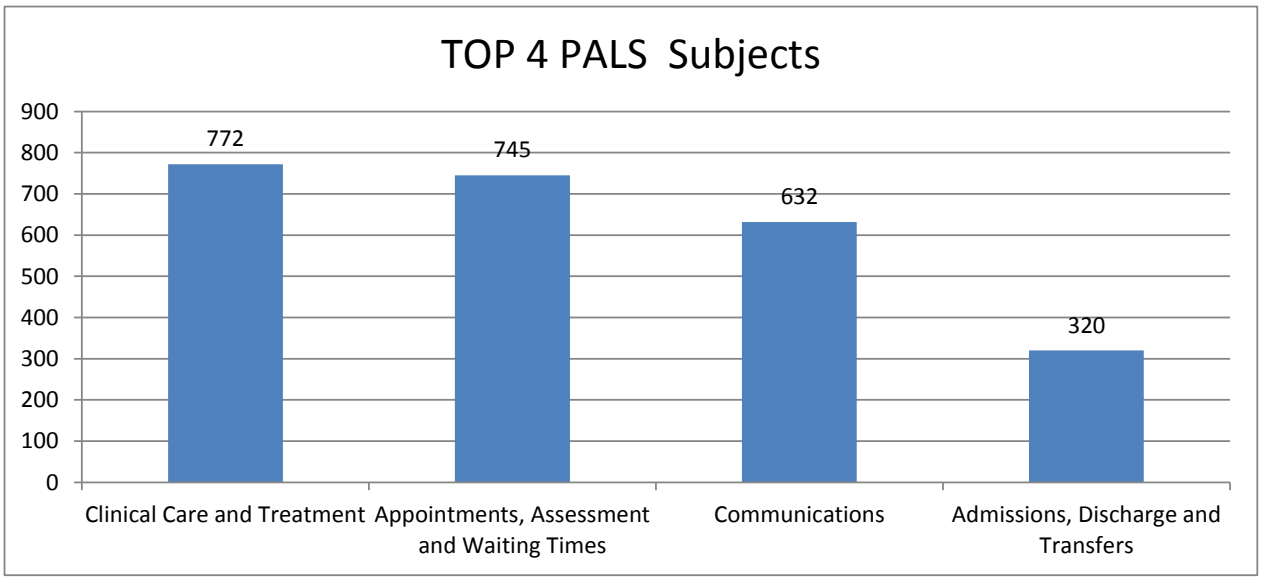
23.9 PALS most common reasons for contact



23.10 PALS activity by Division



23.11 Table showing the top 4 reasons for contacting PALS by subject



24.0 Themes by Division

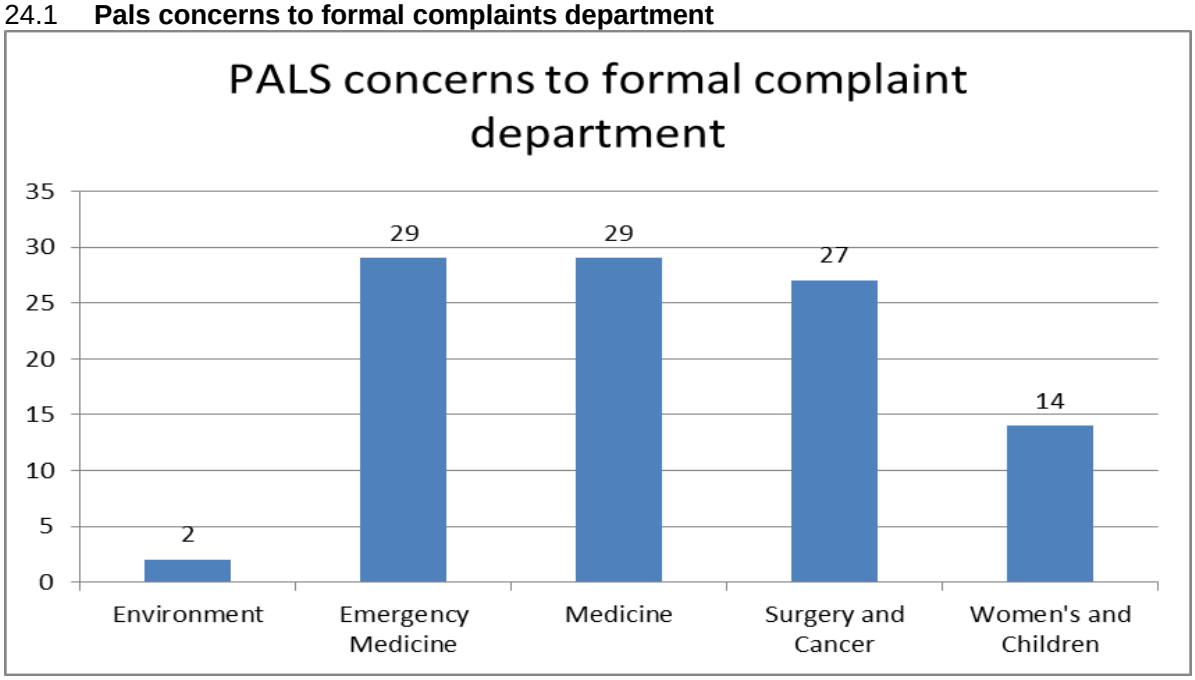
All Divisions have; care and treatment as the main theme of concern followed by communication then discharge.

Medicine had the most concerns regarding care and treatment with 253, followed by surgery 211, medicine 155 and WACS with 96.

The concerns regarding communication; medicine with 184, surgery with 174 concerns raised. These divisions were the highest. In surgery there were reported poor explanation regarding pre and post-operative surgery. In medicine, there were also reports of poor communication in regards to explaining complex problems to patients and/or their relatives. Emergency medicine had 74 and WACs followed with 62.

The highest division with appointments and waiting time's concerns was Surgery. There were reports that appointments have been delayed or cancelled without patient's knowledge and patients have attended only to be turned away.

24.1 **Pals concerns to formal complaints department**



24.2 **Reasons and themes of PALS concerns sent to formal complaints**

All divisions had care and treatment concerns as the main theme. PALS always aim to help, however despite early intervention by the team this is not always successful and complaints are then forwarded onto the formal complaint department to respond to.

24.3 **Learning from PALS concerns**

Historically the learning from PALS concerns has been captured at a Divisional level and not formally recorded by PALS on the Datix system prior to 2018/19. The learning captured by PALS formally since 2018 remains limited due to the reliance on information being submitted from across the Divisions. Discussions with Divisional leads are ongoing to improve the capture of learning as efficiently as possible within the constraints of the system.

24.31 All PALS concerns relating to end of life care and treatment are captured in a bi monthly report that is presented to the End of Life Compassionate Care Panel. The concerns are reviewed and discussed at the meeting and learning is shared with the wider team and used to inform policy and practice as appropriate.

24.32 The Patient Experience Group membership now includes PALS & Interpreting. A report is presented at the bi monthly meetings; highlighting achievements and progress against the Patient Experience & Carer Strategy priorities.

24.33 The PALS Standard Operating Procedure is a Key Performance Indicator (KPI) and reported on monthly as part of the Patient Experience & Carer Strategy dashboard.

24.34 A PALS report is provided to the Patients Panel on a monthly basis. This report highlights any improvements to the concern process and changes to practice within the Trust. It demonstrates how many concerns are dealt with on a monthly basis and any themes or trends.

25 Compliments

25.1 When compliments are received these are logged using Datix. The number of compliments recorded is not necessarily reflective of the number received due to gaps in the process of data collection.

25.2 There were 166 compliments logged for 2018-2019.

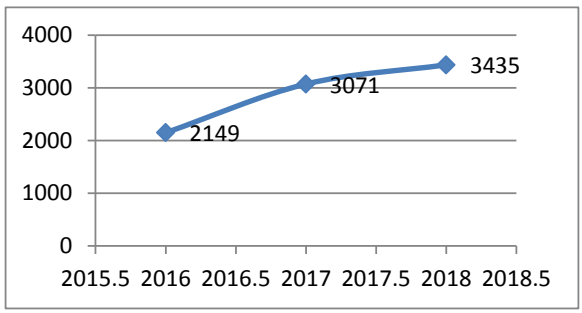
25.3 The themes of kindness, compassion, commitment, care and treatment were mentioned the most frequently, particularly in Medicine Division and reassurance and attention were mentioned in the PALS and Surgery compliments.

25.4 The key themes from WACS were parents thanking staff for their kindness with children and compliments following birth.

26 Interpreting & Translation

The PALS Team are responsible for arranging all requests for interpreters; using the Hertfordshire Interpreting & Translation Service (HITS).

A total of 3435 requests for interpreters was received in 2018/19; 3181 requests for a language interpreter and 254 requests for a sign language interpreter. The volume of requests has increased year on year since the data was recorded in 2016 as per table below.



26 Key Achievements for 2018-2019

- Development of the weekly Tracker for Divisions
- Development of the PALS SOP
- Attendance on Customer care training
- Launch of new Complaints, Concerns and Compliments leaflet
- Inputting Pals as part of the Complaints Handling Policy
- Management of the weekly Tracker in the absence of the PALS Manager
- Presentation on Schwartz round by PALS Team with positive feedback
- Safeguarding training update for PALS Team with improvement in recognition and escalation of safeguarding concerns
- Participating in monthly Trust Induction programme as part of Carer &
- Patient Experience Team

27 The work plan for 2019-2020 is in Appendix 2

28 Recommendations

The Trust Board is asked to receive this report for information and assurance that the Trust is compliant with NHS England Complaints Policy.

Appendix 1

Further developments / Complaints team work plan for 2019 – 2020

Divisional roll out of actions module

Building on the success of the Actions/Investigation Pilot in 2018/2019 the Complaints Service will roll out utilisation of the Actions Module Trust Wide, ensuring that action resulting from complaints is systematically recorded and tracked through to completion.

Response time improvements

To continue to work with the divisions to consolidate the response time improvements and to achieve the Trusts 80% target.

Develop Local Resolution Checklist

A local resolution meeting is the complainant's opportunity to explain in person what it is they are unhappy about and what they would like to happen. It gives both the complainant and the NHS organisation, time to listen and discuss the concerns raised. The Checklist will help both the complaints team and Divisional staff to ensure that all planning steps have been completed. This will result in an effective, professional and well planned meeting which will benefit both the complainant and staff involved.

This will be developed and is part of the work plan for 2019-2020

Develop an informal guide to 'Writing Complaint Responses'

As a service provider, when you receive a letter of complaint your first response may be resentment or irritation. It's only natural as nobody likes to be criticised, and this can feel like a personal attack. It's important to appreciate that all letters of complaint are feedback of the patient's personal experience of the service they feel they have received. The guide is to provide an understanding on the do's and don'ts of complaint responses, some useful guidance and information about the final draft of the response.

This will be developed and is part of the work plan for 2019-2020

Develop a Satisfaction Survey

The Trust is committed to supporting people to raise their concerns and we strive to make the complaints process as user friendly as possible. The complaints service place great importance on understanding and learning from the user experience and a feedback survey will be developed, introduced and issued with every complaint response to gain and learn from customer insights. This survey is to be about the service received from the complaints team not the outcome of the complaint.

This will be developed and is part of the work plan for 2019-2020

Complaints training to be part of the induction process

It has been recognised that complaints training should be part of the induction process. All new staff should receive training on complaints handling in line with the 'Complaints Handling Policy' The Trust recognises that, in order to ensure fairness to staff and complainants, staff should have access to support throughout the investigation of a complaint.

The complaints team should offer regular training on advice for front line staff on how to deal with complaints. The process regarding complaints should be highlighted to new staff at Trust Induction and should ensure that all staff are made aware of the procedure for dealing with complaints and receive appropriate training to ensure that they are able to deal speedily and appropriately with complaints at the point of contact and are aware of the procedure to be followed for more complex complaints handling.

This training is part of the work plan for 2019-2020

Healthwatch and Herts Valley CCG recommendations.

WHHT was to consider the introduction of an initial template which allows complainants to complete in order to make the process of making a complaint easier. This may provide WHHT with more detail during first contact which may mitigate any misinterpretation of issues raised. Once this is developed the template will be uploaded to the internet.

This is part of the work plan for 2019-2020.

Appendix 2

PALS & Interpreting Service work plan for 2019-2020

- Open day for PALS to raise awareness of the service
- Development of a leaflet for staff about the PALS & Interpreting service
- Design and development of a flow chart for requesting interpreters
- Shadowing opportunities for staff to join PALS Team as part of 'whose shoes' initiative
- Collaborate with Complaints and SI team in organising learning events
- Update of PALS & Interpreting information on intranet and internet
- Implement an on line interpreting request system
- Improvements in the recording of learning on Datix through engagement with PALS, Divisions and Departments.

Trust Board Meeting
05 December 2019

Title of the paper	**Quarterly Learning from Deaths report**
Agenda Item	**14/77**
Presenter	**Dr Anna Wood, Deputy Medical Director**
Author(s)	**Deborah Wadsworth, Business Manager**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	The November Dr Foster report shows HSMR as 100.7 and SHMI as 99.23, both of which are within the expected range. Palliative care coding is slightly lower than the national rate at 4.01% versus 4.07%. New conditions alerting as SMR outliers: • Secondary malignancies • Acute and unspecified renal failure • Inflammation, infection of eye Between 1 July 2019 and 30 September 2019, there were 48 cases referred for structured judgement review and the backlog of cases reduced from 71 to 21. 2 SJR cases considered by the avoidability panel were considered to be probably avoidable. 50% of SJRs referred during this period were selected because care was considered sub-optimal. The report was reviewed by the Quality Committee and recommended to the Board.
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

14

<table>
<tr><td></td><td>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>Quality Committee</td><td>28 November 2019</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Committee is asked to receive this report for information and assurance on mortality risk management and learning from deaths</td></tr>
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Agenda Item: 14/77

Trust Board meeting – 05 December 2019

Mortality and Learning from Deaths Quarter 2 2019/20

Presented by: Dr Anna Wood, Deputy Medical Director

1. Purpose

1.1 This paper aims to provide a review of trust mortality and related workstreams across the quarter 2 (1 July – 30 September 2019).

2. Background

2.1 The Trust has a consolidated system for the analysis of mortality. This system includes:

- Examination of monthly mortality reports (produced by Dr Foster)
- Specialty mortality and morbidity meetings
- Trust mortality review group meetings
- Structured judgement review by trained Consultant reviewers
- Medical Examiners who scrutinise deaths at time of Medical Certification of Death

2.2 It allows close scrutiny of mortality trends, highlights outlying groups, when they arise and triggers review to determine influencing factors, including poor care; this provides an opportunity to learn from deaths and make changes to reduce future risk.

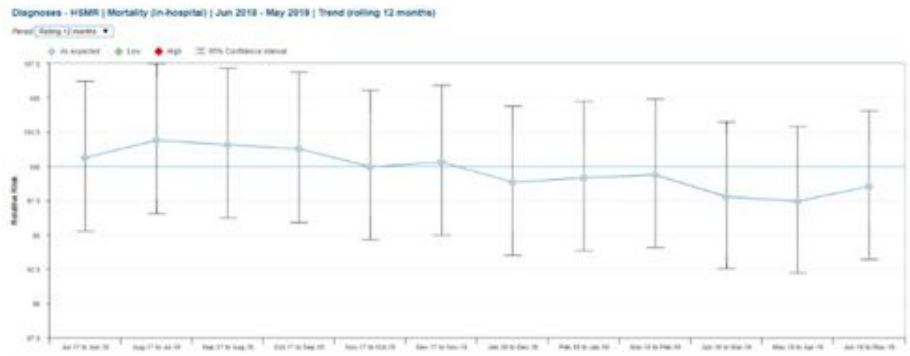
3. Analysis/Discussion **(from November 2019 Dr Foster report which encompasses data from July 2018 to August 2019)**

- **HSMR is 100.7**
- **SHMI is 99.23**, both of which are within the **expected range**.
- Palliative care coding is slightly lower than the national rate at 4.01% versus 4.07%.
- HSMR has increased by 2 to 3 points in all trusts and the increase at West Herts should be considered in this wider context.
- Crude Mortality is 4.0% (vs 3.10% for the peer group)

3.1 Overall quantitative performance (the metrics)

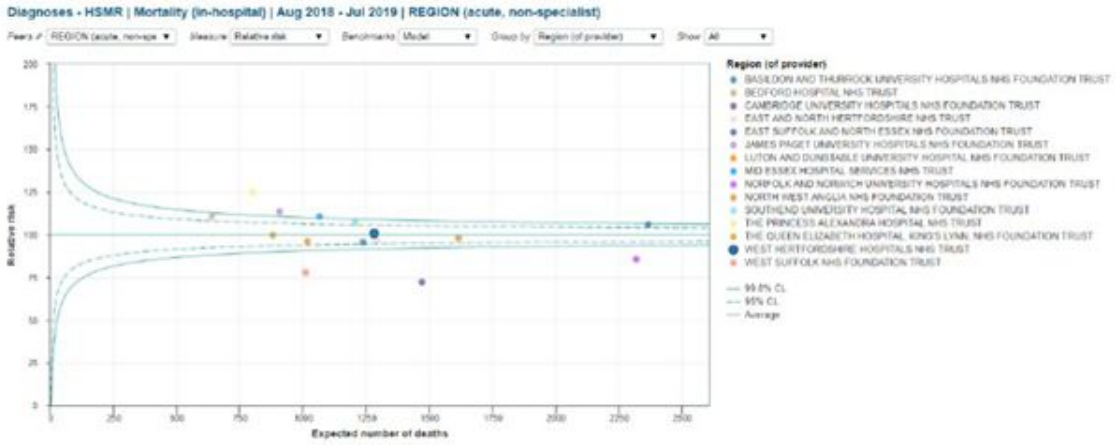
3.1.1 HSMR rolling 12 months (last point is August 18-July 19)

a) Monthly Trend

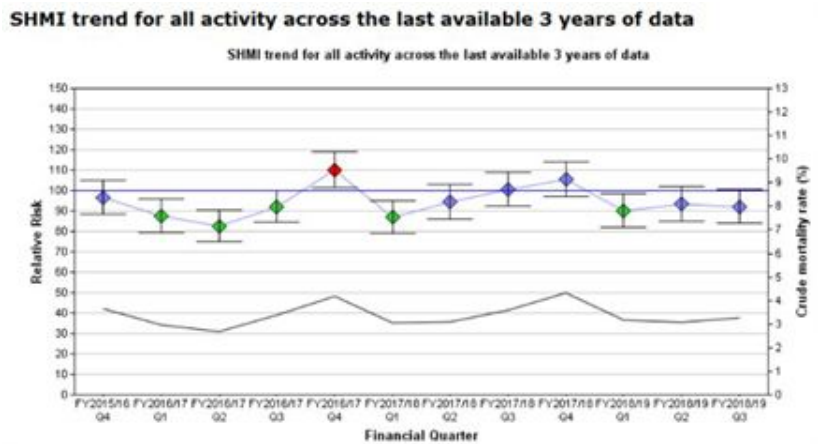


b) Peer comparison

The Trust is 1 of 6 Trusts within the East of England peer group of 15 with an HSMR within 'as expected' range.



3.1.2 SHMI last available 3 years



3.1.3 In conclusion, the metrics of HSMR (The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths) and SHMI demonstrate no excess of risk adjusted deaths overall in the 12 month period in the disease groups defined by them.

3.2 Outlying SMR diagnoses

(The standardised mortality ratio is the ratio of observed deaths to expected deaths with a specific diagnosis) where expected deaths are calculated for a typical area with the same case-mix adjustment

3.2.1 New outlying SMR diagnoses

- Secondary malignancies
- Acute and unspecified renal failure
- Inflammation, infection of eye

3.2.2 Remaining outlying SMR diagnoses

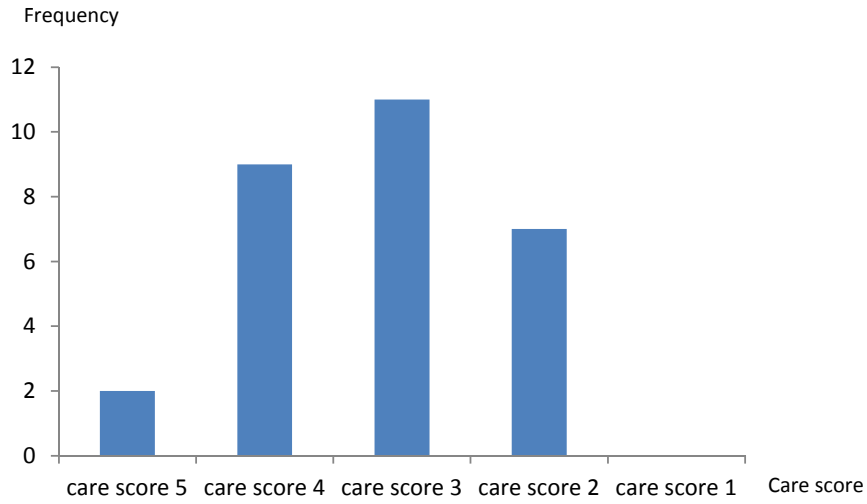
- There are 3 remaining outlying SMR groups
- Otitis media and related conditions – continues to alert
- Varicose veins of lower extremity – continues to alert
- Appendicitis and other appendiceal conditions – continues to alert

3.2.3 The process agreed and used on every occasion that an outlying group is identified by Dr Foster is being applied to the above and case note reviews are being undertaken by our 2 dedicated consultants working with coders . Review outcomes will be discussed at the next Mortality Review Group meeting.

3.4 Structured judgement review (SJR)

3.4.1 Between 1 July 2019 and 30 September 2019, 48 referrals for structured judgement review were made. 29 reviews were received back from consultant reviewers during the July to September window, with overall care scores ranging from 2 to 5. Of the 29, 2 scored a 5 (excellent care), 9 scored a 4 (good care), 11 scored a 3 (adequate) and 7 scored a 2 (suboptimal). 24% were therefore considered to be of suboptimal care. There were none considered to be the worst score of 1

Chart 1 *SJR care scores*

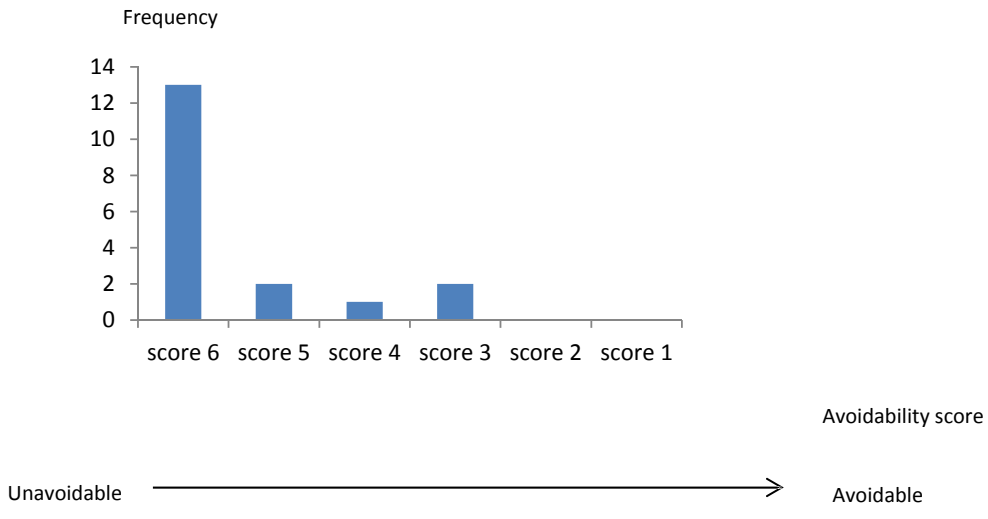


3.4.2 Potential avoidability of death

Of the 29 structured judgement reviews received back from consultant reviewers, 16 had care scores of between 2 and 3. All 16 of these including 2 older cases were considered by the avoidability panel meeting. Of the 18 cases, 13 were considered unavoidable (score 6), 2 were considered to have slight evidence of avoidability (score 5), 1 was considered possibly avoidable (score 4) and 2 were considered as probably avoidable more than 50/50 (score 3).

In other words of 18, it was considered in 2 cases by the panel that there was a more than 50/50 chance that our care contributed to that patient's death. In the first of these cases, there was a four hour delay before a patient with active bleeding received a blood transfusion and in the second there was a failed discharge and on readmission, a second CT scan revealed a missed intracranial bleed. The patient had remained on anticoagulants.

Chart 2 *SJR mortality avoidability (of those with care scores 1-3)*

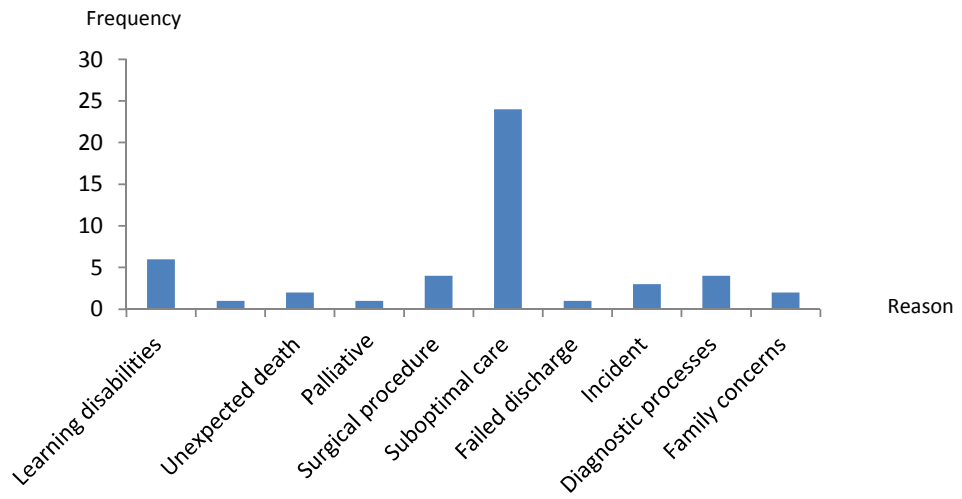


3.4.3 Reasons stated for SJR referral

Reasons for the 48 SJR referrals between 1 July 2019 and 30 September 2019 are as follows:

- Learning disabilities 6 patients
- Severe mental health problem 1 patient
- Unexpected death 2 patients
- Palliative 1 patient
- Surgical procedure 4 patients
- Suboptimal care 24 patients
- Failed discharge 1 patient
- Incident 3 patients
- Diagnostic processes 4 patients
- Family concerns 2 patients

Chart 3 Reasons for SJR referral



The reasons for SJR referral demonstrates compliance with our trust policy

3.5 Current position

3.5.1 There are currently 18 cases with reviewers and 21 cases awaiting allocation for structured judgement review from the 71 case backlog in April 2019. So since 1 April 2019 83% of the backlogged cases have been allocated. The backlog of cases is being managed in a planned way to ensure that new cases are reviewed as they are referred and older cases are subject to a prioritisation approach, in particular deaths of patients with a learning disability

3.5.2 There are 66 new cases (post 1 April 2019) awaiting allocation or reallocation.

3.6 SJR themes and learning

3.6.1 SJR themes are analysed and recorded 6 monthly. This information is currently being updated and captured in a new format.

3.6.2 There is an agreed governance process for SJR. In summary, completed SJRs are shared with Clinicians by 1) disseminating all completed SJRs at Divisional level, 2) summarising the 6 monthly thematic collation of SJRs at Divisional Governance half days and 3) dissemination of completed SJRs to individual specialities for review and feedback of local implementation of actions. Reviews of learning disability deaths are shared with the LeDeR team and themes are starting to be collated and reported at Trust Mortality Review Group by the Safeguarding Clinical Lead. Medical Examiners also receive the completed SJR if they have originally referred the case.

3.6.3 As of July 2019, 19 of the last completed SJR's that have fulfilled the criteria for level 2 review (those with poor, suboptimal and adequate care scores) have been analysed for thematic review.

3.6.4 The themes for improvement include various aspects of end of life care (non contemporaneous DNACPR documentation, ineffective/suboptimal end of life care, aspects of end of life care which require community solutions and integrated working), anticoagulation management around surgical procedures in hospital, fluid balance, medication errors and delayed reviews of diagnostic tests.

3.6.5 These themes are unsurprising in as much as there is good correlation with outcomes from other clinical governance processes such as poor compliance with certain components of DNACPR documentation as demonstrated in the regular trust DNACPR audit and datix incidents (eg delayed review of test results, medication errors).

3.6.6 A recent task and finish working group has been convened to work on a Quality Improvement (QI) project specifically to look at improving the theme relating to DNACPR.

This is an example of learning from SJR and trust audit which has resulted in a QI project.

3.6.7 The other themes for improvement of patient care will be tackled sequentially depending on priority and risk and some may require other solutions such as more education, an example of this being interpretation of coagulation tests in patients on the newer anticoagulant agents prior to surgery as well as multidisciplinary involvement (eg poor fluid balance documentation)

3.6.8 Of note, is that many positive aspects of care have been highlighted in the SJR process, which includes overall very good management in the first 24 hours after hospital admission, good communication with family members, prompt specialist review and prompt investigation.

3.6.9 There has been a further training session on SJR and a further 4 consultants recruited to the pool of reviewers which is now an adequate number for business as usual.

3.7 Medical Examiner service

3.7.1 During quarter 2 the Medical Examiners referred 30 cases for SRJ, which now represents the majority source. This demonstrates that the Medical Examiners are well integrated within the trust Clinical Governance process. Between 1 July 2019 and 30 September 2019, the Medical Examiners scrutinised 222 deaths out of 340 or 65%. Recent guidance recommends that 100% of non-coronial deaths should be scrutinised by 2020.

Regular analysis of the quality data from the ME service demonstrates favourable outcomes with fewer unnecessary coronial referrals (reduction of 24%) and same numbers of coroner post-mortems with scrutiny of deaths in October 2019 amounting to just under 90%.

3.7.2 The Medical Examiner service now operates 5 days a week, with two core Medical Examiners and 2 Trust Consultant Medical Examiners.

3.7.3 Guidance issued by the Department of Health has indicated that the Medical Examiner service operated by Trusts is intended to be cost neutral, Funding allocation has recently been announced and will be quarterly but the exact process have yet to be confirmed.

3.8 Next steps

3.8.1 Next steps planned include:

- Improving the recording and dissemination of learning
- Further reducing the backlog of cases awaiting structured judgement review
- Increasing scrutiny to 100% of deaths

4 Risks

4.1 The mortality governance system has been designed to reduce risk by learning from deaths. The introduction of structured judgement review, has strengthened that system further and appointment of two core Medical Examiners to oversee the process is bringing added rigour, independence, proportionality and clarity.

5 Recommendation

5.1 The Board is asked to receive the report for information and assurance.

Dr Anna Wood
Deputy Medical Director

November 2019

Trust Board Meeting
05 December 2019

Title of the paper	**Bi-annual Board engagement report**
Agenda Item	**15/77**
Presenter	**Tracey Carter, Chief Nurse and Director of Infection Prevention and Control**
Author(s)	**Tracey Carter, Chief Nurse and Director of Infection Prevention and Control** **Jean Hickman, Trust Secretary**
Purpose	*For approval*: *For discussion*: *For information*: ✓
Executive Summary	One of the key lines of enquiry under NHS Improvement's well-led domain is for the Board to actively engage with the people who use the services, the public, staff and external partners. The Board uses a wide range of forums to engage with staff, volunteers, patients and their families and carers in order to see first-hand the realities of providing services and to triangulate the information received at Board and committee meetings. The aim of this paper is to update the Board on the wide range of engagement opportunities taken over the past six months, which includes structured and ad hoc Board visits, as well as regular walkarounds, night walks, presentations to the Board and patient's stories.
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?

15

Previously considered by	N/A
Action required	The Board is asked to receive this report as assurance on the processes in place for the Board to engage with staff and patients.

Agenda Item: 15/77

Trust Board meeting – 05 December 2019

Bi-annual Board engagement report

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

1. Purpose

1.1 The aim of this paper is to update on the active engagement with staff, volunteers, patients and their families and carers which has been undertaken by the Board over the past six months.

2. Background

2.1 A key focus of the Board is on the services provided to patients, ensuring that they remain safe, shaping a positive culture for the organisation and being an excellent employer.

2.2 The well-led framework, published by NHS Improvement in 2017, underpins the Care Quality Commission's (CQC) regulatory assessments of the well-led question. At the last CQC inspection the Trust was rated as 'requires improvement' for well-led and the Trust aspires for this to improve to a rating of 'good' at the next inspection.

2.3 Within the well-led framework, one of the key lines of enquiry (KLOE) relates to engagement with the people who use the services, the public, staff and external partners. Since the last inspection, the Board has focused on engagement with staff, volunteers, patients and their relatives and carers to see first-hand the realities of providing services and to triangulate the information it receives at Board and committee meetings.

3. Board visits

3.1 A programme of structured Board visits was established in May 2019. The programme is managed by the chief nurse and Board members form small groups to visit a pre-arranged area of the Trust for half an hour prior to a Board meeting. The areas can be either clinical or non-clinical and verbal feedback from the visits is received in the private session of the Board meeting. These visits have proved to be extremely worthwhile for Board members and comments from staff have been really positive.

3.2 The schedule of visits to date is attached in appendix 1.

4. Executive director visits

4.1 Individual executive directors visit areas of the Trust on an ad hoc basis and these are captured on a whiteboard in the Trust Offices. Feedback is collated in a spreadsheet which is centrally accessible to all.

4.2 A list of the areas visited over the past six months are set out in the table in the attached appendix 2.

5. Actions taken from visits

Area	Action
Hemel Hempstead/St Albans	• Site environment forums with an agreed matron and environment site lead. Posters of meetings and pictures of leads in place.
Hemel Hempstead	• Review of signage
Watford	• New security access to the acute admissions unit, level 1
Watford	• Dementia works, i.e. toilet doors
All sites	• Use of safe space meetings

6. Regular executive walk rounds

6.1 The chief executive has regular walk rounds with relevant key staff in specific areas. She has monthly walk rounds with the director of environment to review the estate and fortnightly quality visits with the deputy chief nurse to assess clinical areas.

6.2 The chief nurse also carries out maternity safety walk arounds with the director of midwifery and clinical director of obstetrics, and infection control with the deputy director of infection prevention and control and environment staff. In addition, monthly medication safety visits are carried out with the chief pharmacist. Back to the floor is also undertaken by the chief nurse with senior nurses, midwives and AHP's with a focus on harm free care, privacy and dignity and quality improvement projects.

7. Night walks

7.1 There have been a number of night walks arranged over the past six months led by the chief nurse and deputy chief nurse. This has involved executives and non-executives with heads of nursing. The visits have focused on staff safety and security, environment, the transition to a new IT service provider, patient flow and general discussions with staff promoting the internal campaign around the national staff survey results, known as the 'Big 5'.

8. Departmental presentations at the Board

8.1 The Board invites departments to present on the services they provide at the beginning of the public Board meeting. Over the past six months the following services have presented:

8.1.1 The divisional manager and head of nursing for maternity services attended the Board meeting on 02 May 2019 to inform the Board on an improvement initiative known as the Nightingale project which focuses on sharing best practice across ward areas. The Board was informed that the benefits of the project had been recognised through an improvement in staff vacancy and sickness levels and a decrease in the number pressure ulcers.

8.1.2 The safeguarding team attended the June Board meeting to update the Board on work being undertaken to support victims of human trafficking and modern day slavery. The Board was informed that the team had been working with a multi-agency operational group led by Hertfordshire Police and had completed eight operations, including covert hotel operations and brothel raids. This work had led to 42 women being identified and a number of referrals to national support agencies.

8.1.3 The Trust's volunteer coordinator and a volunteer attended the Board meeting on 04 July 2019 to provide an overview of the experience of a volunteer. The volunteer reported that he had been a volunteer for a number of years and he was pleased to be able to engage with and help patients. He noted that the Trust provided an excellent training programme for volunteers.

9. Patient stories to the Board

9.1 Over the past six months, the Board has heard from patients and their families on what it is like to be a patient at the Trust. A short summary of two stories is set out below and lessons learnt from both these stories were discussed at the Board meeting.

9.1.1 A patient who had received maternity care attended the Board meeting in September 2019 to tell the Board about her experience. She reported that although her antenatal care had been good and she had developed a birth plan for a natural birth which had been aligned to the risk factors in her particular case, her experience of the delivery had not been good.

9.1.2 The family of a deceased man who had been an inpatient at Watford hospital attended the Board meeting on 07 November 2019. The nursing staff who had cared for the patient during his stay also attended the meeting. The Board was informed that the patient had been paralysed from the neck down and he had not received the level of care he required for his complex needs.

10. Non-executive director visits

10.1 In addition to the structured Board visit programme, the non-executive directors take frequent opportunities to walk around the sites to talk to staff and triangulate some of the data that is presented at the Board meeting. Some non-executive directors regularly attend clinical group meetings and occasionally attend divisional governance meetings.

10.2 The chairman carries out his own visits and attends patient meetings, which are set out in the table below.

Month	Areas visited
May 2019	• A&E • Walkabout at Watford with patient representative • Walkabout at Hemel Hempstead
June 2019	• Cardiac Imaging Centre • Walkabout at Watford with patient representative • Night walk at Watford • Walkabout at St Albans
July 2019	• Walkabout at Hemel Hempstead
September 2019	• Maternity unit at Watford with a patient representative • Night walk at Watford • Attended a patients' panel meeting for a question and answer session
October 2019	• Walkabout at St Albans

11. Other engagement opportunities

11.1 There have been a variety of other opportunities for Board members to engage with staff, volunteers and patients over the past six months. Some of these are listed below:

- Hosted and attended the long service staff awards.
- Met new staff as part of the induction training.
- Attended an annual staff tea party to thank staff and speak to them about their experience of working at the Trust.
- Had breakfast with staff whose birthday fell within the month.
- Presented winners of the monthly staff awards scheme.
- Delivered cakes and spoke to staff to celebrate achieving no band five adult nurse vacancies.
- Attended an annual volunteer's awards event to thank volunteers for their hard work and dedication.
- Hosted and attended a Stars of Herts award ceremony.
- Ward accreditation awards.
- Cavell star awards.

11.2 Plans are in place to launch a new reverse mentoring scheme in 2019/20 which will offer the chance for Board members to become mentees. The scheme aims to educate leaders about diversity issues by exposing them to challenging and insightful conversations and experiences that they may otherwise never encounter.

12. Recommendation

12.1 The Board is asked to receive this report as assurance on the processes in place for the Board to engage with staff and patients.

Tracey Carter
Chief Nurse

December 2019

Board Visits Schedule

Board meeting date	Site	Location	Lead Director	Directors
02/05/2019	WATFORD	Theatres and day-of-admission areas, Level 6	Jeremy Livingstone	Paul Cartwright
				Natalie Edwards
				Anna Wood
				Louise Halfpenny
		Medical records	Sally Tucker	Phil Townsend
				Mike van der Watt
				Don Richards
				Andy Barlow
		Endoscopy	Arla Ogilvie	Ginny Edwards
				Helen Brown
				Paul da Gama
		Aldenham ward	Tracey Carter	John Brougham
				Jonathan Rennison
				Paul Bannister
				Christine Allen
06/06/2019	WATFORD	Ophthalmology	Jeremy Livingstone	Paul da Gama
				Christine Allen
				Paul Cartwright
		Croxley Ward	Tracey Carter	Helen Brown
				John Brougham
				Ginny Edwards
				Natalie Edwards
		Finance	Don Richards	Andy Barlow
				Jonathan Rennison
				Anna Wood
		PMOK Radiology	Mike Van Der Watt	Sally Tucker
				Phil Townsend
				Paul Bannister
04/07/2019	ST ALBANS	Breast Clinic	Mike Van der Watt	Andy Barlow
				Paul Cartwright
				Helen Brown
		Beckett Ward	Sally Tucker	Ginny Edwards
				Paul Da Gama
				Jonathan Rennison
				Anna Wood
		Fracture Clinic	Jeremy Livingstone	Don Richards
				Natalie Edwards
				John Brougham
		MIU	Tracey Carter	Christine Allen
				Phil Townsend
				Paul Bannister

03/10/2019	WATFORD	Dermatology OPD	Andy Barlow	Phil Townsend
				Helen Brown
				Natalie Edwards
		Sarratt Ward	Mike van der Watt	Jonathan Rennison
				Sally Tucker
				Don Richards
		Pathology	Anna Wood	Paul Cartwright
				John Brougham
				Paul Da Gama
				Paul Bannister
07/11/2019	HEMEL HEMPSTEAD	Main OPD	Sally Tucker	Ginny Edwards
				Paul Da Gama
				Paul Bannister
				Jonathan Rennison
		Dermatology clinic	Andy Barlow	Anna Wood
				John Brougham
		Blood Clinic	Mike van der Watt	Natalie Edwards
				Helen Brown
				Jeremy Livingstone
		Mortuary	Tracey Carter	Paul Cartwright
				Christine Allen
		Children's OPD	Don Richards	Phil Townsend

Executive Director ad hoc visits

Appendix 2

Month	Executive Director	Site
May 2019	Christine Allen	A & E WGH
		Ops Centre, WGH
		Stroke Ward, WGH
		Cardiac Ward, WGH
	Helen Brown	Children's OPD, HHGH
	Don Richards	Minor Injuries Unit, SACH
		Clinic Prep, SACH
		OPD, SACH
		Beckett Ward, SACH
		Delamare Ward, SACH
	Paul Da Gama	JD Forum, WGH
		Mental Health event, WGH
		Cardiology & Cath Lab, WGH
June 2019	Christine Allen	Castle & Tudor Wards, WGH
		Jackett's Field, Kings Langley
		Helen Donald Unit, WGH
		Intensive Care Unit, WGH
		Croxley Ward
		Sarratt Ward
		Medical Records, WGH
		CT & MRI Units WGH
	Helen Brown	Supplies Dept, SACH
		AAA Screening, SACH
		Annual Tea Parties x 3

June 2019	Tracey Carter	Beckett Ward, SACH
		Ridge Ward
		Cleves Ward
		Langley Ward
		ED
		CT/MRI
		Stroke Unit
		ED Triage
		Maternity delivery suite
	Don Richards	Resus
		Majors 1 & 2
		Aldenham Ward
	Paul Da Gama	Cardiology
		Connect BME
	Sally Tucker	OPD Hemel
		Radiology
		Patients Lounge
		Croxley Ward
		Sarratt Ward
		Gade Ward
		Oxley Ward, SACH
		Heronsgate Ward
		Winyard Ward
		Bluebell Ward
		ED Radiology
July 2019	Christine Allen	Pathology Lab, HHGH
		Pharmacy HHGH
		Outpatients HHGH
		Secretaries HHGH
		Urgent Care Centre HHGH
		Radiology HHGH

July 2019	Christine Allen	Delivery Service HHGH
		Children's Outpatients HHGH
		Ophthalmology HHGH
		Starfish Ward
		Endoscopy Unit
	Mike Van der Watt	AAU x 3
		CCU
		Pharmacy
		Radiology
		A & E
		Cardiology
		Cath Lab
	Tracey Carter	Sarratt Ward
		Croxley Ward
		Heronsgate Ward
		Gade Ward
		Aldenham Ward
		Delivery Suite
		Bluebell Ward
		Winyard Ward
		Red Suite
		ED
		CED
	Paul Bannister	AAU WGH
		A & E WGH
	Sally Tucker	Emergency Planning WGH
		IDT WGH
		Ops WGH
		Social Workers WGH
		POA/Ambulatory WGH
		Tudor Ward WGH

July 2019	Sally Tucker	Castle Ward WGH
		Clinic Prep WGH
		Shrodell's WGH
August 2019	Christine Allen	Medical Records HHGH
		Clinic Prep
		Outpatients SACH
		Delamare Ward SACH
		Beckett Ward SACH
		Theatres SACH
		Estates SACH
		Secretaries SACH
		Pre Op SACH
		Ophthalmology SACH
		Pathology SACH
		Pharmacy SACH
	Tracey Carter	Hip Surgery SACH
		Education Centre, HHGH
		Delamare Ward
		Heronsgate Ward
		Gade Ward
		Letchmore Ward
		ED CED/Starfish
		CDU
		AAU L1
		AAU L 3
	Christine Allen	Delamare Ward SACH
		Beckett Ward SACH
		DSU SACH
		Outpatients Dept
	Helen Brown	Delivery Suite WGH
		NEQAS WGH

August 2019	Paul Da Gama	Jacketts Field
	Mike Van der Watt	Maternity WGH
		Cardiology WGH
		AAU Levels 1 & 3 WGH
		Cath Lab WGH
		Sarratt Ward
		ED WGH
		ITU WGH
	Tracey Carter	Pharmacy WGH
		Starfish Ward WGH
		Safari Ward WGH
		CED WGH
		Tudor Ward WGH
		ED WGH
		ACU WGH
	Don Richards	PAU WGH
		Letchmore Ward WGH
		Flaunden Ward WGH
		Surgery Office, WGH
		ESAU WGH
September 2019	Christine Allen	A & E WGH
		Flaunden WGH
		Letchmore Ward WGH
		PALS WGH
		Discharge Lounge WGH
	Tracey Carter	Ridge Ward WGH
		Oxhey Ward WGH
		Cleves Ward WGH
		Delivery Suite
		Langley Ward WGH
		AAU Level 1 WGH

Trust Board Meeting
05 December 2019

Title of the paper	**Strategy Update**
Agenda Item	**16/77**
Presenter	**Helen Brown, Deputy Chief Executive**
Author(s)	**Helen Brown, Deputy Chief Executive**
Purpose	Please tick the appropriate box For approval: For discussion: For information: ✓
Executive Summary	This paper provides an update to the Board on the progress of the key strategic work programmes for 2019-2020. The Board is asked to note the attached paper and current position on the 13 projects within the following programmes; Getting to Good, Clinical Strategy, Integrated Care, Access and Workforce. There are two movements on RAG ratings in month. One favourable and one adverse. Both relate to the Access Programme. Five schemes remain green RAG rated meaning they are complaint with plan. Of the five amber rated projects, they are broadly behind schedule with identified risks and mitigations in plan. Emergency Care Transformation (ED Access) has been revised from amber to red RAG rated with a paper presented to TMC on 30th October. This reflects the fact that the Trust is not currently meeting the performance trajectory for ED 4 hour waits. However it should be noted that our relative performance within the East of England and nationally has improved, reflecting significant work to manage high levels of emergency care demand as effectively as possible.
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	Trust Management Committee - 27 November 2019
Action required	The Board is asked to receive the report as assurance on the progress of the key strategic work programme in delivery for year 2019-2020.

Agenda Item: 16/77

Trust Board meeting – 05 December 2019

Strategy Update.

Presented by: Helen Brown, Deputy Chief Executive

1. Purpose

This paper provides an update to the Board on progress and delivery of the Trust Strategic Plan for 2019-2020 and a brief update on the Trust Strategy refresh.

2. Background

2.1 In line with the new bi-monthly reporting schedule, the following work programmes are included this month and are reporting on the October (M7) position (with the exception of the Access programme which is reporting a September, M6 position):

1. Workforce
2. Getting to Good
3. Clinical Strategy
4. Integrated Care
5. Access

2.2 **Table 1 (Year 1 – 2019-2020 Strategic Priorities)** lists projects which are within a variety of project life cycle stages, ranging from 'development of business case' to 'in delivery' and for which project leads provide RAG rated updates.

2.3 There were two movements on RAG ratings in month relating to the Access Programme priority projects. RAG ratings are based on delivery against the Trust's improvement plans and are reported and tracked through the associated committee.

2.4 The priorities are listed below and known RAGs are as follows.

G	A	R	C	TBC
Green / on track	Amber / some risks or delays.	Red / significant risks or delays.	Complete / closed.	New to list or update yet to be received

Table 1: Year 1 – 2019-2020 Strategic Priorities.

Strategy Delivery Project Executive Summary			November 2019	
Strategic Aim	**Programme**	**Active Projects 2019-20**	**Current Status (Nov 19)**	**Prior Status (Sept 19)**
Great People	Workforce	Developing the Trust's refreshed People Strategy and supporting Implementation Plan	G	
Best Care	Getting to Good	Clinical Pathway Redesign / Royal Free CPG Programme	A	A
Best Care	Getting to Good	Quality Hub Development and QI roll out	A	A
Best Care	Getting to Good	GIRFT (Getting it Right First Time) **	G	G
Best Care	Clinical Strategy / Service Redesign	SACH Expansion of Enhanced Surgical Activity for Enhanced Care Patients	G	G
Best Care	Clinical Strategy / Service Redesign	Vascular Hub	A	G
Best Care	Clinical Strategy / Service Redesign	To merge WHHT Oesophago-gastric cancer unit with Imperial	G	G
Best Care	Clinical Strategy / Service Redesign	Medical Take Redesign (4 week pilot)	G	
Best Care	Integrated Care	Urgent and Emergency Care Redesign	A	A
Best Care	Integrated Care	2019-20 SDIP	A	A
Best Care	Access	Emergency Care Transformation (*ED Acess*) **	R	A
Best Care	Access	Patient Flow Transformation (*Inpatients*) **	A	A
Best Care	Access	RTT & Cancer Programme Yr 1 (*Elective*) **	G	A

Note:
** Progress against these priorities will be tracked and reported to their associated committees.

3. <u>Discussion</u>. Exceptions this month:

3.1 The **RTT and Cancer Programme** RAG has moved from Amber to Green and **Emergency Care Transformation (ED Access)** has moved from Amber to Red, as current performance is adverse to plan. The Performance report on Access Standards was presented to TMC on 30th October and Board on 7th November. Board is required to note that the September RAG rating against this scheme was incorrectly stated as Amber. The correct RAG rating would have been Red as per performance plan.

3.2 The **Vascular Hub** has moved from Green to Amber which is primarily related to the actions required from E&NH's perspective, if they are to complete their OBC at the required pace. After discussion at TMC the matter will be further discussed at CAG and a more detailed paper to be presented to the December TMC.

Further work is required with ENHT to refine the clinical service model on spoke sites (ie WHHT and PAHT) and provide assurance that sufficient vascular expertise will be made available to support patients receiving care on these sites.

3.3 A copy of the Trust's **Research Strategy** was recently presented at the research steering group and the newly established PERC (People, Education and Research Committee) where there was a good discussion and a decision made to make some changes and re-present the strategy in December 2019.

4. Great People

4.1 The Trust senior workforce team have commenced work on refreshing the **Trust's People Strategy** which will cover the period 2020 - 2023. A first working draft of the strategy has been shared with staff in various engagement activities, with a view to a draft for approval being taken through the various committees and seeking Trust Board approval early in 2020.

5. Best Care - Getting to Good

5.1 **CPG roll-out.** The Frailty pathway was added to the programme in September 2019 and all eight pathways have been process mapped and measurement plans agreed with the clinicians.

5.2 The next step is to start working on 'patient voice' / co-design for all the pathways, review the data for unwarranted clinical and non-clinical variation, increasing awareness of the CPG programme via Divisional management team meetings (every 2 months reporting) and organising a WHHT clinical workshop in early 2020.

5.3 **Quality Hub Development and QI roll out.** As well as supporting the 8 CPG projects there are 5 'corporate' QI projects that have commenced and registered with the QI team. The focus of projects is aligned to both the Trust Quality Account and NHS Patient Safety strategy.

1. Improving patient communication – communication bundle
2. Get up, get dressed, get moving
3. Swarming strategy post falls
4. NHSi Pressure Ulcer Collaborative
5. Improving patient hydration.

5.4 A QI coaching course with representation from the Divisions started this month and a Quality Improvement Awareness Campaign is underway. A second QI Lead has now been appointed and will commence work in January 2020.

5.5 A steering group has been set up to oversee the Trust's approach to delivering the national **'Get it Right First Time' (GIRFT)** programme. The first meeting took place in October 2019.

5.6 This group will ensure robust systems and processes are in place to support the programme and oversee divisional and specialty accountability and operational compliance in delivering the GIRFT recommendations.

5.7 As part of the GIRFT governance process, an annual work plan is in place which schedules progress updates on speciality implementation plans to be presented to the Quality Committee by the relevant clinical leads. The next GIRFT visit scheduled is Radiology (December 2019).

6. Best Care - Clinical Strategy/Service Redesign

6.1 Everything to enable **enhanced care procedures** to take place at SACH is now in place. The Trust is holding deep dive meetings with the clinicians to identify possible solutions to improve the performance of elective enhanced care patients as volumes remain lower than target. The initial meetings were productive with the aim of identifying a process that will deliver the minimum required 8 procedures per week as outlined by the SACH business case.

6.2 The process of completing the transfer of both WHHT Surgeons & Registrars and WHHT Patients to the new **Hammersmith Oesophago-gastric cancer unit** has now been completed. The focus is now on backfilling WGH Theatres with benign activity and measuring the performance and associated financial benefit of the move of OG activity to Hammersmith. An update / benefits realisation paper will be presented to TMC in April 2020 (6 months post implementation).

6.3 Initial data on **the Medical Take Redesign Pilot** shows positive results. The decision has been made to continue the pilot to December 2019 to develop a more comprehensive dataset. Issues are still being worked through and iterative developments to the model and operational processes taking place. An initial evaluation is underway to inform decision making on extending the pilot and / or longer term implementation of the model.

7. Best Care - Integrated Care

7.1 The Trust continues to work with partners to develop plans for a west Hertfordshire Integrated Care Partnership and to contribute to the development of the HWE 'integrated care system'.

7.2 In the meantime, the Director of Integrated Care, continues **to support a programme of pathway development activities** designed to streamline and join up care across organisational boundaries – working with both HVCCG and HWE STP teams. This includes work on respiratory and cardiology advice and guidance and dermatology redesign. For dermatology local work continues to refine the tele-dermatology and advice and guidance model but additionally consideration is being given as to how the WHHT service can support other parts of the system who have less well developed dermatology services in place. Discussions are also in progress regarding the improving access to phlebotomy in primary care settings to reduce the need for patients to travel to hospital for simple blood tests..

7.3 **2018-19 SDIP** - Parkinson's Disease: Implementation of a clear protocol for clinical management of inpatients and those presenting non electively. Protocol for the management of complications for people with PD has been approved at a Divisional Level and has being presented through the relevant internal governance groups in Oct 19. Training for the protocol is being rolled out across the Trust.

7.4 Greenbrook Healthcare has been identified as the preferred bidder to provide the **Urgent Treatment Centre** at WGH, with a go live date of April 2020. WHHT and Greenbrook are working together to develop a mobilisation plan, this needs to be confirmed before contract signature (likely to be December / January). The team continues to work with HVCCG and HUC on options for the further development of the SACH minor injuries service (towards a full urgent care offer) and future delivery models for urgent care on both the HHGH and SACH hospital services.

8. Trust Strategy Refresh

8.1 **Trust Strategy Refresh.** Work is underway to create a five year Trust Strategy that reflects the successes of the past few years and the priority plans that will continue this journey and delivery of the ***'very best care, for every patient, every day'.*** The strategy proposes a rebranding of the four key aims of Best Care, Best Value, Great Team and Great Place*. The supporting strategies will be updated in 2020. (*Subject to change after engagement exercise concludes.)

8.2 During November the Trust received pre-election guidance which effectively requires that matters of future strategy should be deferred. Therefore the Trust Strategy Engagement event has been rescheduled to the second week in January.

8.3 A final draft of the strategy will be brought to the January Board with a view to a final strategy being formally signed off at the Board in February.

9. Recommendation

9.1 The Board is asked to receive the report as assurance on the progress towards delivery status of strategic priorities.

Helen Brown
Deputy Chief Executive

December 2019

Appendix A WHHT Strategy Delivery Master Programme 2019-2020

Vision

WHHT Strategy Delivery Master Programme 2019-2020
OUR VISION IS TO PROVIDE THE BEST CARE TO EVERY PATIENT EVERY DAY.

AIMS

Best Care	Best Value	Great People	Great Place

Strategic Priorities 19-20

Getting to Good	CIP	Workforce	Digital Programme
Mike Van der Watt / Tracey Carter	**Rodney Pindai**	**Paul Da Gama**	**Paul Bannister / Sean Gilchrist**
Clinical Pathway redesign / Royal Free CPG programme (7 x clinical pathways)	Private Patients programme	Develop the Trust's refreshed People Strategy (and supporting Implementation Plan)	Electronic Patient Record (Outline Business Case)
Quality Hub development and QI roll out			Health Records Standardisation (Business Case)
Practice Development to support R&R of new workforce and skill mix			Telephony Replacement (Business Case)
GIRFT (Getting it Right First Time)			Transition to ATOs
			New Local Area Network
			Stabilising the IT infrastructure (Migration & Service Improvement)
			Cancer Information System (CIS) - full implementation and benefits realisation

Financial recovery plan	Research Strategy
Don Richards	**Mike Van der Watt**

Clinical Strategy/Service Redesign
Helen Brown
SACH Expansion of Enhanced Surgical Activity for Enhanced Care Patients
Vascular Hub
To merge WHHT Oesophago-gastric cancer unit with Imperial
Medical Take Redesign (4 week pilot)

Integrated Care
Fran Gertler / Helen Brown
2019-2020 Integrated Care (incl SDIP & Urgent and Emergency Care Redesign)

Access
Sally Tucker / Jane Shentall
Emergency Care Transformation (ED Access)
Patient Flow Transformation (Inpatients)
RTT & Cancer Programme Yr 1 (Elective)

Interim Estate
Esther Moors
Consolidation of Orthopaedic Outpatients at SACH (Holywell)
Urology Centre (Business Case) - *in scope*
Develop Interventional Radiology service (OBC)
Neonatal FBC - to improve the environment on Woodlands Neonatal Unit
ED Development (Wave 4 capital - FBC) Capital from NHSI
Watford Theatre Reconfiguration (FBC)
WGH Multi-Storey Car Park FBC & approvals
To improve Pathology service to the Trust and HVCCG (STP Pathology outsourcing)
Back office relocation (to release space at WGH for key estate and IT priorities)
Hemel Planned Care *-in scope*
2019-20 Winter Plans (to provide additional assessment space for Winter)

Acute Redevelopment
Esther Moors
Refresh Strategic Outline Case (SOC) Yr 1

Strategic Programme 2019-20 v8.0 20191107

Trust Board Meeting
05 December 2019

Title of the paper	**Corporate risk register report**
Agenda Item	**17/77**
Presenter	**Mike van der Watt, Chief Medical Officer**
Author(s)	**Sandra Muffett, Head of Patient Safety**
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	The purpose of this report is to provide an update on the status of the Corporate Risk Register (CRR) including current risk scores, new, escalated, de-escalated and closed risks.
Trust strategic aims	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	Since the last report to the Trust Board, the CRR has been reviewed by the Risk Review Group once (on 19 November 2019). Specific elements of the CRR have been reviewed through the committee structure throughout November 2019.

Action required	The Trust Board is asked: • To receive this report for information and assurance on the risk management arrangements in the Trust • To note the changes agreed by the risk review group to risks on the corporate risk register • To consider the impact of the risks highlighted in this report on the areas of responsibility of the other committees, in particular any risks which could compromise patient safety and escalate to the appropriate Quality Committee if required.

Agenda Item: 17/77

Trust Board meeting – 05 December 2019

Corporate Risk Register Report

Presented by: Mike van der Watt, Chief Medical Officer

1. Purpose

1.1 The purpose of this report is to provide the Trust Board with an update on the status of the corporate risk register (CRR) including current risk scores, new, escalated, de-escalated and closed risks.

2. Background

2.1 The CRR forms part of the Trust's overall board assurance and integrated risk management arrangements.

2.2 The CRR contains all risks rated 15 or above from each of the operational/divisional risk registers. The risk register is a 'live' repository of risks recorded on Datix and Risk Owners regularly review and update entries to reflect the current position of the risk.

2.3 Divisions regularly review all their risks rated 12 and under on the risk register and those risks which have been on the register for over two years.

2.4 Risks are closed as appropriate and any outstanding risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to this committee to agree future action.

3. Corporate Risk Register

3.1 This report captures the decisions made by the Risk Review Group (RRG) on 19 November 2019. Data for this report was extracted on 11 November 2019; a total of 25 open risks were registered on the CRR at that time.

3.2 Appendix 1 provides a full summary of all corporate risks as presented to the Risk Review Group on 19 November 2019.

3.3 The table below presents the movement of risks on the CRR by division, against each month since August 2018.

Movement of risks currently on the Corporate Risk Register

Division	Risk ref	Aug 2018		Sept 2018		Oct 2018		Nov 2018		Dec 2018		Jan 2019		Feb 2019		Mar 2019		Apr 2019		May 2019		Jun 2019		Jul 2019		Aug 2019		Sep 2019		Oct 2019		Nov 2019	
Clinical Informatics	3894	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→
	3892	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16							
	3896	16	→	16	→	16	→	16	→	16	→	16		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	3899	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→
	3897	16	→	16	→	20	→	20	↑	20	→	20	→	20	→	20	→	20	→	16	↓	16	→	16	→	16	→	16	→	16	→	**16**	→
	3467	12	→	12	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→														
	4099							15	→	15	→	15	→	15	→	15	→	15	→														
	4114											15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**15**	→
	4116											16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4125											16	→	16	→	16	→	16	→	12	↓												
	4197																											20		20	→	**16**	↓
Clinical Support Services	3965	16	↑	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4082																					16	→	16	→	16	→	16	→	20	↑	**20**	→
	2755																					16	→	16	→	16	→	16	→	16	→	**16**	→
	4137																					15	→	15	→	15	→	15	→	12	↓		
Corporate	3912	20	→	20	→	20	→	20	→	20	→	16	→	16	→	16	→	16	→	12	↓												
	3828	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	15	↓	15	→	15	→	**15**	→
	1011	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	12	↓												
	3710	15	↑	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**15**	→
	3120	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→
	4190																							15		15	→	15	→	15	→	**15**	→
	4191																							15		15	→	15	→	15	→	**15**	→
	4194																									15		5	↓				
	4207																											16		16	→	**16**	→
	4209																													15		**12**	↓
	3949																															**15**	
Emergency Medicine	4068			15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	20	↑	20	→	20	→	20	→	12	↓				
	3995																					15	→	15	→	15	→	15	→	16	↑	**16**	→
	4199																											15		12	↓		
Environment	3958	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4135																	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4154																					16	→	16	→	16	→	16	→	16	→	**16**	→
	2795																					12	↑	20	↑	16	↓	16	→	16	→	**16**	→

Division	Risk ref	Aug 2018		Sept 2018		Oct 2018		Nov 2018		Dec 2018		Jan 2019		Feb 2019		Mar 2019		Apr 2019		May 2019		Jun 2019		Jul 2019		Aug 2019		Sep 2019		Oct 2019		Nov 2019	
Finance		20	→	20	→	15	↓	20	→	20	→	20	→	20	→	15	↓	15	→	15	→	15	→	15	→	15	→	10	↓				
	3742	20	→	20	→	16	↓	20	→	20	→	20	→	20	→	16	↓	16	→	16	→	16	→	16	→	16	→	12	↓				
	3737	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	12	↓				
	3741	20	→	20	→	16	↓	20	→	20	→	20	→	20	→	16	↓	16	→	16	→	16	→	16	→	16	→	12	↓				
	4204																											15		15	→	**15**	→
	4205																											15		15	→	**15**	→
Medicine	4129													15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**15**	→
	4163																			20	→										
	4174																					16	→	16		16	→	**16**				
Surgery and Cancer	4198																									16		**16**				

Key: Purple = Closed risk
Green = New risk/Escalated risk
Orange = De-escalated risk
Blue = Merged

3.4 **Risk activity**

The following provides an overview of risk activity as discussed at the Risk Review Group on 19 November 2019.

New risks
No new risk was approved by the Risk Review Group during this reporting period.

Revised current risk scores
One risk rating was revised and approved by the Risk Review Group during the reporting period:

Risk Ref	Division	Risk Rating	Risk Title	Exec Lead	Rationale for revision of risk score
3949	Corporate	9 ↑ 15	Patient experience and patient safety is compromised due to ongoing challenges with current non-emergency transport provider	Sally Tucker	These ambulances are used for sub-acute transfers for example cardiac interventions at other hospitals. As this is not a contracted service, there is no guarantee that the Trust will have an ambulance available to undertake the transfers resulting in delays in clinical care. Current gaps whereby the Trust does not have a commissioned service to use: - Mental Health informal transfers - Mental Health formal transfer requiring mobility assistance - Out of Area Transfers/Discharges - London outpatient appointments - Transfers to providers within NHSE London area The CCG continues to negotiate a contract for 2019/20.

De-escalated risks
One risk was approved for de-escalation by the Risk Review Group during the reporting period:

ID	Division	Risk Rating	Risk title	Exec Lead	Rationale
4209	Corporate	15 ↓12	Failure to complete Learning from deaths of people with a learning disability (LeDeR) investigations in a timely manner	Tracey Carter	This was presented to the RRG in October 2019 as a new risk and was agreed for de-escalation to the Division as it presented a lower risk to the Trust due to the controls in place.

Closed/Merged risks
There were no closed/merged risks during the reporting period.

Risk still awaiting acceptance onto the CRR:
The below risk was not approved for addition to the CRR at the October Risk Review Group meeting and was represented to the November Risk Review Group:

- **CRR 4197 (Missing Patches – ICT Server Estate)**: This risk returned to the RRG in November for reconsideration; however the group were still unclear on what actual risk was posed and asked for further information to be sent to the Chief Medical Officer prior to the risk being accepted onto the Risk Register.

4. Risks

4.1 There is a risk that failure to keep effective oversight of the Trust's key risks may lead to the Trust not achieving its organisational strategic aims and objectives.

5. Recommendation

5.1 The Board is asked:

- To receive this report for information and assurance on the risk management arrangements in the Trust
- To consider the movement of risks on the CRR
- To consider the impact of the risks highlighted in this report on the areas of responsibility of the other committees, in particular any risks which could compromise patient safety and escalate to the appropriate quality committee if required.

Mike van der Watt
Chief Medical Officer

December 2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

ID	The Risk	Risk Type	Division admitted	Speciality	Executive Risk Lead	Risk Owner	Risk Lead	Opened	BAF Objective	BAF Principle Risk	Board Assurance (Primary)	Impact on business continuity	Description	Rating (initial)	Controls	Rating (current)	Gaps in controls	Assurances	Gaps in assurances	Further actions taken?/Contingency plan(s)?	Rating (Target)	Progress notes	Review Date
Escalated Risk for consideration (1)																							
3949	Patient experience and patient safety is compromised due to ongoing challenges with current non-emergency transport provider	Strategic/Operational	Corporate	Operations	Sally Tucker - Chief Operating Officer	Mason, James	Mason, James	24/10/2017	OB4: To improve our emergency care pathway and discharge processes.	PR4.2 System wide capacity and responsiveness at times of peak pressure	Quality Committee	Yes	The non-emergency transport provider has been unable to provide assurance of service. This could result in longer than necessary hospital stays, poor patient flow and patient experience. Mental Health informal transfers - Mental Health formal transfer requiring mobility assistance - Out of Area Transfers/Discharges - London outpatient appointments - Transfers to providers within NHSE London area	15	1. Where non-emergency transport is not available alternative transport is sought 2. Patients who are delayed in going home as a result of transport will be cared for in the MAU after the discharge lounge has closed. If it gets too late and not appropriate to send home, the patient will be cared for overnight at the hospital until transport arrives the following day 3. Discharge lounge and PALS hold stock of East of England Ambulance Service complaints leaflet which is give if required.	15	1. At present there is no assurance that weekend services will be provided	1. Details of patient delays are shared with HVCCG and recovery of costs is being discussed 2. Incidents are being monitored regularly.	1. Improvement of the service is reliant on co-operation from transport provider and CCG. 2. Competing demands for Private Providers with other Providers	Seeking agreement and assurance regarding weekend services. Private transport provided in place of the usual transport provided.	3	[Mason, James 29/10/19 11:05:17] The CCG continues to negotiate a contract for 2019/20. Current gaps whereby the Trust does not have a commissioned service to use: - Mental Health informal transfers - Mental Health formal transfer requiring mobility assistance - Out of Area Transfers/Discharges - London outpatient appointments - Transfers to providers within NHSE London area	30/11/2019
Revised current risk scores (1) *Risk not yet admitted into the CRR																							
4197	Missing Patches - ICT Server Estate	Non-Clinical	Clinical Informatics	Technical Services	Sean Gilchrist - Chief Information Officer	Vaughan, Simon	Vaughan, Simon	16/08/2019	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and strategic plans, presents cyber security risk	Finance and Performance Committee	No	Background: Patching is the process of repairing system vulnerabilities which are discovered after the infrastructure components have been released on the market. Patches apply to many different parts of an information system which include operating systems, servers, routers, desktops, email clients, office suites, mobile devices, firewalls, and many other components that exist within the ICT infrastructure. The number of patches which are required on a consistent basis can be overwhelming. This is why it is necessary to devise a patch management process to ensure the proper preventive measures are taken against potential threats. Our third party is devising a patch management process for the Trust. Development of a policy in draft stages currently. In the event there is a window of vulnerability, a solid patch management system means a network is being consistently monitored. This allows immediate action to be taken if a patch has yet to be released when a vulnerability is discovered. The importance here is the prevention of what is known as a 'Zero Day Attack' which is an exploit that can occur while a patch is in the process of being produced to repair the vulnerability. Attacks such as these can be minor or they can be as malicious	16	0Anti-virus services replaced by new IT Outsourced Supplier & up-to-date virus signatures maintained New patching policy defining minimum standards for all IT & related systems	16	Not all servers can be updated with new ITO software . 25% of estate needs OS upgrade but still uses older Anti-virus software & older antivirus signatures need updating. New policy in draft awaiting ratification Some legacy end-user devices are not support for patching	Installed a new software tool, provided by an independent IT Security supplier to monitor and track patching in real-time. New ITO supplier contract includes Risk management panel to review top risks for IT	New software still undergoing configuration New ITO supplier Risk management panel still to be scheduled	Reviewing legacy server estate and applications to understand if these can be upgraded or decommissioned. The Electronic Patient Record Programme has started and will look to consolidate applications.	8	Risk updated to reflect discussion at the risk board this includes re-scoring the risk. Working with the third party to pull together a maintenance window to allow patching to occur. 19-11-2019 Email Sandra M with further info to support the risk and its revised score of 16.	29/11/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
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Clinical Support Services (3)																							
4082	Potential shortage of spare parts to repair AAU CT scanner impacting on patient care	Strategic/Operational	Clinical Support	Radiology	Sally Tucker - Chief Operating Officer	Daniels, Sue	Daniels, Sue	01/10/2018	OB1: To deliver excellent clinical outcomes for our patients	PR2.3 Operational implementation of new pathways - where competing priorities and resource implications (e.g. where pathways require ring fenced diagnostic or theatres capacity, changes to clinic templates or job plans)	Quality Committee	Yes	Cause: The CT scanner in AAU at WGH is 1O years old (average life expectancy is 10 years). This unit has been heavily used 24/07 and is experiencing mechanical wear and tear ie.table movement needed several repairs recently. Supplier has warned of shortage of spare parts. There are three CT scanners at WGH, one used for in-patients and Trauma in AAU,one in Cardiac Imaging and one in PMOK (OPD) . Effect: it could break down with the result that no patients could be scanned in AAU. Consequences: Delays for in-patient and trauma CT scans. Possible increased LOS for in-patients. Poor patient experience. There would be an increase in operational costs due to additional out of hours activity at Watford or outsourcing. WHHT would be unable to offer seamless care with potential reputational damage.	16	There are 2 other CT scanners on the WGH site that could be used for trauma and in-patients.	20	Not enough capacity to accommodate this additional activity onto other two scanners without breaching 6 week diagnostic target.	Company able to repair equipment and locate spare parts	Parts becoming increasingly more difficult to source	Business Case complete, decision to replced scanner in ED confirmed. Target completion date March 2020.	4	Update provided by S. Daniels 17th November 2019: CT Scanner to be installed in ED into fluid store and Scanner Audit fluid store being relocated to outside Shrodells. [Daniels, Sue 31/10/19 17:25:45] Turnkey contractors appointed and visited site. Fluid store relocation work has commenced	30/11/2019
2755	Risk of failure of the MRI scanner at HHGH and deterioration in image quality	ORGA	Clinical Support	Radiology	Sally Tucker - Chief Operating Officer	Daniels, Sue	Keble, Martin	28/07/2011	PR6: Failure to maintain business continuity	PR1.2 Not adhering to best practice guidelines	Quality Committee	Yes	Cause: The MRI scanner at HHGH is 16 years old and was installed in 2003(average life expectancy of a MRI scanner is 10 years). This unit has been used during the normal working week and in addition during evenings and weekends and is experiencing mechanical wear and tear ie. coils need replacing and table movement needed a repair. There is one MRI scanner at HH and one at WGH. Effect: it could break down with the result that no patients could be scanned at Hemel. Consequences: The Trust would not be able to meet the 6 week diagnostic target for MRI and would incur financial penalties. Patient lists would need to be cancelled and patients transferred to Watford or other sites for their scans, resulting in a poor patient experience. There would be an increase in operational costs due to additional out of hours activity at Watford or outsourcing. WHHT would be unable to offer seamless care with potential reputational damage.	16	1. The current kit is regularly maintained and serviced in line with manufacturers guidance. 2.Daily QA is carried out by the staff. 3. Staff are informed to report any increase in Helium levels which could indicate a potential problem (> 20 %) 4) All requests are vetted by the Lead MRI Radiographers and requests for examinations that would be affected by deteriorated image quality at Hemel (due to its age) are booked on the 6 year old scanner at WGH. 5). Scans monitored for quality by reporting Radiologists who would escalate if further image deterioration.	16	Potential for scanning patient at HHGH that would require repeat scan at WGH due to poor image qualities	Daily QA and regular servicing of the MRI equipment -checked log and maintenance dates Radiology Services Manager checked QA book confirmed that daily Helium levels recorded by staff Service contract in place.	"go-live" of new scanner at WGH in March 2020	Radiologists are reporting that image quality is deteriorating, more repeats at WGH causing capacity issues for in-patients. Clinicians requesting their patients are not scanned at HHGH. Image quality deteriorating daily complaints.	4	Update on 11th November 2020. In 2020-Business case to determine location and development costs to install in March 2020. Contingency plan for HHGH developed hard standing fro mobile MRI to be installed by March 2020. Standby contract for mobile scanner in negioation. [Daniels, Sue 31/10/19 17:28:47] Confirmation that WHHT will receive central funding for one replacement MRI scanner. In 2020-Business case to determine location and development costs to install in March 2020.	30/11/2019

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3965	Delays in imaging of patients requiring interventional radiology procedures	Clinical	Clinical Support	Radiology	Patrick Hennessy- Director of Environment	Daniels, Sue	Daniels, Sue	11/12/2017	OB12: To improve the quality of our estate and implement our service driven estate strategy	PR12.1 Availability of capital to support the delivery of the interim estate strategy.	Quality Committee	Yes	See Risk 2765 - Lack of comprehensive Interventional Radiology Service at WHHT Cause: There are two fluoroscopic units at WGH but the one in the interventional room is no longer used as the Radiation dose is considered too high when comparing to the unit installed at WGH 18 months ago. The interventional room which is larger and can accommodate more staff and equipment is now not used. The equipment within this room needs replacing so that we can use the room to its full potential. A plant room is needed to facilitate adequate air changes per hour and a four bedded recovery area is also required. Effect: interventional cases are split between the Siemens fluoroscopic room and theatre. This causes theatre capacity issues and is a very expensive IR model. This equipment was due to be replaced in theatre as part of the hybrid theatre but this is no longer the case. There are currently inadequate facilities to carry out sedated or GA IR cases in Radiology. Consequence: Delayed imaging could result in therapeutic/diagnostic delays for patients. WHHT is unable to offer seamless care with potential reputational damage.	16	Interventional cases are carried out in theatre or in the smaller fluoroscopy room at WGH Radiology have worked with Endoscopy to develop a procedure so that very limited sedation can be administered within the Radiology department for patients requiring PTC's Locum IR Radiologist has accepted a substantive post and is carrying out more complex procedures within the departments	16	Theatre capacity limiting when needed for more complex IR cases Lack of facilities to store CD's in the department and recovery area Lack of piped oxygen and suction Room unsuitable for GA's - no extraction for anaesthetic gases and limited space	Patients requiring IR procedures are accommodated at WHHT	Nephrostomy patients requiring sedation need a theatre slot	Level 2 PMOK or alternative solution. W/C 20/08/18 Estates team carrying out initial scoping work before instructing architect. MD has submitted new idea being worked up. RSM met with Paddy, Esther and Steve 18/02/19 to establish whether idea of IR suite in Level 2 AAU feasible - to be worked up. negotiations continue with RFH concerning OOH IR cover.	4	Update 11th November 2019- Business case for new IR suite and development. Discussions with RFL re: potential OOH cover underway. Traget to go live in April 2020.[Daniels, Sue 31/10/19 17:26:58] RFH have agreed honorary contract of one day per week at RFH	30/11/2019
Clinical Informatics (6)																							
3894	ICT Applications reduced availability, poor reliability & performance	Strategic/Operational	Clinical Informatics		Sean Gilchrist - Chief Information Officer	Vaughan, Simon	Vaughan, Simon	12/06/2017	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and strategic plans, presents cyber security risk	ICT Infrastructure Transition Committee	Yes	Cause: Reduced availability, poor reliability & performance of supporting infrastructure including Data Centres, Servers, Networks, End-user Devices. Failure to regularly upgrade/update application software with limited or no software assurance. Basic levels of application maintenance, portfolio management compounded by poor governance (ownership, clear responsibilities). Greater number of vulnerabilities/exploits with older operating systems and applications Legacy applications incompatible with newer technologies. Effect: Applications perform poorly or become unavailable. Applications are unable to scale to meet the demands of the business, new applications purchased to compensate for functional and performance gaps; increasing operating costs. Impact: Delays or disruption to information flows, communications or both. Reduce productivity leading to patient pathway delays and backlogs. Significant impact on staff effort & morale. Higher operating costs, increased vulnerability to Cyber threats. Inability to respond to demands for data growth and compute requirements.	20	•Greater levels of basic maintenance for key applications •Replacement of key applications e.g. PACS •Backups for recovery •Migration of: Trust e-mail, Radiology Information System, File Shares; Anti-coagulation System, Pharmacy Stock Control, Mail Management System, Single Sign-on Systems, IT Security Management Systems (Proxies), Chemotherapy prescribing system, bulk mailing system, Point of Care Analysers, Chemistry Analysers	20	•In some cases backups are unreliable •Applications not migrated: Cancer Management & Clinical Information Systems, Clinical Portal, Orders Comms & Results Reporting System, Theatres Management System, Maternity Management System, Printing Systems, Management Information Systems, Electronic Handover Systems New IT outsourced supplier New Hardware/server purchased for key applications	•Monthly ITO Governance Structures	•New contract with IT outsourced supplier some goverance meeting still to take place/schedule	Capital funding "carry over" bid made against 2018/19 Capital Programme •The Interim Tactical Server Business Case was approved to provide a new SQL environment for the trust held applications This project has just started and will be completed by Nov 2019. •As part of the discussions with the new ITO the trust will be developing an applications strategy to manage the current and future clinical applications as effectively as possible. The infrastructure risk will remain high until full stabilised with the new ITO.	6	7/11/2019 The tactical environment is having a memory upgrade on 9th November, once this is completed both e-handover and iReporter can be moved onto the environment. After this the risk score can be reviewed.	29/11/2019

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DATE: 11 NOVEMBER 2019

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3899	ICT Trust Bleep System	Strategic/Operational	Clinical Informatics		Sean Gilchrist - Chief Information Officer	Vaughan, Simon	Vaughan, Simon	12/06/2017	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and	ICT Infrastructure Transition Committee	Yes	Cause: Equipment damage or failure due to: age of equipment, inadequate environmental controls, and capacity limitations and "supportability" of legacy infrastructure (single supplier). Effect: Bleep System Service available. Impact: Patient or staff harm as the Trust will be unable to communicate or raise alerts rapidly to support: •crash teams in the event of an emergency •site alert in the event of a fire alarm activation •alert staff in the event of a lift entrapment •security in the event of a security emergency	20	Maintenance contract & stock of spare parts held by supplier New inter-site connectivity in place including 4G backup (BlueSky)	20	Single supplier with a single engineer with the appropriate knowledge to support	Bleep system is tested regularly. In May 2017 the bleep system was checked by the orignal supplier and given a clean bill of health.	No gaps identified	Project in-flight to replace bleep system	5	7/11/2019 The Telephony Business Case was approved by both CPFG and TMC in August and October. As such the procurement route is being determined and framework chosen. Timelines being established but anticipate completion by March 2020.	29/11/2019
4116	Delivery of the Trust's Digital transformation programme	Strategic/Operational	Clinical Informatics		Sean Gilchrist - Chief Information Officer	Gilchrist, Sean	Gilchrist, Sean	23/11/2018	OB10: To improve our IT and move towards full digitisation.	PR10.3 Insufficient clinical engagement to drive transformational change required to deliver Digital Vision	ICT Infrastructure Transition Committee	No	Cause: Following the publication of the trust's Digital Vision in May 2018, plans are underway to move the trust into a paperless (digital) workplace. Stakeholder engagement is fundamental to its successful implementation;currently the poor reputation of ICT services, operational pressures and organisational structures act as barriers to obtaining this engagement. Effect: Significant digital changes are planned which will increase the need for intensive stakeholder engagement and will require increased focus and resource; clinical engagement is central to the projects success. Impact: Failure to engage properly may lead to: •Misalignment of plans with the trust's needs – the wrong changes •Failure to achieve the intended benefits – ineffective change •Partial achievement of the intended benefits – ineffective change •Significant disruption or additional effort required to make the change and deliver the intended benefit - inefficient change	16	Goverance Groups - TEC, CAG, Informatics transformation group Digital Vision - describing asperations for change ICT Change Management Processes Chief Clinical Information Officer Role (CCIO)	16	Attendance and buy in at Governance Groups Not enough time allocated to CCIO	• Attendance and buy-in at Governance Groups • Informatics Transformation Group has not met in some time • Further work required to build a strategy underpinned by the Digital Vision • Not enough time allocated to CCIO role (4PA's)	Other stakeholder groups to be engaged Membership and agenda of Imformatics Transformation Group needs more work	• Other stakeholder groups to be engaged • Membership and agenda of Informatics Transformation Group needs further work and the group has not met for some time	6	[Gilchrist, Sean 10/10/19 15:35:59] Tender process to develop user requirements, strategic outline case and outline business case has completed and a business case discussed at Trust Management Committee on 9th Oct for consultancy resources. Detail requirements gathering exercise will be further clinical engagement. Benefits review has completed and a report will be used to reflect back findins of initial engagement. 10/10/2019 10/10/2019 15:35:59 Tender process to develop user requirements, strategic outline case and outline business case has completed and a business case discussed at Trust Management Committee on 9th Oct for consultancy resources. Detail requirements gathering exercise will be further clinical engagement. Benefits review has completed and a report will be used to reflect back findings of initial engagement. 07/11/2019 Funding case taken to TMC and then to Executive team meeting. Asked to seek external funding and then come back to Executive team if unsuccessful. 06Nov19 attended Fast Follower meeting with NHSEI/X and the Royal Free – no	19/11/2019
3896	ICT Data Networks reduced availability, poor reliability & performance	Strategic/Operational	Clinical Informatics		Sean Gilchrist - Chief Information Officer	Vaughan, Simon	Vaughan, Simon	12/06/2017	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and strategic plans, presents cyber security risk	ICT Infrastructure Transition Committee	Yes	Cause: Replacement Wide Area Network (WAN) experiencing a variety of management incidents & performance problems. Large parts of the legacy Local Area Network (LAN) have not been replaced or upgraded under the Make IT Happen Programme. Network support is not responsive enough under the existing managed service. Continuous and various changes to configuration of the network under the new managed service. Effect: Unplanned Network outages, slow performance, gaps in configuration knowledge and documentation. Services and applications using the network perform poorly or become unavailable. Impact: Delays or disruption to information flows, communications or both. Reduce productivity leading to patient pathway delays and backlogs. Significant impact on staff effort & morale. Higher operating costs, increased vulnerability to Cyber threats.	20	•Multiple network links across Watford, St Albans & Hemel Hempstead New multiple data centres with ITO	16	•Network traffic does not always re-route when links fail. Routing issues still being worked on	Monthly Governance meetings	New ITO with governance meeting still to take place/schedule	LAN business case approved at CFPG now going to December 2019 Board HSCN project in-flight to upgrade intersite links and HSCN connectivity due to complete April 2020	6	7/11/2019 In October the hardware component of the business case was market tested on the CSS Framework, with the assistance of procurement. Upon completion of this exercise the business case is being updated to reflect the latest pricing, and the scope of the work involved. Due to supplier discussions regarding this work, the business case is now heading to the December Board	29/11/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

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3897	Cyber Risk	Strategic/Operational	Clinical Informatics		Sean Gilchrist - Chief Information Officer	Vaughan, Simon	Vaughan, Simon	12/06/2017	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and strategic plans, presents cyber security risk	ICT Infrastucture Transition Committee	Yes	Cause: Internal, External malicious or unintentional breaches of, or attacks on information systems. Effect: Loss of Information and Communication Technology (ICT) services, data or both. Impact: Delays or disruption to information flows, communications or both. Reduce productivity leading to patient pathway delays and backlogs. Potential for Financial and Reputational Damage.	16	1. The Trust has a board-level individual who has overall accountability for the security of networks and information systems and drives discussion at board-level. 2. Board level data security training 3. Risk assessments are conducted when significant events potentially affect the essential service, such as replacing a system. 4. There is a documented Information Security Policy 5. Firewalls, Anti-virus, Mail & Internet Filtering appliances, network partitioning 6. Physical access controls to key networking and server equipment 7. Logical controls – user permissions and control groups 8. Two-factor authentication is in place for remote access 9. Basic security controls are in place for the Trust mobile devices (including remote wipe) 10. Server backups to aid in recovery 11. Data Protection and Information Governance Training 12. Information Security Manager in place	16	1. Legacy network equipment that is no longer supported by the vendors typically more vulnerable to exploits 2. Some technical controls missing e.g. Intrusion Detection Software, Network Access Controls 3. Large estate of older operating systems like Windows XP and Windows 2003 Servers more vulnerable to exploits 4. Irregular maintenance security patching routines 5. Inconsistent and inappropriate access controls 6. Excessive provision of privileged access 7. Use of weak administrative and user passwords that are easy to guess 8. Inconsistent administration of user accounts causing large number of accounts not being disabled. 9. Insufficient monitoring coverage 10. Insufficient Mobile Device management 11. Unreliable backup routines 12. Cyber Security Awareness campaign limited 13. Firewall rules that are no longer required are not being removed 14. Hardware and software inventories are not maintained Full list of risks identified is available in Documents and templates section.	1. Information Governance Steering Group & Joint Security Meeting Information Governance approval processes 2. Penetration testing 3. Membership of NHS Digital's CareCERT Early Adopters Assure programme 4. IT Health checks by independent 3rd parties	1. Unable to cover all issues in JSF 2. Follow up activity on Penetration testing 3. Lack of regular audits of internet usage 4. Lack of detailed audits around data management i.e. storage, access and nature 5. Security metrics are not granular enough to manage security improvements on a day to day basis	• Review increasing activities to raise end-user awareness •Review phishing & social engineering response management • Introduction of vulnerability management tool & cyber 360 management deployed 9/1/2019 - Cyber security road-map has been approved by the Information Governance & Joint Security Group. - Patching is in progress for EUD devices and servers.	12	7/11/2019 Working with the third party to pull together a maintenance window to allow patching to occur. The window is mostly known and as such a schedule is being created for the legacy (on site) estate. Following the move to Atos the antivirus software has been updated and replaced. In addition a draft policy has been created for review as this policy rebases all to move to the cyber essentials timeline for patching.	29/11/2019
4114	Delivery of the ICT Service Transition Programme	Strategic/Operational	Clinical Informatics		Sean Gilchrist - Chief Information Officer	Vaughan, Simon	Vaughan, Simon	20/11/2018	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and strategic plans, presents cyber security risk	ICT Infrastucture Transition Committee	Yes	Cause: Delays to the programme plan relating to: • Procurement challenges • Supplier implementation readiness • Trust implementation readiness • Incumbent supplier cooperation Effect: Delays to the physical transition of services from the incumbent provider to a new service provider (ITO) Impact: Increase in running costs of the existing service (incumbent supplier) Increase in programme costs (resources) Delays to service improvements e.g. application performance Delays to the mitigation of ICT infrastructure risks e.g. networks and telecommunications	12	Programme team with clear focused objectives Outline Programme plan Subject matter experts commissioned to tackle procurement issues	15	Funding for team up until full business case Programme plan requires further scrutiny & refinement	Independent consultant to providing oversight and challenge to the programme team Experienced programme Director and Commercial lead Regular fortnighly meetings with the Executive steering group Regular committee meetings with exective and non-executive stakeholders	Oversight of the incumbent supplier's progress and resourcing for the exit of ICT services	Procurement challenges - seeking expert advice and exploring all procurement routes Trust implementation readiness - preparing for supplier engagement and mobilistion Incumbent supplier cooperation - in commercial negotiations with incumbent supplier and regular exit meetings	4	7/11/2019 The main move to Atos was completed on 24th September 2019. All servers that were in CGI's data centers have been moved to Atos data centers and all links with CGI have ceased. There are still some transition activities to be completed but these are mainly around Atos ability to report and monitor the estate. As such suggest that the risk is fully reviewed and closed down in December 2019 when this work will be completed.	29/11/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

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Corporate Services (6)																							
3120	Lack of Storage facility for Patient Medical Notes leading to missing, poor condition and delayed location	Clinical	Corporate	Health Records	Sean Gilchrist - Chief Information Officer	Hearn, Paula	Mason, Martine	09/07/2014	OB10: To improve our IT and move towards full digitisation.	PR10.4 Current ICT infrastructure estate not yet transformed and cannot support immediate and strategic plans, presents cyber security risk	Quality Committee	Yes	Limited, inadequate and poor medical records storage across all sites, poor adherence to tracking processes leading to missing notes. Current practice is inefficient and resource intensive. Lack of availability of notes for clinical episodes of care causes an Information Governance risk related to missing notes and a risk to patient care. Poor patient experience, potential for cancelled appointments and delays, inefficiency (missing clinic notes, delays to provision of records), financial and reputational risks of Information Governance breaches. Delay to cost savings through slow reduction in agency spend. Damaged notes due to leaks from sluice and ceiling light window in Shrodells, pipes in the ceiling in clinic prep at Hemel. WGH library courtyard leaks from roof and, leading to further delays. Risk to staff due to inadequate storage solutions	20	Where notes are not available for clinic, temporary files (flimsies) are prepared including most recent clinical correspondence. Additional clinical information is available on electronic systems PACS and Infoflex. Additional staff in post to help manage the multiple medical records locations Additional storage has been located in shrodells Repairs by estates to rooms where rain leaks or sluice overflows Health and safety assessment undertaken in department and advice to staff on safe working practices, mitigating actions put in place where possible Business case for scanning option has been approved although final finances still need to be approved Update 31/7/2018 First tranche of notes (C 100,000 sets) going for scanning late September 2018 / early October. Once quality assured, notes will be destroyed and scanning bureau will be set up in the health records department. Job description for project manager being rewritten as banding came out too low. Once approved, will be put out to advert. 02/11/2018 09:03:30 Update from Elain Odlum: There was a meeting held and	20	Temporary notes do not contain all medical information such as test results and / or scans. Not always possible where water damage has occurred to retrieve clinical notes or to make good any damaged ones. Where this occurs every effort is made to recover the casenote volumes with available clinic information. Additional storage causes inefficiency in working practice as locations are spread out throughout the Trust. The additinal storage in Shrodells is already full Use of boxes to store medical records presents risk of harm to staff, not all H&S recommendations can be implemented within current constraints e.g. not to have boxes stacked Merger of notes may not be timely or may not occur Final business case with finances may not be approved	Monthly 'snapshot' audits of missing notes undertaken by Medical Records Team. Missing notes recorded as incidents on Datix and thorough searches undertaken. Updates from medical records manager are given to the ADM for medical records and the DM for medicine when the library is reaching crisis point.	Formal reporting of medical records performance needs via divisional governance. Snapshot audits provide only a limited view of the overall issue. Not all episodes of missing notes reported on Datix. Inability to accurately report on tracking compliance due to limitations of PAS. The updates from the medical records manager sometimes results in the library having to close meaning more notes have to be kept in secretarial offices.	14/05: business case for the re-volumisation of Health Records to sent by June.	6	[Hearn, Paula 06/09/19 08:19:27] Business case currently being written for Clinic Prep at SACH to move into area occupied by Orthopedics who are due to move into new area. Multi volume tracking on Patient center still being tested, last test 30/08/2019 failed. 20 Patients who have multi or fat volumes have been sent for trial sanitizing pilot(re-volumisation)on 02/09/2019, these are due to be returned w/c 16/09/2019 and will be shown to clinicians for feedback. Hemel Library racking has completely broken, NHSP staff injured themselves DW124344, Estates have been asked to repair or replace.	19/11/2019
4207	Inadequate post in-patient discharge appointment booking processes	Clinical	Corporate		Sally Tucker - Chief Operating Officer	Tucker, Sally	Jones, Marsha	12/09/2019	OB1: To deliver excellent clinical outcomes for our patients	PR1.2 Not adhering to best practice guidelines	Quality Committee	No	• In Medicine and Surgery & Cancer, there is no standardised process across the wards for booking outpatients referrals upon patient discharge from the ward. Some wards use Infoflex but have to manually look through the entire discharge summary to see if there is mention of a referral needed. This is often just a short sentence that can easily be missed. •Variation in outpatient referral booking practices across the wards. •Shortage of ward clerks across some areas •No ward clerk cover in the evenings and weekends •Inability to back-fill Ward Clerks when they are on annual leave/sick leave etc. •Lack of training for ward clerks to carry out the booking of outpatient referrals on discharge. • There is also no guarantee that if a referral is made that it is received and booked by the receiving booking team/speciality. Some wards work out of a book which requires manual maintenance. The process may fall apart if the ward clerk is not present	20	1.Asking other ward clerks to assist with workload 2.Help from other divisions to ensure proper filing of notes and escalation of duties when ward clerks are off 3.Reviewing of education and training of ward clerks 4 Use of the existing work lists to standardise practice and reduce variation	16	1. There may be pressure on other divisions who may not be able to assist-example unplanned leave like sickness 2.No one individual overseeing ward clerks 3.Ward clerks work to different job specifications	Ensure all incidents are reported Audit number of Datix reports	Inadequate or no reporting of incidents	1. To review a two way process in that a referral needs to be generated and then a receipt is sent back from the booking team or Specialty to discuss options with Manager of Infoflex 2. To ensure responsibility of the referral is sitting with Junior doctors 3. To provide a system whereby requests for outpatient appointments will be made mandatory on the infloflex (Inpatient Discharge Summary). 4. To review roles of all ward clerks, cover provided and hours worked.This would require corporate oversight	8	11th November 2019: Wider workstream looking at the role of ward managers underway in reducing the variation in the way they work. [Otite, Dorothy 22/10/19 16:02:21] 17.10.19 Testing has been completed in infloflex(Inpatient Discharge Summary) have asked for Outpatient App req to be made mandatory and it does pull perfectly onto a worklist that can be given to nominated role to work through This will help mediate the risk but who should book the appointment is still under debate as this will be an organisational change.	19/11/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

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3710	Incomplete / Non compliance with Do Not Attempt Cardiopulmonary Resuscitation process	Clinical	Corporate	Safeguarding	Dr Michael Ivan der Watt - Medical Director	Regal, Frances	Van der Watt, Michael	20/04/2016	OB1: To deliver excellent clinical outcomes for our patients	PR1.2 Not adhering to best practice guidelines	Quality Committee	No	Trust wide risk Cause: 1) Full process not being exercised when completing DNARCPR forms resulting in patient and/or NoK not being included in DNACPR decision making. 2) Non compliance with the Mental Capacity Act when undertaking DNACPR decision making Effect: 1) Timely DNACPR decisions not taken; communication of DNACPR decisions not effectively undertaken with patients and relatives and relevant documentation (DNACPR forms) not appropriately completed. 2) Failure to follow the statutory framework for patients who lack capacity and failure to include relatives in decision making. Impact: 1) Patients resuscitated when not clinically appropriate leading to undignified death and unnecessary suffering. 2) Potential for legal challenge which could potentially have a financial and reputational impact on the Trust.	20	DNACPR e-learning is mandatory for all medical staff. Safeguarding team teach on the new Dr Trust induction Teaching sessions provided at Divisional Clinical Governance meetings One to One teaching sessions with named Consultant Bespoke DNACPR/MCA form developed and distributed across all clinical areas to ensure MCA is considered for appropriate patients. New form promoted by safeguarding team across clinical areas - covered in new doctor induction.	15	Audit shows lack of compliance with DNACPR form Not all departments have allocated Compassionate End of Life Care Champion roles Training is required for staff to feel confident about having conversations of this nature. Poor training compliance	The resuscitation team follows up all resuscitation calls and examine medical notes for evidence of DNACPR consideration. Compliance and audit results are presented at the Resus panel every 3 months. Training compliance is monitored monthly and reports are presented to safeguarding panel. Audits are undertaken as part of the safeguarding audit strategy and these are presented at safeguarding panel. Any actions from these audits are transferred on to the safeguarding work plan which is also monitored via safeguarding panel Monthly dip samples are undertaken and presented to safeguarding panel Quarterly dashboard completed for CCG which monitors compliance with MCA/DoLS training Audits will be carried out on the use of the DNACPR/MCA form and reported to safeguarding panel.	Completion of the forms has improved, however there continues to be a lack of compliance regarding the conversation with the patient or NoK.	3D's poster to be approved and distributed regarding DNACPR process to provide additional guidance. Sage and Thyme training to be explored to help confidence regarding conversations with patients and NoK. 13/09/2018 09:29:07 The risk has been reviewed at the risk review group meeting. The risk write up requires editing, help will be provided by the corporate team. A meeting is being arranged for the following week to go through this process. It has also been suggested that this risk should be added to the corporate risk register. the review date has been set at 2 weeks to ensure all these action have been done. 20/12 Sage and Thyme training has been approved and to go ahead, dates to be confirmed. 3D's posters-to be apart of the QI DNACPR	6	[Regal, Frances 07/11/19 08:31:03] QI DNACPR meeting to place 5th November 2019. Minutes to follow. Summary of meeting as follows: Final version of new DNACPR documentation agreed by QI group (having consulted a number of colleagues in the trust on the draft) ; next steps: Form to be agreed by Resuscitation panel and end of life panel . As the DNACPR documentation is an appendix to the Trust Resuscitation Policy, the revised Policy to be taken to Policy and Guideline's Group followed by QSG for ratification. Group have produced a new draft version of the TEP which will go through a similar consultation process. 3 applications made to UCLP faculty to train Watford clinicians to deliver regular in-house DNACPR conversation teaching DNACPR Questionnaire devised and agreed by QI group to send to consultants to gain understanding of reasons for not having TEP and DNACPR discussions. Method of distribution to be confirmed. Group agreed the approach of regular board round check and challenge of existing DNACPR documentation/ awaiting Deputy Chief Nurse decision from his nursing forum All above to be supported by further education of new documentation and rationale over the next few months at appropriate forums	10/12/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

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3828	Patients may come to harm and have a poor experience due to long waits for elective care	Strategic/Operational	Corporate		Sally Tucker - Chief Operating Officer	Shentall, Jane	Shentall, Jane	09/11/2016	OB2: To implement best practice, integrated care pathways and reduce unwarranted clinical variation in care and outcomes	PR2.5 Failure to deliver in-year reduction of patients waiting more than 18 weeks for treatment, resulting in adverse variance to the RTT performance improvement plan and non-compliance with the 92% open pathway	Quality Committee	Yes	Cause: 1.Whole system demand management schemes are limited/ineffective in controlling overall referral growth, despite achieving reduction within specific services/pathways 2.Reduced elective activity as a result of cancellations due to seasonal increases in non-elective demand, estate infrastructure failure etc 2.Effect: 1. Failure to reduce waiting times with increase in the number of long waits Impact: 1. Patients may come to harm as a result of increased waiting times 2.Patients may choose to go elsewhere for treatment 3. Reputational damage	20	- Chief Medical Officer as Executive Lead, provides the clinical engagement link and oversight of patient harm reviews - Comprehensive suite of information reports - Development of trajectory and tracking methodology which supports overall improvement programme with actions at service level - Target waiting time reduced as each phase achieved - Monitoring and oversight through weekly Access meeting, monthly Elective Care Programme Board, monthly Divisional Performance Reviews, Surgical Division weekly long waits check in with Director of Performance - Development of system wide winter plan - Enhanced care model at SACH - Theatre maintenance programme - Theatre ventilation group - Weekend waiting list initiatives - Surgical division long waits harm review process in place, with SOP and progress tracking - Ring fenced elective bed base has been established at WGH - Scheduling and theatre utilisation project in Surgery - Development of in-house demand and capacity modelling tool RTT rules knowledge and training needs assessment programme for all relevant staff with comprehensive range of e-learning modules now available on Acorn - Engagement with CCG in pathway redesign and commissioning - Outsourcing programme - Surgical Check In meetings with division and Exec team with oversight of surgical transformation plan/actions	15	Urgent care pressures are not always predictable, resulting in unforeseen surge into elective bed base Insufficient capacity available to deliver required levels of activity to reduce backlog. Limited control on independent sector booking practices despite weekly meetings and patient tracking. Inconsistency in adherence to agreed processes relating to patient scheduling	Internal: Oversight of harm reviews and outcomes discussed at divisional governance meetings, with tracking updates which are included in subcommittee IPR and Board paper Weekly performance reports Weekly long wait review with Surgical division Divisional IPRs & performance reviews TMC, Finance & Performance Committee & Board oversight through papers and IPRs Quality committee oversight of the patient harm reviews External: CCG Contract & Quality Review Group NHS Improvement performance review meetings 16/11/18 - update - External review of PTL (by NHSI) undertaken 25/10/18 – no significant concerns identified with regard to PTL management	1. Service level recovery plans are not always robust or well developed. 2. Variable scheduling practices resulting in inadequate list/clinic fill or late/last minute booking	- WGH Theatre reconfiguration project - Surgery transformation group (workstreams: theatre efficiency; scheduling; POA pathways & processes (reducing cancellations); outsourcing) - Surgical check ins with oversight of workstream outputs - Enhanced care programmea at SACH - Weekly Surgical division long waits check in with Director of Performance	10	[Shentall, Jane 29/10/19 17:15:24] Progress continues in line with the performance improvement plan. There is no change to the current risk rating.	30/11/2019
4190	Senior medical staff may alter working arrangements resulting in the Trust being unable	Strategic/Operational	Corporate	Human Resources	Paul Da Gama - Director of HR	Taylor, Jayne	Taylor, Jayne	10/07/2019	OB7: To reduce vacancy rates and reduce our reliance on agency workers.	PR2.5 Failure to deliver in-year reduction of patients waiting more than 18 weeks for	People, Education and Research Committee	Yes	Changes to tax relief on pensions which have had full impact this year, and a reduction in the pension lifetime allowance has resulted in some Consultants and other doctors declining to undertake additional work. In addition, nationally there are reports that these staff may seek to reduce hours or retire early due to these change. This will reduce the Trust's ability to maintain consultant led services. Services rely on sufficient numbers of Consultants being in post and where there is insufficient capacity or where initiatives such as those intended to reduce waiting lists are in place, historically consultants and other senior doctors have taken on additional shifts to maintain service provision. Staff declining additional shifts will impact on the Trusts ability to respond to	20	Insufficent Controls - HR organised Pension Seminars for high earning members of staff. - HR have offered information, advice and guidance for staff affected. - HR monitoring any requests to go part time _ HR monitoring staff members unwillingness of staff to complete the additonal hours	15	We are awaiting national guidance on this issue. Trust is unable to predict staff response to changes in taxation on pension contribution and how this will impact on service delivery.	Reported to TMC and monitoring in connection with national updates on this issue.	Trust can only provide assurance once new national guidance is issued.	Discussed at Local Negotiating Committee and members encouraged to comment on national consultation currently underway about this issue.	12	[Marcus, Tania 26/09/19 14:04:45] This risk remains static as Trust is awaiting national guidance following consultation on this issue. Once further update provided on possible amendments to pension scheme, Trust will plan actions accordingly and communicate widely with staff. Currently we continue to monitor any impact on availability of senior clinicians to undertake additional sessions and no 18th November: a further imminent development was discussed in media	31/12/2019
4191	Risk of a financial liability to Trust following outcome of legal case 'Flowers'	Strategic//Operational	Corporate	Human Resources	Paul Da Gama - Director of HR	Da Gama, Paul (Inactive User)	Bevan, Mrs Laura	10/07/2019	OB6: To have happy, healthy, well supported staff who feel able to deliver great care and 'make a difference' in an inclusive environment and to be a clinically led organisation.	PR1.3 Maintaining staff skills and experience to deliver harm free care	People, Education and Research Committee	No	A recent legal case has been going through the courts which has implications for how holiday pay is calculated. It will go to the highest level of court imminently for a final decision. If the outcome of this national case of Flowers Vs NHS Ambulance Service is negative the judgement will adversely impact upon the Trust and there may be significant financial implications. The potential financial impact is currently being assessed by the finance team. Essentially a high number of staff could be owed money for annual leave calculations going back some time.	20	Have communicated with staff who have raised queries relating to this and advised we like other Trusts are awaiting the legal outcome.	15	Difficult to calculate financial impact and will be based on assumptions.	TBC as financial impact still being calculated by Finance (Rodney P)	TBC once financial impact calculated	Financial impact being calculated. Also communicating with staff who raised queries pertaining to this issue. Expected that NHS Employers will also issue guidance on this matter as affects all Trusts	12	17tNovember 2019 update from Tania Marcus: Awaiting National Directive further to outcome of the legal case. The Trust has calculated potential liability o circ £1.2million.[Bevan, Laura Mrs 26/09/19 13:48:50] Risk is static as case is still progressing through the courts currently and we are awaiting an outcome. Potential financial impact is being calculated currently to indicate financial liability should decision be taken at highest level of court that Flowers is successful in their claim.	10/10/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

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Emergency Medicine (1)																							
3995	Challenges in Recruitment of Emergency Medicine Medical Workforce	Human Resources	Emergency Medicine	Emergency Care	Dr Gamba, Paul	Suri, Nida	Johnson, Stephanie	06/03/2018	OB4: To improve our emergency care pathway and discharge processes.	PR4.3 ED Workforce - vacancies and cultural behaviours	People, Education and Research Committee	Yes	Cause: Insufficient senior medical / clinical decision makers in ED and junior doctor shortages in ED (combination of workforce configuration / under establishment and vacancies in established posts together will competition for candidates. 2:Effect: some shifts understaffed, high use of locums, inability to deliver ED performance standards - significant reputational risk. 3. Impact: adverse impact on patient safety and experience, staff morale and recruitment and retention, delivery of emergency care standards, financial impact, poor patient flow. Reduced capacity to undertake clinical governance and service improvement activities.	20	1. Emergency Transformation plan sets out key milestones to address workforce and monitored via ED transformation group chaired by MD. 2. Recruitment to establishment for ED consultants 3. Rolling advert in place for middle grades, almost up to establishment 4. Approval to increase establishment by 1 for ED consultants.	16	1. Medical staffing (HR) support under review - meeting planned with HR Director 2. We also have 2 x vacant consultant posts and 2 x vacant MG posts 3. Recruitment plan needed (4 x consultant posts and 6 x MG posts)	1. Report to NHSE weekly on shift cover for all medical grades which includes detail regarding level of locum and substantive cover	None	17/05 On going recruitment to consultant posts but lots of competition across the region 15/07/19 Meeting with Exec colleagues on 16/7 to discuss the'offer' for potential applicants. Consultant interviews to take place on 10 September 2019 Business case approved for 2 x additional ED consultants and 4 x MG posts. MG interviews to take place end of August - 4 candidates shortlisted so far.	6	Currently reviewing the option of cross divisonal specialist consultant appointment. For example: ED and ITU.[Cato, Sarah 09/10/19 11:38:58] recruitment process continues, use of agency to support process under consideration	19/11/2019
Environment (4)																							
2795	Management and control of - Asbestos Containing Materials (ACMs)	ORGA	Environment	Estates services	Patrick Hennessy- Director of Environment	Ward, Martin	Hennessey, Patrick	15/12/2011	OB12: To improve the quality of our estate and implement our service driven estate strategy	PR12.1 Availability of capital to support the delivery of the interim estate strategy.	Quality Committee	No	This Risk was decreased to a 16 - agreed at RRG in July 2019 This Risk was increased to a 20 - agreed in May 2019 . Risk: Asbestos management controls have failed on multiple occasion sas identified in the deep dive carried out May 2019. There remains the risk of exposure to Asbestos containing materials (ACM's) Cause: Due to age of Trust building stock, ACMs are present throughout the Trust estate Effect: Exposure to asbestos fibres is know to be harmful to health Restrictions in areas where ACM's are known to be present Although safeguards in place, human error can mean that inadvertent exposure to ACM's can occur Impact: Between 2011 and early 2015 a number of incidents have arisen that cast doubt on the Trust's ability to provide full assurance with respect to the management of ACMs. These have been the subject of RIDDOR reports, HSE intervention and prosecution. Risk 3356 has been amalgamated with this risk (11/12/15)"	20	Trust has appointed Tetra Ltd to act as Authorising Engineer Asbests. Trust has competent personnel trained to P405 standard who act as Responsible persons for Trust RP role has persons in place PJ Annual asbestos awareness and managing asbestos completed in July 2018 training programme to be set. The Asbestos Policy is in place. Online asbestos register database portal has been created - Alpha Tracker, to provide access to all asbestos management information. Restrictions in areas with confirmed (low level) asbestos contamination, appropriate procedures in place to access Annual management survey carried out High risk asbestos schedules have been identified to be addressed as soon as capital funding has been identified. Management survey has been completed across all 3 sites. Capital team carryout full survey before any capital project proceeds Permit to work system with IT to be reinforced	16	Additional CP to be identified and trained due to long term absence. Unable to fully implement asbestos management plan as levels of capital funding to address high risk issue is unknown. SOP in place for the checking/identifying/stamping of all work dockets by Estates Supervisors before docket is issued not utilised Additional governance procedures need to be put in place to ensure Capital Teams capture asbestos risks prior to commencement of any Project Bates and CGI are not following process	Competent UKAS accredited consultant in place to carry out management surveys, annual management audits with action plans, Tetra Ltd. Trust has appointed Suitably trained manager as the Responsible Person (Asbestos) Reporting through the Environment Divisional Governance Group to the Health and Safety panel and Safety & Quality Group. All estates staff subject to rolling annual training program On-line portal ensure up to date information is available to all staff and contractors working across all 3 WHHT sites. Tetra engaged to undertake risk review of Risk Register and update Alpha Tracker database with current observations. to be completed by Sept 18	Management surveys are non destructive/ non-invasive, unknown levels of hidden asbestos (full R&D surveys required when works undertaken) Defined asbestos removal program to be agreed on confirmation of capital funding availability. No estates Asbestos Management Group in place Unable to determine levels of previous exposure to staff, numbers of persons potentially exposed unknown.	Capital team governance procedures implemented Summer 2019 - to be reviewed Nov 2019 Permit to work system and contractor induction to be reviewed by November 2019. IT notified that no permit will mean no access for their contractors . All lift shafts have now been surveyed awaiting reports - Project Team to advise on dates for reports - Review End of November.	6	[McLoughlin, Sarah 30/10/19 10:31:31] Capital team governance procedures implemented Summer 2019 - to be reviewed Nov 2019 Permit to work system and contractor induction to be reviewed by November 2019. IT notified that no permit will mean no access for their contractors . All lift shafts have now been surveyed awaiting reports - Project Team to advise on dates for reports - Review End of November.	29/11/2019
3958	Risk of condensate Tank failing - WGH Boiler House	Strategic/Operational	Environment	Estates services	Patrick Hennessy- Director of Environment	Ward, Martin	Hennessey, Patrick	17/11/2017	OB12: To improve the quality of our estate and implement our service driven estate strategy	PR12.1 Availability of capital to support the delivery of the interim estate strategy.	Quality Committee	Yes	Risk: Loss of heat and hot water to main areas at WGH. Cause: Extensive Corrosion of the cast steel hot well tank in the boilerhouse. The tank is at the end of its operational life and requires replacement. Effect: The boilerhouse would flood with the potential for damage to the CHP generator control panels situated directly under the tank. Also, PMOK/Maternity/Shrodells/Willow House/H Block/Spice of Life/Catering Block/ AAU/Facilities Offices and Pathology would lose heat and hot water should the tank fail. Impact: Loss of vital utility services impacting on patient safety and trust reputation.	16	- Weekly maintenance inspections are carried out, condtion reports go to Estates Managers for monitoring and actions as required. - Surveys have been completed and final specification of replacement hot well tank agreed . - Works have been tendered by Projects department - New tanks are on site. Preparation works and pipe modifications have commenced - April 2019 - Phase 1 of enabling works started week commencing 22/7/19 - Business continuity plan in place	16	- Inability to review works and gain approval by AE due to not being able to recruit to the post due to a national shortage of skilled workers.	- Regular scrutiny at Risk Review Group and Emergency Planning Committee	- Lack of an AE to provide legal certification - Legal requirement isn't able to be met due to a lack of AE.	The Projects Team have advised that work is due for completion on 18th November. The risk will then be discussed with a view to removing from the risk register	6	17th November update from PH: Snagging to be completed in December 2019. [McLoughlin, Sarah 30/10/19 10:13:35] The Projects Team have advised that work is due for completion on 18th November. The risk will then be discussed with a view to removing from the risk register	31/12/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

ID	The Risk	Risk Type	Division admitted	Speciality	Executive Risk Lead	Risk Owner	Risk Lead	Opened	BAF Objective	BAF Principle Risk	Board Assurance (Primary)	Impact on business continuity	Description	Rating (initial)	Controls	Rating (current)	Gaps in controls	Assurances	Gaps in assurances	Further actions taken?/Contingency plan(s)?	Rating (Target)	Progress notes	Review Date
4135	Lack of A E & CP's across Safety Groups in accordance with HSE and DoH Managing safely guidance and accepted Codes of Practice	Strategic/Operational	Environment	Estates services	Patrick Hennessy- Director of Environment	Hennessey, Patrick	Hennessey, Patrick	15/02/2019	OB12: To improve the quality of our estate and implement our service driven estate strategy	PR2.2 Project, analytics and finance support capacity and alignment of internal processes to implement pathway redesign.	Quality Committee	Yes	Risk: There is limited access to non substantive Authorising Engineers (AE's) for Fire/Confined spaces/Pressure. Cause: There is a national shortage of skilled workforce. Effect: There is no external assurance. Having an AE in post is a statutory requirement. Impact: Non compliance with statutory regulations and inability to recruit competent/able people.	20	- Authorised (AP) and competent persons (CP) are in post within the Estates Team for HV & LV, Medical Gases, Ventilation, Decontamination, LOLA and Water. - PAM methodology deep dive will identify all gaps in assurance and potentially compliance (Completed by end of April) Interim , fully qualified AP/AE has been appointed - April 2019	16	- There is limited availability of competent AE's for Fire, LOLA, pressure systems and confined spaces.	- All AP/CP certification in place - PAM deep dive underway - Governance structures are in place from Ward to Board which provide assurances on the controls and the any gaps in control. - ARIDAD & PAM are in place and informing the governance reporting.	- AP & CP accreditation is incomplete. - There is a national shortage of AE's available. Legal requirements are not currently covered adequately due to the national shortage of people to fill these posts.	This risk currently remains static Recruitment continues and will be reviewed in Mid November 2019 New Head of Compliance appointed October 2019 - One Year fixed Term contract	12	Update 17th November: AE post-potential strong candidate identified, interviews scheduled end of November 2019. [McLoughlin, Sarah 30/10/19 10:44:20] New Head of Compliance appointed October 2019 - One Year fixed Term contract	30/11/2019
4154	Non-compliance with HTM00 (safe systems of work)	Strategic/Operational	Environment		Patrick Hennessy- Director of Environment	Hennessey, Patrick	Hennessey, Patrick	08/04/2019	OB12: To improve the quality of our estate and implement our service driven estate strategy	PR9.3 Environmental factors result in reduced activity / income or the need to expend additional unexpected funds.	Quality Committee	Yes	Risk: Non compliance with HTM00 (safe systems of work) Cause: Lack of evidence against Premises Assurance Model (PAM) Effect: Governance and compliance are not adequately demonstrated Impact: Risk to Patient Safety & Health & Safety which could result in the Trust's reputation being put at risk; there is also a high risk of prosecution or a major incident occurring.	16	- All areas are being audited against the PAM SAQ sets. - Deep dive has highlighted the gaps. - Gap Analysis is underway and an action plan being developed - Relevant AE & suitably authorised person has agreed the processes. - AE's for HV, LV, Medical gases,ventilation, decontamination, LOLA and water safety recruited.	16	- Once gap analysis is complete the Trust has a requirement to address, Potential financial impact and lack of funding. - Backlog maintenance cost known to be £188 million, of which £2.9million is Statutory compliance related - no bids for funding in place - Gaps continue to be identified through ongoing audit programme - Limited ability to source AE's in Fire, pressure system and confined spaces (please see risk 4135) - Documentation not easily accessible, duplicated, factually inaccurate or missing - No Documentation management	- The Trust has a low incidence (lower than the national average) of Environment incidents - Governance structure in place with upward reporting and review by the board. - ARIDAD and PAM are in place and informing governance reports.	- Unable to fully inform the reports due to a lack of full evidence due to lack of systems.	ARIDAD has superceded the previous actions . This continues to develop - Review November 2019 ATR being presented to vacancy panel to recruit to Health and Safety Manager role - Currently an interim manager in place (Started Mid October) - Review November 2019 New Head of Compliance recruited October 2019 (Fixed Term Contract)	6	[McLoughlin, Sarah 30/10/19 10:40:24] Risk continues to remain Static. Interim H & S Manager joined Mid October New Head of Compliance recruited October 2019 (Fixed Term Contract) Review risk Mid November	30/11/2019

WEST HERTFORDSHIRE HOSPITALS NHS TRUST
CORPORATE RISK REGISTER
DATE: 11 NOVEMBER 2019

ID	The Risk	Risk Type	Division admitted	Specialty	Executive Risk Lead	Risk Owner	Risk Lead	Opened	BAF Objective	BAF Principle Risk	Board Assurance (Primary)	Impact on business continuity	Description	Rating (initial)	Controls	Rating (current)	Gaps in controls	Assurances	Gaps in assurances	Further actions taken?/Contingency plan(s)?	Rating (Target)	Progress notes	Review Date
Finance (2)																							
4204	Risk of not receiving Provider Sustainability Fund income as a result of failure to achieve financial plans	Strategic/Operational	Finance	Finance	Don Richards - Chief Financial Officer	Dunham, Stephen	Dunham, Stephen	05/09/2019	OB9: To deliver best value care.	PR9.6 Failure to develop sufficient efficiency ideas and failure to implement these ideas as expected to support achievement of the financial plan.	Finance and Performance Committee	Yes	Cause: Trust does not meet the conditions required for receipt of Provider Sustainability Funding (PSF), i.e. achievement of phased control total and key performance measures. Effect: Planned cash is not received (PSF), the Trust's deficit increases, additional loan funding required. Impact: Financial instability. Likely regulatory action. 2019/20 plans assume achievement of PSF conditions, and with them receipt of £8.3m (Q1 £1.25m). Reputational damage.	20	- Standing Financial Instructions (SFIs) in place - Robust efficiency programme in place - Formal financial plan in place - PSF funding relies on achievement of financial and other plan objectives, therefore controls for this risk are analogous to those for achieving the plan itself.	15	At this point there are no known gaps in control. Risks directly relating to the Trust's ability to meet its control total are covered within other risks.	- SFIs are reviewed annually and approved by the Trust Board - The efficiency programme is reported on regularly to the Board; audited annually and reported in the statutory accounts - The financial plan is approved by the Trust Board; progress against the financial plan is reported on an ongoing basis to the Board and to the Regulators; Regular monitoring calls from the Regulator - Budgetary reports and commentary on plan vs actual achievement. - Forecast and early identification of detailed potential risks to plan achievement, with associated plans.	At this point there are no known gaps in assurance.	N/A	6	[Dunham, Stephen 28/10/19 08:44:07] The agreement of a Minimum Income Guarantee (MIG) between the Trust and HVCCG will not necessarily improve the chances of the Trust meeting its financial plans. It will, however, effectively fix a significant part of the Trust's financial position and enable a greater focus on cost improvement. [Otite, Dorothy 28/10/19 12:37:10] Update from Stephen Dunham: The Trust achieved its year to date deficit target as at month 6 (September) and therefore expects to receive the relevant portion of PSF income. The risk remains at corporate levels as the margin by which this achievement occurred was narrow, and later parts of the financial year are more challenging as efficiency expectations in particular increase.	27/11/2019
4205	Risk of not receiving Financial Recovery Fund as a result of failure to meet base criteria	Strategic/Operational	Finance	Finance	Don Richards - Chief Financial Officer	Dunham, Stephen	Dunham, Stephen	05/09/2019	OB9: To deliver best value care.	PR9.6 Failure to develop sufficient efficiency ideas and failure to implement these ideas as expected to support achievement of the financial plan.	Finance and Performance Committee	Yes	Cause: Trust does not meet the conditions required for receipt of Financial Recovery Funding (FRF), i.e. achievement of phased control total only; non-financial measures are not considered for FRF. Effect: Planned cash is not received, the Trust's deficit increases, additional loan funding required. Impact: Financial instability. Likely regulatory action. 2019/20 plans assume achievement of FRF conditions, and with them receipt of £14.8m (Q1 £2.2m).(Note: In 2019/20 the FRF can only be accessed by providers in deficit who sign up to their control totals.). Reputational damage.	20	- Standing Financial Instructions in place - Robust efficiency programme in place - Formal financial plan in place - FRF funding relies on achievement of financial objectives only, therefore controls for this risk are analogous to those for achieving the plan itself.	15	Clarity not yet secured regarding actions required to secure Financial Recovery Fund beyond simple achievement of the annual control total.	- SFIs are reviewed annually and approved by the Trust Board - The efficiency programme is reported on regularly to the Board; audited annually and reported in the statutory accounts - The financial plan is approved by the Trust Board; progress against the financial plan is reported on an ongoing basis to the Board and to the Regulators; Regular monitoring calls from the Regulator - Budgetary reports and commentary on plan vs actual achievement. - Forecast and early identification of detailed potential risks to plan achievement, with associated plans.	Formal written communication from NHSI/E explicitly stating the terms and conditions required to secure FRF payments.	Further actions planned - Development of an independent assessment of 'drivers of the deficit'. (In progress - Chief Financial Officer, December 2019) - Further development of financial position, and hence access to the FRF, based on drivers of the deficit analysis. (Chief Financial Officer, December 2019) Further assurances planned - Secure formal written communication from NHSI/E explicitly stating the terms and conditions required to required to secure FRF payments. (Chief Financial Officer, by November 2019.	6	[Dunham, Stephen 28/10/19 08:46:07] The agreement of a Minimum Income Guarantee (MIG) between the Trust and HVCCG will not necessarily improve the chances of the Trust satisfying the FRF criteria. It will, however, effectively fix a significant part of the Trust's financial position and enable a greater focus on cost improvement / recovery actions. [Otite, Dorothy 28/10/19 12:36:21] Update from Stephen Dunham: The Trust achieved its year to date deficit target as at month 6 (September) and it is expected that a payment of some sort is payable. Ongoing uncertainty around the precise criteria against which the Trust is being measured means this cannot be confirmed at the time of writing. The risk remains at corporate levels for this reason, and also because the margin by which this achievement occurred was narrow, and later parts of the financial year are more challenging as efficiency expectations in particular increase.	27/11/2019
Medicine (1)																							
4129	Unreliable functioning of central cardiac monitor	Clinical	Medicine	Cardiology	Van De Watt, Mike	Santhosh, Minimol	Hadjiloizou, Nearchos (Inactive User)	25/01/2019	OB9: To deliver best value care.	Non BAF Risk	Quality Committee	Yes	Dragger central monitor intermittently shutting down since 2016. The frequency has increased in 2018 especially in summer. During Christmas and boxing day of 2018, central monitor failed to monitor acute cardiology patients with life threatening arrhythmia's for a prolonged period (almost 24hrs). This has escalated via internal incident reporting system and cardiology managers meeting. Dragger has been contacted to get a new quote for more effective and advanced monitoring system. A business case has been initiated by the lead physiologist.	15	1.Business case proposal being written. 2.In the event of a monitor Failure staff should follow the following guidance: Inform Senior Nurse Increase volume of bedside monitors Reiterating the use of call bells by patients Curtains should drawn back to allow visualisation of monitor and patients. High risk patients where plan is for central monitoring and detecting deterioration promptly may have an adverse result from any delays in escalation of changes- need forward planning with possible one to one	15	1.Due to human factors- alarm bell may be missed 2. Patients may alert staff later loosing the opportunity of quick escalation, patient may feel the effect of the change in condition later 3. Not enough staff for one to one care 4. High risk patients where plan is for central monitoring and detecting deterioration promptly may have an adverse result from any delays in escalation of changes. delay	Auditing of Frequency of failure or malfunctioning of the monitor to determine any changes to the frequency of monitor failure. Monitoring of numbers of patients with threatening Arrhythmia. and impact During the last failure we did not have any cases of threatening Arrhythmia	The failure of the monitor may be random and may not benefit from a pattern recognition to predict future failures Staff may not escalate failure of monitor if there were no adverse effect on patients	Consultants admitting patients are aware of the possibility o monitor failure to highlight high risk patients	5	Update 18th November: Medicine Division has decided to progress replacements with Draegar.[Hussain, Maryam 05/11/19 13:38:57] 21/10/19- Head of Clinical Engineering has obtained a price from Draeger and now await pricing from Philips by 23rd October 2019.Once this price is received, the two options will need to be discussed by the department to decide a way forward.	21/11/2019

Trust Board Meeting
05 December 2019

Title of the paper	**Completion report on well-led improvement plan**
Agenda Item	**18/77**
Presenter	**Phil Townsend, Chair** **Christine Allen, Chief Executive** **Jean Hickman, Trust Secretary**
Author(s)	**Jean Hickman, Trust Secretary**
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	The Board has been closely monitoring the progress of an improvement plan which was developed to address areas of improvement that were identified in a series of external observations and assessments in 2018/19, under the scope of the national well-led framework. Following a full Board review in November 2019, this report aims to provide assurance on the onward governance pathway for each of the areas of the improvement plan which require future monitoring. For ease of reference, the areas of the plan that have been completed have been removed. The Board is asked to review the latest version of the well-led improvement plan as seen in appendix 1 and approve the recommended future monitoring arrangements. Once approved, the chair and executive lead for the appropriate assurance committees will be advised of their monitoring responsibilities and asked to ensure that committee work plans are updated accordingly. Issues will be escalated to the Board as necessary.
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	N/A
Action required	The Board is asked to review the latest version of the well-led improvement plan and approve the recommended future monitoring arrangements.

Well-led framework improvement plan

Number	Key themes from feedback	Action	Future monitoring arrangements
1	Participation in research and development is not fully developed	Research and development strategy to be developed	A research and development strategy has been developed and will be presented to the Board in February 2020, after which progress to the delivery of the strategy will be monitored by the People Education and Research Committee.
2		Board to receive a presentation on the aims for the future of research and development	
4	The alignment between the various strands of the Trust's strategy is not clearly articulated.	Simplify and clarify the narrative around the Trust's overarching strategy to explain the interrelationships between the various strategies and operational plan. Including how the STP and Royal Free partnership works together	The overarching five year strategy is being developed and will be presented to the Board for approval in February 2020. Following approval, the monitoring of progress towards the delivery of the strategy will fall to the Trust Management Committee. The Board will receive regularly updates.
5	A culture of quality improvement is not completely embedded throughout the business of the Trust	Continue the quality improvement work already underway, with the Institute of Healthcare Improvement	The Quality Committee regularly monitors quality improvement and will escalate issues to the Board as necessary.
6	Collaborative relationships with external partners are not fully developed	Formalise and prioritise an external stakeholder engagement plan to build a shared understanding of the challenges and needs of moving towards an integrated care system and becoming a more effective system player.	A joint engagement plan is being developed with Herts Valleys Clinical Commissioning Group . This will be included as part of the development of the integrated care partnership.
10	The oversight of risk management is not fully embedded	Introduce risk appetite process and risk statement	The Board is asked to approve a risk appetite statement and threshold matrix as part of the Board Assurance Framework report on this Board meeting agenda . Following approval, the Board will use the statement and matrix to support its decision making process. Both the statement and matrix will be updated at least biennially.
12	There is no clear organisational development strategy	Pull together current examples of existing organisational development practice into an overarching strategy and implementation plan, which articulates how the benefits and impact of OD activities align with the Trust's vision and objectives	A refreshed People Strategy for 2020 – 2023, which will include an OD strategy will be received by the Board for approval in February 2020. Future monitoring of the delivery of the People Strategy will fall to the People, Education and Research Committee.

Number	Key themes from feedback	Action	Future monitoring arrangements
14	It is unclear whether the Board has sufficient strategic/planning capabilities now and in the future to take the Trust to the next stage of its journey.	Undertake a Board skills review to asses the capabilities of the current Board	A 360 degree appraisal programme of the Board is underway and an analysis report will be received by the Board in January/February 2020.
15	Also the capacity and capability of senior leadership is insufficient to enable the Board and executive to step up.	Develop a succession planning process which identifies and trains individuals who could take on future leadership roles within the Trust.	Succession planning and talent management falls under the terms of reference of the People, Education and Research Committee.
19	Strategic objectives are not fully embedded into the day to day work of the Trust and do not focus the work of the Board	The Board to receive a bi-annual report on progress towards achieving the strategic objectives	In January 2020, the Board will receive draft strategic objectives for 2020/21 for approval. Following approval, the Board work plan will include a bi-annual report to allow the Board to track progress made towards achieving the strategic objectives.
20	The equality and diversity strategy is out-of-date and not devised in conjunction with staffing groups or networks	Use a staff engagement process to refresh the equality and diversity strategy	A significant amount of work has been undertaken to improve the experience of staff in respect of diversity and equality. Further work to bring together a cohesive approach will be monitored by the People, Education and Research Committee.
27	All staff do not feel valued for their contribution to the Trust	Appraisal targets not fully met	Compliance against the 90% appraisal target was met in October 2019. Regular monitoring of appraisals is undertaken by the People, Education and Research Committee.
32	The approach to sharing lessons learnt across all areas of the Trust does not have enough focus	Using the quality improvement framework, review and increase the opportunity for staff to share lessons learnt across all areas of the Trust	The Trust is using the quality improvement framework to disseminate lessons learnt. Quality improvement falls under the terms of reference of the Quality Committee.

Agenda Item: 19/77

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**05 December 2019**
Recommendation:	**For assurance**
Chairperson:	**Christine Allen, Chief Executive**
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Trust Management Committee at its meeting on 13 November 2019.
Background	The Committee meets twice monthly and its areas of responsibility are:- • Delivery of the clinical strategy • Revenue investment up to £1m • Operational performance • Operational risk • Safety and business continuity • Information technology • Internal and external communication strategy • Clinical quality • Business planning • Environment
Business undertaken	**Topics covered at the meeting, included:** • An update on a successful pilot scheme of a paediatric assessment unit. It was reported that feedback on the pilot had been positive, with short stay admissions to Starfish ward having reduced. It was acknowledged that further investment would be required to maintain the service and a business case was being developed, which would be considered at a future trust management committee meeting. • A delay to the refresh of the five year strategy was reported due to pre-election regulations. A current working draft of the strategy was circulated for comments by members outside of the meeting. • The committee was updated on the installation of a new cancer information centre. It was reported that testing of the redesigned software would be completed by the end of November 2019 and the committee requested a further update in January 2020. • An update on three strategic projects was received by the committee; namely workforce, getting to good and clinical strategy.

- The committee considered and agreed the Care Quality Commission's self-assessment for the end of life care, outpatients, maternity, paediatrics. It was agreed that all divisions would undertake a self-assessment of the outpatients' areas which were spread across a number of areas.

- New branding for the Herts and West Essex local maternity system was reviewed and approved to be used on maternity documentation.

- The committee received reports from the clinical advisory group and the professional advisory group.

Risks to refer to the risk register None

Items to escalate to the Board None

Attendance

Freddie Banks	Associate Medical Director, Clinical Strategy
Andy Barlow	Divisional Director, Medicine
Paul Bannister	Chief Information Officer
Mary Bhatti	Divisional Manager, Women and Children's
Howard Borkett-Jones	Associate Medical Director for Education
Helen Brown	Deputy Chief Executive
Tracey Carter	Chief Nurse
Debbie Foster	Programme Director, Urgent and Emergency Care
Sean Gilchrist	Director of Digital Transformation
Louise Halfpenny	Director of Communications
Jean Hickman	Trust Secretary
Stephanie Johnson	Divisional Manager, Medicine
Martin Keble	Divisional Director, Clinical Support
Paula King	Head of Nursing, Surgery, Anaesthetics and Cancer
Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer
Jason McKee	Divisional Manager, Surgery, Anaesthetics and Cancer
Natalie Miles-Kemp	Head of Programme Delivery Support
Esther Moors	Acute Redevelopment Programme Director
Elaine Odlum	Divisional Manager, Medicine
Sally Tucker	Chief Operating Officer
Mike Van Der Watt	Chief Medical Officer
Karen Walker	Head of Nursing, Children's
Angela Wellman	Head of Nursing, Medicine and Emergency Medicine
Anna Wood	Deputy Medical Director

In attendance for specific items

Alison Fuller	Interim Associate Chief Nurse
Stella Roberts	Deputising for Director of Midwifery
Tania Marcus	Head of Human Resources, Business partnering and Organisational Development

Report to:	Trust Board
Title of Report:	Assurance report from Finance and Performance Committee
Date of meeting:	05 December 2019
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 Performance Committee at its meeting on 28 November 2019.
Background	The Committee meets monthly and provides assurance on scheduled reports from all Trust operational committees with a finance, investment and access performance brief according to established work programmes.

Access Performance

The Committee reviewed the waiting time performances in October, for ED, ambulance handovers, cancer treatment, elective care referral to treatment (RTT) and diagnostic tests.

RTT

The RTT 18 week performance improved by 1% from last month to 86.8% in October, which is just below the recovery plan target of 87.1%, and above the latest national median of 84.5%. The Committee was encouraged by the consistent improvement in performance, this being the sixth successive month on month improvement since April, and the best monthly performance for almost two years, since November 2017.

The Committee was assured that, subject to the risk of extreme winter pressures, the Trust was on track to meeting its recovery plan target of 90% by March 2020, compared to the national standard of 92%.

The Committee reviewed the actions in place to improve performance in underachieving specialities, including pain management, urology and ENT, and was assured that improvement actions are in place, including a review of theatre capacity and usage, and outsourcing.

The Committee noted that at the end of October there were no patients whose waiting time exceeded 52 weeks.

The Committee was assured that an appropriate harm review process is in place for all patients exceeding the national waiting times.

A&E

Whilst the Trust's performance remains well below the A&E four hour waiting time national standard of 95%, there were further encouraging signs of continuing improvement. The October performance of 83.4%, is 0.4% better than last month and matches RTT in that it is the sixth successive month on month improvement since April. It is the best months performance since October last year, but is below the recovery plan for October of 87.8%.

The Committee noted that the waiting time standard was maintained at the MIU in St Albans and the UTC in Hemel Hempstead, and month on month improvements in all areas of Watford ED, and that the latest national median performance, based on September, is just 1% higher at 84.3%.

The Committee reviewed the progress against the ED improvement plan, including the medical take pilot which started in October, with early signs of making a positive impact on waiting times, and the implementation of a UTC at Watford, which was approved by the October Board, and planned to go live from April 2020, and is expected to make a significant improvement.

A key factor on performance is the increase in attendances this year, which is up by 11.6% across all three sites, and demand management initiatives in the local system have only had a limited impact.

The Committee was assured that plans to improve performance should lead to a material improvement next year, but was not assured that the recovery plan target of 93% by March would be achieved.

Cancer

Four of the eight cancer waiting time targets were met in October, compared to five in September.

The Committee focussed on the four targets that were not met, and discussed recovery actions to return to standard.

The Committee noted that two targets reported as not met, the 31 day maximum wait from decision to treat to first definitive treatment, and the 31 day maximum wait requiring subsequent surgery, were provisional outcomes, with performances marginally below standard and possible improvement when results are finalised. The Committee was assured that both are performing above standard year to date, with expectations of achieving standard on a regular basis.

The Committee focussed on the two standards that were not achieved, both in the month and year to date, the maximum 62 day waits from urgent GP referral for suspected cancer to first treatment, and urgent referral from NHS cancer screening to first treatment. Provisional performances in October of 76.7% and 61.5% are well below the respective standards of 85% and 90.0%, as are the year to date performances of 80.9% and 78.6%.

The Committee noted the relatively high number of breaches in both, and asked for a detailed update on causes and recovery actions at the December Committee.

Ambulance Turnarounds

Following a reduction in delays last month, there was an increase in October with delays over 30 minutes increasing from 453 to 518, twice the level than October last year. The Committee sought assurance that the recently agreed joint action plan with EEAST, would significantly reduce delays, and asked for an update on progress at the December Committee.

Diagnostic Tests

The Committee noted the continued strong performance in achieving the national standard of ensuring that at least 99% of patients should wait for no more than six weeks for diagnostic testing. Performance in October was 99.9%.

Integrated Performance Report

The Committee is responsible for reviewing the effectiveness of the Trust's IPR reporting arrangements and recommending any changes to the Board.

The Committee concluded that the report is effective in highlighting key performance issues, with appropriate back up detail in the appendices, and subject to correcting a small number of inconsistencies supported submission of the IPR to the December Board.

Financial Performance

i I&E

The Committee reviewed the October results and the latest forecast for the year to seek assurance that the full year budget deficit of no more than £22.7m would be met.

The Trust generated a surplus of £0.1m in October, in line with budget and £0.4m better than forecast. The year to date deficit of £17.7m is also in line with budget. Revenues of £219.8m are £1.6m lower than budget, as a result of lower higher cost drugs which has no impact on the deficit as there is an offsetting saving in non-pay costs. In total non-pay costs of £84.3m are £3.5m lower than budget.

With the Minimum Income Contract for the year now agreed with HVCCG, the key challenge that the Trust faces to achieve the full year deficit target is to lower the rate of spend on pay costs, without jeopardising patient care. Pay costs to date of £153.2m are £1.9m higher than budget, with medical and nursing pay, combined, £2.4m above budget.

The Committee reviewed the action plans to reduce the rate of pay costs. The risk to achieving the full year deficit budget remains unchanged from

last month's review at £1.4m, but the plans are now more defined and underway.

The Committee noted the continued strong performance in CIPs delivery with £7.6m achieved year to date, £2.2m ahead of budget, and following review was assured that the Trust was on track to deliver the £15.0m budgeted CIPs for the year.

Whilst the Committee noted the progress being made to reduce the rate of pay costs there needs to be more evidence of reductions achieved in the rest of the third quarter to be assured that the Trust is on track to achieve the deficit budget for the year.

The Committee is also aware that, although it is assured that robust winter planning is in place, the severity of winter pressures could still have an adverse impact on achieving the deficit budget. The Committee recommends that a paper on the forecast deficit for the year, including recovery plans and risks, is presented to the December Board.

ii Capital Spend

The Committee reviewed capital expenditure to date and the programme of spend for the year.

Capital spend in October of £0.9m brought year to date spend to £4.5m. The Committee was pleased to note that the Trust's application earlier in the year for a £4.8m emergency capital loan has now been approved by NHSI, which brings authorised capital spend in the year to £20m.

The Committee reviewed and supported the planned programme of spend for the remainder of the year, and was assured that business cases supporting the spend would be completed in time to enable the £20m to be spent.

iii Revenue Funding

Funding of revenue spend is subject to monthly approval by NHS and following review the Committee recommends ratification by the December Board of an NHS revenue support loan of £3.4m to meet the funding requirements in November.

iv Drivers of the Deficit

KPMG presented a draft report on the drivers behind the Trusts underlying deficit, before central funding, of £46m. Their approach used benchmarking, including Model Hospital, to compare to other national averages and peers, reviewing the Trusts operational and financial data, interviews with staff, and CQC reports. The Committee reviewed the key findings which were that approximately £20m of the deficit is due to productivity and efficiency, £13m is due to poor infrastructure mainly estates and IT, and £11m relates to system issues, including income.

The Committee welcomed the draft report which reinforces the Trusts plans to drive for transformational change and for increased focus on

improved productivity.

The final report will be reviewed at the December Committee and the January Board.

Corporate Risk Register (CRR) and Board Assurance Framework (BAF)

The Committee reviewed the updates to all risks under its remit on both the CRR and BAF. The Committee agreed with the recommendation that the BAF Risk 4b, relating to planned care access standards should be reduced from high to medium, and that there should be no change in ratings to the finance risks on the CRR.

The Committee was assured that the finance risks with ratings below the threshold of the CRR should be unchanged in terms of ratings and that actions and mitigations were up to date.

Finance Policies

The Committee reviewed the status of the seven Trust-wide policies that are within its remit and was assured that all approvals were up to date, with due date reviews scheduled for future Committees.

Business Cases

i Business Case to replace the Local Area Network (LAN)

The Committee reviewed the business case to replace the Trust's LAN, which is in urgent need of an upgrade to improve existing telephony and digital services and provide the enabling platform for future advanced IT services, including electronic patient records.

The Committee was assured by the process of recommended suppliers, and that transitioning to a modern fit for purpose LAN infrastructure would deliver major benefits in terms of both patient experience and productivity.

The plan is for the transition to be complete by the end of calendar 2020.

The Committee recommends the Business Case is submitted to the December Board for approval, and for the Board to delegate approval of supporting contracts to the TMC and Chief Executive.

ii Update on the Full Business Case(FBC) for a Multi Storey Car Park (MSCP) at Watford

The Committee was updated on the progress made in finalising the FBC, which is scheduled for approval by the Trust Board as early as possible in the fourth quarter, and submission to NHS for authorisation to proceed.

The Committee reviewed the key commercial, operational and financial aspects of the current draft and recommends an update is presented to

	the December Board for information and comments.
Risks to refer to risk register	See above
Issues to escalate	The Committee recommends the following: To Part 1 of the December Board: **For ratification** NHS revenue support loan of £3.4m to meet the funding requirements in November. To Part 2 of the December Board: **For approval** • LAN Business Case, with delegated approval to TMC/Chief Executive to finalise contracts. **For discussion and comment** • The forecast deficit for the year, including recovery actions and risks. • Update on Multi Storey Car Park (MSCP) at Watford.

Attendance record

Present
John Brougham, Non-Executive Director (Committee Chair)
Christine Allen, Chief Executive
Tracey Carter, Chief Nurse
Don Richards, Chief Financial Officer
Phil Townsend, Trust Chair
Sally Tucker, Chief Operating Officer
Mike van der Watt, Chief Medical Officer

In attendance
Tom Drabble, Patient representative
Stephen Dunham, Associate Director of Efficiency, Costing and Financial Risk
Rodney Pindai, Director of Contracting, Efficiency & Commercial Development
Soheb Rafiq, Head of Financial Management
Jane Shentall, Director of Performance

Minutes
Laura Abel, Assistant Trust Secretary

Attended for specific items:
Colin O'Toole, Director KPMG Advisory – Drivers of the deficit
Paul Bannister, Chief Information Officer – LAN replacement business case
Tim Duggleby, Strategic Estates – MSCP update

Apologies
None

Report to:	Trust Board
Title of Report:	Assurance report from Quality Committee
Date of meeting:	05 December 2019
Recommendation:	For information and assurance
Chairperson:	Jonathan Rennison, Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Quality Committee at its meeting on 31 October 2019.
Background	The purpose of the Quality Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes that are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

Assurances received / areas of challenge

Medical division quality assurance report

The Committee received an assurance report from the medical division with a robust discussion and challenge session on their performance and progress against plans.

The report included a good update on the medical take pilot, progress on key metrics and targets, work being undertaken on recruitment and retention, progress on QI within the department and an update on external quality assurance visits and their outcomes.

The Committee also discussed key challenges and risks and the committee was assured of progress being made within the department and that appropriate plans are in place to address challenge and manage key risks.

Integrated Performance Report

The Committee received the integrated performance report and had a detailed discussion on key areas of performance; particular focus was given to quality and safety metrics. The Committee noted:

1. Improved reporting of patient safety incidents demonstrating continued focus on patient safety.
   Assurance on the continued work to reduce and manage pressure ulcers within the Trust and were assured of our overall low rate of HAPU (below the national average).

2. Continued improvements in compliance with duty of candour for moderate harm, with improvements in the divisional process and monitoring of this.

3. Robust management of infection prevention and control, with a particular focus on our management of c-diff. While numbers of c-diff cases have been increasing the Trust remains within the expected range (when compared to previous years and when the new reporting criteria are applied). All cases are reviewed, and learnings identified and included in our ongoing IPC work to continue to drive improvements. To date 26 cases have been reviewed, 19 of which have had no lapses in care identified.

4. The Committee noted the improvements across a range of metrics for maternity services. While some of the metrics still rate red, there have been notable improvements and the Committee was assured of the sustainability of these improvements so that we can expect to see further improvements. We triangulated these improvements through a discussion of cases that result in litigation (NHSR data is showing a significant drop in number of cases resulting in litigation over a period of time).

Annual Infection and Prevention Report
The Committee received the annual IPC report and were assured of continued strong performance in this area within the Trust, and that the Trust was compliant with the Hygiene Code.

Delivery of seven day services and the seven day Board Assurance Framework
The Committee reviewed this and were assured of progress against the requirements of this framework and recommend it to the Board for approval and submission.

Quality Improvement Reports
The Committee received three reports on quality improvement for the Trust, with a focus on addressing key areas arising from previous CQC visits as well as priority areas which we know will improve services for our patients. The Committee was assured of progress in these areas, with projects and action plans being on track.

The Committee also received a report on self-assessments that have been taking place across the Trust in readiness for our next CQC visit. These self-assessments are being carried out to evaluate progress across all areas of the Trust so that we can identify progress in 'getting to good'. The Committee was assured that the assessments were objective and critical, and provide assurance of progress in key areas, as well as identifying priority areas for further improvement.

The Committee also received an update on a number of quality improvement initiatives:
1. Improved communication
2. Get up, get dressed, get moving
3. Swarming post-falls
4. NHSI pressure ulcer collaborative
5. Improving patient hydration

	The Committee was provided with assurance on the progress of these initiatives, how learning is being captured and embedded and plans to extend and roll-out some of these programmes more widely in order to continue to drive quality improvement across the Trust. The Committee also received an update on how QI is being embedded through staff training and development.
Risks to refer to risk register	There were no new risks to escalate to the Board.
Recommendations to the Board	Recommendation that the Board approved the seven day board assurance framework submission to NHSI

Attendance record

Attended
Ginny Edwards, Non-Executive Director (co-chair)
Jonathan Rennison, Non-Executive Director (co-chair)
Christine Allen, Chief Executive
Tracey Carter, Chief Nurse and Director of Infection Prevention and Control
Marsha Jones, Associate Chief Nurse, Quality Governance
David Thorpe, Deputy Chief Nurse
Sally Tucker, Chief Operating Officer
Mike van der Watt, Chief Medical Officer
Anna Wood, Deputy Medical Director

Attendees
Jean Hickman, Trust Secretary
Laura Abel, Assistant Trust Secretary (notes)

Attendees for specific items
Andy Barlow, Divisional Director Medicine
Angela Wellman, Head of Nursing, Medicine
Annesha Archyangelio, Deputy Director of Infection Prevention and Control
Alison Fuller, Interim Associate Chief Nurse

NHS
West Hertfordshire Hospitals
NHS Trust

21

Report to:	Trust Board
Title of Report:	Assurance report from Quality Committee
Date of meeting:	05 December 2019
Recommendation:	For information and assurance
Chairperson:	Jonathan Rennison, Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Quality Committee at its meeting on 28 November 2019.
Background	The purpose of the Quality Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes that are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.
Assurances received / areas of challenge	**Children's services quality assurance report** The Committee received a report from Children's Services setting out their ongoing work to maintain high standards of care and as well as their clear focus on improvement and working to achieve an outstanding CQC rating for our Children's Services. The reported demonstrated a strong culture of learning where incidents, complaints and issues are robustly reviewed or investigated to understand what went wrong and to develop clearly planned solutions. The team demonstrated how well learning is disseminated, as well as having clear evidence of learning becoming embedded. The also provided evidence of their learning culture through their excellent quality improvement initiatives, some of which have been presented and recognised nationally, as well as being accepted for publication in international peer reviewed journals. One of their consultants, Dr. Sankara Narayanan has been recognised with a national award: HQIP clinical practitioner of the year (local) 2019 audit heroes award. The report highlighted their proactive approach to risk management, how key risks are shared, and staff are made aware of them to support active risk management on a day-to-day basis. Key risks highlighted relate to both junior doctor and nurse staffing. These risks are being actively managed on a daily basis to ensure safe staffing, with robust mitigations and escalations in place and with a clear focus on long-term solutions through improved recruitment and retention

initiatives. The committee was assured that we have a robust approach in place to ensure the provision of a safe service.

External visits from HVCCG recognised that the team have a very strong caring focus. A peer CQC preparation visit from Milton Keynes Hospital demonstrated a strong focus on learning, quality improvement and proactive risk management.

Key issues and areas of focus for further service development and improvement include supporting young people, with a particular focus on those at key transition stages, such as 16-17 year olds, in particular those with mental health issues for this group. There was good evidence of working with safeguarding team, HPFT CAMHs/CCAT, with a clear focus on ensuring the needs of this group are met now and in future. Futures plans include how we can better integrate psychological support into our services for this group of vulnerable young people. There was also recognition of the emotional toll on staff in dealing with this group – the committee was assured that staff received appropriate professional supervision and support, with signposting to additional support where appropriate.

Corporate risk register and board assurance framework report
We received the Corporate Risk Register. There was one escalated risk:

Risk 3949 – Patient experience and patient safety is compromised due to ongoing challenges with current non-emergency transport provider.

This is an ongoing problem with patients who are ready for discharge to another care setting or home. HVCCG continues to negotiate for a new contract.

One risk was de-escalated as robust reviews have shown that due to the controls that are now in place the level of risk posed has reduced:

Risk 4209 – Failure to complete learning from deaths of people with a learning disability (LeDeR) investigations in a timely manner.

Overall, the Committee was assured that risks are being appropriately managed, with clear controls in place and a robust review process that allows risks to be escalated and dealt with in a timely manner.

Annual report on end of life care strategy
We received the annual report on the Trust's end of life care strategy. The Committee noted that satisfaction ratings in the family surveys tend to be positive, which indicates a good service. The services takes action on complaints and implements learning, it actively listens to feedback from individuals, families and carers and has had a proactive approach to concerns raised by the CQC. The team provided evidence of improvements and changes, with a clear forward plan for further improvements. Good evidence of learning and a strong focus on continuous improvement. A key area of focus is a quality improvement initiative on DNACPR and working to address this area, supporting staff

to recognise dying patients earlier ensuring appropriate conversations are had with families and the individual and that an agreed care plan is in place that is developed based on the best interests of the patient.

Quarterly learning from deaths report

The committee received the quarterly report on learning from deaths and were assured that we have a robust approach in place to capture and disseminate learning from deaths. It was acknowledged that more work may be required in seeking to understand how divisions use information and learnings that are shared with them, so an approach to getting feedback and capturing how learning is applied is being developed. Key learning themes include:

- End of life care
- Anticoagulation management around surgical procedures
- Fluid balance
- Medication errors
- Delays in reviewing diagnostic tests

These themes correlate with existing data and internal reporting and therefore help with taking a targeted approach to addressing these issues on a priority basis.

Dr Foster data on mortality rates was reviewed. Mortality rates (HSMR SHMI) continue to be in the expected range. However, our crude mortality rate is higher than the national average. This data is currently included in the board IPR and flags as red as it is higher than the national average, yet our HSMR and SHMI rates continue to remain within the expected range. The committee had a discussion on the utility of crude mortality rate as an indicator in the board IPR. The discussion concluded that crude mortality rates are not useful in the context of the board IPR but it is a meaningful and important indicator to track as it can be an early warning sign of negative changes in mortality rates. It was agreed that crude mortality rate would continue to be scrutinised, alongside HSMR and SHMI within the mortality review group. The board will continue to monitor HSMR and SHMI through the IPR and also through mortality review and learning from deaths reports, however, crude mortality rates would no longer be reported in the monthly board IPR.

The Dr Foster report also highlighted a number of outlying SMR diagnoses. Each month the report highlights new outlier areas for the Trust as well as any areas that continue to be outliers from previous reports. All outlying areas are scrutinised through the mortality review group, with case notes being examined, coding of cause of death being checked, discussions with consultants to identify trends, issues and learning. Often, we have found that outlying cases result from incorrect coding and this is shared with Dr Foster, which results in outliers being removed as data is adjusted based on correct coding. Outliers vary from month to month but are closely monitored and scrutinised for trends and learning so that action can be taken were we believe we can improve our services.

Recommendation:
The committee recommends to the board the removal of crude mortality rates as an indicator in the monthly board IPR.

Report on correlation of data from Dr Foster and perinatal mortality review tool
The committee received these reports and were assured that our approach to perinatal mortality reviews is robust and clear and that we apply the criteria for review appropriately and that all cases are robustly scrutinised to assess if the care we provided to mothers and babies could have contributed to the death of the babies. The current report provides strong assurance that our care did not contribute to the deaths of the babies reviewed using the PMRT. However, the reviews of these individual cases did identify a number of areas for learning and improvement. These areas are being addressed with new approaches being piloted and tested. The committee commented that many of the actions and areas for improvement have been reported several times previously but the report does not demonstrate progress or improvement. The team highlighted that they are changing the report format and that future reports will draw on data from a number of different quality improvement initiatives across the division to demonstrate progress and improvements, which address issues highlighted and will provide further assurance of high quality and safe care for mothers and babies. The committee welcomed this approach.

The Committee was assured that there is a robust understanding of the key issues and that there are clear plans in place to address these areas, or to identify appropriate solutions for the areas of concern. The committee was assured that there is a strong governance process in place for PMRT and looks forward to receiving assurance of actions and progress.

GIRFT programme update
The committee received two reports on the GIRFT programme:

- Ophthalmology
- ENT

The Committee noted areas of progress and actions completed for each report. However, a common theme emerged for both areas concerning recommendation and actions, in particular for actions that are tracking as amber or incomplete – the recommendations are not readily accepted or are in contention. The committee expressed that it did not understand why the recommendations would not be accepted or why we would not be willing to explore the recommendations and develop an approach to work towards the recommended target. If the target is not realistic for our service, then also we wish to see an appropriate evidence-based rationale for why a target may not be appropriate for us. The committee was not assured that there is an appropriate process at divisional level for reviewing recommendations and the development of appropriate responses and action plans to support the recommendations. The

divisions and executive committee were asked to take an action to develop a more robust process for GIRFT recommendations and addressing them at divisional level, so that we can have improved assurance.

Patient and carer experience strategy report
We received an update on progress against our patient and carer strategy. The report contained evidence and assurance of progress that has been made. Evidence and assurance was taken from regular operational audits of activity focused on patient experience, improving patient feedback rates in a number of areas, improvement is complaints process and evidence of learning from complaints, increasing volunteer numbers and diversification of our volunteer group and the range of roles that volunteers now fill and therefore providing broader support to patients.

The presentation of data on the use of the patient lounge was questioned by the committee as it was felt that it did not demonstrate the positive progress that we have made in this area. The Committee asked the patient experience team to separate out data for our weekday and w/end usage of the patient lounge and to develop and appropriate target for w/end usage. This will provide stronger assurance on use of the discharge lounge as well providing further assurance on 7-day working to support discharge.

Briefing on Care Quality Commission state of care report
We received a report on the most recent CQC state of care report with a discussion of the main themes and issues that we should be aware of, review and address as part of our approach to quality improvement across the Trust. Key issues raised by the report include;

- Access to care remains a challenge and supporting improved access to care through system working and collaboration is important in addressing this.
- Staffing remains a challenge across all care settings and ensuring creative and new approaches to addressing staffing issues, having a strong focus on valuing and caring for staff to improve retention are important.
- Continuing increased emergency attendances year on year is raised as an issue.
- Concerns relating to mental health provision, specialist services and the appropriately trained staff for specialist services remains a concern.
- A wide range of issues in adult social care – workforce, quality of services, specialist staff, funding pressures, etc.
- Strong focus on collaboration and systemwide working to address challenges and the role of innovation and technology in finding creative solutions to the key challenges.

Risks to refer to risk register

There were no new risks to escalate to the Board.

Recommendations to the Board	Recommendation to the board that crude mortality figures should be removed from the learning from deaths report

Attendance record

Attended
Jonathan Rennison, Non-Executive Director (co-chair)
John Brougham, Non-Executive Director
Christine Allen, Chief Executive
Tracey Carter, Chief Nurse and Director of Infection Prevention and Control
Marsha Jones, Associate Chief Nurse, Quality Governance
David Thorpe, Deputy Chief Nurse
Sally Tucker, Chief Operating Officer
Mike van der Watt, Chief Medical Officer
Anna Wood, Deputy Medical Director

Attendees
Jean Hickman, Trust Secretary
Laura Abel, Assistant Trust Secretary (notes)

Attendees for specific items
Mary Bhatti, Divisional Manager, Women's and Children's
Karen Walker, Head of Nursing, Children's services
Michelle Sorley, MacMillan Lead Nurse
Miss Faye Barampouti, Ophthalmology Consultant and Clinical Lead
Mr Chee Toh, ENT Consultant and Clinical Lead

Apololgies
Ginny Edwards, Non-Executive Director (co-chair)

Agenda Item: 22/77

Report to:	Trust Board
Title of Report:	Charity Committee Assurance Report to Board
Date of meeting:	05 December 2019
Recommendation:	For Information and Assurance
Chairperson:	Jonathan Rennison, Non-Executive Director

Purpose

The report provides an update to the Corporate Trustee on actions since the last Charity Committee on 26 September 2019.

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

- Following last year's success, the Trust's charity has once again launched it's 'Raise a smile this Christmas' appeal, asking the public to donate presents for older patients spending the festive season in hospital. The special Christmas project will make sure that every patient in across the hospitals will have at least one gift to open on Christmas day.

- The Corporate Trustee approved the use of PayPal to support donations to the charity. However, despite assurances from the ICT service, this has not yet been enacted upon. Discussions will continue with ICT to move this forward as quickly as possible.

- A comprehensive tender process to commission an external auditor to carry out the mandatory end of year audit on the charity's accounts has been carried out. Grant Thornton is the preferred bidder and the Corporate Trustee is asked to approve this appointment.

- Sofia Sheikh will take up the post of charity director on 16 December 2019 and she will be joined by Belle Prentice, a new fundraising officer.

Escalation to the Corporate Trustee

The charity committee asks the Corporate Trustee to note the update and approve Grant Thornton as the external auditor.

Charity committee members
Jonathan Rennison, Non-Executive Director
Ginny Edwards, Non-Executive Director
Helen Brown, Deputy Chief Executive
Louise Halfpenny, Director of Communications

Attendees
Tracey Carter, Chief Nurse
Paul da Gama, Director of Human Resources
Jean Hickman, Trust Secretary
Onali Mohamadali, Financial Controller
Sandhya Patel, Financial Accountant

TRUST BOARD MEETING IN PUBLIC
AGENDA

09 January 2019 at 9.30am – 12.30pm
Executive Meeting Room, Watford Hospital

Apologies should be conveyed to the Trust Secretary, Jean Hickman on jeanhickman@nhs.net or call 01923 436 283

Time	Item ref	Title	Objective	Accountable officer	Paper or verbal	Link to BAF
9.30	01/78	**Opening and welcome**	Information	Chair	Verbal	
	02/78	**Patient story**	Information	Chief Nurse	Present-ation	
INTRODUCTION TO THE MEETING						
9.50	03/78	**Apologies for absence**	Information	Chair	Verbal	
	04/78	**Declarations of interest**	Information	Chair	Paper	
	05/78	**Minutes of the meeting held on 05 December 2019**	Approval	Chair	Paper	
	06/78	**Board action log from 05 December 2019 and previous meetings and decision log**	Information	Chair	Paper	
	07/78	**Chair's report**	Information	Chair	Paper	
	08/78	**Chief Executive's report**	Information	Chief Executive	Paper	
	09/78	**Board assurance framework**	Approval	Chief Executive	Paper	
PERFORMANCE						
	10/78	**Performance report on access standards**	Information and assurance	Chief Operating Officer	Paper	4a&b
	11/78	**Integrated performance report (month 7)** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Finance Officer •	Information and assurance	Chief Operating Officer	Paper	4a&b
AIM ONE: BEST QUALITY CARE (OBJECTIVE 1 – 4)						
	12/78	**Report on paediatric annual establishment review**	Information and assurance	Chief Nurse	Paper	

	13/78	**Annual report on end of life care**	Information and assurance	Chief Nurse	Paper	
AIM TWO: A GREAT PLACE TO WORK AND LEARN						
	14/78	**Research and development strategy**	Approval	Chief Medical Officer	Paper	
	15/78	**Business case for overseas nurse recruitment**	Approval	Chief People Officer	Paper	
STRATEGY						
	16/78	**Draft refreshed five year strategy**	Information	Deputy Chief Executive	Paper	
	17/78	**Strategy programme update**	Information	Deputy Chief Executive	Paper	
RISK AND GOVERNANCE						
	18/78	**2020/21 corporate aims and objectives**	Approval	Deputy Chief Executive	Paper	
	19/78	**Corporate risk register report**	Approval	Chief Medical Officer	Paper	
ASSURANCE FROM COMMITTEES						
	20/78	**Assurance report from Trust Management Committee**	Information and assurance	Chief Executive	Paper	
	21/78	**Assurance report from People, Education and Research Committee**	Information and assurance	Chair of Committee/Chief People Officer	Paper	
	22/78	**Assurance report from Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper	
	23/78	**Assurance reports from Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper	
CORPORATE TRUSTEE						
	24/78	**Report from the Charity Committee**	Information and assurance	Chair of Committee/ Deputy Chief Executive	Paper	
ADMINISTRATION						
	25/78	**Any other business previously notified to the chair**	N/A	Chair	Verbal	
QUESTIONS FROM THE PUBLIC						
	26/78	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal	
	27/78	**Questions from our patients and members of the public**	N/A	Chair	Verbal	
CLOSING						
	28/78	**Draft agenda for next meeting**	Approval	Chair	Paper	
	29/78	**Date of the next board meeting:** 06 February 2020, Lecture Hall, Postgraduate Centre, St Albans	Information	Chair	Verbal	