TRUST BOARD MEETING IN PUBLIC
AGENDA

07 November 2019 at 9.30am – 12noon
Seminar Room, Education Centre, Hemel Hempstead

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	01/76	**Opening and welcome**	Information	Chair	Verbal	
	02/76	**Patient story**	Information	Chief Nurse	Present-ation	
INTRODUCTION TO THE MEETING						
9.50	03/76	**Apologies for absence**	Information	Chair	Verbal	
	04/76	**Declarations of interest**	Information	Chair	Paper	
	05/76	**Minutes of the meeting held on 03 October 2019**	Approval	Chair	Paper	
	06/76	**Board action log from 03 October 2019 and previous meetings and decision log**	Information	Chair	Paper	
	07/76	**Chair's report**	Information	Chair	Paper	
	08/76	**Chief Executive's report**	Information	Chief Executive	Paper	
	09/76	**Board assurance framework**	Approval	Chief Executive	Paper	
PERFORMANCE						
10.05	10/76	**Performance report on access standards**	Assurance	Chief Operating Officer	Paper	4a&b
	11/76	**Integrated performance report (month 6)** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Finance Officer	Assurance	Chief Operating Officer	Paper	4a&b
AIM ONE: BEST QUALITY CARE (OBJECTIVE 1 – 4)						
10.35	12/76	**Seven-day board assurance framework report**	Approval	Chief Medical Officer	Paper	4c
AIM TWO: GREAT PLACE TO WORK AND LEARN (OBJECTIVE 5 – 8)						
10.45	13/76	**Annual report on freedom to speak up/whistle blowing**	Approval	Ginny Edwards, Non-Executive Director	Paper	
	14/76	**Annual report on guardian of safe working standards**	Assurance	Chief People Officer	Paper	

	15/76	**Staff seasonal flu vaccination campaign update**	Assurance	Chief People Officer	Paper	
AIM THREE: IMPROVE OUR FINANCES (OBJECTIVE 9)						
11.10	16/76	**Report on long term financial planning**	Approval	Chief Financial Officer	Paper	9b
AIM FOUR: A STRATEGY FOR THE FUTURE (OBJECTIVE 10 – 12)						
11.20	17/76	**Strategy update**	Assurance	Deputy Chief Executive	Paper	12a-d
	18/76	**Business case for urgent and emergency care services**	Approval	Deputy Chief Executive	Paper	12b
RISK AND GOVERNANCE						
11.30	19/76	**Corporate risk register report**	Assurance	Chief Medical Officer	Paper	
	20/76	**Progress report on well-led improvement plan**	Assurance	Chair/ Chief Executive/Trust Secretary	Paper	
ASSURANCE FROM COMMITTEES						
11.40	21/76	**Assurance report from Trust Management Committee**	Assurance	Chief Executive	Paper	
	22/76	**Assurance report from Finance and Performance Committee**	Assurance	Chair of Committee/Chief Financial Officer	Paper	
	23/76	**Assurance report from Quality Committee**	Assurance	Chair of Committee/ Chief Nurse	Paper	
	24/76	**Assurance report from Audit Committee**	Assurance	Chair of Committee/Chief Financial Officer	Paper	
	25/76	**Assurance report from People, Education and Research Committee**	Assurance	Chair of Committee/Chief People Officer	Paper	
CORPORATE TRUSTEE						
11.50	26/76	**Assurance report from Charity Committee**	Assurance	Chair of Committee/ Deputy Chief Executive	Paper	
ADMINISTRATION						
	27/76	**Any other business previously notified to the chair**	N/A	Chair	Verbal	
QUESTIONS FROM THE PUBLIC						
11.55	28/76	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal	
	29/76	**Questions from our patients and members of the public**	N/A	Chair	Verbal	
CLOSING						
12.00	30/76	**Draft agenda for next meeting**	Approval	Chair	Paper	
	31/76	**Date of the next board meeting in public:** 05 December 2019, Executive Meeting Room, Watford	Information	Chair	Verbal	

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Acronyms and abbreviations

A

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

B

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

C

CAB/C&B	Choose and Book
Caldicott Guardian	The named officer responsible for delivering and implementing the Confidentiality and patient information systems
CAMHS	Child and adolescent mental health services
CAS	Central Alert System
CCG	Clinical Commissioning Groups
CCIO	Chief Clinical Information Officer
CCORT	Clinical Care Outreach Team
CCU	Critical Care Unit
CDI	Clostridium Difficile Infection
C.Diff	Clostridium Difficile
CEO	Chief Executive Officer
CfH/CFH	Connecting for Health
CFO	Chief Financial Officer
CHC	Continuing Health Care
CHD	Coronary heart disease
CIO	Chief Information Officer
CIP	Cost improvement programme
CIS	Care Information Systems
CMO	Chief Medical Officer
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
COI	Central Office of Information
COO	Chief Operating Officer

COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control of Substances Hazardous to Health
CPA	Clinical Pathology Accreditation
CPD	Continuing Professional Development
CPOP	Clinical Policy and Operations
CFPG	Capital Finance Planning Group
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
CRS	Care Records Service
CSE	Child sexual exploitation
CSSD	Central Sterile Service Department
CSU	Commissioning Support Unit
CT	Computerised Tomography

D

DBS	Disclosure Barring Service
DCC	Direct Clinical Care
DD	Divisional Director
DGH	District General Hospital
DGM	Divisional General Manager
DM	Divisional Manager
DIPC	Director of Infection Prevention and Control
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
07 November 2019

Agenda item: 04/76

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		

TRUST BOARD MEETING IN PUBLIC

03 October 2019

Executive Meeting Room, Watford Hospital

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 Officer and Director of Patient Safety	Yes
Non-voting members		
Dr Andy Barlow	Divisional Director, Medicine	Yes
Paul da Gama	Chief People Officer	Yes
Natalie Edwards	Associate Non-Executive Director	Yes
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	No
Sally Tucker	Chief Operating Officer	Yes
Anna Wood	Deputy Medical Director/Associate Medical Director for Clinical Audit	Yes
In attendance		
Kerri Bishop	Freedom to Speak Up Champion	Yes
Howard Borkett-Jones	Freedom to Speak Up Champion	Yes
Adam Haspinell	Freedom to Speak Up Champion	Yes
Jean Hickman	Trust Secretary (notes)	Yes
Yvonne John	Freedom to Speak Up Champion	Yes
Caroline Lankshear	Head of Employee Relations	Yes
Justine Powell	Employee Relations Manager	Yes

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
PERFORMANCE			
01/75	**Opening and welcome**		
01.01	The chairman opened the meeting and welcomed the Board and members of the public.		
02/75	**Freedom to speak up**		
02.01	Ginny Edwards advised the Board that October was freedom to speak up (FTSU) month and as the Trust's FTSU guardian, she would be using the opportunity to raise awareness across the Trust. She advised that the Board would receive the FTSU annual report in November 2019 which would outline the work completed to date, as well as explaining the plans in response to new published guidance. Ginny Edwards reminded the Board that the Trust had been an early adopter of FTSU and currently 20 staff had volunteered as FTSU champions. It was reported that new posters with photos of the champions would be displayed across the three hospitals to raise their profile amongst staff.		
02.02	The champions informed the Board on the reasons why they had personally chosen to be champions, which included wanting to promote a culture of openness and ensure that staff were able to report in confidence any bullying or equality and diversity issues. The Board was informed that FTSU formed an important part of the induction of new doctors and the champions said that they found being able to support other who were facing difficulties as rewarding and often staff just needed someone to talk to. The Board was assured that if complex issues were raised they were referred to the workforce department to manage. Ginny Edwards thanked the workforce team for its support and guidance around FTSU and also the strong commitment by the chief people officer and chief nurse in responding immediately to FTSU cases and taking them seriously.		
02.03	The chairman asked whether the Trust was on the right path to having a healthy open culture to support people to speak up. Howard Borkett-Jones, freedom to speak up champion responded that the organisation had the right culture and noted the importance of the senior leadership team leading by example to help staff to know that they would be listened to if they spoke up.		
02.04	The chief operating officer recognised the significant achievement in recruiting the large many champions and enquired what support was available to the champions. The head of employee relations advised that an FTSU champions network had been established to allow champions to share experience from cases and the workforce team was available to support them also. It was noted that any patient safety related cases were referred to Ginny Edwards to manage and the chaplaincy service was available to champions and to the staff who came to them for help. In addition, training and developed was available.		
02.05	Paul Cartwright asked whether the Trust managed black and ethnic minority (BME) issues effectively. Yvonne John, FTSU champion responded that people found it hard to talk about race and stressed the importance of being open and allowing people to be heard. She advised that until different cultural backgrounds were fully understood then they could not really be accepted. The chief finance officer suggested that the FTSU awareness campaign could also promote		

Agenda item	Discussion	Lead	Dead-line
	black history month. The chief people officer advised that the Trust would be launching a reverse mentoring scheme whereby executives would be mentored by people from a BME background as part of black history month.		
02.06	The chief people officer thanked Ginny Edwards for her hard work in the role of FTSU guardian which had allowed the Trust to achieve so much.		
OPENING			
03/75	**Apologies for absence**		
03.01	Apologies were received from the divisional director for surgery, anaesthetic and cancer.		
04/75	**Declarations of interests**		
04.01	No further interests were declared than those circulated prior to the meeting.		
05/75	**Minutes of the meeting held on 05 September 2019**		
05.01	The minutes were agreed to be an accurate record of the meeting.		
06/75	**Board action log previous meetings and decision log**		
06.01	All actions were completed. It was noted that the decision log had been archived.		
07/75	**Chair's report**		
07.01	The chairman asked the Board to receive his self-explanatory report for information. He praised the Trust for its recent excellent achievements, including being awarded the title of UK employer of the year in the Nursing Times awards and achieving no band five nurse vacancies in adult inpatient wards.		
08/75	**Chief Executive's report**		
08.01	The Board received a report from the chief executive. She highlighted that the Trust had successful managed a complex transition onto a new IT partner and thanked the IT and business continuity teams for their excellent work. The chief executive reported good progress had been made to a redecoration programme which included painting, new lighting, plumbing and floors at Watford. The Board was pleased to note that the Trust's annual flu programme had started well and over 1,000 staff had been vaccinated to date. Other staff news included the launch of birthday breakfast events, the annual staff survey was underway and a new practice supervisor and assessor programme had been established. The chief executive concluded her report by informing the Board that the board assurance framework had been refreshed and a draft version would be reviewed in the private session of the meeting.		
09/75	**Performance report on access standards**		
09.01	The Board received an overview of performance against the national access standards from the chief operating officer.		
09.02	John Brougham advised that the finance and performance had reviewed the report and was pleased that it now compared performance against the Trust's plan and also nationally. He noted that A&E performance remained a key concern and asked for the Board to be updated on a pilot of a new model of the medical 'take' which was currently underway in the emergency department. The divisional director for medicine reported that the pilot had only been in operation for one full day, however early indications were positive with a significant reduction in the number of admitted patients than had been		

Agenda item	Discussion	Lead	Dead-line
	predicted. The Board was informed by the chief operating officer that the A&E department felt more controlled with less congestion and the mood of staff had improved. It was emphasised that it was early days in regard to the pilot which would be closely monitored and modified as required. Ginny Edwards asked for clarity on the actions being taken to sustain any improvement at the end of the pilot and Natalie Edwards enquired how long it would take to go back to the previous system if necessary at the end of the trial. The divisional director of medicine advised that the new model would be unsustainable for longer than four weeks and if the proof of concept demonstrated that the model should become business as usual, then difficult discussions would be required. The chief medical officer acknowledged that it would represent a significant financial impact should the new model become permanent, however, in the medium to long term the changes to the model would cover its own costs. The deputy chief executive commented that weekends should be included in the pilot to ensure patients received the same treatment whatever day of the week they attended the emergency department. Paul Cartwright enquired whether the new model would be sufficient to support the Trust to achieve the national A&E standard. The chief operating officer reported that the majority of trusts were experiencing unexpected demand with no identified themes or trends and advised that in addition to the pilot a wide range of other actions were underway as part of the ED improvement plan.		
10/75	**Integrated performance report - month 5**		
10.01	The chief operating officer noted that the integrated performance report (IPR) was in a new format which had been modified following discussion at a Board development session in September 2019. The report now included key messages from the chief operating officer, chief medical officer, chief nurse, chief people officer and chief financial officer. The chief operating officer advised that the executive team would reflect on how the presentation had flowed at the Board meeting and make adjustments as required. The non-executive directors welcomed the refreshed IPR as a positive step forward and John Brougham stated that executive directors delivering their respective key messages demonstrated clear accountability. The non-executive directors suggested some revisions to the report and the chief executive confirmed that the finance and performance committee would consider and approve any suggested amendments or additional data to the IPR.		
10.02	The chief operating officer, chief medical officer, chief nurse, chief people officer and chief financial officer provided an overview of their respective sections of the IPR and highlighted the areas of good performance and those which required improvement. The chairman advised the Board that he would reflect on the feedback from the meeting with the chief executive to plan future performance reporting.		
10.03	Ginny Edward enquired how the Trust could be assured that all pressure ulcers were being detected and reported within the national guidelines. The chief nurse assured the Board that the Trust's quality and safety group closely monitored pressure ulcer performance and explained the measures in place, including a pressure ulcer review group, working with the emergency team to assess people prior to admission and an established network of pressure ulcer champions.		
10.04	Jonathan Rennison pointed out the importance of being clear in the IPR on the difference between mandatory and essential training.		

Agenda item	Discussion	Lead	Dead-line
10.04	Ginny Edwards noted that a staff turnover rate of 15.1% remained below target and asked what actions were being taken to address this. The chief people officer explained that the majority of the turnover came from staff in bands two to four which was expected due to the nature of the staffing groups. He advised that the Trust held new starter meetings and sent out questionnaires to try to understand why staff were leaving and a process was in place to meet with managers to gain further intelligence.		
10.06	Jonathan Rennison asked what lessons had been learnt from the never event reported in August 2019. The chief medical officer advised that the never event related to a misplaced nasogastric tube which was currently being investigated and any learning would be shared. He assured the Board that no patient had come to harm as a result of the incident.		
11/75	**Bi-annual establishment review – adult inpatient wards**		
11.01	The chief nurse provided the Board with an overview of an establishment review into safe staffing in adult inpatient areas. The Board was assured that the review had been conducted using the evidence based safer nursing care tool and been signed off by matrons, heads of nursing and the chief nurse. It was reported that the review had resulted in minimal changes to templates with the main changes being in Tudor, Heronsgate and Gade wards. The Board was pleased to note that the nursing establishment was in a positive position with no band five nurse vacancies, which allowed senior nurses to fully support the overall management of the wards.		
12/75	**Annual report on safeguarding**		
12.01	The Board received an annual report on safeguarding from the chief nurse. It was noted that the report had been widely discussed at a number of meetings and assurance was given that the key indicators demonstrated that the Trust was appropriately protecting its vulnerable patients and making referrals as required. It was noted that during the reporting period there had been an increase in the number of safeguarding referrals of children and adults compared to the previous years.		
12.02	The Board thanked the chief nurse for the well written report and congratulated the safeguarding team on being a finalist in the Royal College of Nursing awards and in the HSJ safety awards and to Michelle Mulvaney, lead nurse for safeguarding, for being shortlisted as nurse of the year.		
13/75	**Quarterly learning from deaths report**		
13.01	The deputy medical director presented a report which showed that hospital standardised mortality ratios (HSMR) and summary hospital-level mortality indicator (SHMI) were within the expected range. The deputy medical director reported that during the timeframe of the report, 20 referrals had been made for structured judgement reviews (SJR), 10 of which were considered by the avoidability panel and one case was agreed to have more than a 50% chance that the care had contributed to the patient's death. The Board was pleased to learn that an increase in the number of medical examiners was working well and a previously reported backlog in SJR was being addressed. It was noted that end of life care had been identified as a theme and was a feature of the quality improvement plan.		
13.02	The Board thanked the deputy medical director for the well-written,		

Agenda item	Discussion	Lead	Dead-line
	clear report.		
14/75	**Strategy update**		
14.01	The Board was updated by the deputy chief executive on the progress of the five year strategy refresh. She advised that Board and committee reporting would move to a bi-monthly basis and would be by exception only. The Board was reminded that a business case relating to the procurement of urgent care services at Watford would be discussed in the private session of the meeting. The deputy chief executive informed the Board that all IT projects had been reviewed for viability and delivery within the current financial year.		
14.02	The Board was pleased to be advised that the Trust was included in a list of six hospitals that would receive a share of £2.7bn government investment over the next five years. The deputy chief executive clarified that guidance had only very recently been published on how the new approach to funding would work and cautioned that there would be implications on the Trust to take this forward at pace. The chief executive advised that the Board would receive the Trust's refreshed strategy in December 2019 which set out four clear aims and the key programmes of work needed to be delivered in order to take the Trust forward. This would include a transition plan for estates and digital improvements. The Board was informed that good progress was being made towards achieving the capital, winter, theatres and emergency care programmes. It was reported that a programme of engagement around the Trust's refreshed strategy would commence in October 2019.		
14.03	The chairman brought the Board's attention to delays to the development of a multi-storey carpark at Watford and the deputy chief executive explained that this had been due to complications and challenges in achieving a commercial agreement with the external provider. She assured the Board that all parties remained committed to the scheme and the Trust was working closely with Watford Borough Council and Kier to find a mutually agreeable solution. John Brougham requested a verbal update at the next finance and performance meeting from the Riverwell partnership board meeting on 24 October 2019, prior to an update at the Board in November 2019.		
14.04	John Brougham asked for clarity on the status of the local area network project which was rated 'green' in the strategy report and an 'extreme' risk in the Board assurance framework. The chief information officer reported that the Trust was on track strategically to move to a new network, however due to the condition of the current network it was at a high risk of collapse. He assured the Board that a business case for the local area network would be reviewed by the finance and performance committee in October 2019 and by the Board in November 2019.		
14.05	It was noted that the finance and performance committee had received an update on the development of private patient services and it was agreed that future updates would be included in the strategy report to the Board.	HB/DR	12/19
15/75	**Development of integrated care partnership**		
15.01	The deputy chief executive outlined a paper which summarised the aims and implications of the development of an integrated care partnership (ICP) for west Hertfordshire. She clarified that following an ICP seminar and working jointly with Herts Valleys Clinical Commissioning Group Boards of all partner organisations were being asked to consider and confirm their commitment in playing an active		

Agenda item	Discussion	Lead	Dead-line
	role in the development of the ICP and agree the strategic milestones.		
15.02	John Brougham welcomed the direction of travel set out in the report. He stressed the importance of managing the key risks to the organisation and in ensuring that the Trust had sufficient capability to take this forward. The chief executive assured the Board that the trust management committee had discussed the capacity and capability requirements and noted that due to the departure of HVCCG's accountable officer the Trust would be driving the development of the ICP alongside other partners. The deputy chief executive reported that additional support would be secured to help guide the process and noted that a significant element of HVCCG's capacity would be refocused on ICP work. In response to a question from Ginny Edwards, the chief executive confirmed that the programme of work would be set under a robust methodology framework. Paul Cartwright reminded the Board of the importance of having clear non-executive director (NED) governance and advised that discussions around this would commence at a NED sustainability and transformation partnership meeting in October 2019. Natalie Edwards pointed out the merits of staff engagement early in the process in order to make staff feel part of the development.		
15.02	Resolution: The Board confirmed its support for the proposed development of an integrated care partnership for west Hertfordshire and agreed the key future steps.		
16/75	**Corporate risk register report**		
16.01	The chief medical officer presented an update on the status of the corporate risk register. He reported that there were 26 open risks on the register, six risks had been de-escalated and five new risks had been added. It was noted that the finance and performance committee had approved a revised set of financial risks on 26 September 2019 which would be included in future reports.		
16.02	Resolution: The Board endorsed the changes to the corporate risk register.		
17/75	**2019/20 committee terms of reference and work plans**		
17.01	The Board received the outstanding sets of 2019/20 committee terms of reference and work plans from the trust secretary. She advised that the Sep.		
17.02	Resolution: The Board approved the 2019/20 terms of reference and work plans.		
18/75	**Assurance report from Trust Management Committee**		
18.01	The chief executive presented an assurance report on the work of the trust management committee. The Board acknowledged the significant amount of work undertaken by the committee and the chairman suggested that the chief financial officer check whether the £1m threshold for business cases to be approved by the Board worked well for the organisation. The chief financial officer agreed to do a benchmarking exercise with other NHS trusts and, if required, to reflect any changes to the threshold level in the 2019/20 standing financial instructions which would be considered by the audit committee on 18 October 2019 for recommended approval by the Board in November 2019.	DR	11/19
19/75	**Assurance report from Finance and Performance Committee**		
19.01	The Board received an assurance report from John Brougham on the		

Agenda item	Discussion	Lead	Dead-line
	work of the finance and performance committee. On behalf of the committee, John Brougham recommended that the Board ratify a revenue support loan to cover funding requirements in September 2019.		
19.05	Resolution: A loan of £3.7m was ratified by the Board.		
20/75	**Assurance report from Quality Committee**		
20.01	Ginny Edwards presented an assurance report on the work of the quality committee. She advised that the committee had been assured and recommended a number of reports to the Board for approval, namely the safeguarding annual report, the bi-annual establishment review and the learning from deaths report. The committee had also received assurance from a quality corporate risk report, a CQC getting to good report and quality performance indicators.		
21/75	**Assurance report from Auditor Panel**		
21.01	Paul Cartwright reminded the Board that the assurance report from the Auditor Panel had been discussed verbally at the previous meeting and the report was the formal record of the meeting. He advised that a procurement process was ongoing for internal, external and counter fraud services and the Board would be updated at the November 2019 meeting.		
22/75	**Assurance report from Charity Committee**		
22.01	The Corporate Trustee received an assurance report from Jonathan Rennison on the work of the charity committee. He advised that a new charity director had been recruited and would take up post in December 2019. In the meantime, an interim charity director would launch a Christmas and a capital appeal for 2020/21. It was noted that arrangements were being put in place to launch the previously agreed lottery. Furthermore, an interview process was underway to recruit a charity administrator.		
22.02	On behalf of the charity committee, Jonathan Rennison recommended to the Corporate Trustee that it approved the terms of reference and work plan for 2019/20. He noted that both documents had been reviewed and restructured against the essential trustee guidance and cross referend with the good governance code.		
22.03	Resolution: The Corporate Trustee approved the 2019/20 terms of reference and work plan.		
23/75	**Any other business**		
23.01	No other business was raised.		
24/75	**Questions from Hertfordshire Healthwatch**		
24.01	Meg Carter, representative from Hertfordshire Healthwatch welcomed the report on the ICP and advised she would be sharing this with Healthwatch colleagues and would come back with queries if necessary. She acknowledged the further work required and the challenges in bringing together multi-disciplinary and multi-agency teams in order to support the ICP.		
24.02	The Board was asked if patient feedback would be collated in relation to a pilot ongoing in the emergency department. It was reported that a questionnaire was being developed which would help to establish whether the new model was improving the experience of patients using the service.		
24.03	Meg Carter advised that she found the new format of the IPR helpful and accessible.		

Agenda item	Discussion	Lead	Dead-line
25/75	**Questions from patients and members of the public**		
25.01	There were no questions raised by patients or the public.		
26/75	**Draft agenda for the next meeting**		
26.01	The Board approved the draft agenda.		
27/75	**Date of the next meeting**		
27.01	The next meeting would be held on 07 November 2019, seminar room, education centre, Hemel Hempstead.		

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda item: 06/76

Action log Part 1 – 07 November 2019

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	18.01/75	Benchmarking exercise with other NHS trusts to be undertaken to check that the threshold level for business cases to be approved by the Board worked for the organisation and, if required, to reflect any changes to the threshold level in the 2019/20 standing financial instructions (SFIs).	Chief Financial Officer	Nov-19	A benchmarking exercise has been undertaken which concluded that the threshold was consistent with other similar sized trusts. Therefore the Audit Committee recommend no changes should be made to the SFIs.
2	14.05/75	An update on private patient services to be included in future strategy reports to the Board.	Deputy Chief Executive/ Chief Financial Officer	Dec-19	Due Dec-19

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**
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 Investment 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 Investment 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
07 November 2019

Title of the paper	**Chairman's report**
Agenda Item	**07/76**
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: 07/76

Trust Board Meeting – 07 November 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. On 30 October 2019 Parliament passed the Early Parliamentary General Election Bill, which amended the Fixed Term Parliament Act to hold a General Election on 12 December 2019. At the time of writing this report, the Bill is currently awaiting Royal Assent to become law. If passed, the country will go into a period called 'purdah' as from 06 November 2019 and will run until 13 December 2019 or when a new government is formed.

2.2. During this pre-election period the Trust is required to be sensitive to the impact of its work on the outcome of local and national elections and election campaigns. This affects the support for public announcements which could be seen to call into question political impartiality or activities, such as visits by politicians that could give rise to accusations that public resources are being used for political purposes.

2.3. With regard to Board meetings, the agenda should be confined to those matters that need a Board decision or require oversight. Matters of future strategy or the future deployment of resources may be construed as favouring one party over another and should be avoided.

Proposals for legislative change

2.4. NHS England and NHS Improvement's are inviting patients, NHS staff, partner organisations and interested members of the public to give their views on potential proposals for changing current primary legislation relating to the NHS. The proposed changes, which are targeted at change to support delivery of the NHS long term plan, are set out in a document entitled 'Implementing the NHS long term plan: proposals for possible changes to legislation'.

2.5. The proposals and link to complete the survey can be found at www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation

Annual report on health care and social care

2.6. The Care Quality Commission (CQC) has published a report on the overall state of health care and adult social care in England 2018/19. The report is an annual assessment of health and social care in England and looks at trends in quality, shares examples of good and outstanding care, and highlights where care needs to improve.

2.7. The report is available on the CQC's website, wwwhttps://www.cqc.org.uk.

Freedom to speak up

2.8. October was freedom to speak up month and Ginny Edwards, the Trust's freedom to speak up (FTSU) guardian and FTSU champions have been busy promoting their role and the value that comes from an organisation where speaking up is a welcome and safe thing to do.

2.9. The National Guardian's Office (NGO) has published a report on a new FTSU index, which monitors a 'speaking up culture' in the NHS based on four questions from the annual NHS staff survey. The report sets out the FTSU index score for every trust in England and includes case studies of how the FTSU guardian role and positive speaking up cultures have been taken forward in a range of trusts. NHS England has also announced a £100,000 investment in a scheme to support staff who speak up.

2.10. Following a presentation at the October Board meeting, this meeting agenda includes an annual report on the Trust's approach to FTSU and a Board development session on 14 November 2019 will explore the new national guidance which was published in July 2019.

2.11. More information on the FTSU index can be found at www.cqc.org.uk/national-guardians-office.

The health infrastructure plan

2.12. The Department of Health and Social Care (DHSC) has released its healthcare infrastructure plan, setting out changes for how NHS capital funding will be prioritised and allocated to the frontline. This plan follows recent funding announcements for capital investment for trusts across 2020-2030.

2.13. The HIP sets out the delivery for a long-term, rolling five year programme in health infrastructure. While including capital to build new hospitals, the government has signalled its intention is to modernise the primary care estate, invest in new diagnostics and technology, and to eradicate critical safety issues in the NHS estate. The plan also commits to allocating capital across the wider health infrastructure, such as public health and social care.

2.14. The Trust welcomes the opportunity to accelerate the final approval of its plans to redevelop the estate that provides acute services to the population of West Hertfordshire. Being included in the first cohort of the Health Infrastructure plan recognises the urgency of the need to renew the ageing estate that our services are currently provided from and to modernise the way that services are provided.

2.15. Full details can be found at www.gov.uk.

The role and remuneration of chairs and non-executive directors

2.16. One of the actions in the interim NHS People Plan published in June 2019 was to develop competency frameworks for senior NHS leadership roles to assist in the recruitment, development and appraisal of leaders.

2.17. With this in mind, it has been agreed nationally to align remuneration for chairs and non-executive directors of NHS trusts and foundation trusts. A thirty-month period of phased alignment began in October 2019 which focuses first on establishing a standard level of remuneration for non-executive directors and addressing the most significant discrepancies across chair roles.

2.18. The Trust's remuneration committee will receive a briefing report on the new national guidance with regard to non-executive director pay at its next meeting.

3. LOCAL NEWS AND DEVELOPMENTS

Funding awarded for redevelopment of services

3.1. On 29 September 2019 the Government announced that the Trust will be one of six trusts to share £2.7bn of Treasury funds to improve buildings and facilities. This is obviously wonderful news and will dramatically improve the environment for our patients, staff and visitors.

3.2. Over numerous years there have been a series of plans to transform the Trust's estate, however these have never been awarded the funding to proceed. The recently announced funding will now allow patients and staff to look forward to receiving and providing care in modern surroundings.

3.3. This excellent move forward was only possible due to the hard work and dedication of Helen Brown, deputy chief executive and her team who have been working tirelessly with colleagues in Herts Valleys Clinical Commissioning Group (HVCCG) to draw up possible options for the future of services in west Hertfordshire.

3.4. The Trust will continue to work closely with regulators and HVCCG to consider how the funding will be used and proposals will be shared as soon as possible.

Ministerial visit

3.5. Following the announcement that the Trust will receive Government funding, the Rt Hon Boris Johnson MP visited Watford hospital on 07 October 2019 to gain a better understanding of the need to improve the environment for patients, staff and visitors.

3.6. As well as meeting members of the executive team, the prime minister visited ridge ward where he met staff and patients and also met with the chief executive and colleagues of Hertfordshire Partnership NHS Foundation Trust for a conversation on mental health services. The prime minister concluded his visit with tea with two nurses who work in the emergency department.

Integrated care partnership

3.7. The Trust continues to work at pace and closely with colleagues in the Hertfordshire and West Essex Sustainability and Transformation Partnership (HWE STP) to develop an integrated care system (ICS) by April 2021.

3.8. Within the ICS there will be three geographical integrated care partnerships (ICP), with a fourth ICP around mental health still being considered. The three geographical ICPs are west Essex, east and north Hertfordshire and west of Hertfordshire. The ICS will act as a strategic planner and commissioner for the health and care needs of a whole population and will align the system in terms of strategy, commissioning and delivery. It will commission care from ICPs that focus care needs for specific population cohorts ICPs coordinate care delivery at place levels between multiple providers, reducing barriers between organisations and enabling a shift in focus from traditional disease or pathway based approach to a holistic and individual value based approach.

3.9. At its meeting in October 2019, the Board confirmed its support for the proposed development of an integrated care partnership for west Hertfordshire and agreed the key strategic milestones.

Local leadership changes

3.10. The chief executive of HVCCG, Kathryn Magson will be taking up a secondment at the end of December 2019 as the interim chief executive of health and social care on the Isle of Man.

3.11. The Trust wishes Kathryn well in her new role which will report directly to the Government's chief secretary and will be responsible for the delivery of excellent quality, patient and service-user focused health and social care on the island.

3.12. HVCCG are in the process of appointing a joint accountable officer and shared senior management team to cover the three clinical commissioning groups.

Staff choir

3.13. 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. Following auditions, a number of staff have been selected to join Gareth and take part in a multi-faith concert at Watford hospital in the run up to Christmas.

Black history month

3.14. A series of events for staff to celebrate the Trust's diverse workforce and the contributions made to the NHS were organised by the multicultural staff network group throughout October. The events celebrated national black history month and included film screenings, question and answer sessions and special menus in the restaurant.

Celebrating staff

3.15. Huge congratulations to Bonnie Sparkes, the Trust's clinical nurse specialist for safeguarding adults who has won the Nurse of the Year award at this year's Nursing Times Awards.

3.16. In June 2019 the Board heard about the innovative project that Bonnie is involved in, working with the police to support possible victims of human trafficking and modern slavery working in the sex trade. The project led to the development of a pioneering service giving advice, support and healthcare to possible victims, many of whom have been trafficked into the UK from Europe.

Supporting national healthcare campaigns

3.17. The following events were organised in October 2019 in support of national healthcare campaigns:

- Wellbeing cafes were held to mark world mental health day, as well as staff and patients contributing to a canvas which travelled across the three hospital sites.
- As part of world stroke day, staff were provided with information and reminded of the support available to reduce stress, depression, anger and anxiety which can help to increase the risk of stroke.
- Twitter was used to celebrate the outstanding contribution that allied health professionals play in patient care, as part of allied health professions day.
- Staff were encouraged to use a new app to support them to stop smoking as part of Stoptober.

4. BOARD NEWS

4.1. I'm pleased to report that I have been asked to serve a further term as a non-executive director at this Trust. My re-appointment has been made by NHS Improvement using powers delegated by the Secretary of State for Health. The new term of office will start on 01 December 2019 and end on 30 November 2020. I am very much looking forward to continuing to work over the coming years to help the Trust to deliver the very best care for every patient, every day.

4.2. As part of the monthly Board visit programme, the Board visited four areas at Watford hospital in October 2019, namely the dermatology outpatient department, sarratt ward and the pathology department. Verbal feedback from the visits has been received by the Board and will form part of a formal paper which is included later on this meeting's agenda.

5. KEY MEETINGS

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

- ICP planning
- Presented a staff award
- Attended a local chair's meeting
- Visited Andy Field, chair of Ashford and St Peter's Hospitals NHS Trust to look at the STP and IT plans
- Attended a number of committee meetings
- Undertook a walkabout at St Albans hospital
- Chaired an interview panel to appoint a consultant radiologist
- Met with David Williams, leader of the council, Hertfordshire County Council.

6. RECOMMENDATION

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

Phil Townsend
Chairman

November 2019

Trust Board Meeting
07 November 2019

Title of the paper	Chief Executive's report
Agenda Item	08/76
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.

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Agenda Item: 08/76

Trust Board meeting – 07 November 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. SERVICES

Improving patient flow

2.1. As part of the Trust's continued strategy to improve patient flow, a pilot to improve the medical 'take' is underway. The main aims of the pilot are to bring forward a speciality review of patients admitted as an emergency, maximise the use of non-admitted pathways such as ambulatory care and hot clinics and for the medicine division to work as a more integrated team with emergency medicine. The overall goal is to reduce emergency department waiting times and reduce the inpatient bed base, thus ensuring that the right patients are seen in the right place at the right time by the right team.

2.2. It is early days in the pilot, however initial signs are that there are improvements in the pathway and a reduced number of admissions. The Board received feedback on this important pilot in the private session of the Board meeting in October 2019 and will continue to be updated on progress in due course.

Changes in adult community health services

2.3. Central London Community Healthcare NHS Trust (CLCH) became the main provider of adult community health services in west Hertfordshire from 01 October 2019. This change means that staff on Simpson ward at Hemel Hempstead Hospital, who were employed by Hertfordshire Community Trust have now joined the Trust, as have the acute inpatient speech and language therapy team.

2.4. Over time, and in collaboration with the Trust and Herts Valleys Clinical Commissioning Group (HVCCG), CLCH will be developing a new integrated model of care, in line with NHS England's long term plan. The new adult community services contract between HVCCG and CLCH is designed to deliver a fully joined-up service between community, GPs, mental health, social care and voluntary services.

Preparation for a no-deal EU exit

2.5. As EU leaders have agreed a flexible extension to the EU exit date to 31 January 2020 in order for the UK to hold a General Election on 12 December 2019, the submission of daily situation reports and conference calls have been stood down at the current time. However, the Trust's internal planning group will continue to meet on a monthly basis.

2.6. Preparations for a 'no-deal' EU exit scenario remain high up the agenda with the national strategic commander, Keith Willetts continuing to lead on preparations. The risks remain as explained to the Board at its meeting in October 2019 and the Trust's executive lead continues to be the chief operating officer.

2.7. The Department of Health and Social Care announced in October 2019 that a new service to deliver urgent medicines and medical products into the UK has been set up as part of the EU exit preparations. The £25m contract to set up an express freight service will allow small parcels of medicines and products to be delivered within 24 hours, with the potential for larger quantities to be moved within two to four days.

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2.8. Safeguards in respect to the supply chain for all essential goods remains nationally managed and to date there are no local issues that are not mirrored nationally.

3. ESTATES INFRASTRUCTURE

Urgent treatment centre, Watford

3.1. Plans are progressing well to create a new urgent treatment centre at Watford, where patients who do not require secondary care facilities/expertise will be seen and treated. Additionally, there will be a new CT scanner installed in the emergency department, a new medical assessment unit adjacent to an expanded ambulatory care unit, and an expansion of the emergency department.

3.2. A procurement process to commission an organisation to run the urgent treatment centre service has been completed following approval of an outline business case by the Boards of both the Trust and HVCCG in October 2019. A preferred bidder has been identified, subject to approval of a full business case by this Board (item 19 on the meeting agenda) and the Board of HVCCG.

3.3. HVCCG has also supported the appointment of a programme director to facilitate the mobilisation of the contract from November onwards, with a plan to have the full service in place by the end of March 2020.

4. PEOPLE

Flu vaccination programme

4.1. In light of the news of the severity and early peak of Australia's flu season, it is pleasing to report that the Trust's 2019/20 flu vaccination campaign to keep patients and staff well over the winter months has got off to a good start with 50.2% of patient facing staff having been vaccinated at the time of this report being published. The campaign includes all staff and aims to decrease sickness absence, reduce the risk of cross-infection and to have a positive impact on the delivery of high quality care.

4.2. The Board will receive a full progress report later on this meeting agenda.

Clinical supervision programme

4.3. A new clinical supervision programme was launched in October 2019, which provides an opportunity for clinicians to meet with an experienced colleague to reflect on and review their own practices, discuss individual cases in depth and to learn from their supervisor's experiences in clinical practice.

Reverse mentoring

4.4. A new scheme aimed at educating leaders about diversity issues by exposing them to challenging and insightful conversations with BME staff is being planned. The scheme known as reverse mentoring will turn traditional mentorship on its head as Board members will become the mentees and colleagues from BME staff will become the mentors. The scheme will initially run for 12 months and will then be evaluated to realise the benefits and to improve on its effectiveness.

Staff payroll

4.5. Staff are now able to access their payslips, P60s and pension information online via a self-service portal. This is good news for the staff and also supports the Trust's move to have electronic payslips in place by the end of the financial year as part of its 'green' commitment to reducing paper consumption.

National staff survey

4.6. 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.

4.7. This year's survey has been launched and staff are being strongly encouraged to be honest and say what they think works well and where there's room for improvement. The Trust will use feedback to advance the work its doing to try to improve the working lives of all staff.

5. STRATEGY

Strategy refresh

5.1. Work is underway to create a five year Trust strategy that reflects the achievements of the past few years and the priority plans that will continue this journey and deliver the 'very best care, for every patient, every day'.

5.2. The strategy proposes a rebranding of the four key aims of Best People, Best Value, Great People and Great Place. The supporting strategies will be updated in 2020.

5.3. The strategy was discussed in detail by the trust management committee in October and a further series of internal and external engagement events are planned through to the end of November, with the aim of the Board receiving a draft for approval in December 2019.

6. COMMUNICATIONS

6.1. Please below for an overview of communication activity during September 2019. This covers regularly used key communication channels including press and media, website and social media.

Media

Date	Subject	Channel	Publication/channel	Reputation
3.9.19	***Disruption expected with Hemel Hospital phone line on Tuesday morning*** Health bosses warned there may be problems with direct dial telephone numbers at Hemel Hempstead Hospital in the early hours of Tuesday 3 September. The issue was related to planned maintenance work from 1-4am.	External reporting	Hemel Today	Neutral
10.9.19	• ***Herts Valleys CCG to face judicial review over hospital plans*** Herts Valleys CCG faces a judicial review over hospital redevelopment plans and a perceived lack of consultation.	External reporting	The Watford Observer and Herts Advertiser	Negative
12.9.19	***Nursing vacancies slashed at west Herts hospitals*** The number of nurses who want to work in west Hertfordshire hospitals is increasing – with the number of vacancies having dramatically decreased.	Press release	The Watford Observer	Positive
18.9.19	***The 11 Hertfordshire towns set to be transformed in the next few years following redevelopment plans*** West Hertfordshire is set for a £350 million redevelopment. Watford General Hospital as well as Hemel Hempstead and St Albans hospital sites will be majorly transformed after West Hertfordshire Hospitals NHS Trust approved a strategic outline case back in July.	External reporting	The Hertfordshire Mercury	Positive
24.9.19	***Construction expert questions plans for renovating west Hertfordshire hospitals*** Plans to renovate hospitals in west Hertfordshire have been slammed as unfeasible by an expert in hospital construction. In a 35-page report for the New Hospital Campaign, Mr Scott said there is "no prospect of constructing a credible redevelopment or new build plan within that limit", and described the feasibility of the plans as "unproven and the subject of major doubt".	External reporting	The Herts Advertiser	Negative
25.9.19	***Health campaigners' withering verdict on hospital plans for West Herts*** The verdict of health campaigners on the plans to rebuild Watford Hospital, rather than construct a new hospital on a greenbelt land, is that they are "unproven" and "the subject of major doubt".	External reporting	Gazette & Express	Negative

Date	Subject	Channel	Publication/channel	Reputation
27.9.19	***BBC Three Counties Radio*** A feature on The Andy Collins Show on BBC Three Counties Radio reported that plans to redevelop hospitals in west Hertfordshire could be scrutinised in the court and that West Herts and Herts Valleys CCG now say that a new planned care centre could be built on a new site with less investment at Watford.	External reporting	BBC Three Counties Radio	Negative
27.9.19	***New hospital best says build expert*** A construction expert claimed that a new hospital in south west Hertfordshire will be "more cost effective" than renovating Watford General Hospital. Robert Scott, a construction expert who was commissioned by the campaign group the New Hospital Campaign, was unimpressed with proposals to renovate Watford General, St Albans and Hemel Hempstead Hospitals.	External reporting	The Watford Observer	Negative
29.9.19	***West Herts Hospital Trust to receive major investment*** West Herts is set to see huge investment, Health Secretary Matt Hancock confirmed. The UK government announced West Herts Hospitals Trust is one of six recipients of £2.7 billion funding. WHHT and Herts Valleys CCG has been fighting for a £350 million investment.	External reporting	The Watford Observer	Positive

Website

	Total page views	Total unique page views	Number of unique visitors
September 2019	292,545 (+1.6%)	109,231 (+1.75%)	33,766 (+3.3%)
August 2019	287,822	107,344	32,693

Social Media

Twitter	Followers	Posts	Retweets	Engagement rate (for total of all monthly posts)
September 2019	7,036 (+1.1%)	144 (+1.9%)	355 (+108%)	1.8% (+50%)
August 2019	6,959	102	170	1.2%

The Trust's most popular tweet with 26,979 impressions, 60 likes and 12 retweets was:

Facebook	Page likes	Posts	Average reach
September 2019	2,639 (+2.2%)	54 (58%)	2,262 (+2.6%)
August 2019	2,581	34	2,203

Our most popular Facebook post in September with 440 reactions, 1,304 people engaging with the post, 26 shares and a reach of 5,519 was:

7. RECOMMENDATION

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

Christine Allen
Chief Executive

November 2019

Trust Board Meeting
07 November 2019

Title of the paper	Board assurance framework report						
Agenda Item	09/76						
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 objectives are being appropriately mitigated, to consider those elements that report direct to Board and any escalated from Board to Committees with regard to gaps in control or assurance. The majority of risks are managed through Board committees, supported by reports to the Board. The Board Assurance Framework (BAF) has been cross referenced against the operational risks on the corporate risk register. Over the past months, the BAF has been reviewed and refreshed. As well as reflecting the 2019/20 corporate objectives and the updated corporate governance structure, the opportunity has also been taken to review the format of the BAF to ensure that it allows the Board to be fully aware of the risks to the Trust not meeting the corporate objectives. A review of a wide range of different formats has been undertaken, looking at best practice and also the formats used by trusts that have achieved an outstanding rating from the Care Quality Commission. The Board can take assurance that since the last Board meeting, the Audit Committee reviewed the risk management arrangements and was assured that the Trust had sufficiently robust controls in place to manage risk. In October 2019, specific components of the BAF were reviewed by the appropriate committees (Quality, Finance and Performance and People, Education and Research). Two recommendations by lead committees of changes to the BAF are detailed in the report for approval. The development of the BAF is ongoing and, from discussions at committee meetings in October, it was recognised that the assurances outlined in the BAF required further refinement in order to provide the Board with full assurance/evidence that appropriate levels of mitigation was in place across a number of 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	• Finance and Performance Committee – 31 October 2019 • People, Education and Research Committee – 31 October 2019 • Quality Committee – 31 October 2019			
Action required	The Board is asked to approve the recommended changes made by the lead committees.			

Agenda Item: 09/76

Trust Board meeting – 07 November 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 escalated from Board to Committees with regard to gaps in control or assurance.

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. In short, a BAF is a list of the promises made by the Trust and an assurance that these will be delivered despite all the challenges faced by the Trust on the way. The BAF "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 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. Analysis/discussion

3.1 The current BAF can be found in appendix 1, (not inclusive of the recommended changes below). A different format is being utilised to enhance the BAF's effectiveness and enable Board members to more easily focus on those elements that require further action. This followed a review of other BAFs in existence. Whilst there were several different formats, it was felt that the refreshed BAF now enables all the information to be included and presented in an easy to understand format.

3.2 The previous robust monthly committee review process has now resumed, whereby each month the components of the BAF are reviewed by the responsible executive lead and the appropriate assurance committee and recommendations of proposed changes are brought to the Board's attention.

3.3 The Board can take assurance that since the last Board meeting, the Audit Committee has reviewed the risk management arrangements on 18 October 2019 and was assured that the Trust had sufficiently robust controls in place to manage risk.

3.4 The Board should note that this and future Board meeting agendas are aligned to the risks on the BAF to help to drive the work of the Board and determine where to make the most effective use of resources in order to improve the quality and safety of care.

3.5 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. The BAF identifies strategic risks at quite a broad level over a full-year period; therefore the risks are not expected to change significantly over a year, although the key controls and assurance elements may do. The Trust's risk register identifies the precise day-to-day risks that make up those broad principal risks and those entries may stay relatively stable for the year or change day by day.

4. Monthly review

4.1 Elements of the BAF were reviewed on 31 October 2019 by the Quality Committee; People, Education and Research Committee and the Finance and Performance Committee. The following changes are recommended to the Board for approval.

Risk no.	Risk description	Executive lead	Lead committee	Recommendation
5c:	Failure to identify clinical capacity within job plans to support enhanced research capacity	Chief Medical Officer	People, Education and Research	It is recommended that the narrative of this risk be re-defined and the rating reduced to medium.
10a:	Failure to achieve a successful and safe transition to a new IT provider	Chief Information Officer	Trust Management Committee	The Trust has successfully transitioned to a new IT provider. Therefore it is recommended that this risk is removed from the BAF. An exit report is available as evidence of the successful transition.

4.2 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 gain approval to upgrade the LAN is being developed and will be presented to the Board in December 2019.

4.3 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 national emergency department access standards	The performance report on access targets and integrated performance report under item 10 and 11.
4b	Non-delivery of the national planned care access standards	
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.

5. Next steps

5.1 The BAF now includes the three lines of defence model; divisional management assurance is the first line of defence in risk management, the established committee oversight function is the second line of defence, and independent assurance is the third. Following discussion at committee meetings in October 2019, it was recognised that the assurances outlined in the BAF require further refinement in order to provide the Board with full assurance/evidence that appropriate levels of mitigation was in place. This work will take place over the next.

5.2 The standard operating procedure for the BAF will be updated to reflect the new format and will be circulated to appropriate staff.

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 approve the recommended changes made by the lead committees.

Christine Allen
Chief Executive

November 2019

Appendix 1 Board Assurance Framework

		OBJECTIVE	Detailed objective	LINKED STRATEGIES & ACTION PLANS	Metrics / monitoring mechanism	BOARD ASSURANCE	Lead Executives
AIM ONE: BEST QUALITY CARE	1.	To deliver excellent clinical outcomes for our patients - mortality - harm free care *Full suite of quality and outcome indicators reported in the Integrated performance report.*	1.1 To sustain expected or better than expected performance on key mortality indicators (SHMI and HSMR)	Learning from deaths action plan	SHMI & HSMR	Quality Committee	Chief Medical Officer
			1.2. Top quartile performance for harm free care by 2020	Quality Account	Nationally specified harm free care metrics	Quality Committee	Chief Medical Officer/ Chief Nurse
	2.	To implement best practice, integrated care pathways and reduce unwarranted clinical variation in care and outcomes.	2.1 Working with the RFL group, implement a minimum of 8 standardised ' in hospital' pathways per year, with demonstrable improvement in consistency of care and improved outcomes.	Royal Free Partnership Work Plan	Pathway specific metrics to be agreed on a pathway by pathway basis	Quality Committee	Chief Medical Officer
			2.2 To work with partners to redesign 'end to end' care pathways, integrate care and reduce unnecessary visits to hospital for our patients. *(Full programme to be agreed with the CCG via the QIPP Board)*	Joint QIPP work plan	Overarching metrics to be defined (e.g. % non face to face OP activity, split of activity by site) & specific metrics to be agreed on a pathway by pathway basis	Quality Committee	Deputy Chief Executive
			2.3 To develop patient centred planned and ambulatory care pathways [note 1]	Trust Strategy / Interim estate strategy		Quality Committee	Chief Operating Officer / Divisional Director of Emergency Care
			a. surgical and cancer services – maximising the St Albans City Hospital site.			Quality Committee	Divisional Director Surgery, Anaesthetics and Cancer / Divisional Director Clinical Support Services
			b. medical services – maximising the Hemel Hempstead General Hospital site.			Quality Committee	Divisional Director of Medicine / Divisional Director Clinical Support Services
			c. women's and children's services			Quality Committee	Divisional Director of Women's and Children's
	3	To implement & embed our 'quality commitment' and 'west Herts way' quality improvement methodology	3.1 Develop / commission QI training programme for clinical and support staff to ensure consistent QI approach embedded across the organisation and staff skills and capability strengthened.	Quality Account	Number of staff trained in wHw QI methodology (detailed metrics TBC)	Quality Committee	Chief Nurse
			3.2 To roll out our ward accreditation scheme to all wards in 2018/19. All wards achieving 'silver' by December 2020.	Quality Account	% Wards achieving silver rating or higher.	Quality Committee	Chief Nurse
	4	To improve patient experience and the responsiveness of our services.	4.1 Improved waiting times for emergency and urgent care (Emergency care access standards)	Emergency Care Transformation Plan	ED capacity breaches % streaming (admitted and non admitted) Internal professional standards % performance	Quality Committee	Chief Operating Officer / Divisional Director of Emergency Medicine
			4.2 Improve discharge processes and reduction in long lengths of stay.	Patient Flow Transformation plan	Bed capacity breaches % discharges via discharge lounge Reduction in IP LOS > 21 days	Quality Committee	Chief Medical Officer / Chief Operating Officer / Divisional Director of Medicine
			4.3 Improved waiting times for planned care (18 week RTT access standard)	RTT Improvement Plan	performance against RTT standards	Quality Committee	Chief Operating Officer / Divisional Director of Medicine / Divisional Director of Surgery

4.4 Improved waiting times for cancer (cancer access standards)	Cancer Improvement Plan	performance against cancer standards	Quality Committee	Chief Operating Officer / Divisional Director of Medicine / Divisional Director of Surgery
4.5 Maintain excellent access to diagnostics (diagnostics 6 weeks standard)	~	performance against diagnostic standards	Quality Committee	Chief Operating Officer / Divisional Director Clinical Support Services
4.6 Deliver patient experience improvements as set out in the quality account.	Quality Account	as per metrics in QA once finalised	Quality Committee	Chief Nurse / relevant executive director leads.

AIM TWO: A GREAT PLACE TO WORK AND LEARN	5	To further develop the Trust's participation in Research and Development.	5.1 Exceed Clinical Research Network Recruitment targets	R&D strategy		People, Education and Research Committee	Chief Medical Officer
			5.2 Increase income from NIHR commercial research (target 20% increase over 2 years)		NIHR research income		
			5.3 Increase applications to funders of research, particularly the NIHR and NIHR partner grants (minimum 3 bids per annum).		Number of applications for research grants		
	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 clinically led organisation.	6.1 To achieve improved scores in the 2018 & 2019 staff surveys, aiming to be a top 20 performing acute trust by 2019.	Workforce Strategy & staff survey action plan Medical engagement action plan	Annual staff survey results & local temperature checks. Analysis of key questions in staff survey by professional group (Band 8a and above).	People, Education and Research Committee	Chief Medical Officer / Chief Nurse / Chief People Officer
			6.2 To have improved in seven out of the nine indicators which make up the WRES (Workforce Race Equality Standard)	WRES ACTION PLAN			Chief People Officer
	7	To reduce vacancy rates & reduce our reliance on agency workers.	7.1 To reduce the overall trust vacancy rate to 9%	Recruitment & Retention action plan	IPR metrics	People, Education and Research Committee	Chief People Officer
			7.2 To reduce the vacancy rate for Band 5 nurses to 16%				
			7.3 Turnover rates to reduce to 14% by 01/04/19 and 12% by 01/04/20				
			7.4 To have in place a number of 'new' roles:		WTE ANPs WTE Nurse associate roles WTE support ODP roles	People, Education and Research Committee	
			• 16-20 new Advanced Nurse Practitioners –				
			• Creation of 30 new Nurse Associate roles				
			• 15 new support ODP roles				
	8	To become an excellent organisation for employee development.	8.1 To achieve Teaching Hospital Status by April 2020.	(to be developed)	Teaching Hospital Status achieved	People, Education and Research Committee	Chief Medical Officer / Chief People Officer
			8.2 Apprenticeships: To be drawing down at least 80% of the apprenticeship levy by 31/3/2020, with apprenticeships available to both existing and new staff in both clinical and non-clinical fields. To have a pass rate in line with national requirements.	Apprenticeship Levy Action Plan	Apprenticeship Levy draw down		Chief People Officer
			8.3 Educational Compliance: To maintain core and essential training levels at 90%	Workforce Strategy	Core and essential training % compliance		Chief People Officer
			8.4 Leadership and Management Sessions: To have in place clear development options for every banding of role within the Trust.	Workforce Strategy	Numbers of staff accessing leadership and management training by grade	People, Education and Research Committee	Chief People Officer
			8.5 To have instituted a coaching service within the Trust that provides, on demand, leadership, professional and/or career coaching to all staff requiring it, either on self or manager referral with coaches to be drawn from volunteers within the Trust, trained and supervised to ICF standards and the service underpinned by Trust policy.	Workforce Strategy	WTE staff who have received in house coaching Number of sessions coaching per month WTE staff trained to provide coaching		Chief People Officer
			8.6 Ensure staff feel supported to access appropriate training and development to help them fulfil their role and develop their potential.	Workforce Strategy	Analysis of key questions in staff survey by professional group		Chief People Officer

AIM THREE: IMPROVE OUR FINANCES	9	To deliver best value care.	9.1 Deliver our in-year financial plan.	Finance plan	Year end financial outturn vs plan.	Finance and Performance Committee	Chief Financial Officer
			9.2 Demonstrate year on year improvement in the Trust's underlying financial position and performance against key value for money metrics. *(E.G. model hospital, Carter metrics)*	CIP	Improvement of Underlying deficit (vs Plan). (see appendix 1 for metrics)	Finance and Performance Committee	

AIM FOUR: A STRATEGY FOR THE FUTURE	10	To improve our IT and move towards full digitisation.	10.1 Successful and safe transition to new IT outsourced provider, with some service improvement	IT strategy and refreshed roadmap	Business cases to set out expected benefits and measures. Post project reviews to report on benefits delivery.	Board	Chief Information Officer
			10.2 Business case approved for Electronic Health Records produced and approved subject to availability of external funding			Board	
			10.3 Implement scanning and electronic document management for medical records. (One year			Board	
			10.4 Business case approved for new Local Area Network (LAN). Implementation of new network commenced by Dec 2019, majority complete by Mar 2020.			Board	
			10.5 Implement a review of structures and ways of working in the IT department that ensure a more successful hybrid model and ensure the new ITO provider is a success			Board	
			10.6 Implement remote access to radiology and other specialty images. (March 2019)			Board	
			10.7 Meet the compliance requirements of GDPR and Data security toolkits and associated audits	GDPR implementation plan	Information governance breaches	Board	
	11	To work with local stakeholders and partner organisations to identify where, by working together, we can improve care for our patients.	11.1 proactively communicate and engage with local communities and stakeholders in the development and delivery of services, continuing to build confidence and trust of the local community.	stakeholder strategy	stakeholder strategy metrics	Board	Director of Communications
			11.2 Demonstrate active engagement in the HWE STP & the development of an integrated care system for HWE.	STP Health and Care Strategy	n/a	Board	All
			11.3 Contribute to the development of an integrated care partnership for West Hertfordshire.	(Integrated care partnership 'brief' to be developed)	n/a	Board	Chief Financial Officer
			11.4 Work with HVCCG to test new contractual forms that share risk and support innovation.	QIPP plan	% contract income covered by new contracting models	Board	Chief Financial Officer / Director of Integrated Care
			11.5. To formalise our partnership with the Royal Free Group and deliver the agreed work plan. *(see also objective 2.1)*	Royal Free Partnership MOU	As set out in RFL benefits log.	Board	Deputy Chief Executive / All
	12	To improve the quality of our estate & implement our service driven estate strategy	12.1 Deliver 2018/19 priority one capital programme.	Capital programme	Capital expenditure vs plan Estate compliance metrics	Board	Deputy Chief Executive / Director of Estates
			12.2 Development control plans and business cases to deliver the strategic priorities set out within the interim estate strategy. Secure funding via STP and ITTF applications and explore full range of alternative funding options. (ED phase two, Theatres FBC, neonatal & maternity, business cases to optimise WGH, SACH and HHGH.)	Interim estate strategy implementation plan	DCPs x 3 Agreed programme, business cases completed & additional funding secured	Board	Deputy Chief Executive
			12.3 New multi-storey car parking at WGH (business cases completed and approved, construction commenced. Target opening 2020.)	Interim estate strategy implementation plan	Multi-storey car park @ WGH in construction phase by 2020.	Board	Chief Financial Officer

			12.4 Outline business case/s, approvals and agreed way forward for long term redevelopment of our hospitals.	Programme Plan to be developed following SOC approval.	Business cases approvals & clear programme in place for WGH, SACH and HHGH.	Board	Deputy Chief Executive

[i] Links / co-dependent with capital and interim estate strategy.

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 EXECELLENT 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	Consultant coders and medical examiners established. SJR process embedded	1. Morbidity and mortality meetings 1. Divisional Governance meetings 1. 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	
	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	
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	Campaign started. Paper received by Quality Committee Progamme developed. Awaiting approval from Trust Management Committee

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 4. **TO IMPROVE PATIENT EXPERIENCE AND THE RESPONSIVENESS OF OUR SERVICES**	4a	Non-delivery of the national emergency department access standards	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 national planned care access standards - 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, and some are adverse to 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 ent of the risk 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	Ongoing annually	
	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	Chief executive to present the Trust's views on any funding cuts at the CEO's meeting	Chief Executive		
	5c	Failure to identify clinical capacity within job plans to support enhanced research capability	Chief Medical Officer	People, Education and Research			High	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	Ongoing annually	
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 known culture issues in 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	Ongoing annually	
	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	Culture change of this nature takes time. Limited BAME representation at senior levels of the organisation	To further promote development opportunities for BAME staff To establish programme of reverse mentoring	Chief People Officer	Ongoing annually	

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.	Currently recruiting to Head of Medical Resourcing and seeking to strengthen team with better skill mix.	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.						
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	This is in early stages and so still more information required to inform steps to be taken and exact timescales.	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.	Establishing a formal senior workforce group where this can be tracked and will report to TMC and PERC on progress.	Chief People Officer	Dec-19		
	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.	Subjects that require practical training experiencing DNAs currently which wastes capacity in these sessions.	Agreeing communications to managers in line with policy to follow up on non attendance	Chief People Officer	Ongoing		
	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.	Not fully utilising apprentice levy currently so more scope available to develop apprenticeships.	Apprenticeship group established to review use of this locally and link up with STP.	Chief People Officer	Ongoing		

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 ent of the risk 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 Ongoing 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

What the organisation aims to deliver (outcome required)	Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving ent of the risk 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					
	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				
	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	
	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	

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	

OUR VALUES
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Trust Board Meeting
07 November 2019

Title of the paper	**Performance report on access standards**
Agenda Item	**10/76**
Presenter	**Sally Tucker, Chief Operating Officer**
Author(s)	**Jane Shentall, Director of Performance**
Purpose	*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%	83.0%	↑
Diagnostic waits	99%	99.7%	↔
RTT incomplete pathways < 18 weeks	92%	85.8%	↑
52 week waits	0	3	↓
2 week wait referrals	93%	93.3%	↑
2 week wait breast symptomatic referrals	93%	100.0%	↑
31 day first definitive treatment	96%	94.9%	↓
31 day subsequent - surgery	94%	100.0%	↔
31 day subsequent - drug	98%	94.1%	↓
31 day subsequent - palliative	94%	100.0%	↔
31 day subsequent - other	94%	100.0%	↔
62 day referral to first treatment	85%	85.7%	↑
62 day screening referral to first treatment	90%	64.0%	↓

↑ 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 (September 99.7%).

There has been good improvement in ED performance at 83.0% (from 80.5%) although the position remains adverse to plan (88%).

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	Performance against the RTT 92% standard is similar to the previous month, at 85.8% and is just below the trajectory plan (86%) for the month. There were three 52 week breaches at month end, all patient choice delays. Harm reviews continue but there has been no increase in the number of harms reported, which remains at 12 Orthopaedic patients (no change) and 7 Urology patients (was 3) identified as incurring a low degree of harm as a result of delays to treatment. Two week wait and two week wait breast symptomatic performance is compliant. There has been significant improvement in performance against the 62 day first treatment standard, at 85.7% (target 85%) and is better than plan, but the 62 day screening position is currently below target. The 31 day first and 31 day subsequent drug targets have also not been met.
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: Trust Management Committee — Date: 30 October 2019 Committee/Group: Finance & Performance Committee — Date: 31 October 2019
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.

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Agenda Item: 10/76

Trust Board meeting – 07 November 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.

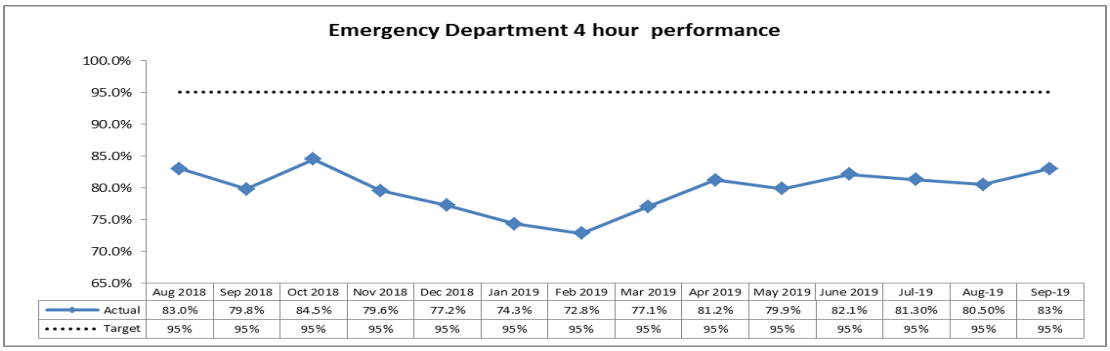
2. Indicators not achieved in the reporting period

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

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	83.0%	↑
Ambulance handovers between 30-60 minutes	0	351	↓
Ambulance handovers over 60 minutes	0	102	↑
RTT incomplete pathways < 18 weeks	92%	85.8%	↑
52 week waits	0	3	↓
31 day first definitive treatment	96%	94.9%	↓
31 day subsequent treatment - drug	98%	94.1%	↓
62 day screening referral to first treatment	90%	64.0%	↓

3 A&E 95% target

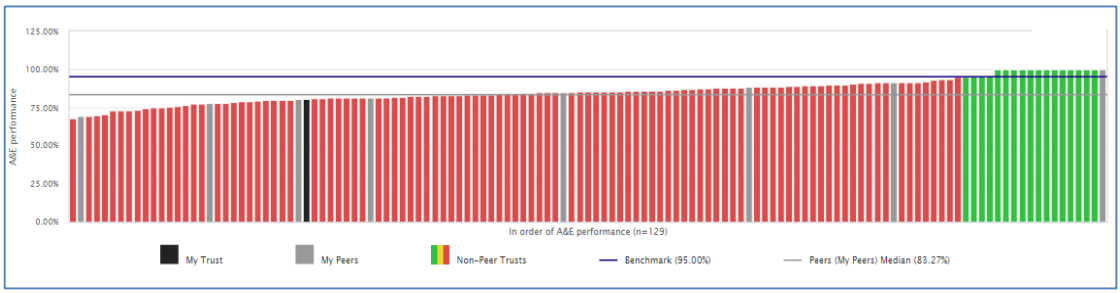
3.1 Performance is much improved at 83.0% (from 80.5%). Compliance with the standard was maintained at MIU (100%) and UTC (99.4%). Minors performance has improved further, at 94.9% (last month 93.4%), as has Majors at 57.3% (from 54.0%). However, CED performance was lower than the previous month (97.1%) at 92.9%.



	Aug 2018	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
Actual	83.0%	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%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

3.2 Benchmarking using Model Hospital shows WHHT placed 100th of 129 providers in terms of A&E performance in August 2019 (latest available period) with a regional peer median of 86.4% and a national median of 85.2%.

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 83.2%.



3.3 WGH attendances were higher than in the previous month, and 11.4% higher when compared with September 2018 and the 2019/20 year to date total (52902) is 8.3% up on the same period last year (48851).

2019/20 Month	% Increase on 18/19	WGH atts 2019/20	WGH atts 2018/19	WGH only 2019/20	WGH only 2018/19
April	10.3%	8586	7787	71.5%	82.0%
May	3.5%	8818	8516	68.8%	79.8%
June	4.0%	8650	8316	72.1%	78.9%
July	8.6%	9316	8578	70.9%	75.5%
August	12.6%	8537	7579	70.4%	74.5%
September	11.4%	8995	8075	74.0%	69.6%

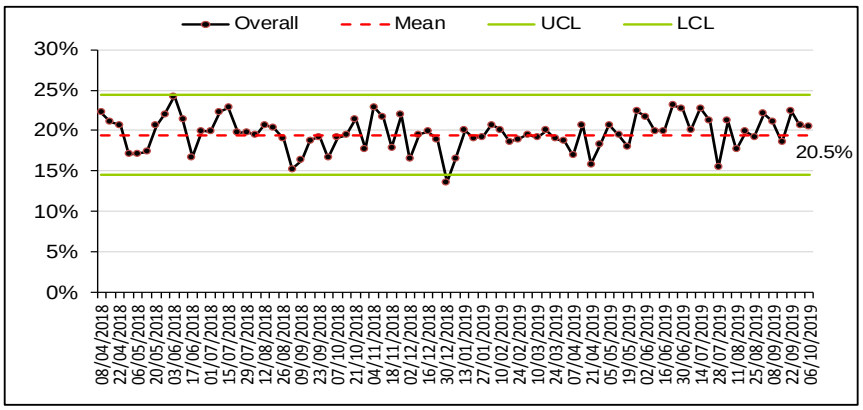
3.4 There was little change in the number of ED arrivals by ambulance this month (September 2641 / August 2668). However, comparison with 2018/19 shows that the monthly total this year was just over 10% higher, and a little over 7% when comparing year to date totals (15923 vs 14864).

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

4 Ambulance Handover Delays

4.1 Delays between 30 and 60 minutes deteriorated (351 vs 332), but there was good improvement in delays over 60 minutes (102 vs 195). 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.

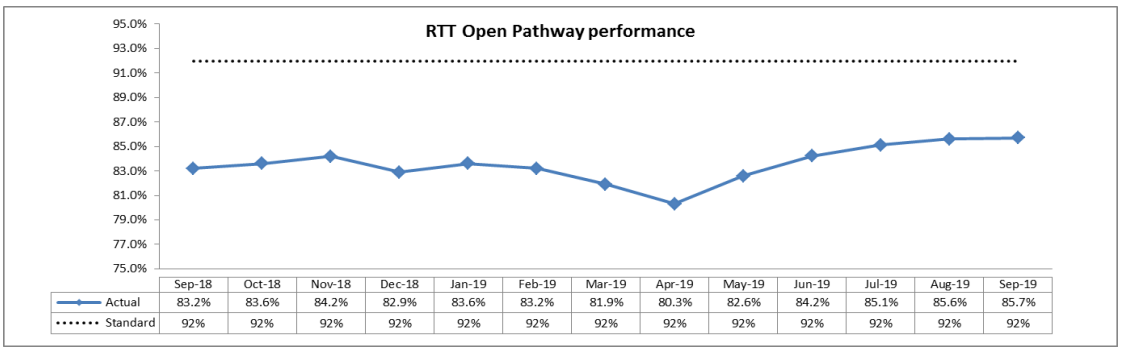
4.2 Patient flow is also dependent upon timely availability of inpatient beds. The Discharge Working Group, chaired by the Chief Medical Officer, oversees a number of work streams focusing on improving discharge processes, one of which is intended to increase the number of discharges before midday. The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



5 RTT Incomplete pathways

5.1 Performance against the 92% open pathway RTT standard is slightly higher than the previous month, at 85.8%.

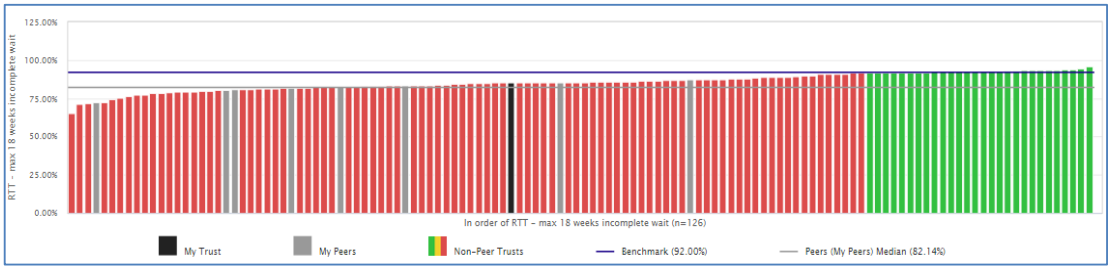
At divisional level, Clinical Support Services, Women's & Children's Services and Medicine remain compliant. The trend of improvement seen in Surgery, Anaesthetics & Cancer has been maintained, at 78% achieved this month. Service level detail is included in appendix 2.



	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
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%	85.7%
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

5.2 Benchmarking using Model Hospital shows WHHT is placed 72nd of 126 providers in terms of RTT incomplete pathway performance in July 2019 (latest available period as at 25th October), the national sector median being 85.5% and the regional median 84.8%.

The chart below benchmarks WHHT with the Nightingale Group (see p4) where the median is 82.1%.



5.3 The total PTL size has reduced (September 22738 / August 23610) and remains lower than that of March 2019 (24178) as does the backlog over 18 weeks, with 27% fewer non-compliant pathways when compared with April 2019 (3219 vs 4653).

5.4 No breaches of the 28 day rebooking rule occurred in September.

6 52 week waits

6.1 At the end of September there were three patients whose waiting time exceeded 52 weeks. Despite offered dates within the 52 week period, the patients opted to defer treatment until September.

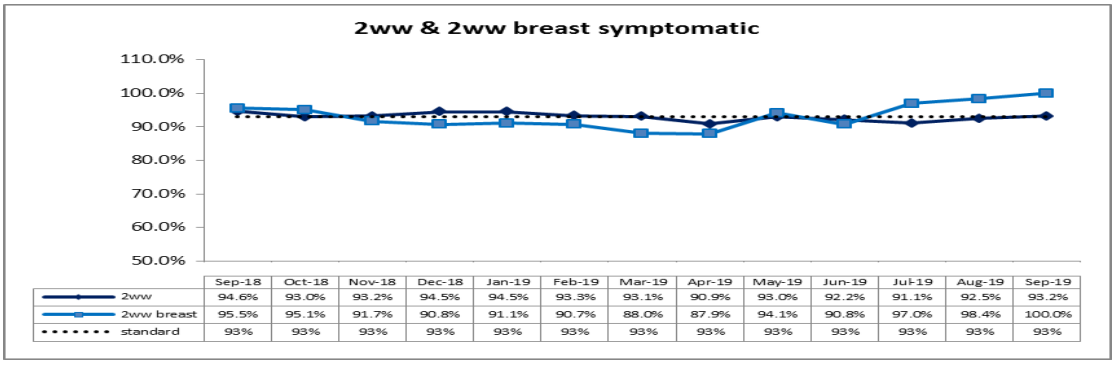
6.2 Harm reviews for patients whose wait exceeds 48 weeks continue. There has been no change in the number of harms identified, which remains 12 Orthopaedic and 7 Urology patients (previously 3) are considered to have experienced harm (low degree,) in the form of prolonged or increased levels of pain 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.

7 Cancer Waiting Times Performance

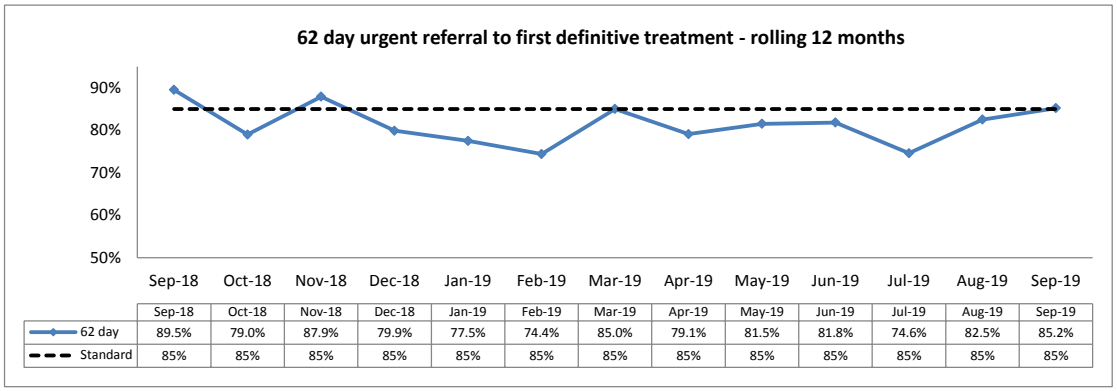
7.1 62 day referral to first treatment performance has improved and is better than target (85%) at 85.7%.

The 62 day screening target has not been achieved. The current position of 64% represents 4.5 breaches within 12.5 pathways. Of these, 4 were in lower GI (from bowel screening). Patient choice was a factor with delays occurring before colonoscopy which resulted then in late referral to the lower GI team. In 2 breaches, the patient was unwell or unfit during part of the pathway resulting in delays.

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



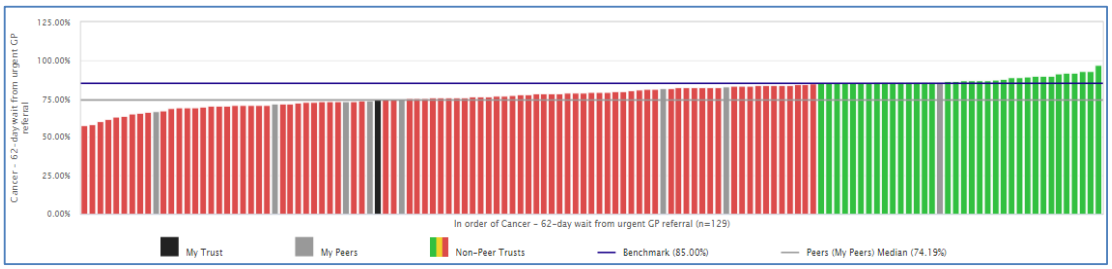
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
2ww	94.6%	93.0%	93.2%	94.5%	94.5%	93.3%	93.1%	90.9%	93.0%	92.2%	91.1%	92.5%	93.2%
2ww breast	95.5%	95.1%	91.7%	90.8%	91.1%	90.7%	88.0%	87.9%	94.1%	90.8%	97.0%	98.4%	100.0%
standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%



	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
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%	85.2%
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

7.2 Benchmarking using Model Hospital shows WHHT ranked 92nd of 129 providers in terms of the 62 day urgent referral to first definitive treatment standard in July 2019 (latest available period as at 25th October), the national sector median being 79.1% and the regional median 73.7%.

The chart below benchmarks WHHT with the Nightingale Group (see p4) where the median is 74.2%.



8 Performance Improvement Plans

8.1 Performance against the trajectories is detailed in appendix 4.

8.2 RTT performance at 85.8% is just below plan (86%). A significant factor here is the reduction in the number of pathways under 18 weeks (almost 700 fewer pathways this month) which has offset the improvement in backlog reduction.

8.3 Two week wait performance is compliant and in line with the trajectory plan. The improvement in performance has been achieved through the reduction in polling ranges, which mean that if the first appointment offered is declined, there is still time within the 14 day window to rebook within the target. This has been particularly successful in 2 week wait breast symptomatic, where 100% compliance was achieved in September.

8.4 Performance against the 62 day cancer standard has improved considerably and is better than plan. Actions at service/tumour site level are progressing well. Significant developments include the establishment of a lung cancer action group where pathway review and redesign is overseen and a year's fixed term post, funded from STP monies to review and revise the prostate pathway has been confirmed and the post holder took up post this month.

8.5 ED performance remains adverse to plan although the gap between performance and target has reduced. A review of the improvement plan and relevant KPIs has been progressing, while roles and day to day responsibilities have been confirmed with regard to oversight of specific areas and associated performance.

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 Board 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 – September 2019

Service	18 Weeks Plus	% Under 18 Weeks
GENERAL MEDICINE	0	100.00%
ANAESTHETICS	0	100.00%
PAED CLINICAL HAEMATOLOGY	0	100.00%
STROKE MEDICINE	0	100.00%
TRANSIENT ISCHAEMIC ATTACK	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
CLINICAL NEUROPHYSIOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
OBSTETRICS	0	100.00%
GYNAECOLOGICAL ONCOLOGY	0	100.00%
ORTHOPTICS	0	100.00%
ORTHOTICS	0	100.00%
CLINICAL ONCOLOGY	0	100.00%
NEPHROLOGY	1	98.21%
HEPATOLOGY	1	98.08%
PAED DERMATOLOGY	2	97.78%
GYNAECOLOGY	20	97.69%
DERMATOLOGY	57	96.95%
RESPIRATORY MEDICINE	17	96.04%
PAED ENDOCRINOLOGY	1	96.00%
ENDOCRINOLOGY	16	95.54%
CARDIOLOGY	72	94.90%
PAEDS	44	94.44%
BREAST SURGERY	13	94.37%

Service	18 Weeks Plus	% Under 18 Weeks
GASTROENTEROLOGY	107	93.50%
CLINICAL HAEMATOLOGY	17	93.25%
GERIATRIC MEDICINE	8	92.59%
RHEUMATOLOGY	38	92.35%
PAED EPILEPSY	1	92.31%
NEUROLOGY	88	92.11%
DIABETIC MEDICINE	6	91.78%
PAED GASTROENTEROLOGY	8	91.11%
PAED CARDIOLOGY	10	90.83%
COLORECTAL SURGERY	59	85.85%
GENERAL SURGERY	248	84.88%
PAED OPHTHALMOLOGY	38	83.97%
PAED UROLOGY	38	82.16%
TRAUMA & ORTHOPAEDICS	404	81.28%
OPHTHALMOLOGY	311	80.98%
UPPER GI SURGERY	7	79.41%
ENT	457	75.76%
VASCULAR SURGERY	46	75.27%
ORAL SURGERY	362	74.63%
ORTHODONTICS	35	74.26%
UROLOGY	498	73.58%
PAIN MANAGEMENT	188	68.72%
OTHER	1	0.00%
Total	**3219**	**85.84%**

Appendix 3

Cancer waiting times performance – update (at 31/10/19)

Standard	Target	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	YTD
2ww	93.0%	94.6%	93.1%	93.3%	94.1%	94.8%	93.2%	93.0%	91.3%	93.0%	92.3%	91.1%	92.5%	93.2%	92.4%
2ww breast	93.0%	95.5%	96.0%	91.6%	90.8%	91.1%	90.7%	88.0%	87.4%	94.1%	90.8%	97.0%	98.4%	100.0%	95.0%
31 day 1st	96.0%	97.0%	94.1%	96.9%	97.9%	97.5%	97.7%	97.7%	99.4%	96.8%	98.2%	98.9%	96.5%	94.9%	96.8%
31 day surgery	94.0%	85.7%	95.7%	100.0%	100.0%	92.6%	96.3%	100.0%	100.0%	95.0%	93.8%	100.0%	100.0%	100.0%	97.2%
31 day drug	98.0%	100.0%	100.0%	100.0%	100.0%	97.1%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	99.4%
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%	100.0%	63.6%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	N/A	100.0%	N/A	N/A	100.0%	100.0%
62 day	85.0%	89.5%	77.6%	87.4%	78.7%	77.5%	74.3%	84.2%	78.9%	83.1%	81.8%	74.6%	82.5%	85.7%	80.2%
62 day screening	90%	95.2%	92.6%	66.7%	86.7%	90.0%	80.0%	75.0%	100.0%	100.0%	64.7%	90.3%	83.3%	64.0%	80.0%

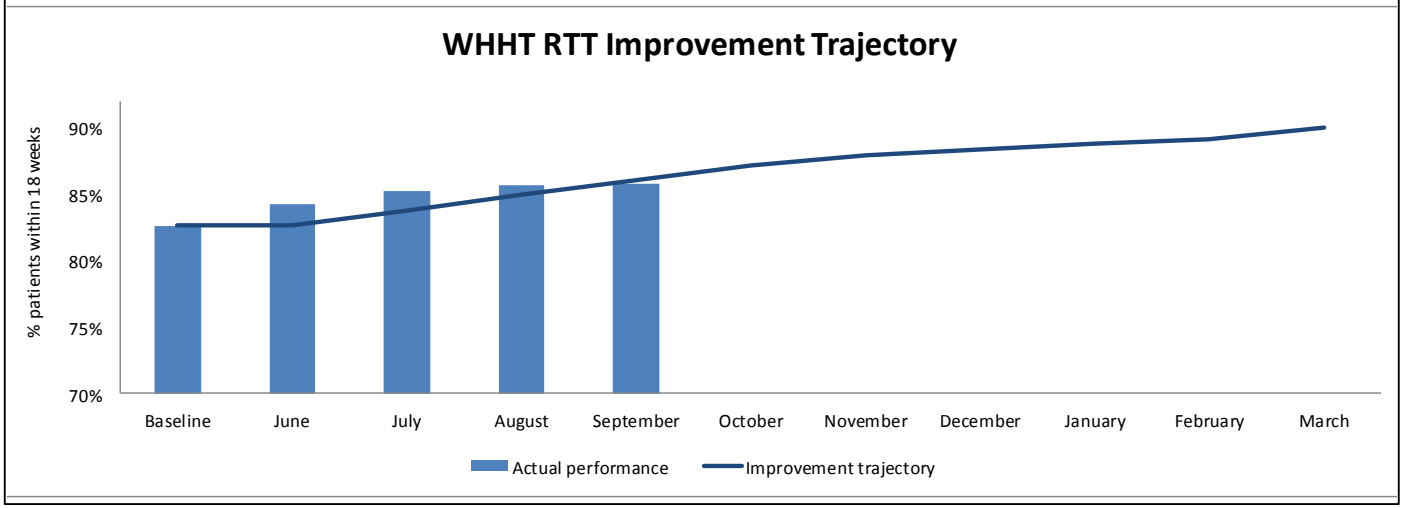
NB: performance is provisional at the time of writing

Appendix 4

RTT Improvement trajectory

Trajectory Plan - RTT

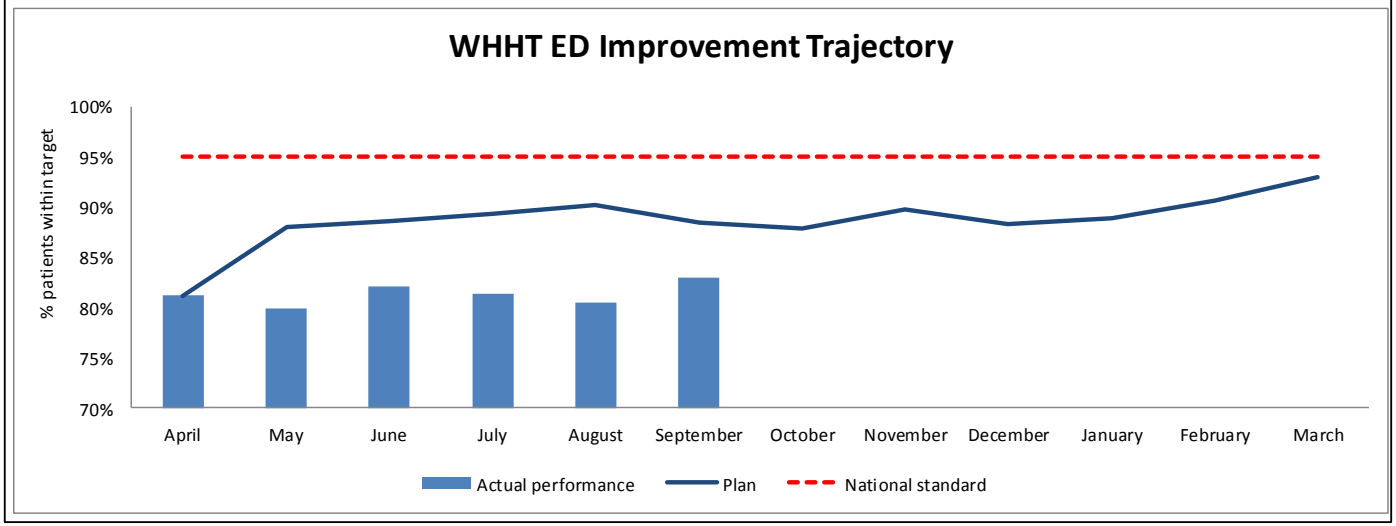
Trust	Baseline	June	July	August	September	October	November	December	January	February	March
National standard		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Plan	82.6%	82.7%	83.8%	84.9%	86.0%	87.1%	87.9%	88.4%	88.8%	89.2%	90.0%
Actual performance	82.6%	84.2%	85.2%	85.6%	85.8%						



ED Improvement trajectory

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%						

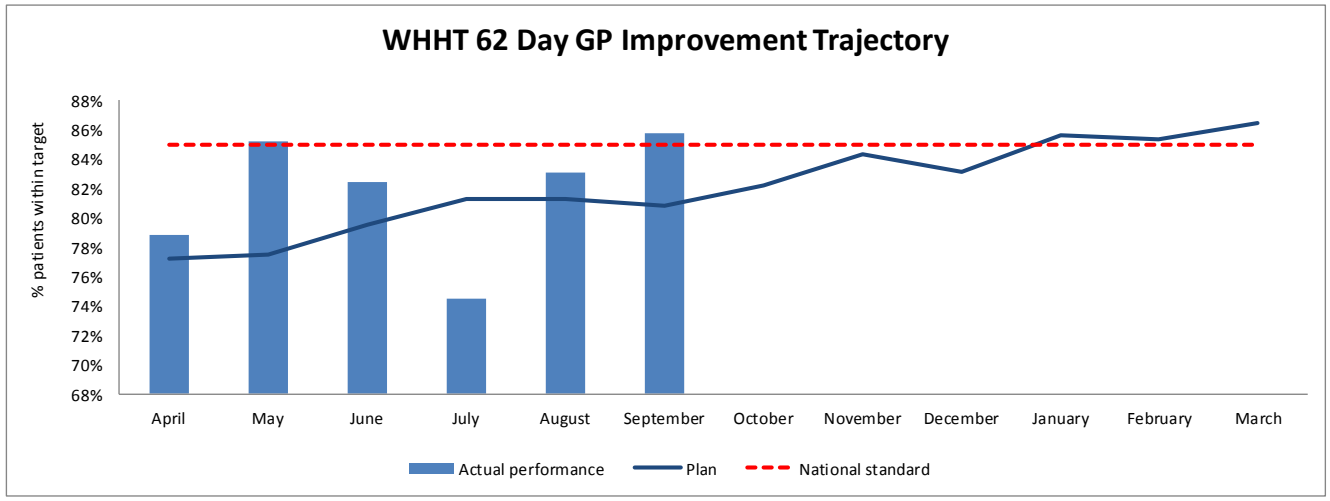


Cancer improvement – 62 day trajectory

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%						



NB: 62 day performance for September is provisional and pre-validation

Trust Board Meeting
07 November 2019

Title of the paper	**Integrated Performance Report** ***(October 2019 reporting period – September data)***
Agenda Item	**11/76**
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 96.2, SHMI 95.4, crude mortality 4.5% (slides 4, 21) • There were 4 cases of hospital and healthcare apportioned clostridium difficile cases (slides 4, 22-23) • At 33.4%, C-section rates are outside of the national target (28%), the major increase being the elective rate which at 17.8% is above the ceiling target (11%) (slides 4, 25). • The indicator for safe care, nursing shift fill, at 100.2%, is better than target (95%) (slides 4, 26) • The percentage of patient safety incidents that are harmful, is similar to the previous month, at 8.4% (was 8%) (slides 4, 30) • Safety thermometer new harms, at 97.6% are better than the national picture, with 2 category 3 and no category 4 pressure ulcers) (slide 4, 32-33) • VTE assessment is just below target at 94.5% (slides 4, 34) • Stroke indicator performance shows 63% of patients were admitted to the Stroke unit within 4 hours (target 90%, national average 56.3%), and 95% 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 351 from 332) but delays over 60 minutes are much improved (at 102 from 195) (slides 5, 36) • Delayed transfers of care (DToCs) have almost doubled this month at 6.3% (from 3.4%) against a target of 3.5% (slides 5, 38) • Inpatient, Day Case and Maternity Friends & Family positive scores are all above the 95% target this month but A&E scores have fallen to 92.9% (slides 5, 39-40) • As expected, complaints response times improved, now at 81.5% (was 73.1%) with 7 reactivated complaints received in the reporting period (slides 5, 41) • ED 4 hour performance was better this month at 83% (from 80.5%) (slides 5, 36) • RTT (incomplete) performance improvement is maintained, at 85.8% with three 52 week breach (slides 5, 43) • Cancer 31 day first (94.3%) and subsequent treatment – drug (94.1%) performance has not reached the standard (96% and 98%) (slides 5, 44) • 62 day urgent referral to first treatment is compliant at 85.7% but 62 day screening has not achieved the standard (85%) at 64% (slides 5, 46)

Workforce & Finance

- 12 month turnover rates are improved, at 14.6% (from 15.1%) but remain above target (13%) and the vacancy rate is unchanged and almost on target (10%) at 10.5% (slides 5, 48)
- All staff appraisal rates have increased at 87.9% (was 86.6%) (including medical staff) (slides 5, 49)
- Mandatory training rates remain consistently better than target, at 91.4% and although Essential training rates are below target (slides 5, 49)
- Bank pay is within the target range at 11.4%, as is agency pay at 4.2% (target 4.4%) (slides 6, 16)
- Within the new finance indicators, the actual deficit and the forecast are more or less in line with plan (slides 6, 10-11)
- CIP delivery is just behind plan (£1.154m) at £1.077m) (slides 6, 18)
- A range of activity counts are now included for information(slide 6):
  - Elective spells (overnight) are behind plan (574) at 509
  - Elective day cases are above plan (3325) at 3370
  - Total elective spells are very slightly behind plan (3899) at 3879
  - Outpatient attendances are lower than planned (20934) at 20268
  - Non-elective spells are higher than planned (3996) at 4352)
  - Births are lower than planned (408) at 346

Trust strategic aims

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
Trust Management Committee	30 October 2019
Finance & Performance Committee	31 October 2019

Action required

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

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

October 2019

Reporting Period: September 2019

The very best care for every patient, every day

NHS
West Hertfordshire Hospitals
NHS Trust

How Are we Doing?

Safe Care & Improving Outcomes	Caring & Responsive Services	Workforce & Finance
Safety Thermometer New Harm Free Care 97.6% Target 95%	**Complaints response times** 81.5% Target 80%	**Mandatory Training** 91.4% **Appraisal Rates** 87.9% Target 90%
C Diff cases 4 Target 3	**ED 4 hour standard** 83.0% Target 95%	**% Agency Pay** 4.2% Target 4.4%
VTE assessment 94.5% Target 95%	**RTT open pathways** 85.8% Target 92%	**Vacancy rate** 10.5% Target 10%
Inpatient Friends & Family positive scores 95.4% Target 95%	**CWT: 62 day referral to first treatment** 86.5% Target 85%	**Income & Expenditure** -£2,144 Surplus(Deficit)Plan -£2,143

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 95.4** **HSMR 96.2**	**Complaints response times** Above target & stable	**81.5%** **Ytd 82.4%**	**All staff appraisal** Lower than previous month	**87.9%** **Ytd 86.6%**
Infection Control – C diff Hospital & healthcare associated cases – variable	**4** (cat 1: 4 + cat 2: 0) **Ytd 30**	**Inpatient Friends & Family Test** Response rates below target Positive scores below target	**Resp 21.5%** **+ve 95.4%**	**Mandatory training** Consistently achieved and stable	**91.4%** **Ytd 91.8%**
Serious incidents & Never Events (NE) Variable	**SI 3 Ytd 15** **NE 0 Ytd 1**	**Mixed sex accommodation** Variable but consistently low numbers	**4** **Ytd 23**	**Turnover at 12 months** Below target but stable	**14.6%** **Ytd 15.0%**
Patient safety incidents which are harmful Variable	**8.4%** **Ytd 8.8%**	**Outpatient DNA rates** Better than previous month	**8.7%** **Ytd 8.6%**	**Income & Expenditure vs plan** Just below plan	**(£2.1m)** **Ytd (£17.8m)**
Combined Caesarean Section Standard not achieved - variable	**33.4%** **Ytd 31.9%**	**ED waiting times** Variable, below target and adverse to plan	**83.0%** **Ytd 81.3%**	**Capital Spend vs plan**	**(£0.47m)** **Ytd (£3.60m)**
VTE assessments Standard not achieved Deterioration against recent months	**94.3%** **Ytd 95.0%**	**RTT waiting times** Improving, below target but better than plan	**85.8%** **Ytd 83.9%**	**CIP Efficiency** Full year savings of £15.15m identified (target £15m)	**£1.07m** **Ytd (£6.2m)**
Stroke Indicators Admission to the Stroke Unit within 4 hrs – variable & not achieved 90% admission spent in the Stroke Unit – variable, achieved	**4 hr 63.0%** **Ytd 61.9%** **Adm 95.0%** **Ytd 93.7%**	**Cancer waiting times** 2ww achieved but variable 62 day achieved but variable	**2ww 93.2%** **Ytd 92.1%** **62 86.5%** **Ytd 80.6%**	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	**FRR 3** **Elec 3,879 vs 3,899** **Non-Elec 4,352 vs 3,996**
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	Jul-19	Aug-19	Sep-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 improved and better than target	97.0	96.5	95.4			Feb-19	National	100	Feb-19
		HSMR - Total (Rolling three months)	21	100	Performance deteriorated but better than target	96.7	93.2	96.2			May-19	National	100	May-19
		HSMR - Crude mortality %	21	2.8	Performance deteriorated and worse than target	4.2	3.9	4.5			May-19	National	2.8	May-19
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	22		Performance deteriorated and worse than target	6	1	4	20		Sep-19	National		
		Clostridioides Difficile - Healthcare associated (Cat 2)	22		Performance stable and better than target	2	4	0	10		Sep-19	National		
		Clostridioides Difficile - Hospital and Healthcare associated Total	22	3	Performance stable but worse than target	8	5	4	30	22	Sep-19	National		
		Hand Hygiene Compliance	23	95%	Performance stable and better than target	97.3%	98.0%	98.3%	97.7%	95%	Sep-19	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	24	4.3%	Performance stable and better than target	3.7%	3.6%	3.5%	3.5%	4.3%	Feb-19	National	4.3%	Feb-19
		30 Day Emergency Readmissions - Emerg *	24	13.5%	Performance stable and better than target	12.8%	12.5%	11.3%	12.1%	13.5%	Feb-19	National	13.5%	Feb-19
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	25	28.0%	Performance stable but worse than target	34.8%	28.4%	33.4%	31.9%	28.0%	Sep-19	Local	26.7%	Apr15-Aug15
		Caesarean Section rate - Emergency*	25	15.0%	Performance stable but worse than target	18.5%	14.6%	15.6%	16.2%	15.0%	Sep-19	Local	15.3%	Apr15-Aug15
		Caesarean Section rate - Elective*	25	11.0%	Performance stable but worse than target	16.3%	13.7%	17.8%	15.6%	11.0%	Sep-19	Local	11.4%	Apr15-Aug15
		Patient Safety												
		% nursing hours (shift fill rate)	26	95.0%	Performance deteriorated but better than target	101.4%	103.0%	100.2%	101.9%	95.0%	Sep-19	National	n/a	
		Serious incidents - number*	30	tbd NHSI^	Performance stable and better than target	5	4	3	15	tbd NHSI^	Sep-19	National	n/a	
		Serious incidents - % that are harmful*	30	n/a	Performance stable and better than target	100.0%	100.0%	100.0%	100.0%	n/a	Sep-19	National	n/a	
		% of patients safety incidents which are harmful*	30	n/a	Performance stable and better than target	9.7%	8.0%	8.4%	8.8%	n/a	Sep-19	National	n/a	
		Never events	30	0	Performance stable and better than target	0	1	0	1	0	Sep-19	National	n/a	
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	32	95.0%	Performance stable but worse than target	91.4%	91.7%	89.5%	91.2%	95.0%	Sep-19	National	93.9%	Sep-19
		Safety Thermometer % New Harm Free Care (acquired within Trust)	32	95.0%	Performance stable and better than target	98.8%	99.0%	97.6%	98.6%	95.0%	Sep-19	National	97.8%	Sep-19
		Category 4 pressure ulcers - New (Hospital acquired)	33	0	Performance stable and better than target	0	0	0	0	0	Sep-19	Local		
		Category 3 pressure ulcers - New (Hospital acquired)	33	0	Performance stable but worse than target	1	1	2	11	0	Sep-19	Local		
		VTE risk assessment*	34	95.0%	Performance deteriorated and worse than target	95.8%	94.6%	94.3%	95.0%	95.0%	Sep-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	73.2%	58.1%	63.0%	61.9%	90.0%	Sep-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	97.6%	92.3%	95.0%	93.7%	80.0%	Sep-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			

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Jul-19	Aug-19	Sep-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 stable but worse than target	319	332	351	1934	0	Sep-19	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	126	195	102	867	0	Sep-19	National	n/a	
		% Patients admitted through A&E - 0 day LOS		TBC	Performance deteriorated but better than target	35.4%	32.8%	35.8%	31.9%	TBC	Sep-19	National		
		Patient Flow: In hospital flow												
		Discharges between 8am and 12pm (main adult wards excl AAU)			Performance stable and better than target	19.8%	19.7%	19.8%	19.7%		Sep-19	National		
		Mixed sex accommodation breaches	37	0	Performance stable but worse than target	3	3	4	23	0	Sep-19	National	52 Trusts breaching	Aug-19
		LOS > 21 days	38	76	Performance stable but worse than target	79	91	101	101	76	Sep-19	National	n/a	
		Delayed Transfers of Care (DToC)*	38	3.5%	Performance deteriorated and worse than target	3.6%	3.4%	6.3%	4.3%	3.5%	Sep-19	National	6.0%	Feb-16
		Delayed Tranfers of Care (DToC) beddays used in month	38	n/a	Performance stable and better than target	637	835	794	4584	n/a	Sep-19	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	38	n/a	Performance stable and better than target	21	27	26	30	n/a	Sep-19	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	39	95%	Performance stable but worse than target	88.9%	95.4%	92.9%	91.5%	95%	Sep-19	National	86.2%	Aug-19
		Inpatient Scores FFT % positive	39	95%	Performance stable and better than target	95.0%	95.8%	95.4%	94.5%	95%	Sep-19	National	95.9%	Aug-19
		Daycase FFT % positive	39	95%	Performance stable and better than target	97.4%	98.2%	99.4%	97.8%	95%	Sep-19	National	n/a	
		Maternity FFT % positive	39	95%	Performance stable and better than target	96.3%	95.2%	95.7%	96.0%	95%	Sep-19	National	96.4%	Aug-19
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	41	80%	Performance stable and better than target	84.6%	73.1%	81.5%	82.4%	80%	Sep-19	National	n/a	
		Reactivated complaints	41	0	Performance deteriorated and worse than target	4	5	7	27	0	Sep-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 stable but worse than target	81.3%	80.5%	83.0%	81.3%	95.0%	Sep-19	National	85.4%	Sep-19
		Referral to Treatment - Incomplete*	43	92.0%	Performance improved but worse than target	85.2%	85.6%	85.8%	83.9%	92.0%	Sep-19	National	85.0%	Aug-19
		Referral to Treatment - 52 week waits - Incompletes	43	0	Performance deteriorated and worse than target	4	1	3	17	0	Sep-19	National	1233 (all Trusts)	Aug-19
		Cancer												
		Cancer - Two week wait *	44	93.0%	Performance stable and better than target	91.1%	92.5%	93.2%	92.1%	93.0%	Sep-19	National	90.2%	Q1 19/20
		Cancer - Breast Symptomatic two week wait *	44	93.0%	Performance improved and better than target	97.0%	98.4%	100.0%	94.1%	93.0%	Sep-19	National	77.5%	Q1 19/20
		Cancer - 31 day *	45	96.0%	Performance stable but worse than target	98.9%	96.5%	94.9%	97.2%	96.0%	Sep-19	National	96.1%	Q1 19/20
		Cancer - 31 day subsequent drug *	45	98.0%	Performance deteriorated and worse than target	100.0%	100.0%	94.1%	99.1%	98.0%	Sep-19	National	99.2%	Q1 19/20
		Cancer - 31 day subsequent surgery *	45	94.0%	Performance stable and better than target	100.0%	100.0%	100.0%	97.8%	94.0%	Sep-19	National	91.6%	Q1 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%	Sep-19	National		
		31 Day - Subsequent Treatment at WHHT - Other Treatments	45	94.0%	Performance stable and better than target	100.0%	100.0%	100.0%	99.3%	94.0%	Sep-19	National		
		Cancer - 62 day *	46	85.0%	Performance stable and better than target	74.6%	82.5%	86.5%	80.6%	85.0%	Sep-19	National	77.8%	Q1 19/20
		Cancer - 62 day screening *	46	90.0%	Performance stable but worse than target	90.3%	83.3%	61.5%	79.6%	90.0%	Sep-19	National	87.4%	Q1 19/20
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	47	5.0%	Performance stable and better than target	5.0%	5.2%	3.6%	4.4%	5.0%	Sep-19	Local	n/a	
		DNA rate	47	TBC	Performance stable and better than target	8.6%	8.5%	8.7%	8.6%	TBC	Sep-19	National	n/a	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Jul-19	Aug-19	Sep-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 improved but worse than target	14.9%	15.1%	14.6%	15.0%	13.0%	Sep-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	18.4%	21.2%	17.2%	19.5%	n/a	Sep-19	National	n/a	
		Vacancy rate	48	10.0%	Performance stable but worse than target	11.2%	10.5%	10.5%	10.4%	10.0%	Sep-19	National	13.5% (local survey)	Q1 18/19
		Sickness rate	48	3.5%	Performance stable and better than target	3.2%	3.4%	3.5%	3.3%	3.5%	Sep-19	National	3.8% (EoE orgs)	Q1 18/19
		Developing Staff												
		Appraisal rate (Total)	49	90.0%	Performance stable but worse than target	87.1%	86.6%	87.9%	86.6%	90.0%	Sep-19	National		
		Mandatory Training	49	90.0%	Performance stable and better than target	92.2%	91.4%	91.4%	91.8%	90.0%	Sep-19	Local	88.0% (local survey)	Q1 18/19
		Essential Training	49	90.0%	Performance deteriorated and worse than target	87.9%	88.6%	88.4%	86.0%	90.0%	Sep-19	Local		
		Finance overview												
		Financial Risk Rating	10-19	3	Performance improved and better than target	3.00	3.00	3.00			Sep-19	Local		
		Income & Expenditure Actual vs Plan	10-19	-£2,143	Performance stable and better than target	-£1,276	-£2,336	-£2,144	-£17,807	-£17,809	Sep-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	Sep-19	Local		
		Cash balance at the end of the month*	10-19		Performance improved and better than target	£4,867	£5,752	£6,585	£6,585		Sep-19	Local		
		Capital expenditure**	10-19	-£1,790	Performance stable but worse than target	-£700	-£380	-£472	-£3,602	-£10,750	Sep-19	Local		
		CIP delivery against plan	10-19	£1,154	Performance stable but worse than target	£1,229	£1,731	£1,077	£6,211	£4,039	Sep-19	Local		
		% Bank Pay	10-19	12.0%	Performance stable and better than target	11.2%	12.3%	11.4%	11.5%	12.0%	Sep-19	Local	n/a	
		% Agency Pay	10-19	4.4%	Performance improved and better than target	5.7%	4.2%	4.2%	5.3%	4.4%	Sep-19	Local	7.5% (local survey)	Q1 18/19
		Activity (chargeable)												
		GP referrals		7,465	Performance stable and better than target	8,699	7,559	7,632	47,058	47,152	Sep-19	National		
		A&E attendances		9,718	Performance stable and better than target	11,252	10,342	10,849	63,530	59,280	Sep-19	National		
		Elective spells (overnight)		574	Performance stable but worse than target	516	480	509	3,033	3,424	Sep-19	National		
		Elective daycase		3,325	Performance stable and better than target	3,681	2,920	3,370	19,711	19,948	Sep-19	National		
		Total elective spells		3,899	Performance stable but worse than target	4,197	3,400	3,879	22,744	23,372	Sep-19	National		
		Non-elective spells		3,996	Performance stable and better than target	4,576	4,165	4,352	24,983	23,612	Sep-19	National		
		Births		408	Performance stable but worse than target	386	344	346	2,138	2,411	Sep-19	National		
		Outpatient attendances		20,934	Performance stable but worse than target	21,593	17,904	20,268	118,911	119,317	Sep-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

Mortality indices remain stable, and better than expected and Doctor appraisal rates range between 96.4% - 100% across the divisions, demonstrating an even higher compliance rate than usual.

The Medirota roll-out is nearing completion, which will improve application of team job plans, and reduce cancellations.

The Medical take pilot has commenced and early indicators are promising. Improvements seen in 4hr target for medical patients, improved patient experience, and approximately 11 admissions avoided daily. It has been unusual to see patients handed over to the night team (previously 10-15 patients), and general feedback very positive. Some further adjustments are being done, and will be subject to weekly review.

Urology and anaesthetic capacity is creating performance issues, and is subject to a weekly performance review. This is in addition to the surgical review, and focus is on improving the utilisation of theatres at SACH, and detailed review of lists 3 weeks in advance.

Chief Nurse

Falls with harm contribute to a number of safety alerts on the ward dashboard although this remains below the national average and peers on model hospital.

Although a small number of category 3 pressure ulcers have been reported in recent months, this remains below the national average and the harm free care team continue to work with wards to maintain standards and promote best practice in tissue viability.

The 90 day e-coli improvement project has completed and teams presented their work on hydration. This work will form part of the quality improvement programme to support sustainability and roll out.

The safeguarding team ran a successful learning disability event for staff across the trust which has been evaluated well. The team are planning to host a national conference at the trust to share good practice in safeguarding which includes some of the work they have been doing around modern slavery.

As part of winter planning staffing has been reviewed to ensure safety of areas used for increased capacity and expansion plans underway.

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Key messages for the Board

Caring & Responsive Services

Chief Nurse

The focused redecoration of the Acute Admissions Unit (AAU) and the wards has continued. This has included work to improve the environment for patients with dementia.

Patient discharge follow-up calls have been undertaken for the last three months by the ward nurses, this has been an opportunity to resolve any concerns and gain immediate feedback. An evaluation will be undertaken which will be reviewed by the quality committee in December.

The trust has had a successful bid for an end of life care volunteer co-ordinator post to work with our 'rose volunteers' who support patients and relatives across our wards at the end of life.

Chief Operating Officer

September continued to be a busy month for the Trust with attendances being higher week on week against plan compared to the same time last year. Despite this performance against the ED four hour standard was better when compared against the same period during 18/19.

Two business continuity incidents were declared in month, one 29/8/19 – 4/9/19 running over the course of a weekend and the second 26/9/19 – 27/9/19.

The Trust experienced significant issues with patient transport services which is provided by EEAST. We were advised that a secondary provider contracted by EEAST had gone into liquidation leaving the ambulance fleet short of the 3 ambulance crews needed to support the WHHT element of the contract. Some significant disruption to patients was caused and in the immediate days post this event the Trust experienced a number of failed discharges. The Trust in partnership with Herts Valleys CCG was able to establish a business continuity plan by sourcing some resources from a private provider which supported an improved experience for our patients.

Winter planning continues with plans to expand assessment capacity and within the ED refurbishment project, plans now include a CT scanner within the department itself.

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. Our overall assessment of performance in relation to key workforce metrics remains green. This year's flu campaign has begun strongly and we have vaccinated 44% of staff in three weeks. Response rates to staff survey has been much slower and is at 19%, with the intention being to significantly increase publicity and send reminders over the coming weeks. The Trust has been actively celebrating Black History month with a series of talks, communications regarding the contribution of black people to the NHS and the launch of a reverse mentoring programme for our Executive team. This month also saw the launch of the Trust's new front line management programme Rise, which has received extremely positive feedback. The Trust is also working with two other health care providers on a new tender for the provision of its bank services, it is hoped that this work will be completed by early December. Finally work has begun on a revision of the Trust's workforce strategy with the new strategy due to be completed by early January.

Chief Finance Officer

We continue to report success against the most important short term financial target for the Trust, to ensure our revenue expenditure exceeds income by no more than £22.741m over the 2019/20 year. After six months we remain on track to achieve target, with a deficit of £17.8m. Elective activity and income has improved in September but overall charges to our host commissioner remain within indicative contract value. This supports our eventual move to a block contract with this commissioner.

After 6 months we're still achieving more efficiencies than planned for at the start of the year (£6.2m, vs £4.0m planned). We expect savings to rise to £15.2m by the end of the year. However seeing pay costs overspend in this month (despite non-recurrent non pay underspends and efficiencies in other areas) could result in the Trust missing our Control Total if further action is not taken to improve the management of costs. Continued, unexpectedly high, emergency care pressures have contributed to overspending against medical staff budgets. Our success in reducing nursing vacancies continues to present cost control challenges, while newly recruited nurses complete necessary qualifications. . A set of recovery actions within the Divisions of Surgery and Medicine are core to successful recovery.

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 additional sources of investment. £8m of this had already been approved. £5m was earmarked for the Trust, but dependent on approval of a full business case to improve our emergency department facilities. Another c£5m is linked to an emergency loan, expected to be approved, to support fire safety. The timing of approvals for the emergency department facilities has led to the Trust re-forecasting capital expenditure to £21m for the year.

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Workforce & Finance: Income and Expenditure September 2019

Trust Definition	Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance		YTD Budget	Actual	Variance	
Income	Divisional Income	55,727	4,534	4,838	304	Bii	24,687	24,844	156	Fii
	NHS Revenue	324,083	27,174	27,104	(71)	Bi	162,766	161,400	(1,366)	Fi
	Income Unallocated CIPs	515	48		(48)		50		(50)	
Income Total		**380,326**	**31,756**	**31,942**	**186**	**B**	**187,503**	**186,244**	**(1,259)**	**F**
Pay	Medical Pay	(78,838)	(6,893)	(7,081)	(188)		(39,316)	(40,486)	(1,170)	
	Non-Clinical Pay	(51,481)	(4,174)	(3,981)	193		(25,203)	(24,222)	981	
	Nursing Pay	(75,738)	(6,198)	(6,542)	(344)		(37,976)	(39,177)	(1,201)	
	Other Clinical Pay	(28,557)	(2,253)	(2,328)	(75)		(14,237)	(14,250)	(12)	
	Scientific, Technical & Profes	(25,694)	(2,158)	(2,237)	(79)		(12,905)	(13,408)	(502)	
	Pay Unallocated CIPs	3,688	141		(141)		(199)	42	241	
Pay Total		**(256,620)**	**(21,535)**	**(22,168)**	**(633)**	**C**	**(129,837)**	**(131,501)**	**(1,664)**	**G**
Non Pay	Clin Supp Serv	(31,035)	(2,412)	(2,442)	(30)		(15,344)	(15,419)	(75)	
	Drugs	(22,357)	(1,782)	(1,791)	(9)		(11,204)	(10,446)	758	
	OTHER (NON CLIN)	(82,388)	(7,217)	(6,646)	571		(42,572)	(40,752)	1,820	
	Non Pay Unallocated CIPS	1,630	62		(62)		(263)		263	
Non Pay Total		**(134,149)**	**(11,349)**	**(10,878)**	**471**	**D**	**(69,383)**	**(66,617)**	**2,766**	**H**
Recharges	Recharges		()				()	()		
Recharges Total			**0**				**0**	**0**		
Financing Charges	Depreciation	(8,999)	(741)	(766)	(25)		(4,445)	(4,363)	81	
	Trust Debt Redemption	(3,241)	(270)	(272)	(2)		(1,619)	(1,564)	55	
	Unwinding Discount	(57)	(5)	(1)	4		(29)	(6)	23	
Financing Charges Total		**(12,297)**	**(1,015)**	**(1,039)**	**(24)**	**E**	**(6,092)**	**(5,933)**	**159**	**I**
Total		**(22,741)**	**(2,143)**	**(2,144)**	**(1)**	**A**	**(17,809)**	**(17,807)**	**2**	**J**

A – The trust reported a breakeven position in month by delivering a planned deficit of £2.14m in September. The YTD position is also on plan with a £17.8m deficit (J).

B- The in month income position showed an over performance of £186k against plan.
Bii – Divisional income showed an over performance of £304k against plan in month this is due to recognition of overseas visitor income and an increase in car parking revenues. The YTD divisional income position is now better than plan by £156k (Fii).
Bi- NHS Revenue underperformed in month by £71k. The main drivers are: Elective under performance of £279k , other SLA under performed by £478k and this is offset by the over performances within Non Elective (£523k) . The YTD position on NHS revenue shows under performance of 1,366k (Fi). Within this, there is a £1m underperformance relating to pass through high cost dugs and devices which demonstrates good performances against other points of delivery.

C – The overall pay bill for the month was £22,168k which was £633k overspent. 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 £1,664k overspent (G).

D – The non pay position reported an underspend of £471k in month. With the exception of high cost drugs being below plan, other aspects of non pay were mostly within budget. However, It should be noted that a prior year invoice relating to Soft FM services caused a £0.3m pressure within other non clinical budget lines. This was offset by a revenue to capital transfer and an increase in the amount of VAT reclaimable

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E – Financing charges overspent by £24k . This is linked to the timing of interest payable on revenue loans.

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Workforce & Finance: Finance overview dashboard

Financial Overview as at 30 September 2019

Month 6 FY20 Income & Expenditure

£m	Plan	Actual	Var
Surplus / (Deficit)	(2.1)	(2.1)	0.0

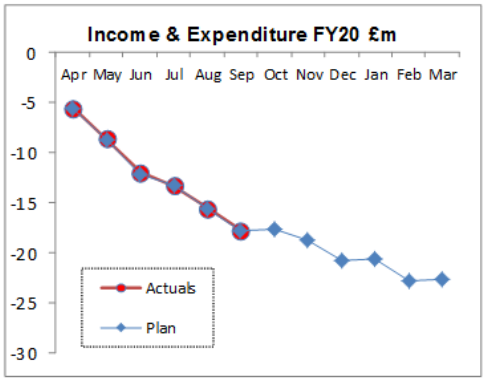
Year to Date

£m			
Surplus / (Deficit)	(17.8)	(17.8)	0.0

Statutory / Regulatory Duties

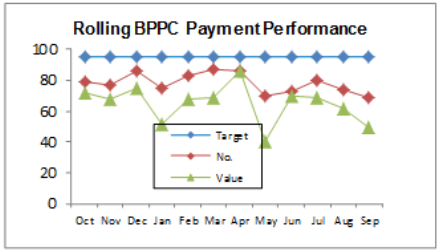
Breakeven	The Trust has a deficit plan of £22.7m for FY20.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 30/09/19 equated to 7 days' spend	R
BPPC	Month 6 performance - 69% on number, 49% on value (95% target)	R

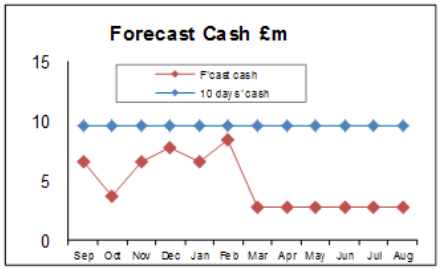
Financial Risk Rating	FY20	3

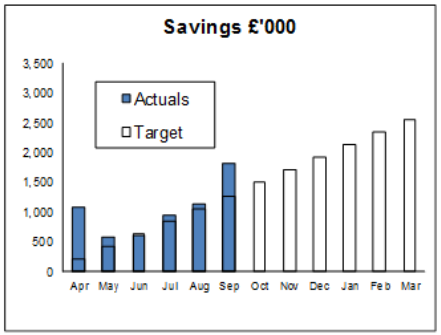


Variances by Division £m

	M6	YTD
Medicine	(0.6)	(1.1)
Unscheduled Care	0.3	2.0
Surgery	(0.5)	(2.3)
Women's	0.4	(0.1)
Clinical Support	(0.1)	(0.3)
Estates & Facilities	(0.0)	(0.5)
Corporate	(0.4)	(0.9)
Other	0.9	3.1
Total	**(0.0)**	**0.0**







Commentary

- See earlier pages for I&E detail.
- A financial risk rating of 3. Six divisions: Medicine, Surgery, Women's & Children's, Corporate, CSS and Environment are adverse to budget.
- The Better Practice Payment statistics show 69% on number and 49% on value. This represents a deterioration compared to previous months.
- The cash balance at the end of September was £6.6m.
- Savings were £1.8m in September.

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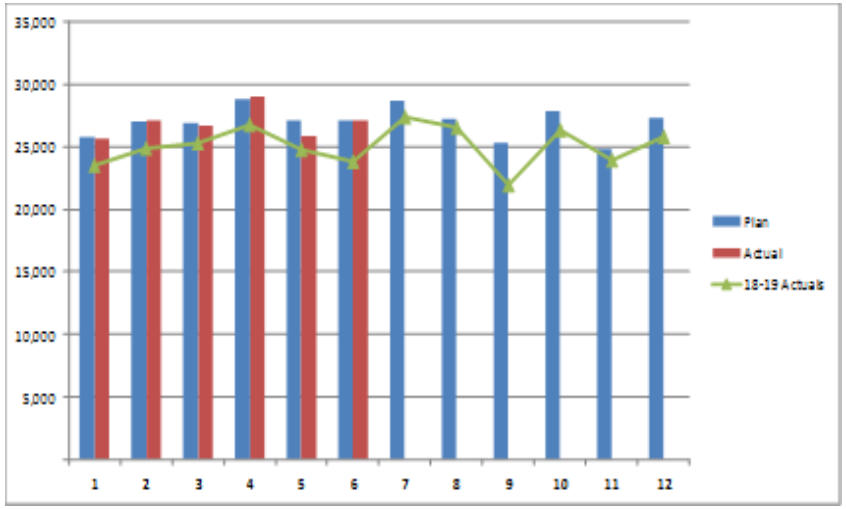
Workforce & Finance: Trust Income - September 2019

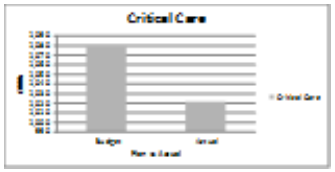
NHS Revenue: Performance by Month (£s)

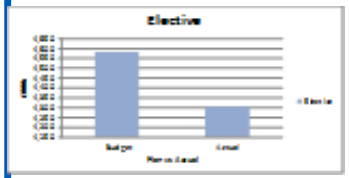


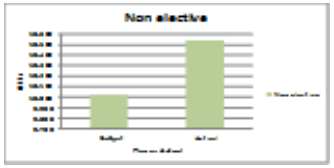
NHS Revenue in September delivered £27.1m against a plan of £27.2m resulting in a breakeven with a small underperformance of £71k.

This can be explained at a point of delivery level:

- A&E over performed by £110k which was linked to both an increase in volume and complexity of attendances.
- Critical care showed an under performance of £57k. Occupancy levels continue to remain consistent.
- Elective performance was £279K away from plan. Although this saw a recovery from the August position, underperformance was centred around the surgical division.
- For Non Elective the in month position was £523k above plan . This month the majority of the over performance was attributed to an increase in activity going through the paediatric assessment unit (PAU) and an increase in trauma lists within Surgery.
- Outpatient performance was £110k better than plan. Over performance within Medicine (£100k) and Clinical support (£62k) were partially offset by other divisions.
- Finally other SLA income under performed by £478k. This relates to pass through items and is offset with the expenditure position.







In Month Performance (£s)

Expense Type	POD	Annual Budget	In Month (£000's) Budget	Actual	Variance
NHS Revenue	A&E	20,052	1,645	1,755	110
	Critical Care	13,147	1,079	1,022	(57)
	Elective	55,082	4,584	4,305	(279)
	Non elective	117,497	10,020	10,544	523
	Other SLA	43,180	3,598	3,119	(478)
	Outpatient	75,125	6,248	6,358	110
	NHS Rev Unallocated CIPs				
NHS Revenue Total	**Total**	**324,083**	**27,174**	**27,104**	**(71)**

In Month Performance (spells)

Expense Type	POD	Annual Budget	In Month (Activity) Budget	Actual	Variance
NHS Revenue	A&E	124,013	10,193	11,208	1,015
	Critical Care	21,831	1,843	1,049	-794
	Elective	46,421	3,868	3,888	20
	Non elective	51,550	4,404	4,835	431
	Other SLA	3,731,065	310,888	265,784	-45,104
	Outpatient	453,623	37,745	39,512	1,767
NHS Revenue Total	**Total**	**4,428,503**	**368,941**	**326,276**	**-42,665**

Divisional Income

Divisional income showed an over performance of £304k against plan in month. The majority of this is driven by Overseas patients income.

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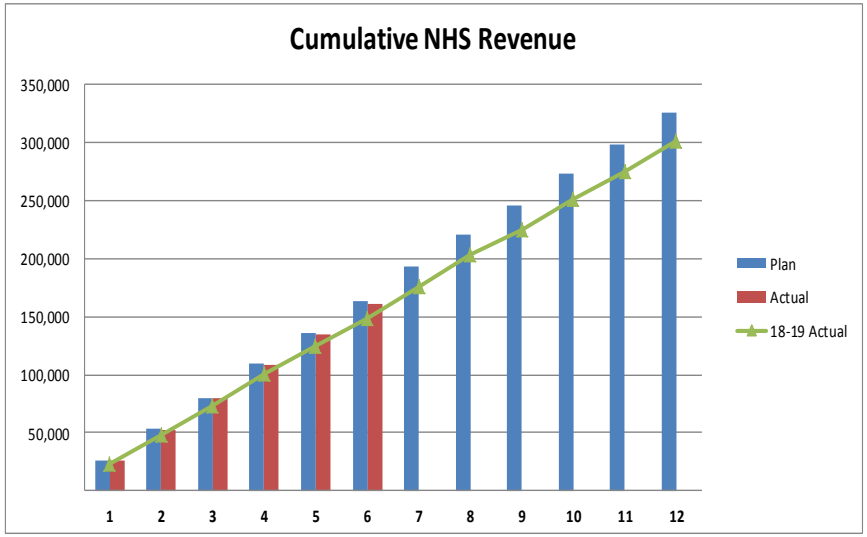
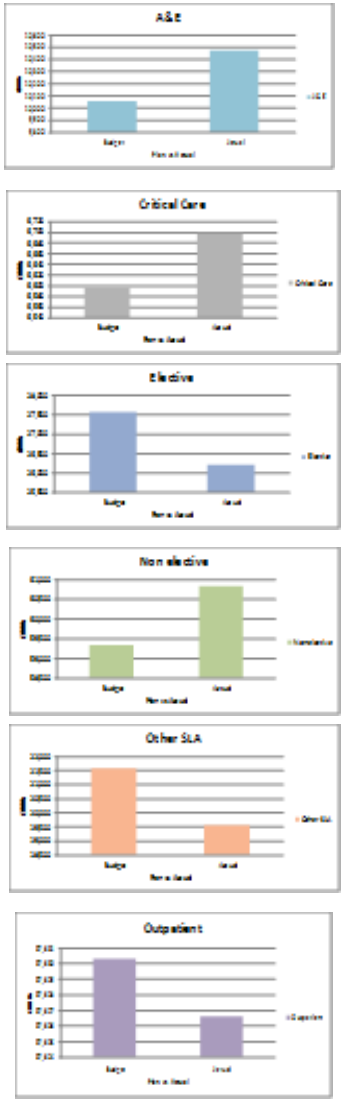
Workforce & Finance: Trust Income - Year to date

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	10,060	10,475	415
Critical Care	6,596	6,698	102
Elective	27,568	26,209	(1,359)
Non elective	59,346	60,829	1,483
Other SLA	21,565	19,562	(2,003)
Outpatient	37,630	37,627	(4)
NHS Rev Unallocated CIPs			
Total	**162,766**	**161,400**	**(1,366)**

YTD Performance (spells)

POD	YTD (Activity) Budget	Actual	Variance
A&E	62,176	66,124	3,948
Critical Care	10,997	6,843	-4,154
Elective	23,211	22,752	-459
Non elective	26,021	27,258	1,237
Other SLA			
Outpatient	227,554	233,843	6,289
Total	**349,959**	**356,820**	**6,861**

Divisional Income

The YTD shows divisional income to be £156k 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 September 2019

Trust Pay Performance

Expense Type	Annual Budget	In Month (£000's)			WTE		
		Budget	Actual	Variance	Budget	Actual	Variance
Medical Pay	(78,838)	(6,893)	(7,081)	(188)	679.97	687.72	-7.75
Non-Clinical Pay	(51,481)	(4,174)	(3,981)	193	1,255.32	1,188.26	67.06
Nursing Pay	(75,738)	(6,198)	(6,542)	(344)	1,613.05	1,607.43	5.62
Other Clinical Pay	(28,557)	(2,253)	(2,328)	(75)	1,007.59	984.20	23.39
Scientific, Technical & Profes	(25,694)	(2,158)	(2,237)	(79)	502.50	509.81	-7.31
Pay Unidentified CIPs	3,688	141		(141)	0.00	0.00	0.00
Total	**(256,620)**	**(21,535)**	**(22,168)**	**(633)**	**5,058.43**	**4,977.42**	**81.01**

The Trust reported an in month underperformance of £633k.

The key areas of underspend are;

The Medical pay position was overspent by £188k.

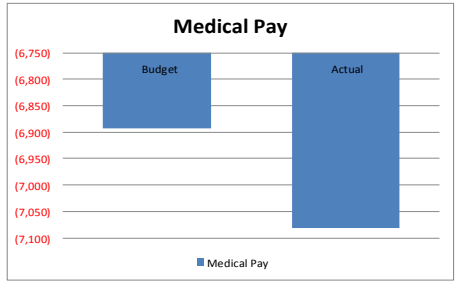
Within Women's' & Children's' there was an overspend of £160k in monthly. The majority of this related to retrospective shifts.
There was a £58k overspend within Emergency Medicine. This is linked to temporary staffing premiums for medical cover within A&E.
Furthermore, the retrospective medical pay award caused a small non recurrent pressure of £70k.

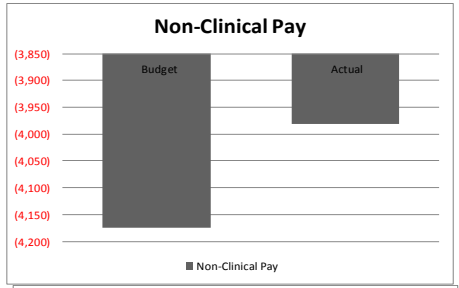
Nursing pay is overspent by £344k.

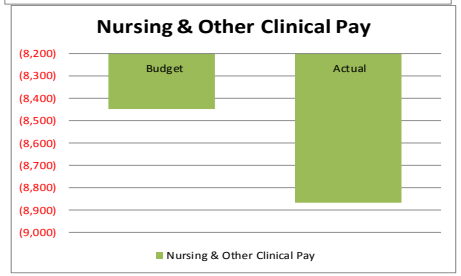
£148k of the overspend was within the Surgery division and is attributed to both temporary staffing cover and additional session costs within Theatres, predominately on the Watford site.
Medicine and Emergency medicine are overspent by £76k and £85k respectively due to the double running costs of recently recruited nurses.

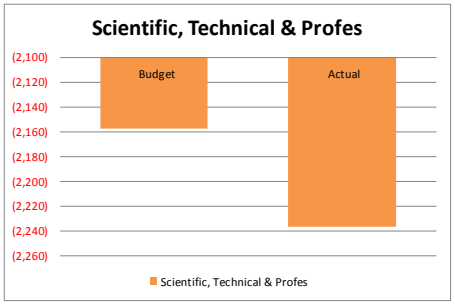
Agency premium to cover scientific and professional vacancies across clinical support, theatres and cardiology generates a combined overspend of £92k in month.

The phasing of the CIP target created a negative variance within the pay lines of £141k.









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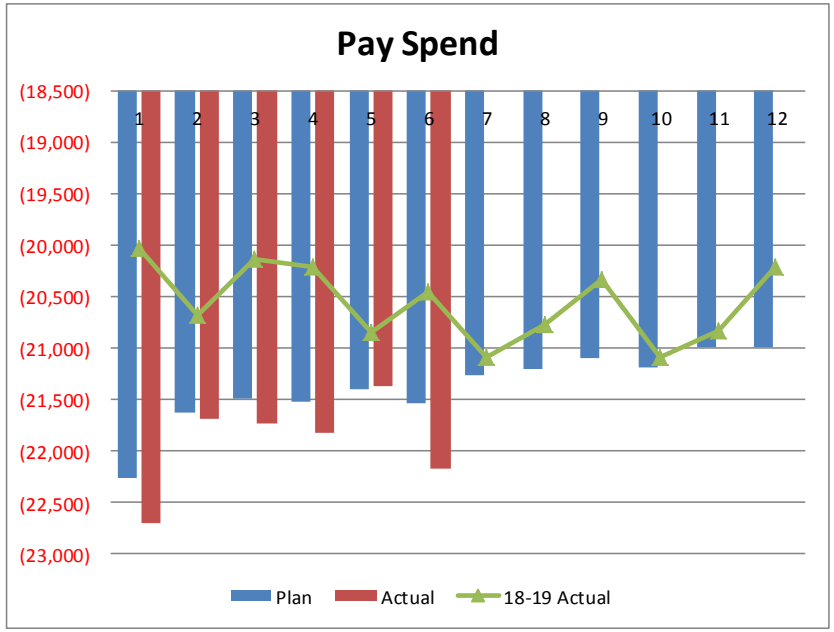
Workforce & Finance: Trust Pay year to date

YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(78,838)	(39,316)	(40,486)	(1,170)
Non-Clinical Pay	(51,481)	(25,203)	(24,222)	981
Nursing Pay	(75,738)	(37,976)	(39,177)	(1,201)
Other Clinical Pay	(28,557)	(14,237)	(14,250)	(12)
Scientific, Technical & Profes	(25,694)	(12,905)	(13,408)	(502)
Pay Unallocated CIPs	3,688	(199)	42	241
	(256,620)	(129,837)	(131,501)	(1,664)



1) The year to date reported position shows an overspend of ££1,664k.

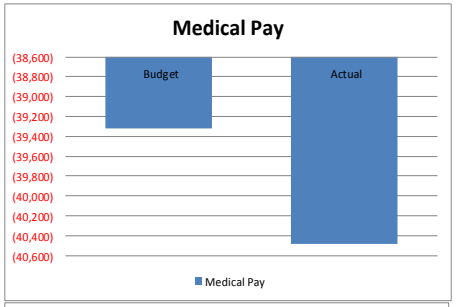
2) Key year to date themes to note are:

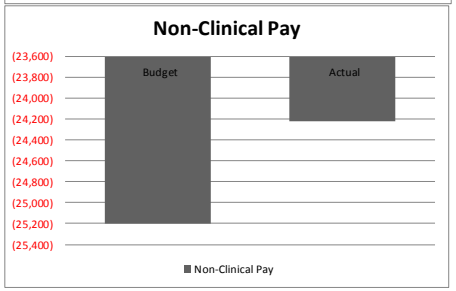
3) Medical pay – is showing an overspend of £1,170k. This is a significant cost pressure for future months and represents agency premium to cover vacancies and pockets of sickness across all divisions. An element of this also related to unfunded posts in relation to winter surge at the start of the year.

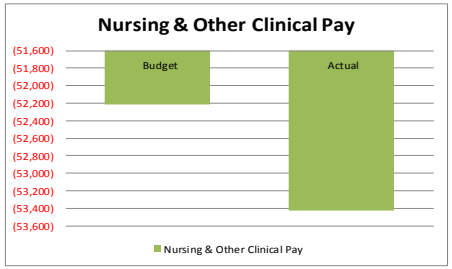
4) Nursing and Other clinical pay combined overspent by £1,201k – The majority of this overspend relates to double running costs associated with qualified nursing. In addition to this, 1:1 nursing care continues to be a key driver for spend. The YTD overspend on 1:1 nursing care is £193k.

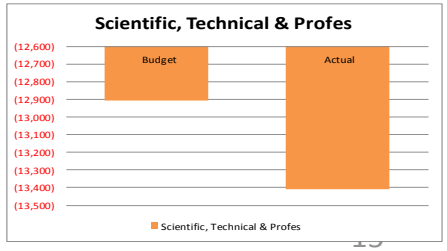
5) Scientific & therapeutic vacancies across clinical support, theatres and cardiology are causing a £502k YTD overspend.

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









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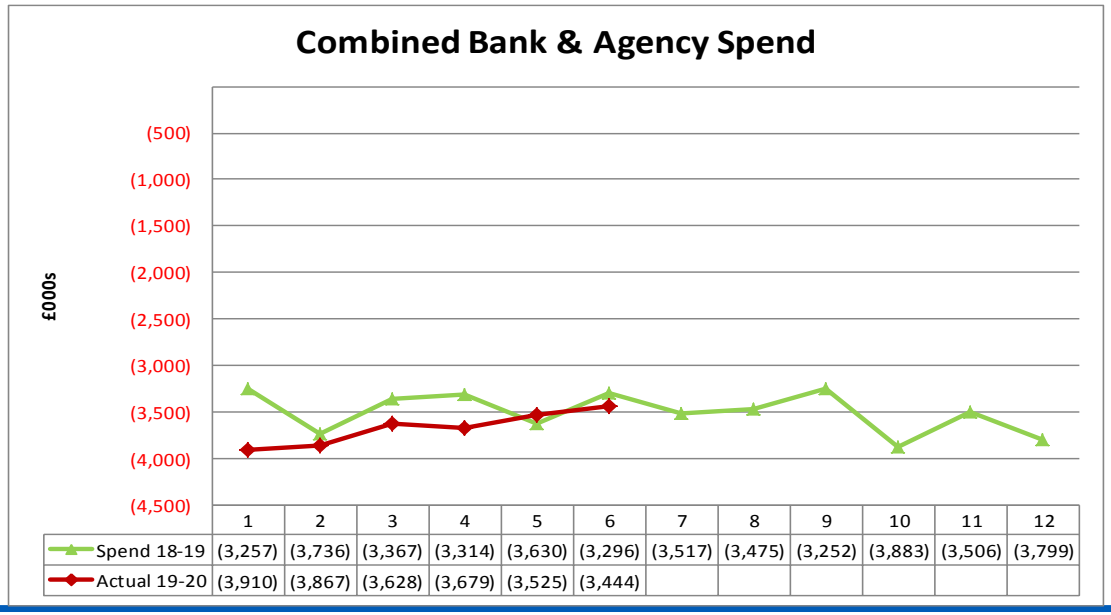
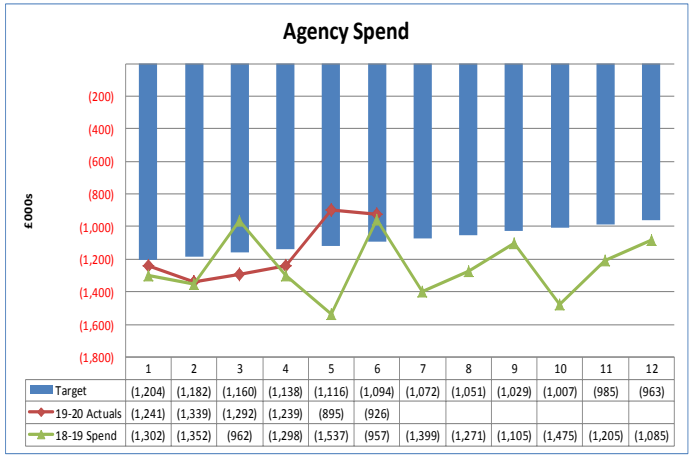
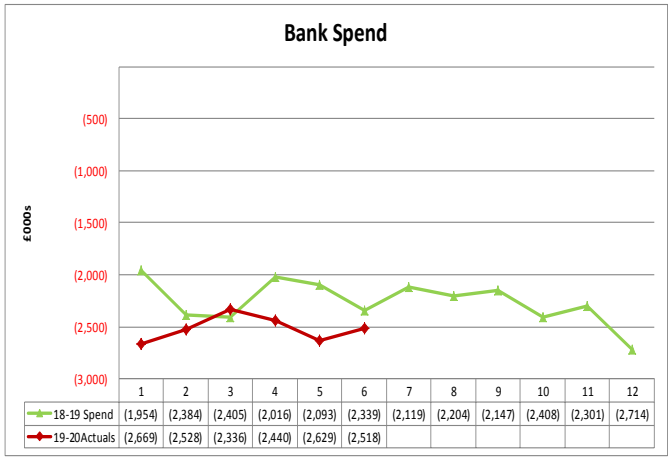
Workforce & Finance: Bank & Agency Spend September 2019



	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)						



	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)						
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)						

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 £926k. This was lower than the in month target of £1.1m.

YTD the Trust is £0.2m adrift of its internal agency target but well within the ceiling set by NHSI.

Bank

Bank spend for September was £2.5m.

There continues to be a shift from agency to bank as shown by the graphs. However the Trust has spent £0.2m more on bank & agency when compared to the same period last year. Cumulatively, 19-20 spend for temporary staffing is £1.5m higher than the same period last year.

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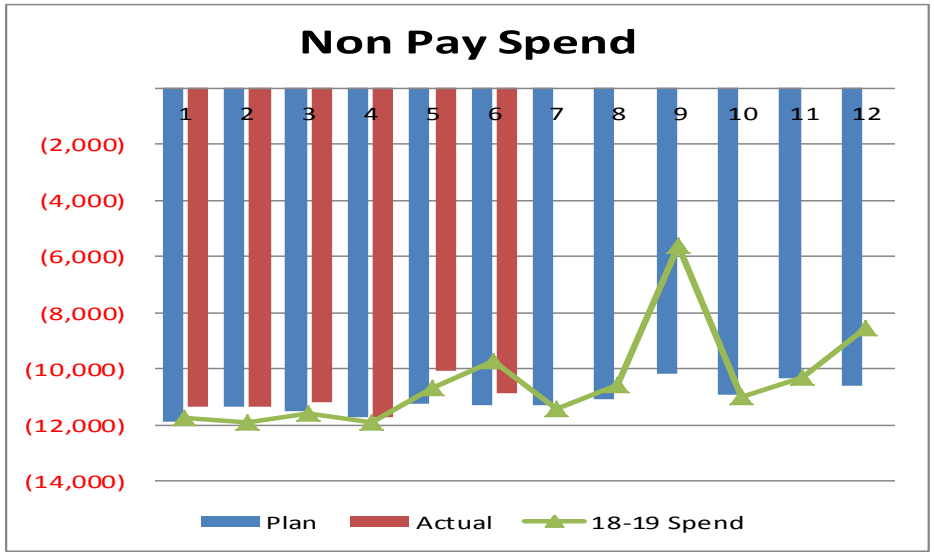
Workforce & Finance: Non Pay August 2019

Non Pay Performance

Expense Type	Annual Budget	In Month (£000's)			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
Clin Supp Serv	(31,035)	(2,412)	(2,442)	(30)	(15,344)	(15,419)	(75)
Drugs	(22,357)	(1,782)	(1,791)	(9)	(11,204)	(10,446)	758
OTHER (NON CLIN)	(82,388)	(7,217)	(6,646)	571	(42,572)	(40,752)	1,820
Non Pay Unallocated CIPS	1,630	62		(62)	(263)		263
Total	**(134,149)**	**(11,349)**	**(10,878)**	**471**	**(69,383)**	**(66,617)**	**2,766**



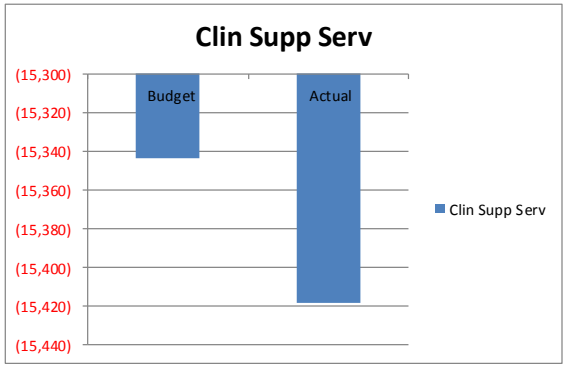
The in month non pay position reported an underspend of £1,233k. Actual Spend was £10.01m against a budget of £11.3m.

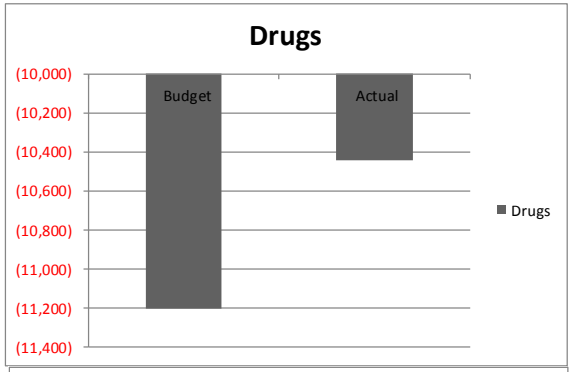
The main drivers of the position include:

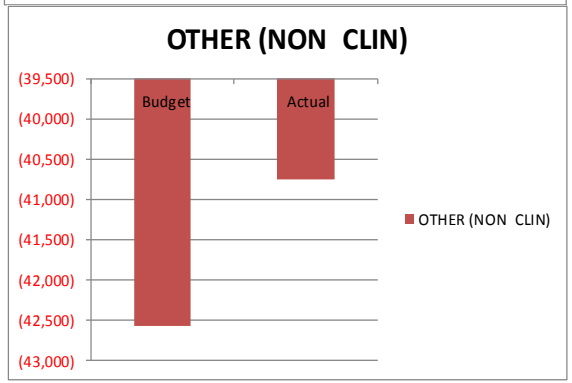
1. An underspend position against Clinical Supplies of £32k. The reduction was linked to lower activity spells performed in month.
2. A £101k overspend against Drugs. The majority of this relates to pass-through items and is offset by income.
3. A £1,148k underspend spend on Other Non Clinical. This was due to the release of a central provision held to manage risks which as at month 5 have not materialised

The YTD non pay position shows an underspend of £2.3m. This is driven by lower pass through expenditure on drugs and unutilised growth monies. In addition to this, the in month release of a central provision masks 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 M6 CIP Efficiency Performance Summary

FY20 M6 Performance - CIP Efficiency Divisional Trust Target	In Month (M6)			Year to Date (M6)			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	324	335	11	1,132	1,883	751	4,206	4,215	9
Emergency Medicine	99	107	8	347	662	316	1,287	1,324	37
Surgery & Anaesthetics	343	322	(21)	1,201	2,000	799	4,461	4,393	(69)
Womens & Children	142	152	9	499	550	51	1,852	1,553	(299)
Clinical Support	107	108	1	375	573	198	1,393	1,081	(312)
Environment	138	19	(119)	483	214	(269)	1,796	370	(1,426)
Corporate	128	35	(94)	448	328	(120)	1,665	561	(1,104)
Trustwide	-	-	-	-	-	-	-	1,658	1,658
Total	**1,282**	**1,077**	**(204)**	**4,486**	**6,211**	**1,726**	**16,661**	**15,155**	**(1,505)**

FY20 M6 Performance - CIP Efficiency Divisional Control Target	In Month (M6)			Year to Date (M6)			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	291	335	44	1,019	1,883	864	3,786	4,215	429
Emergency Medicine	89	107	18	312	662	350	1,159	1,324	165
Surgery & Anaesthetics	309	322	13	1,081	2,000	919	4,017	4,393	376
Womens & Children	128	152	23	449	550	101	1,668	1,553	(115)
Clinical Support	96	108	11	338	573	235	1,254	1,081	(173)
Environment	124	19	(105)	435	214	(221)	1,617	370	(1,247)
Corporate	115	35	(81)	404	328	(75)	1,499	561	(938)
Trustwide	-	-	-	-	-	-	-	1,658	1,658
Total	**1,154**	**1,077**	**(77)**	**4,039**	**6,211**	**2,173**	**15,000**	**15,155**	**155**

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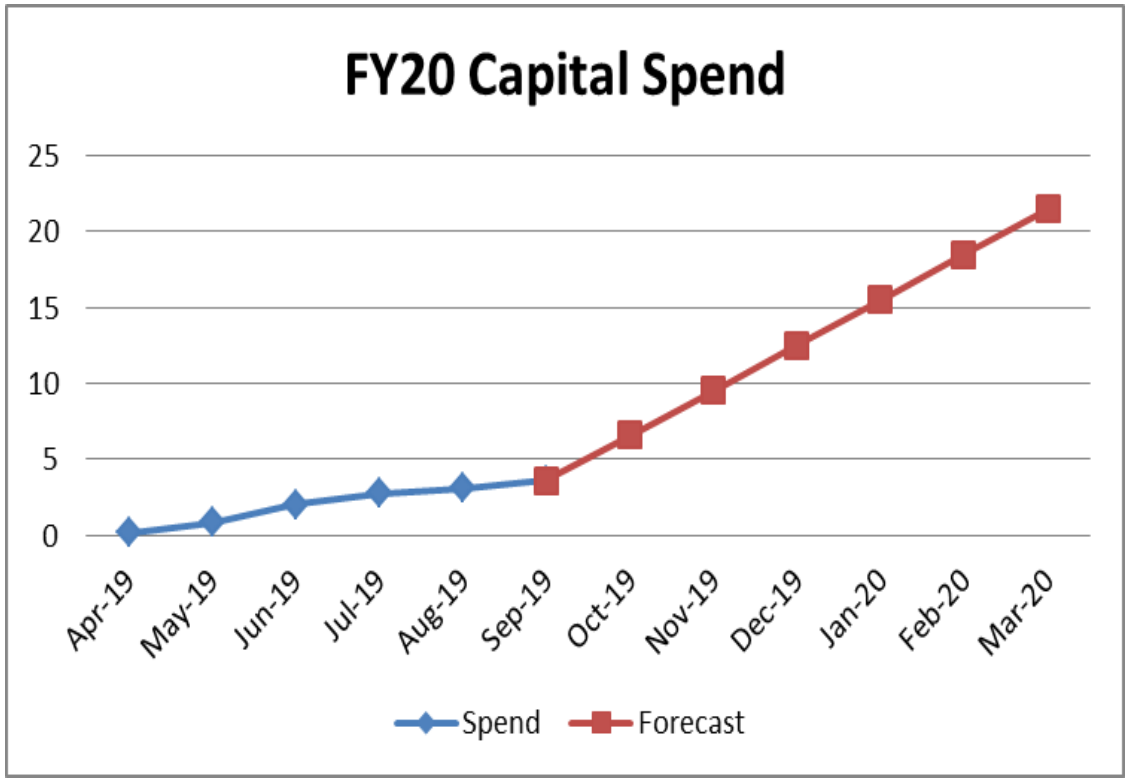
Workforce & Finance: Capital Expenditure August 2019



The Annual Plan for 2019/20 has reverted to £25m a with revised capital forecast of £21.5m.

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**
	YTD Spend	**3.60**

West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

In this reporting period:
The Summary Hospital Mortality Indicator's (SHMI) latest performance available at the time of reporting (for April 2018 to March 2019) was 98.55 and within the 'as expected' range (band 2). For the 12 month period (June 2018 to May 2019), the Trust's overall HSMR of 98.5 was in the 'as expected' range.

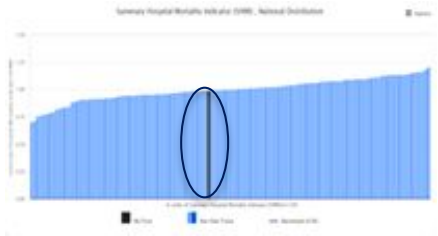
Factors / Themes:
A case note deep dive review is undertaken for each 'outlying' primary diagnostic SMR group with a speciality or senior trust consultant and the coding manager.

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

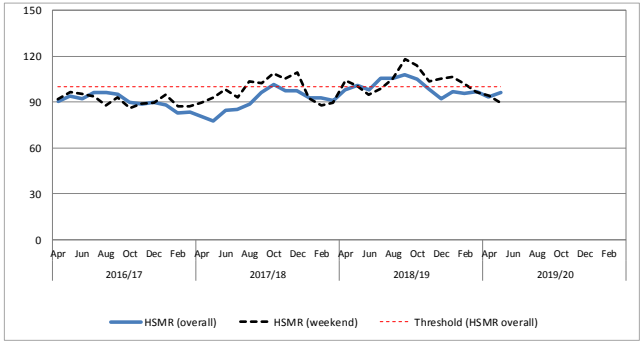
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



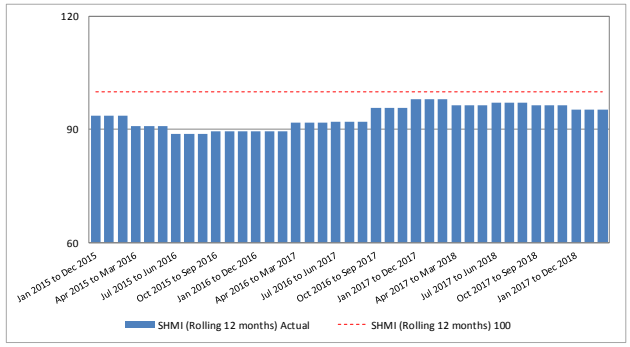
Period: 31/04/19

WHHT 0.99 **Sector: 1.00**

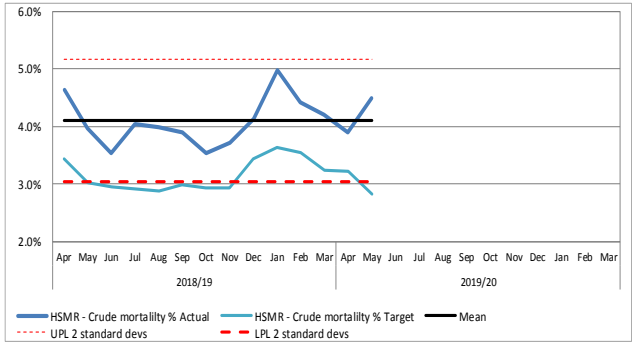
HSMR – rolling 3 months



SHMI – rolling 12 months



HSMR – monthly crude mortality (%)



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 reviewed the guidance and developed a strategy for implementation of the new objectives, which is in progress.

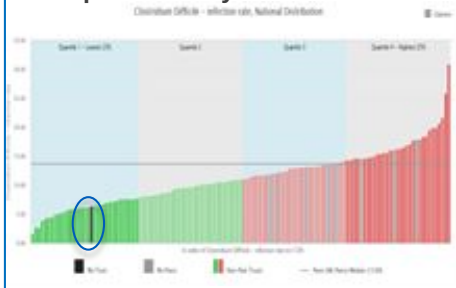
In September, 4 x cat 1 cases and zero cat 2 case. Monthly RCA meetings are undertaken with community and CCG colleagues, appeals for lapses in care were also undertaken. Three cases were successful at the appeal meeting, plus one will be removed from the figures following review, all 4 with no lapses 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 September.

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 new CDI process and 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.
Next steps:.
To provide oversight and assurance the CCG IPC team are working with us to do a review in October of the action plan, data and a visit to clinical areas.

Performance stable
Worse than target/threshold

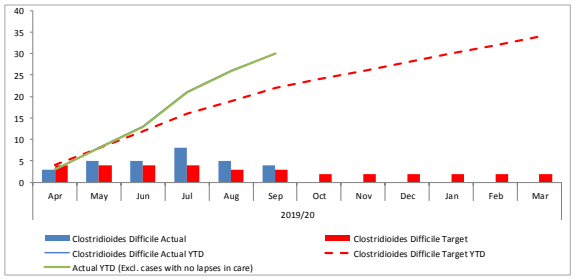
Benchmarking: MODEL HOSPITAL
Rolling 12 month trust apportioned Cdiff infections / 12 month avg occupied bed days



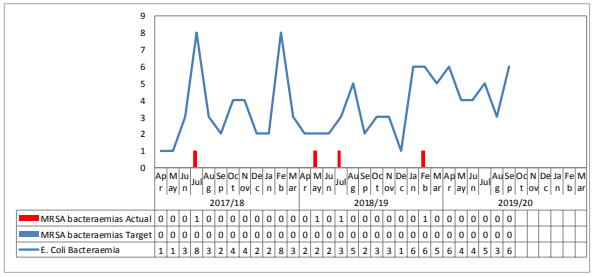
Period: to March 2019
WHHT 6.42 Peer 13.68
National 11.11

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

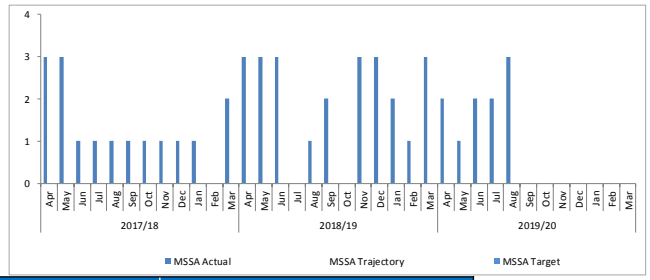
Clostrioides Difficile Infection (CDI)



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 6 post-48hr (trust apportioned) cases and 17 pre-48 hour cases (non-trust) reported in September. 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 organisations which includes a 90 day quality improvement project which will be completed in October 2019, with representation from 2 wards from WHHT. The work is looking at improving hydration in patients and prevention of UTIs, progress reviews at 30 and 60 days are planned with a final presentation on day 90 on October 21st.

Methicillin-sensitive Staphylococcus aureus (MSSAb)

There were zero post-48 hour (trust apportioned) cases and 4 pre-48 hour (non-trust) cases of MSSAb reported in September. Each case is reviewed by a microbiologist using an RCA tool to identify and share learning.

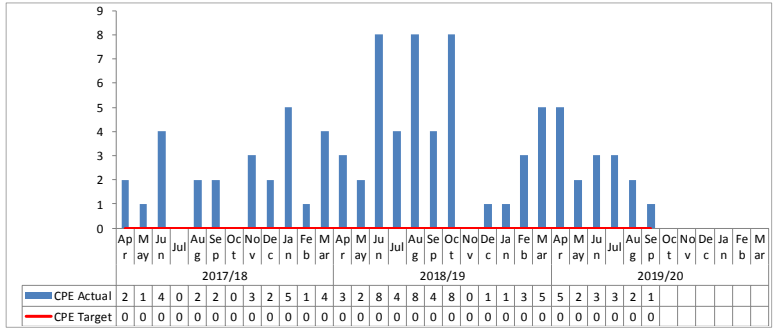
Infection Prevention Control (IPC) Progress Update

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 September work on the use of PPE, hand hygiene practices, ANTT and Chlorclean is in progress. There was overall increase in the COP scores in September for those undertaken by IPC, wards and department needs to undertake COP audits alternate months 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 have been held with the matrons to discuss measures to improve these areas. A review is in progress following the identification of a cluster of Serratia & Pseudomonas in the Endoscopy department. There were no non-compliances nor failings were identified. Scope 17 which is involved is still under investigation. There is continued monitoring of water quality, ventilation, decontamination, antimicrobial stewardship and cleaning across the trust.

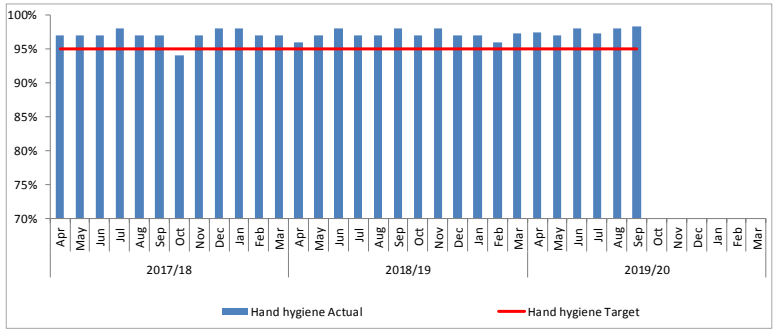
Factors / Themes: IPC monitoring of alert organisms is time consuming, increased ownership is required for IPC ensuring this is everyone business. Continued effort is required to improve environment al cleaning .

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. Re-instate weekly senior environmental walk around. Increase IPC engagement.

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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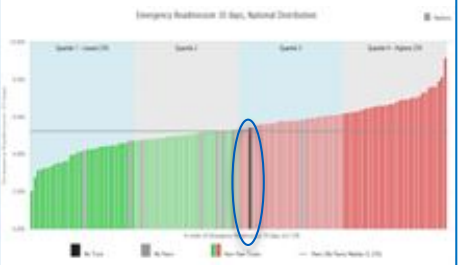
Safe care & Improving Outcomes: Emergency Readmissions

In this reporting period:
The readmission rate, benchmarked against the most up to date national position (February 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

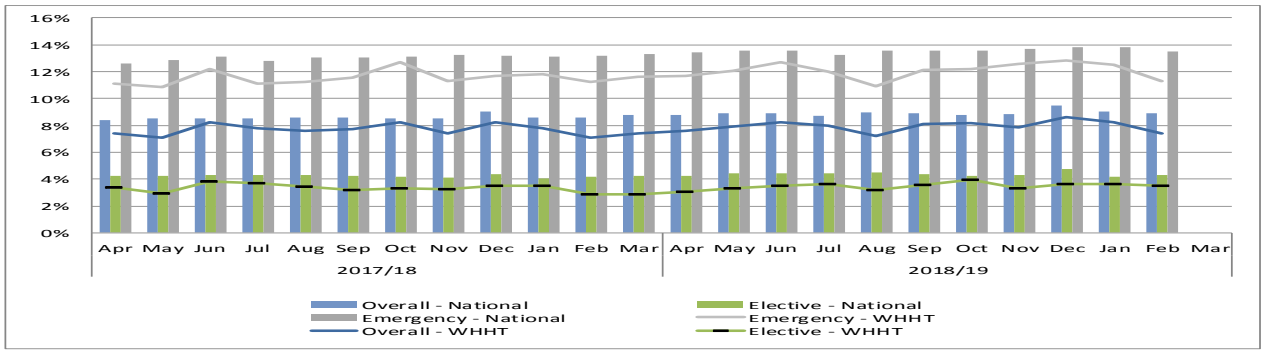


Period: Q2 2019/20

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 Trust is looking at the complexity of the births and changes in Better Birth Agenda to ensure the emergency sections are appropriate. In addition, Figo Training and CTG training are continuing.

Next steps:

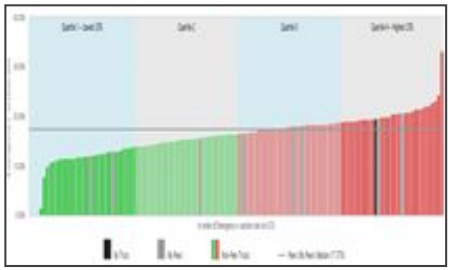
1. Continuous monitoring of data and responding appropriately.

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

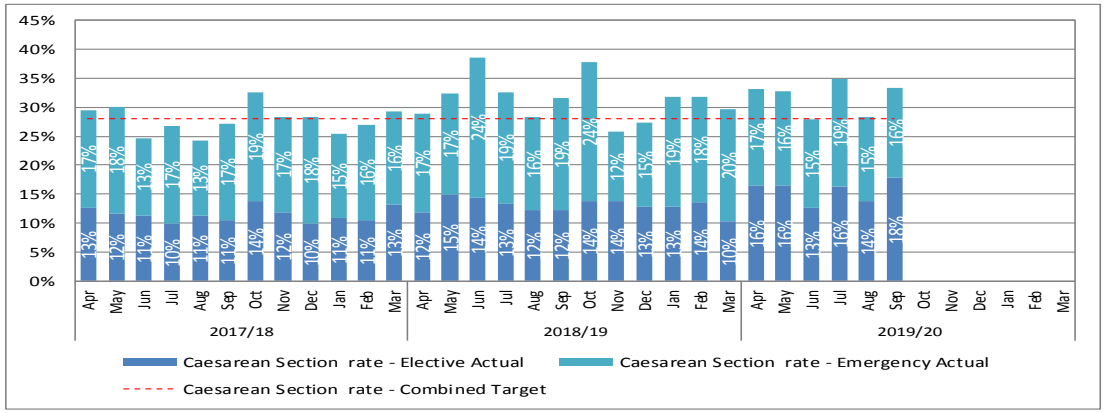


Period: July 2019

WHHT 19.63 Peer: 17.37%
National: 16.58%

(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 101.4%, above the national threshold of 95%. Within the total fill rates 98.3% were registered and 97.9% were unregistered 69.6% shifts were RAG rated green, 30% shifts were rated amber and 0.1% rated red. Current inpatient ward Band 5 vacancy rate is 0%, with turnover at 15.5% that demonstrates a clear correlation between recruitment strategy and good grip and control from ward managers, matrons and HONs/Midwifery. There were no red flags relating to shifts with less than 2 RNs identified.,15 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 managers have to balance supervision with safety of the ward; within the month the supervision time was 72.1% indicating the majority of their time was focused on promoting patient safety, developing/supporting junior staff and managing the ward. The other 27.9%, is deployed to clinical time supporting safe staffing.

Safe Care % utilisation – Of the 31 inpatient areas, 3 had fill rates below 95%. (range: 91.2% - 94.5%), two had fill rates below 90% (range 78.4% - 84.1%). 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 63,348 hours with a fill rate of 88.4%; (74.8% bank and 11.7% agency). A number of escalation beds were open - the highest utilisation being on the 1st September when there were an additional 35 beds open across seven areas. All additional shifts requested within hours have to be authorised by Head of Nursing and out of hours by the senior nurse in discussion with on call manager. Enhanced care team usage in September was 659 shifts . CHPPD is currently 7. 70 a decrease of 0.19 from last month. July data on model hospital shows peers at 7.9 and National at 8.2.

Factors / Themes:

For N&M staffing the Trust continues to positively benchmark for CHPPD against our peers on Model Hospital. July data on model hospital shows WHHT at 7.9, peers at 7.9 and National at 8.2.

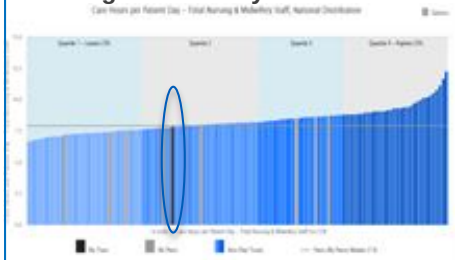
Next steps:

- ESRGo Project – Continue to progress the ESRGo implementation
- EWTD – violation now turned on e-roster, SOP re escalation process to be developed
- RSM Audit in 2018 – supporting evidence for each recommendation submitted.
- September establishment review meetings scheduled with HON this month
- Paediatric Establishment review sign off scheduled for November, paper to TMC December 2019
- Continue to monitor the bank and agency use within nursing and midwifery as part of the ongoing KPIs
- Successful recruitment campaign to Ireland

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL

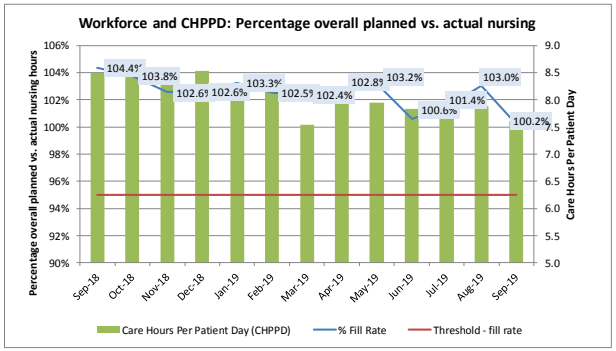
Care hours per patient day – total nursing & midwifery staff



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		

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Ward scorecard: themes from adult IP scorecard & Safety Thermometer

Analysis

Safety Alerts – in September there were 41 safety alerts. Falls with harm and pressure ulcers are the main cause of the safety alerts. As per detailed slide on Pressure ulcers this is higher than in previous months but above the national average according to the safety thermometer- although this is point of care data.

Process Alerts: In September there were 62 process alerts compared with 63 in August
Supervisory time and documentation were key areas of under performance. The process alerts are similar to August.

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 has started on Croxley and Tudor ward
3. Swarming to be introduced to the Trust using a QI approach on Heronsgate starting October 2019
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
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 second consecutive month
- For pressure ulcers and falls the safety thermometer data is lower than national average.
- Tissue viability and falls remain a focus within Divisions.

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Ward Scorecard

Ward Scorecard September 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	6 / 24	0 / 27	4 / 32	4 / 26						0 / 26	2 / 30					17 / 32		2 / 30	21 / 29	6 / 30	n/a		
	Safety					11 / 34	n/a	n/a	5 / 26	10 / 26			4 / 33	1 / 33	6 / 33	4 / 33		0 / 30						
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	✓ 97%	✓ 100%	✓ 97%	✓ 100%	✓ 0	0	0	! 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 96%	! 31%	✓ 0	✗ 1	✗ 71%	✓ 98%	9.23	0	2
	AAU G1	! 88%	✓ 96%	✓ 97%	✓ 100%	✗ 2	3	2	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 15%	✓ 0	✓ 0	✗ 14%	✓ 99%	8.82	1	3
	AAU P1	✓ 100%	✓ 100%	✓ 98%	✓ 100%	✓ 0	2	0	! 3	✗ 2	✓ 100%	NA	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 15%	✓ 0	✓ 0	✗ 71%	✓ 101%	8.88	1	2
	AAU Y1	✓ 91%	✓ 99%	! 88%	✓ 97%	✗ 4	0	0	! 3	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 95%	! 32%	✓ 0	✓ 0	✗ 48%	✓ 115%	10.15	2	3
Medicine	AAU B/Y 3	! 81%	✓ 96%	! 82%	! 86%	✗ 4	1	4	! 3	✓ 0	✓ 100%	✓ 97%	✗ 1	✓ 0	✓ 0	✓ 100%	✗ 22%	✓ 0	✗ 1	! 76%	✓ 106%	7.58	2	5
	Frailty	✓ 100%	✓ 98%	✓ 100%	✓ 100%	✓ 0	0	0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 0	! 86%	✗ 19%	✓ 0	✓ 0	NA	NA	NA	1	1
	CCU/ P/G 3	✓ 100%	✓ 99%	✓ 99%	✓ 97%	✓ 0	0	0	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✓ 38%	✓ 0	✗ 1	! 81%	✓ 96%	6.75	0	1
	Aldenham	NA	✓ 96%	✓ 95%	✓ 93%	✗ 3	0	0	! 2	✗ 1	✓ 100%	✓ 98%	✓ 0	✓ 0	✓ 0	✓ 100%	! 31%	✓ 0	✓ 0	✗ 43%	✓ 99%	6.68	2	2
	Bluebell	✓ 96%	✓ 97%	✓ 92%	! 86%	✗ 4	0	1	✗ 7	✗ 5	✓ 100%	✓ 90%	✓ 0	✗ 1	✗ 1	✓ 100%	✗ 26%	✓ 0	✓ 0	✓ 95%	! 95%	11.01	5	3
	Cassio	✓ 98%	✓ 100%	✓ 99%	✓ 100%	✓ 0	0	0	✗ 7	✗ 4	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 94%	✓ 70%	✓ 0	✓ 0	✗ 43%	✓ 119%	6.21	2	1
	Croxley	NA	✓ 100%	✓ 96%	✓ 100%	✗ 3	0	0	! 2	✓ 0	✓ 100%	✓ 94%	✓ 0	✓ 0	✓ 0	! 83%	✓ 60%	✓ 0	✓ 0	✗ 71%	✓ 97%	6.08	2	1
	Heronsgate & Gade	✓ 94%	✓ 98%	✓ 92%	✓ 92%	✓ 0	0	0	✗ 8	✗ 2	✓ 100%	NA	✗ 1	✓ 0	✗ 1	✓ 93%	✗ 20%	✓ 0	✓ 0	✗ 67%	✓ 103%	6.27	4	2
	Oxhey	✓ 94%	✓ 100%	✓ 90%	✓ 94%	✓ 0	0	0	! 3	✓ 0	✓ 100%	✓ 92%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 6%	✓ 0	✓ 0	✗ 62%	✓ 96%	6.10	0	2
	Red	✓ 98%	✓ 92%	✓ 98%	✓ 100%	✗ 2	0	0	! 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 1	✓ 91%	! 30%	✓ 0	✓ 0	✗ 38%	✓ 100%	6.01	2	2
	Sarratt	✓ 94%	✓ 97%	✓ 99%	✓ 100%	✓ 0	0	1	! 4	✓ 0	✓ 100%	✓ 94%	✓ 0	✓ 0	✓ 0	✓ 98%	✓ 64%	✓ 0	✓ 0	✗ 55%	✓ 111%	7.42	0	1
	Stroke	✓ 96%	✓ 96%	✓ 98%	✓ 100%	✓ 0	0	0	✗ 9	✗ 3	✓ 100%	✓ 95%	✓ 0	✓ 0	✓ 0	✓ 93%	! 30%	✓ 0	✗ 2	✗ 67%	✓ 101%	8.05	2	3
	Tudor	✓ 97%	✓ 98%	✓ 97%	✓ 100%	✓ 0	0	0	✗ 8	✓ 0	✓ 100%	! 86%	✓ 0	✓ 0	✓ 0	✓ 93%	✓ 38%	✓ 0	✓ 0	✗ 62%	✓ 113%	7.46	1	2
	Winyard	✓ 94%	✓ 95%	✓ 96%	✓ 100%	✓ 0	1	1	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 93%	✓ 68%	✓ 0	✓ 0	! 88%	✓ 98%	5.74	0	1
Surgery	Cleves	! 85%	✓ 100%	✓ 99%	✓ 100%	✓ 0	0	1	! 2	✓ 0	✓ 100%	! 86%	✓ 0	✓ 0	✓ 0	✓ 93%	! 33%	✓ 0	✓ 0	✓ 95%	✓ 103%	5.77	0	3
	DLM	✓ 100%	✓ 100%	✓ 98%	! 84%	✓ 0	0	0	! 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 97%	✓ 57%	✓ 0	✓ 0	✓ 100%	✓ 97%	10.28	0	1
	Flaunden	! 89%	✓ 100%	✓ 99%	✓ 96%	✗ 1	0	2	! 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 94%	✓ 49%	✓ 0	✓ 0	! 84%	✓ 95%	6.64	1	2
	ICU	✓ 94%	✓ 98%	✓ 98%	✓ 100%	✗ 3	0	0	✓ 0	✓ 0	✓ 100%	✓ 96%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 11%	✓ 0	✓ 0	✓ 100%	! 94%	19.41	1	2
	Langley	✓ 99%	✓ 100%	✓ 99%	✓ 100%	✓ 0	0	0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	! 85%	✓ 57%	✓ 0	✓ 0	! 89%	✓ 115%	5.94	2	1
	Letchmore	✗ 71%	✓ 100%	✓ 92%	! 87%	✗ 2	1	2	! 2	✗ 1	✓ 100%	NA	✗ 1	✓ 0	✗ 1	✓ 92%	✓ 42%	✓ 0	✓ 0	✗ 46%	✓ 115%	6.76	3	3
	Ridge	! 82%	✓ 100%	✓ 95%	✓ 97%	✓ 0	0	0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 1	! 84%	✓ 50%	✓ 0	✓ 0	! 89%	✓ 115%	6.97	2	2
	Elizabeth	NA	✓ 100%	✓ 99%	✓ 100%	✓ 0	0	0	! 4	✗ 1	✓ 100%	✓ 100%	✗ 1	✓ 0	✗ 1	✓ 92%	✗ 21%	✓ 0	✓ 0	✗ 51%	✓ 105%	5.56	3	2
Paeds	SCBU	NA	NA	✓ 94%	NA	✓ 0	0	0	NA	NA	NA	✓ 94%	✓ 0	✓ 0	✗ 1	✓ 100%	✓ 40%	✓ 0	✓ 0	✓ 100%	✓ 104%	10.01	1	0
	Starfish	NA	NA	NA	NA	✓ 0	0	0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 7%	✓ 0	✗ 10	✓ 100%	! 91%	7.98	0	3
	CED	NA	NA	✓ 95%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 2%	✓ 0	✓ 0	✓ 100%	NA	NA	0	1
	Safari	NA	NA	✓ 99%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 99%	✓ 34%	✓ 0	✓ 0	✓ 100%	NA	NA	0	0
Maternity	Delivery Suite	✓ 100%	✓ 93%	! 88%	NA	✗ 1	0	0	NA	NA	NA	✓ 97%	✓ 0	✓ 0	✓ 0	✓ 96%	✓ 46%	NA	NA	NA	! 94%	22.10	1	2
	Katherine	NA	NA	! 85%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 92%	NA	NA	NA	NA	✗ 84%	4.83	0	2
	ABC	NA	NA	✓ 96%	NA	✓ 0	0	0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 96%	✓ 46%	NA	NA	NA	✗ 78%	30.34	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) September 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 / 21	0 / 15	8 / 18	3 / 13	1 / 9	8 / 16	TBC	TBC	1 / 33	18 / 27	18 / 27	17 / 27		10 / 13		
	Safety													2 / 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	✓ 96%	NA	✗ 74%	NA	NA	NA	287	0	✓ 0	✗ 88%	✗ 16%	✗ 90%	✓ 100%	✗ 1%	0	5
	MIU	NA	NA	✓ 100%	NA	NA	✗ 87%	2	0	✓ 0	✗ 86%	✗ 27%	✗ 64%	! 88%	✗ 2%	1	5
	UCC	✓ 97%	NA	✓ 99%	NA	NA	✓ 98%	83	0	✓ 0	! 93%	✗ 12%	✗ 85%	✓ 91%	! 5%	0	4
Paeds	SCBU	✓ 94%	✓ 94%	NA	NA	! 98%	✗ 87%	41	0	✓ 0	! 93%	✗ 33%	✓ 100%	✓ 100%	✓ 40%	0	3
	Starfish	NA	✓ 100%	NA	NA	NA	NA	5	0	✓ 0	✗ 88%	✗ 10%	✗ 86%	✓ 100%	✗ 7%	0	4
	CED	✓ 95%	✓ 100%	NA	NA	NA	✓ 100%	15	0	✓ 0	! 90%	✗ 23%	✓ 97%	✓ 100%	✗ 2%	0	3
	Safari	✓ 99%	✓ 100%	NA	NA	NA	✗ 89%	4	0	✓ 0	✗ 82%	✗ 14%	✓ 100%	✓ 99%	✓ 34%	0	3
Maternity	Delivery Suite	! 88%	✓ 97%	NA	NA	✓ 99%	✓ 95%	64	0	✗ 1	✓ 96%	✗ 13%	✓ 98%	✓ 96%	✓ 46%	0	3
	Katherine	! 85%	✓ 100%	NA	NA	NA	✓ 100%	11	0	✓ 0	! 91%	✗ 15%	✗ 85%	NA	NA	0	4
	Community	! 87%	NA	NA	NA	NA	NA	0	0	✓ 0	! 94%	✗ 26%	✗ 71%	✓ 97%	NA	0	4
	ABC	✓ 96%	✓ 100%	NA	NA	! 98%	✓ 100%	5	0	✓ 0	✓ 96%	✗ 20%	! 90%	NA	NA	0	2
clinical support	Radiology WGH	✓ 91%	NA	✓ 98%	✓ 4%	NA	NA	25	0	✓ 0	! 94%	✓ 9%	✗ 82%	✗ 50%	NA	1	2
	Radiology HHGH	NA	NA	✓ 99%	✓ 4%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 100%	NA	0	0
	Radiology SACH	NA	NA	✓ 100%	✓ 4%	NA	NA	0	0	✓ 0	✗ 88%	✓ 4%	✗ 0%	✓ 100%	NA	0	2
	Radiology AAU	✓100%	NA	NA	NA	NA	NA	0	0	✓ 0	NA	NA	NA	NA	NA	0	0
Medicine	Outpatient WGH	✓100%	✓ 96%	✗ 91%	✗ 9%	! 98%	✓ 95%	28	0	✓ 0	✓ 97%	✓ 3%	✓ 95%	✓ 93%	NA	0	2
	Outpatient HHGH	✓100%	✓ 100%	✓ 93%	✗ 9%	✓ 99%	✗ 81%	0	0	✓ 0	✓ 96%	✗ 10%	! 94%	✓ 95%	NA	0	4
	Outpatient SACH	✓100%	✓ 100%	✗ 91%	✓ 8%	! 98%	✓ 96%	0	0	✓ 0	✓ 97%	✓ -4%	✓ 100%	✓ 95%	NA	0	1
	Endoscopy HHGH	✓ 99%	✓ 100%	✓ 95%	NA	✗ 94%	✗ 86%	0	0	✓ 0	✓ 97%	✓ 7%	✗ 88%	✓ 97%	✗ 11%	0	4
	Endoscopy WGH	✓ 98%	NA	✗ 91%	NA	✓ 99%	✗ 62%	0	0	✓ 0	! 94%	✗ 9%	✓ 97%	✓ 97%	✗ 7%	0	5
	Cath lab WGH	✓ 98%	✓ 100%	NA	NA	! 97%	✗ 69%	3	0	✓ 0	! 94%	✗ 41%	✓ 100%	✓ 100%	✗ 16%	0	4
	Dermatology WGH	NA	NA	✓ 96%	✓ 7%	NA	NA	4	0	✓ 0	! 92%	✓ 3%	✓ 97%	✓ 91%	NA	0	1
	Dermatology SACH	NA	NA	✓ 98%	✓ 7%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 96%	NA	0	0
	Dermatology HHGH	NA	NA	✓ 98%	✓ 7%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 95%	NA	0	0
	Helen Donald WGH	✓100%	NA	NA	NA	NA	NA	0	0	✓ 0	! 93%	✓ 5%	! 95%	✓ 92%	✗ 3%	0	3
Surgery	Day surgery SACH	NA	✓ 100%	NA	NA	NA	✗ 94%	21	0	✓ 0	✓ 97%	✓ 7%	✗ 82%	✓ 99%	✗ 28%	0	3
	Opthalmology WGH	NA	NA	✓ 92%	✓ 7%	NA	NA	0	0	✓ 0	! 90%	✗ 9%	✗ 62%	✓ 100%	NA	0	3
	Pre Op WGH	NA	NA	✗ 83%	✗ 9%	NA	NA	1	0	✓ 0	✗ 84%	✗ 17%	✓ 100%	✓ 92%	NA	0	4
	Pre Op HHGH	NA	NA	✓ 100%	✓ 7%	NA	NA	0	0	✓ 0	✓ 96%	✓ 8%	! 94%	✓ 100%	NA	0	1
	Pre Op SACH	NA	NA	✗ 81%	✓ 4%	NA	NA	0	0	✓ 0	NA	NA	NA	✓ 92%	NA	0	1
	Theatres WGH	! 86%	✓ 100%	NA	NA	NA	✓ 100%	20	0	✓ 0	✗ 86%	✗ 25%	✗ 84%	NA	NA	0	4
	Theatres SACH	✓ 94%	✓ 90%	NA	NA	NA	NA	0	0	✓ 0	✓ 95%	✗ 24%	✗ 57%	NA	NA	0	2
	Theatres Delivery WGH	✓ 92%	NA	NA	NA	NA	NA	2	0	✓ 0	NA	NA	NA	NA	NA	0	0
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%		

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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 September.

Serious Incidents

There were 3 serious incidents declared in September 2019 in the following divisions: 1 in Surgery; 1 in women's' and Children's and 1 in Medicine.

At the end of September the Trust had 12 open Sis. Of these, 4 investigations were complete and with commissioners pending formal closure on StEIS. There were 8 ongoing SI investigations.

Learning from SIs

There was 1 completed report submitted to the commissioners during September. The recommendations from this report focused on training for staff in ED to include NEWS scoring and the presentation of patients with necrotising fasciitis.

Action plans are developed for all completed SI's, signed off and monitored by the division leading the investigation into the incident.

% of patient safety incidents which are harmful

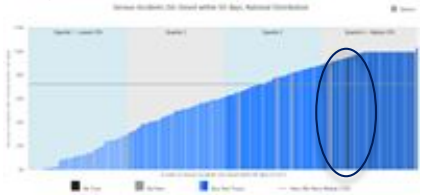
8.4% of incidents reported in September 2019 were recorded as having caused harm to the patient, compared to 8% in August 2019.

There were 13 incidents reported in September 2019 with a moderate or above level of harm. There was 1 incident reported in September 2019 with a harm level of Death/Catastrophic which are detailed below:

1. The patient was readmitted 3 days after discharge following hemiarthroplasty; the patient deteriorated and died 5 days later. The incident will be presented to SI panel for discussion.

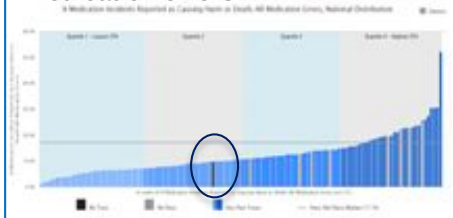
Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



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

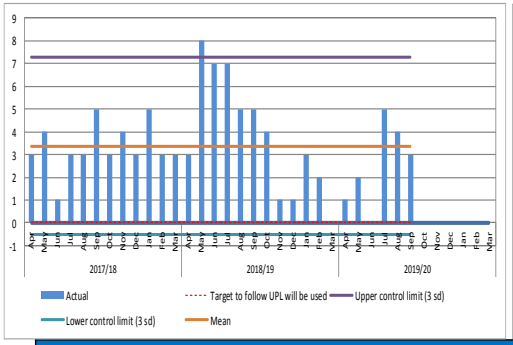
Benchmarking: MODEL HOSPITAL
% medication incidents reported as causing harm or death/all medication errors



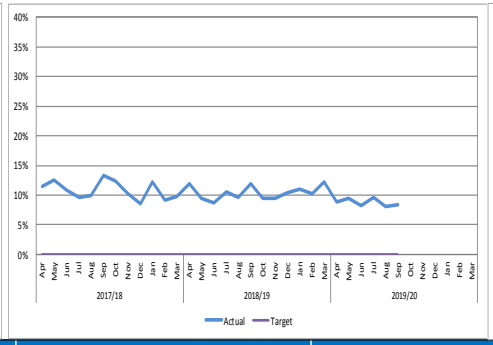
Period: 31/03/2019
WHHT 10.0% Peer: 17.1%
National: 10.7%

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

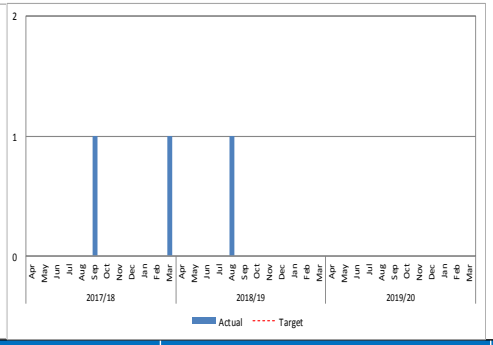
Serious Incidents



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 September Analysis of September falls with harm data shows that 16 (66.7%) falls were not witnessed, 8 falls were witnessed, 11 incidents occurred during the day shift and 13 during the night shift, 16 (66.7%) incidents involved patients with cognitive impairment. Of these 7 patients were reported has having dementia. The majority of falls 18 (75%) occurred around the bed area, 2 of the falls with significant harm occurred during the day shift and 1 during the night shift. Falls with harm remains low in comparison to the number of falls reported locally and nationally. Recurrent fallers still account for a significant number of fallers. 8 patients accounted for 21 incidents. Of the 93 inpatient falls reported in September several clinical areas reported 7 or more falls, these included;

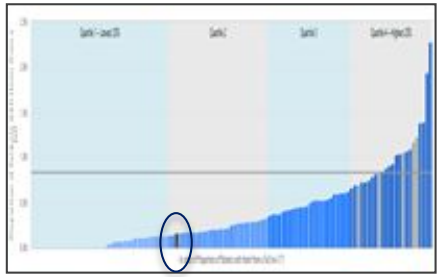
Stroke unit – 9, Tudor/Castle – 8, Heronsgate/Gade – 8, Cassio – 7, Bluebells – 7

Actions:

- Increase awareness around suitable foot wear for patients continues
- 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 QIF
- Meeting planned to explore how to take the NHSI falls collaborative work on reducing hypertensive medication in frail elderly patients forward
- Matron and Ward Charge Nurse from Heronsgate attended London Falls Prevention Network in October. To feedback on falls prevention work.
- Using a QI approach- plan to measure impact on Heronsgate of swarming on post fall review and prevention of recurrent falls.
- Learning from RCAs and deep dives are discussed at Quality Forums to improve awareness, patient experience and the care provided.
- Work to improve medical team compliance with completing multi-factorial falls assessments continues.
- Cohorting of patients also called 'bay watch' continues and evaluation of project will be presented at the falls group- To be reviewed at August Falls meeting – 29/8/19.
- Increase awareness around highlighting and managing high risk fallers in safety huddles .

Performance stable
Better than target/threshold

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

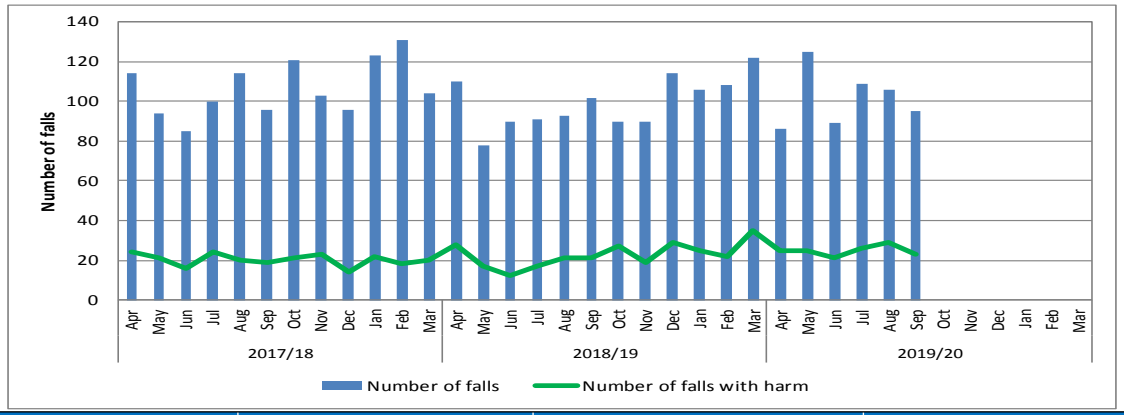


Period: April 2019

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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The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

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 September 97.6 % compared to national average of 97.8%

September comparison with national data:

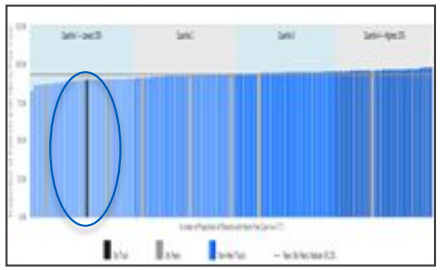
- New Pressure Ulcers 0.8% (an increase of 0.3% compared with August) vs national figure 1%
- Falls with harm 0.3% vs national figure 0.5%
- New VTE 1% % vs national figure 0.4% This is an increase of 0.7% since August and the Trust is above the national data.
- Patients with a urinary catheter 16.4% vs national figure 14%. Patient with catheter and UTI 1.7%vs national figure 0.7% The occurrence of UTI has increased by 1.2.% since August.

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 not reported in September 2019. This will be reported next month when the information within the Children and Young People's Safety Thermometer is updated.

Maternity Safety Thermometer: The combined harm free care score was below the national average of 76.5% at 67.3%. 0% of women experienced a 3rd /4th degree tear in this audit, below the national average of 1.1% which is a significant decrease from August's audit which was 4.6%. The proportion of term babies born with an APGAR of 7 or less at 5 minutes is 3.9% which is more than the national average of 3.1%. The proportion of woman with a maternal infection from onset of labour to 10 days postnatal has increased to 7.3% in September with the national average being 6.2%. Our PPH rates remain below national average for the 6th month running sitting at 7.3% 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

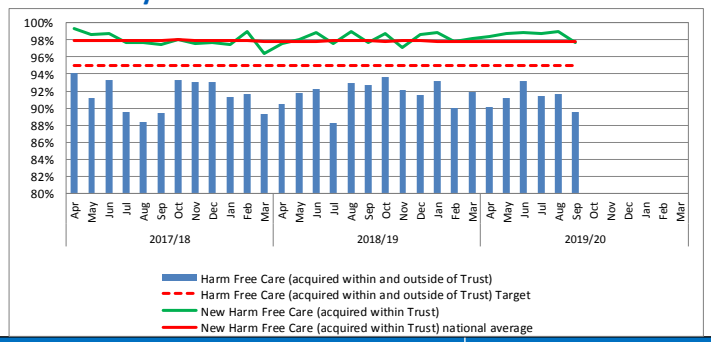


Period: April 2019

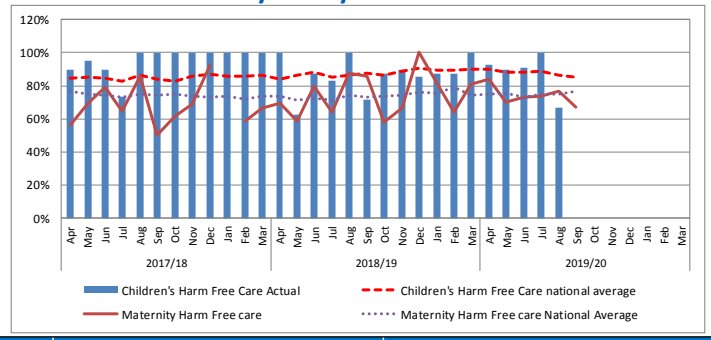
WHHT 90.1% **Peer 93.2%**
National 94%

(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 September there were 35 reportable* HAPU's affecting 22 patients. In addition there were 10 category 1 pressure sores affecting 7 patients and 14 cases of SDTI affecting 9 patients.

Category 4-0, Unstageable – 5, Category 3-2, Category 2-28, Category 1-10, SDTI -14

There has been an increase in pressure ulcers reported in September. The majority of pressure damage remains in the medical division. 8/45 cases of pressure damage was in the surgical divisions. 11/14 SDTI's occurred on the heels, a significant increase compared to previous months data.

Despite the increase in the number of pressure ulcers the Trust is still below the National data 0.8% compared with 1% nationally in September.

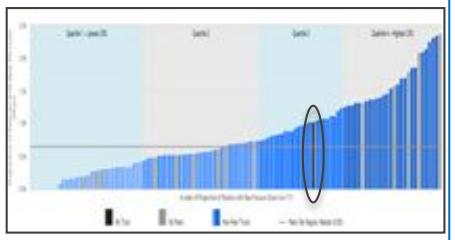
Actions:

- Focus within the safety huddles patients with medical devices and heel offloading.
- Trial of a different pressure ulcer RCA tool to elicit learning which enables SI decisions to be made.
- Target work from the a TVN team member working alongside HCA and clinical support workers to enable role modelling good patient care in relation to skin management.
- Working with the safeguarding team in relation to pressure ulcer management and outcomes.
- 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 has commenced on Croxley and Tudor ward.

Stable

Benchmarking: MODEL HOSPITAL

Proportion of patients with new pressure ulcers (grade 2-4)

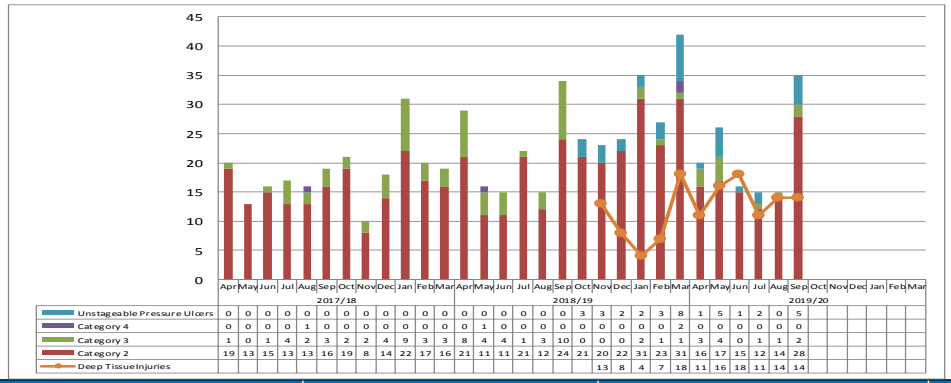


Period: April 2019

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

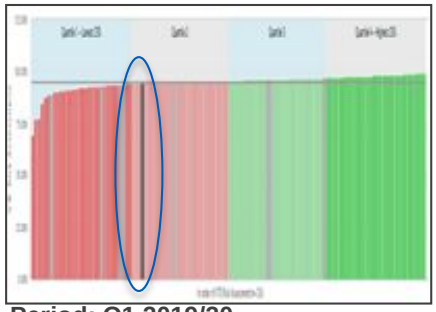
In this reporting period:
The current reported position is below target, but as in previous months, compliance is expected to improve as inpatient episodes are completed and then coded.

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

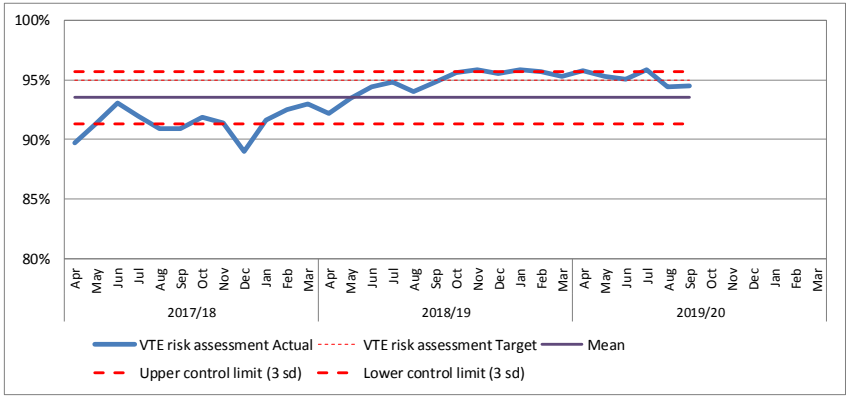


Period: Q1 2019/20

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:

4 hour target
Performance against the 4 hour target for admission to the stroke unit was 63.0%.

90% stay
95.0% of stroke patients in this reporting month spent 90% of their stay on the stroke unit which is above the 80% target.

Percentage of patients thrombolysed within 1 hour is 60%.

This is measured by SSNAP with a quarterly target (55%), the Trust achieving 62.8% .

Factors / Themes:
Maintaining ring fenced beds on the stroke unit has not always been possible as the Trust continues to experience seasonal capacity constraints affecting "right bed" availability. However patients continue to receive stroke specialist care and input while they await transfer to the stroke unit.

Stable

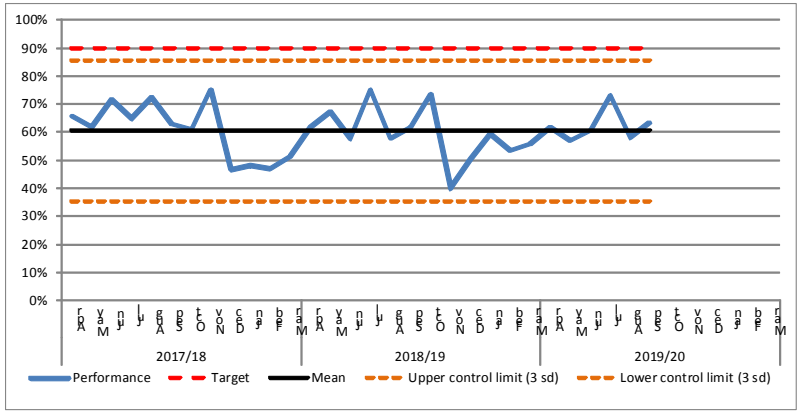
Benchmarking: SSNAP

Period: January to March 2019

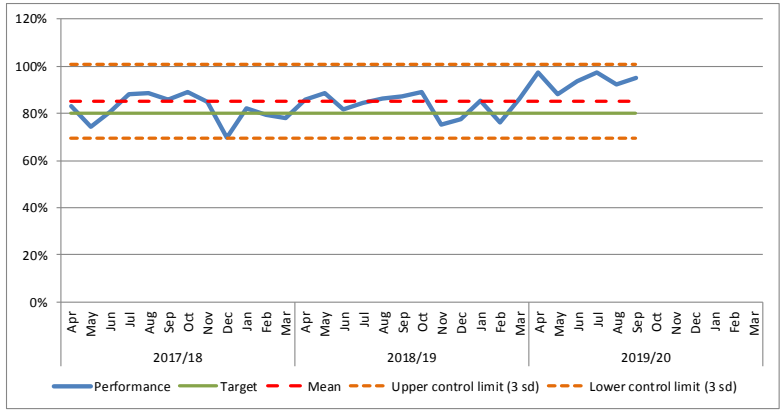
Admission within 4 hours: 55.5%

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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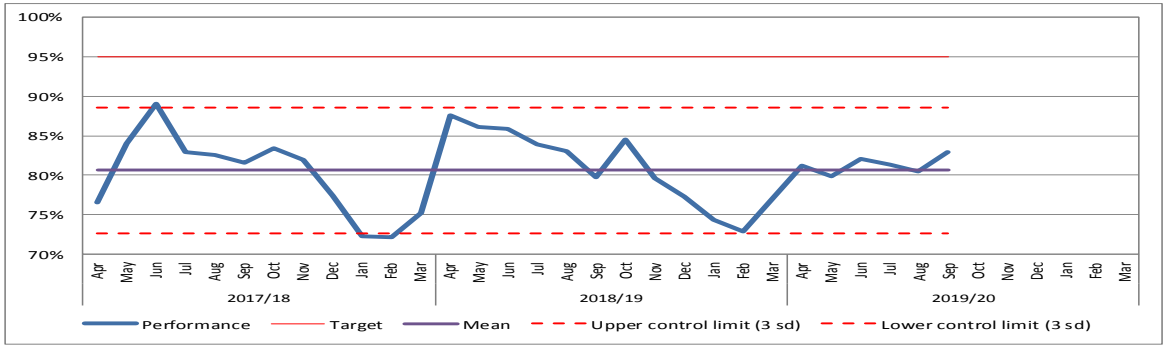
Caring & Responsive Services: Emergency Department

In this reporting period: Overall performance against the Emergency 4 hour standard has improved from 80.5% to 83.0%. Minors performance has improved from to 93.4% to 94.9% however CED performance has dropped to 92.9%. Of note, both majors and admitted performance has improved to 57.3% and 59.4% respectively.

Factors/Themes:
Attendances were higher than in August at 8998 which represents a 5.4% increase in attendances. Ambulance attendances remained the same as August levels. The number of patients attending with mental health issues is increasing and this creates further pressure on the department, particularly when the cases are complex or out of area.

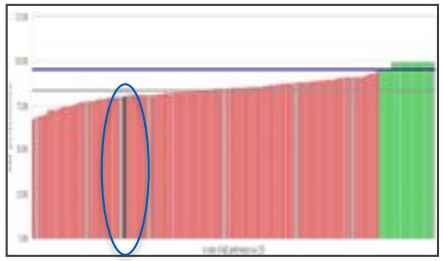
Next Steps:
- The regular check in meetings between the service team and Exec colleagues continue , together with the weekly access meetings. There is a robust framework for monitoring the improvement plan.
- Work continues with the expansion of the ambulatory care service with the service returning 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.
- 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 dept is reviewing the possibility of joint posts and being supported by recruitment agencies.
- The new medical take model is underway with regular review meetings being held.

AE&: Attendances within 4 hours



Performance stable
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
% of patients admitted or discharged within 4 hours of arrival



Period: August 2019

WHHT 80.5% **Peer: 83.3%**
National 85.2%

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

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 4 mixed sex accommodation breaches in September. 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 breaches occurred in ITU and were due to pressures on the emergency care pathway. Both patients were awaiting general medical beds.

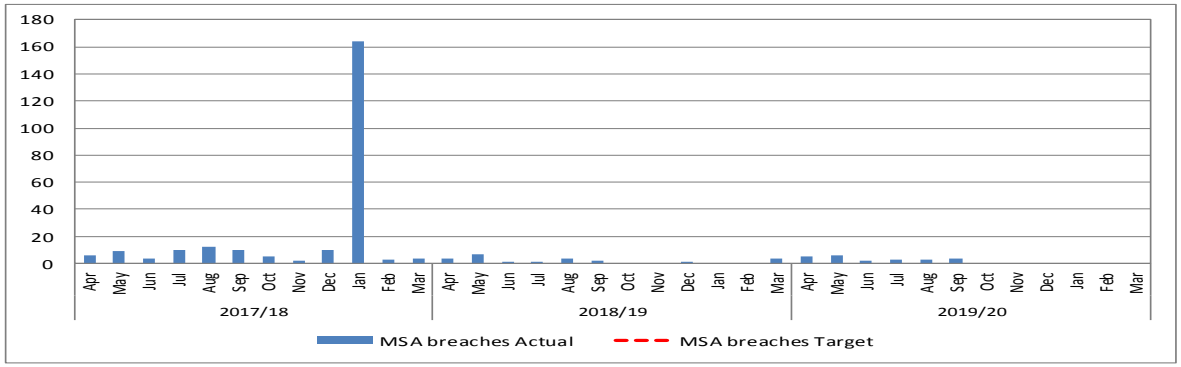
Next steps:
The monitoring and management of patients requiring step down from ITU is reviewed daily as part of the regular operational management meetings.

Performance stable
Worse 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		

11

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Caring & Responsive Services: Delayed Transfers of Care

In this reporting period: Delayed Transfers of Care (DToC) patients represented 6.3% of occupied beds in September, higher than the previous month's reported position of 3.3%. 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 832 bed days, the equivalent of 27.7 beds.

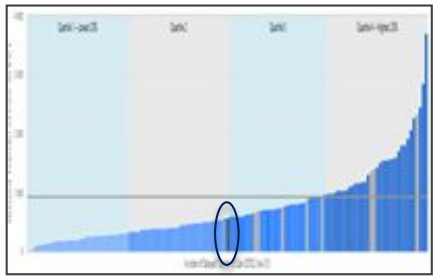
LOS MDT meetings continue, with participation from, IDT both social and health, surgery , therapy and a representative from HVCCG. The Trust is trying to encourage our new community partners to attend. Discharge assessment review teams (DART) visit the ward and identify ever patient over 21 days and assess. This review is clinically led. The Trust has been dealing with two very complicated out of area delays which account for the highest LOS. One has now been discharged and the other is due to go Monday. There is also a further challenging patient for which at present no facility is prepared to accept. Several delays seen due to no capacity for IMC with many patients on a waiting list. It is hoped that the new community providers will help with this issue but in the mean time the CCG have spot purchased some additional IMC beds. There are also delays awaiting Discharge home to assess beds. One community ward has come back under the care of the acute Trust. There are many delays on this ward so the teams are focusing on ensuring these patients are moved through the system and any blockages removed.

Factors / Themes:
Out of area complex discharge and waits for IMC and QDS package of care

Next steps:
Continue dialogue with out of area to try to move on longest LOS

Performance improved
Better than target/threshold

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

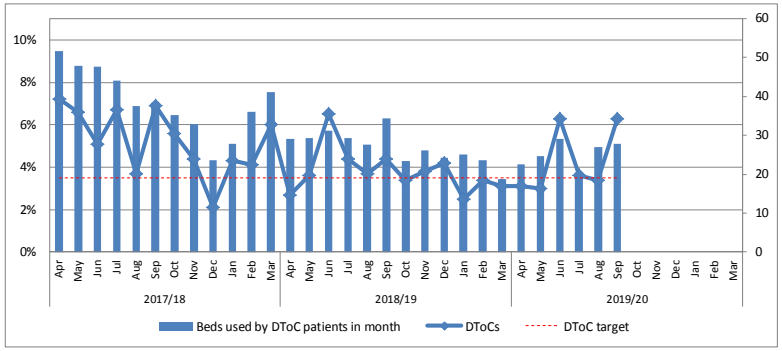


Period: March 2019

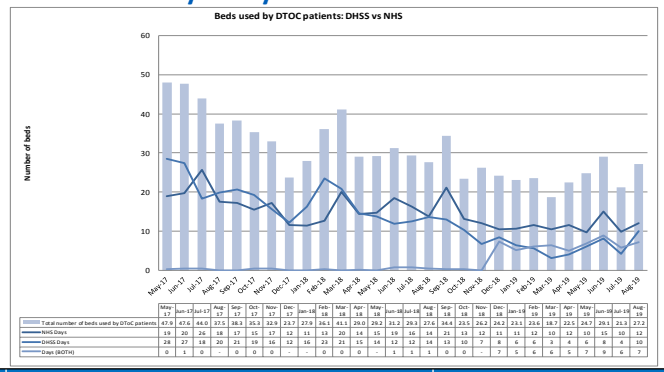
WHHT: 579 **Peer: 928**
National: 579

(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:

Inpatient

The recommendation rate is unchanged at 96% with a 0.5% increase in those not recommending the service (from 1.1% to 1.6%). The response rate has reduced to 22% (from 29%) overall but when the in-patient wards (2,827 patients) are separated out from the areas that admit patients for day case treatments and procedures the average response rate is 34.7%. This is above the national average rate of 26% for in patients.

The 11 areas that admitted 4,038 patients for day case treatments and procedures (Ambulatory care, Cardiac Cath Lab, Day surgery & Endoscopy SACH/WGH, ESAU, GACU, Helen Donald unit, Safari day unit and Windsor) average score is 16.5%.

A total of 819 comments were received from inpatients, of which 795 were positive and 24 were negative. The main areas of concern from patients were: noise; organisation of care and poor communication resulting in delays with discharge and ongoing care. The positive comments described staff as "*Lovely staff, very friendly and informative* " GACU, WGH and on Flaunden ward at WGH "*My care was 2nd to none. Praise to everyone*." On AAU L3 patients said "*The nursing staff are efficient attentive and diligent in their day to day activities, but above all cheerful.".*

A&E

The response rate is 2.74% compared to 3.1% in August with a similar level of change in the recommendation rate at 92.9% compared to 95.4% and number of those not recommending is 2.8% compared to 2.3%.

The reason given by those not recommending was due to the length of time spent waiting to be seen; there were 13 negative comments with the majority generated from UTC at HHGH . The recommendation rate is 95.4%. The 156 (out of a total of 169) positive comments identified *"Reception very good. Nice to have a triage nurse to make sure my problem can be treated in the minor injuries department. My nurse called in another nurse and asked for help and advice. Both very caring. Thank you".* A review of the data for ED rates nationally indicate that the average response rate remains at 12%, the recommendation rate is 86% and those not recommending is 9%.

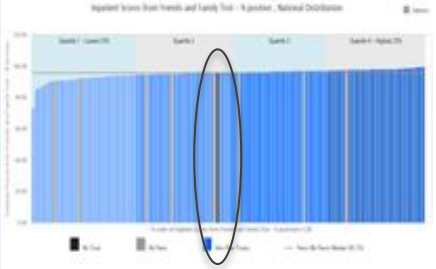
Next steps:

A review of the use of electronic devices to collect feedback is being considered as part of the tendering process for the FFT contract that expires in April 2020.

Performance stable
Better than target/threshold

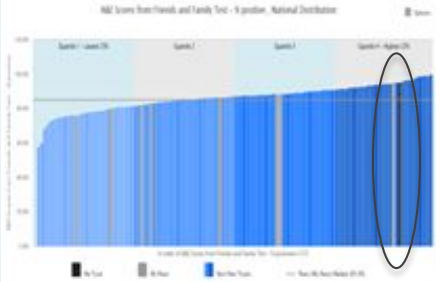
Benchmarking: MODEL HOSPITAL

Inpatient FFT scores % positive



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

A&E scores - % positive

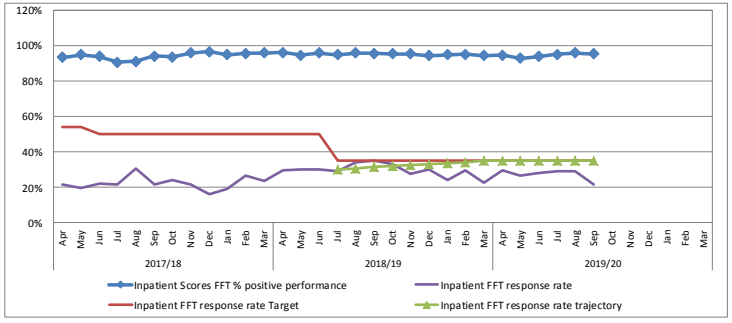


Period: August 2019

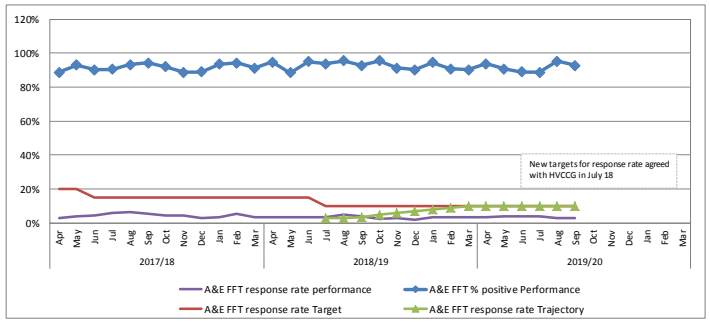
WHHT 95.4% Region 85.0%
National 87.2%

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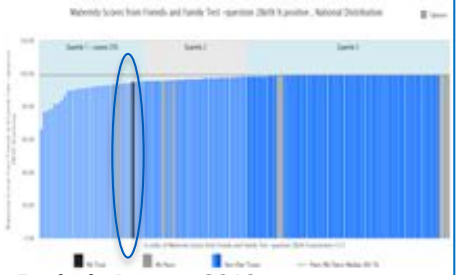
Caring & Responsive Services: Friends & Family Test (2 of 2)

Day Case
The average response rate within day surgery is 16.3%; St Albans is 27.6% and Watford is 5.2%. The recommendation rate is 99%.
Outpatients
Responses have increased from 3528 to 4453 this month. The recommendation rate has improved by 1.1% to 95% and the rate of those not recommending has is 0.7%; an improvement of 0.6%.
A review of the responses, 2090 of which included a free text comment, has identified a small number (41) of negative comments Trust wide. The comments related to the delays in being seen, lack of continuity in care and time spent waiting for an appointment date to be set. The 2049 positive comments included: Phlebotomy, WGH *"I came for a blood test, I did not have to wait Gloria introduced herself, was pleasant, efficient and informative and blood test was skillfully done, virtually painless".*
Maternity
The response rate has returned to a more average level of 46.2%; remaining above the 35% target response rate set by the CCG. The improvement in recommendation rate and those not recommending have been sustained with 95.7% recommending (compared to 95.2%) and 0.5% would not recommend (compared to 1.8% in August). There were 271 comments from ABC & Delivery Suite; 2 were negative and 269 were positive including the following: "*a nice and calm environment with friendly, efficient staff. Karina, Inna and Tina were fantastic. We felt very well looked after throughout the whole experience*. "
Next steps:
A review of the response rates for all areas across the Trust compared to the national average response rates has identified that the inpatient ward areas, maternity and out patients are exceeding the national average rates. This achievement will be recognised with the introduction of internal targets that will be different to the targets set by HVCCG. This change acknowledges the effort of the in patients wards to improve the level of feedback being collected from patients.
A review of the areas included in the inpatient return that are treating patients attending for day case and day procedures will be undertaken as part of the implementation of the FFT changes in April 2020.

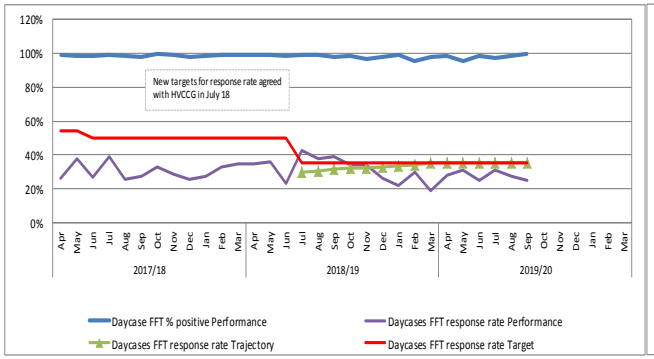
Performance stable
Better than target/threshold

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

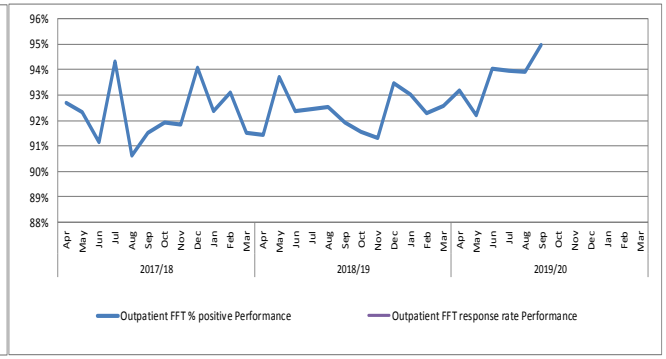


Period: August 2019
WHHT: 95.2% Peer: 99.1%
National: 98.4%
(Peers = Nightingale Group – acute multi-site trusts)

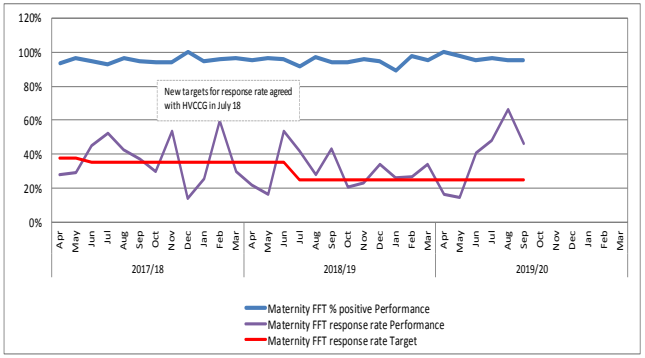
Daycase FFT: responses and % positive



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:
September's response rate, at 81% was below the required 85% target. 29 new complaints were received in August 2019.

- 28% (8) relate to Surgery, Anaesthetics and Cancer (SAC)
- 28% (8) Medicine
- 24% (7) Emergency Medicine/USC
- 7% (2) Women's & Children's (WACs)
- 7% (2) Corporate
- 3% (1) Environment
- 3% (1) Clinical Support Service. At month end there were a total of 52 live complaints.

29 complaints were closed in the month and one complaint was over 6 months old.
7 complaints were reopened, 3 more than the previous month:

- 5 for the Division of Surgery, Anaesthetics and Cancer
- 1 each for Medicine and Emergency Medicine.

Factors/Themes:
In August we saw a rise in complaints for the first time this year when compared to the same period in 18/19, however September has seen the same number of complaints as the corresponding period. As stated this may be evidence of the complaints having reached a level in which we may not see significant monthly variations from corresponding periods last year.

Trust wide, most common themes remain all aspects of clinical care (incl. clinical care and treatment) 51% (15); attitude of staff and communication at 28% (8), 10% (3) around admission and delays in appointments .. The remaining complaints 11% (3) are non clinical in nature, such as Parking.

Performance improved
Better than target/threshold

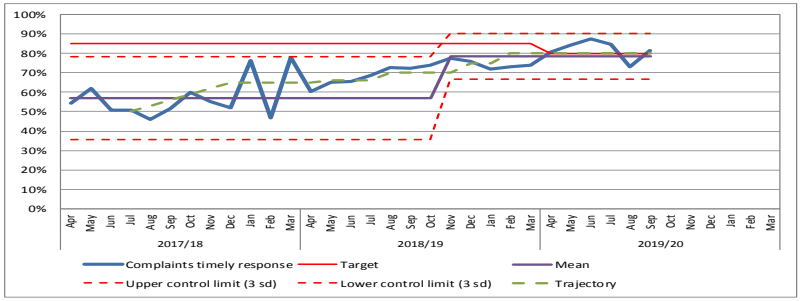
Benchmarking: MODEL HOSPITAL
Number of written complaints received per 1000 staff (wte)

Period: Q1 2019/20

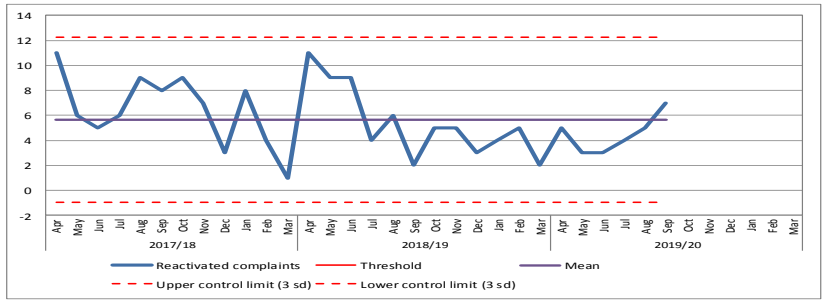
WHHT 18.38 Peer 29.03
National 24.27

(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		

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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 September, 86 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 9 patients who died in a setting that was not their preferred place of death (PPD). In in 7 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 4 patients whose death was reviewed in September, there was 1 patient who did not have an IPCD and it was deemed that this would not have been appropriate this patient. 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)

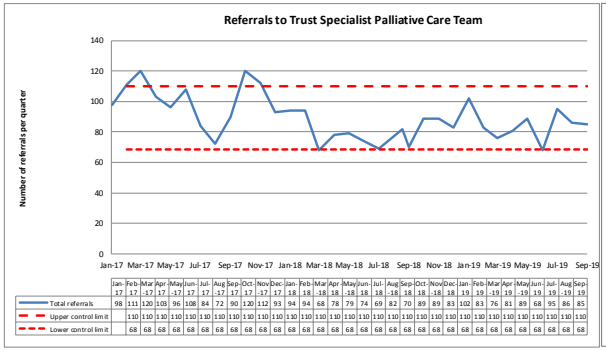
Treatment Escalation Plans ensure that every patient's care is reviewed, individualised and their levels of care are considered, in line with the Trust's guidelines. In September 2019, of the 4 deceased patients reviewed 4 had a TEP in place. In 1 of those patients, the TEP had been reviewed as needed and was appropriate. There were no patients without a TEP.

Stable

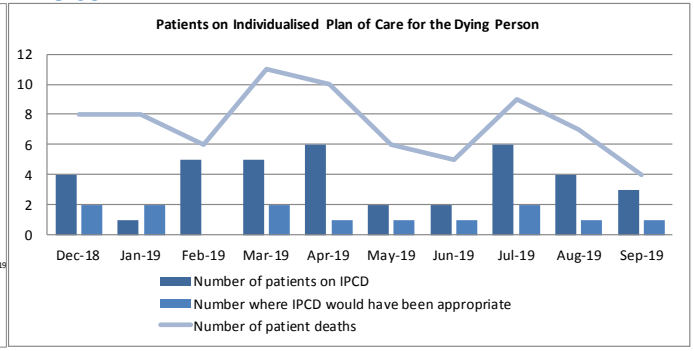
Benchmarking:

Not currently available

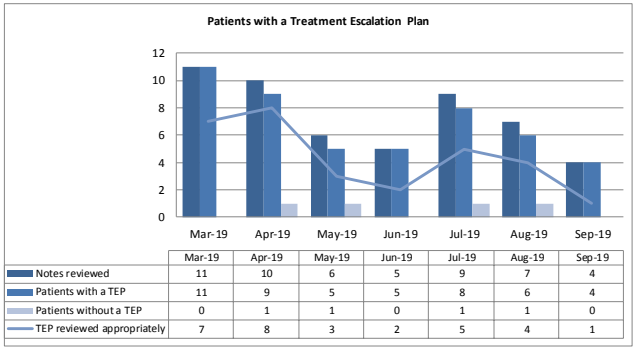
Referrals to Trust Specialist Palliative Care Team



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
Notes reviewed	11	10	6	5	9	7	4
Patients with a TEP	11	9	5	5	8	6	4
Patients without a TEP	0	1	1	0	1	1	0
TEP reviewed appropriately	7	8	3	2	5	4	1

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, this month to 85.8% and remains in line with plan. The most recent national data available (August 2019) shows that WHHT performance that month was better than the national average (85.0%).

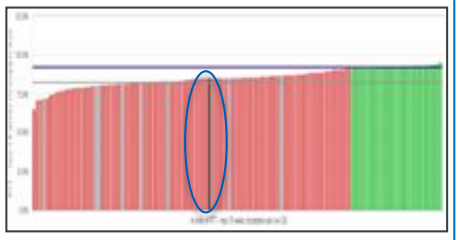
The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was better than the national position (7.6 vs 8.0 weeks) but worse than the 92nd percentile wait time (24.0 vs 23.7 weeks). The overall PTL size remains lower than the March 2019 position and is on track to meet national expectations. The 18 week plus backlog continues to decrease.

At the end of the month there were 3 patients whose waiting time exceeded 52 weeks, all having chosen to defer treatment.

Next steps:
As mentioned above, 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

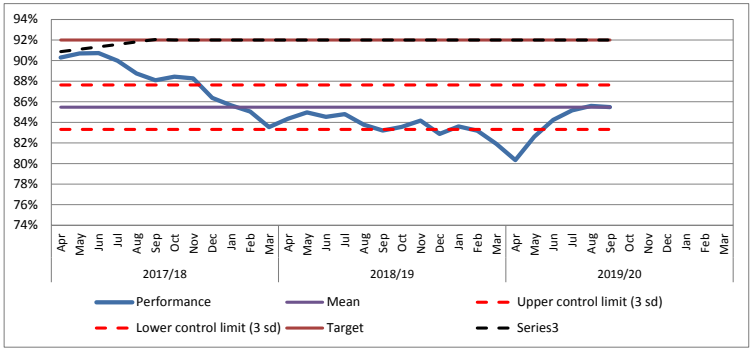


Period: July 2019

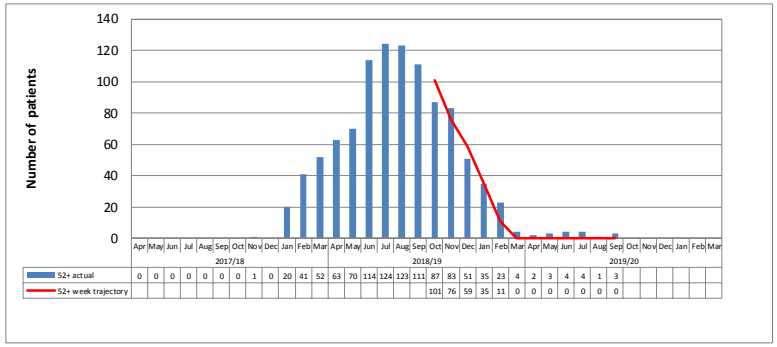
WHHT: 85.2% **Peer: 82.14%**
National: 85.6%

(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		

11

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

2 week wait
The provisional position for September is compliant at 93.2% with 1425 referrals of which 97 were seen beyond 14 days. The referral numbers are marginally lower than the average (Average since April 2019 is 1598 referrals/month)

Breast symptomatic
The provisional position for September is compliant at 100%. There were 117 referrals all patients were seen within 14 days.

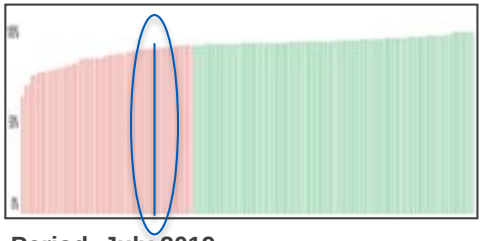
2WW Factors / Themes:
The areas with the highest number of breaches were:
Skin with 32 and LGI with 33

All services have either lowered their polling range to 8 days or are working towards that. In June 2019, 74% of patients were see in the second week and in October that has reduced to 49%. This work continues but there are aspects where further improvement is still anticipated.

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

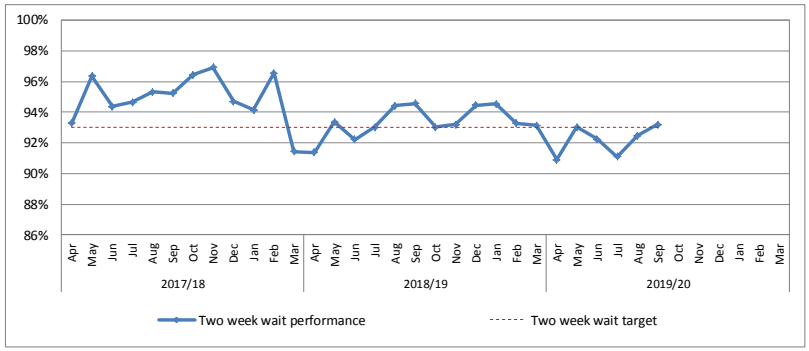


Period: July 2019

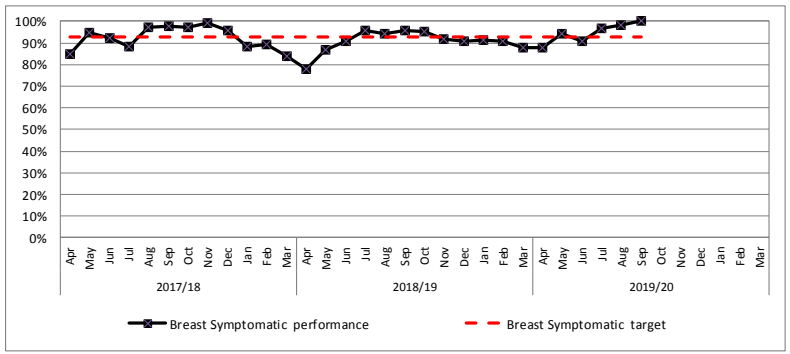
WHHT: 91.1% **Peer: 92.7%**
National: 90.0%

(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		

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Caring & Responsive Services: Cancer 31 day

In this reporting period:

31 day first

The position for September is provisionally non-compliant at 94.9% with 158 pathways with 8 breaches. There were 2 x breast , 2 x LGI, 1 x skin and 3 x urology

31 day subsequent Surgery

The provisional position for September is provisionally compliant at 100%, with 9 compliant pathways and 0 breaches.

31 day subsequent Drug,

The provisional position for September is provisionally non- compliant with 94.1% . There were 17 compliant pathways and 1 urology breach

31 day subsequent other

The provisional position for September is compliant at 100 %

Factors / Themes:

Ensuring that escalations happen effectively when arranging TCI dates.

Next steps:

Continue to ensure that all staff understand the importance of booking in target and escalations are effective when used.

Performance deteriorated
Worse than target/threshold

Benchmarking: NHS England

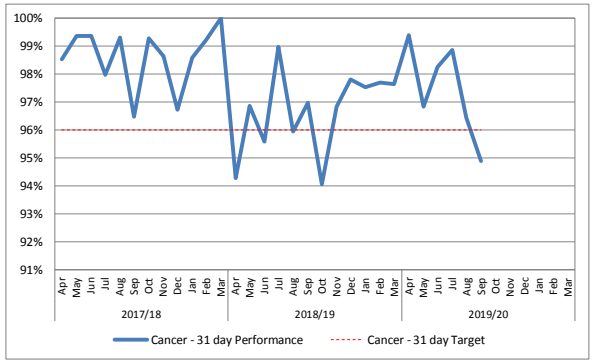
April to June 2019

31 day first: 96.1%

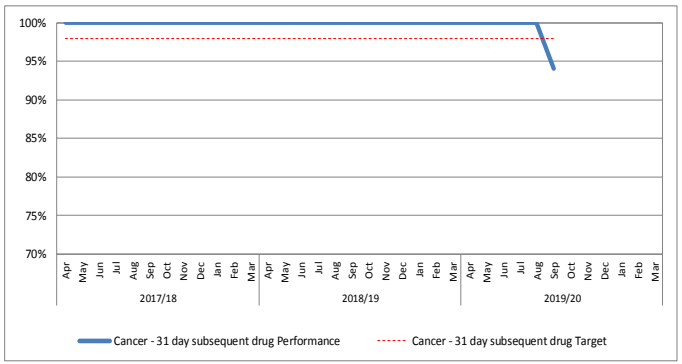
31 day subsequent (surgery): 91.6%

31 day subsequent (drug): 99.2%

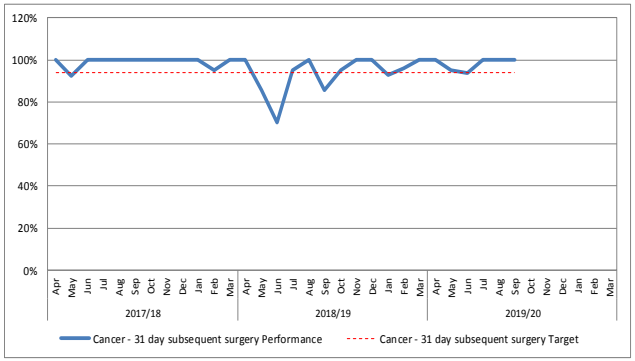
31 day first: % within target time



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		

11

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Caring & Responsive Services: Cancer 62 day urgent GP referral

In this reporting period:
The provisional position for September is compliant at 86.5%
There are 85 treatments with 11.5 breaches (20 patients).
Breaches

Lung x 2	H&N x 5
Gynae x 2	UGI x 3
Urology x 7	LGI x1

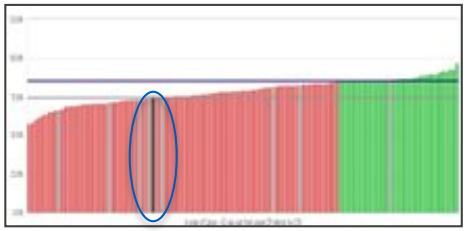
A preliminary review of the breaches indicate: Delays for diagnostics: Trus, CT, colonoscopy, thinking time in urology, some tertiary centre delays with WHHT sending ITR before day 38, patient re-arranging appointments, waiting for clinic letters (not 2ww clinics) These breaches have not yet been validated and it is possible that more treatments will be added before submission on the 1st November.

Pathways >104 days
Open pathways:
In September's submission there were 11 patients on an open pathway that was >104 days. Colorectal x 4, urology x 5, UGI x 2
Breach reasons: patients not sufficiently fit for procedures and delays caused by cancelling and rebooking, PET scan delays, delays waiting for clinical review or letters from virtual clinics,
Closed: – Provisionally the Trust has closed 6 pathways over 104 days (including consultant upgrades and screening) in September : 1 x gynae, 1 x H&N, 1 x UGI, 1 x urology, 1 x colorectal screening and 1 urology consultant upgrade

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

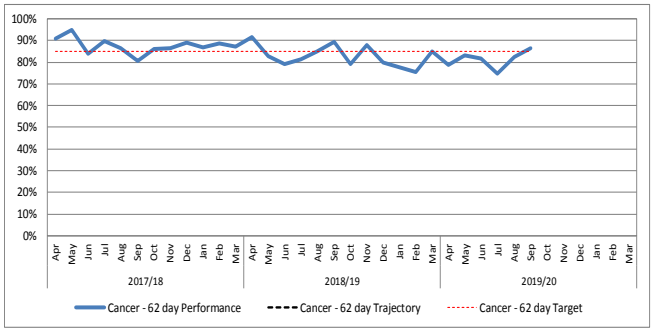


Period: July 2019

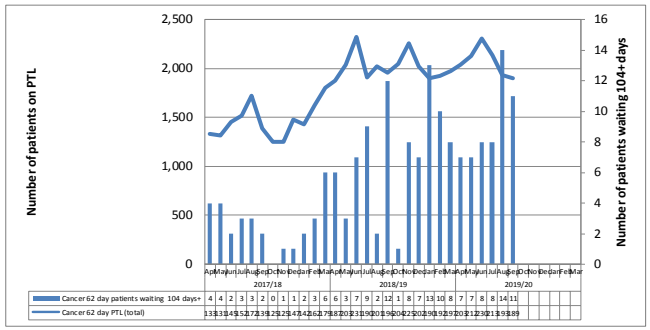
WHHT: 74.1% **Peer: 74.2%**
National: 79.1%

(Peers = Nightingale Group – acute multi-site trusts

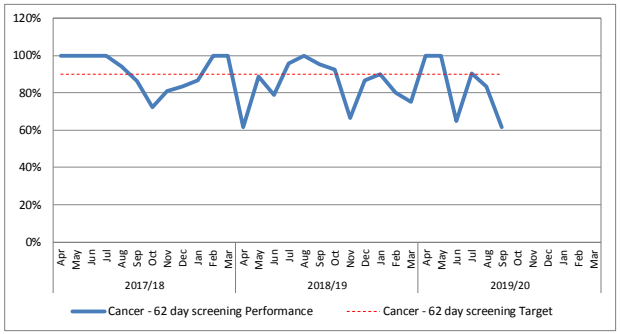
62 day GP: % within target time



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 have improved significantly and are well below target (5%) at 3.6% this month (excluding valid cancellations and patient initiated cancellations) .

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 is similar to the previous month (8.5%) at 8.7%.

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.

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Did not attend rate

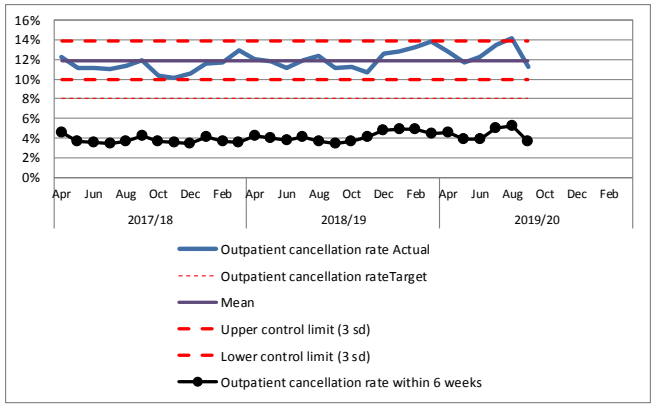
Period: Q2 2019/20

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

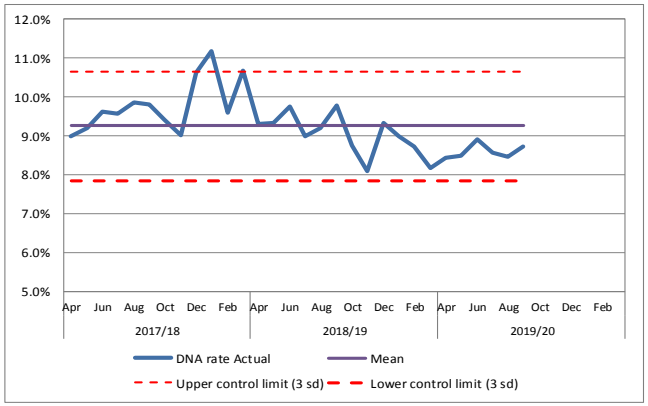
(Peers = Nightingale Group – acute multi-site trusts

Total cancellations: 26.5%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
11.3%	3.6%	12.7%	10.0%

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 4,512wte in September. This is an increase of 139wte over the last 12 months. The funded establishment has increased by 128wte 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, and for Theatre establishment increases in August and Endoscopy later). The Trusts workforce establishment is now 5044wte.
- The number of vacancies is currently 531wte in Sept, and in percentage terms this is 10.5%. This compares to 601wte in Sept 2018. For Band 5 nurses the vacancy rate is maintained at 0%, which is a significant decrease from 123wte or 17.2% in March 2018. NB – the Band 5 Nurse vacancy wte figure includes approx. 33 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 :

- September sickness absence is currently 3.49%, lower than the 3.5% target. The rate is well below the Herts and Beds average (3.9% at end of Q1 19/20). A revised benchmark report will be available for the next report

Labour Turnover and Number of staff leaving within first year

- Turnover based on a rolling 12 month period is currently 14.6%, the lowest rate for several years, and significantly lower than 17% as at Summer last year. The Trust also measures 3 monthly turnover rates which help identify more immediate changes in trends, and the rate is currently 15%. The percentage of staff who leave their post before serving 1 year is currently 17.2%. 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 17.2% in September.

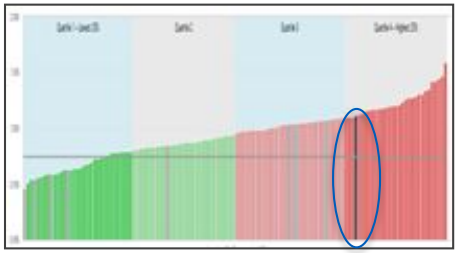
Next steps:

The on-boarding and retention project includes 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

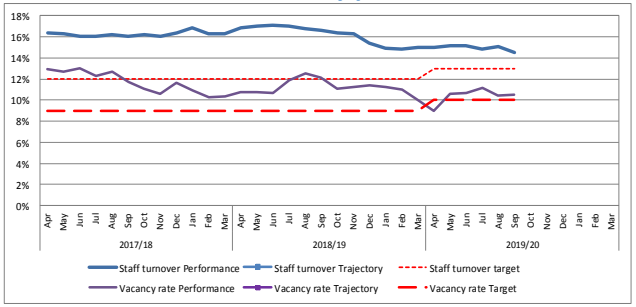


Period: July 2019

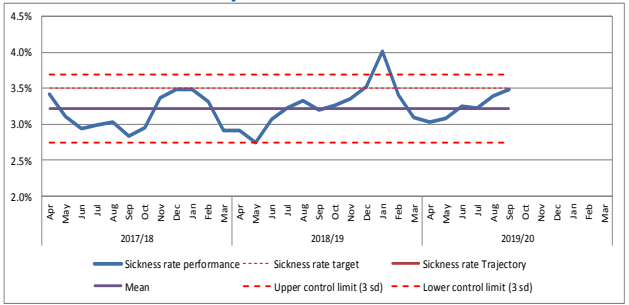
WHHT: 1.11% Peer: 0.74%
National: 0.96%

Peers = Nightingale Group – acute multi-site trusts)

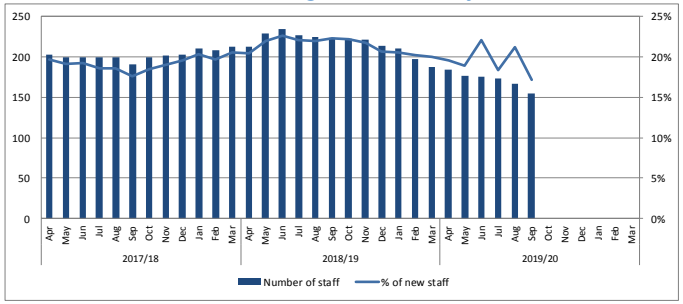
Staff turnover and vacancy performance



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

The values based appraisal rate at the end of September was 87.9% compared with 73% at the beginning of the 17/18 year. The target is 90%. This figure now includes medical staff (apart from Deanery training grade medical staff).

Divisional HR Business Partners are continuing to work closely with Divisions on maintaining and improving appraisal rates. Going forward there will be an increasing attention on ensuring the link between appraisal and incremental progression in preparation for the pay incremental process for 20/21.

At the end of Q1 19/20 , the average for the Herts and Beds area (ten Trusts) was 80%, for Hertfordshire it was 88% The Trust was ranked 4th out of 11 Trusts. The model Hospital information was correct at the time if reporting but these rates are from 17/18 and the Trust has improved since then.

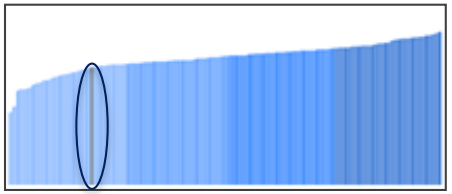
Mandatory training

- The all Trust mandatory training rate remains above target at **91%, the same as last month**. Compliance in the low 90's has now been consistently maintained since November of 2018. This means that the Trust has reached and exceeded its all-Trust mandatory training target of 90% and that this high level of compliance is confirmed as sustainable, as is the ability to produce accurate reporting
- With the all-Trust targets met, attention is now focussed on any subject, department or staff group where specific help will continue to reach compliance is still required, 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

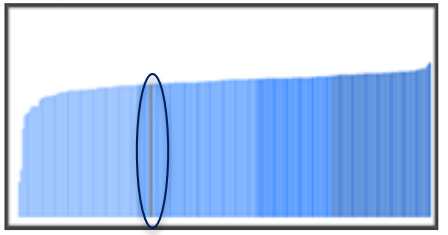


Period: 2017/18
WHHT: 76% **Peer: 83%**
National: 93%

Performance stable
Better than target/threshold

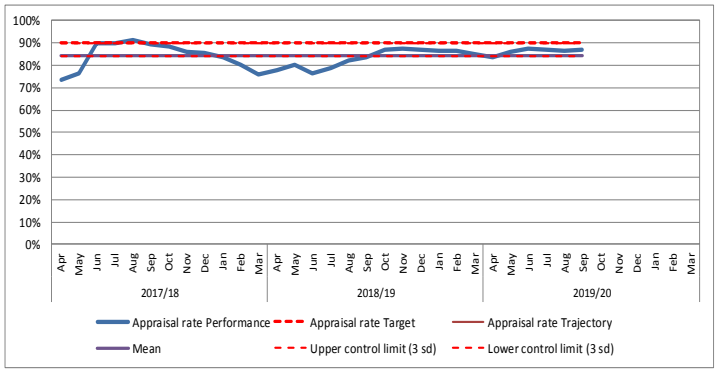
Benchmarking: Model Hospital

Statutory & Mandatory training compliance rate

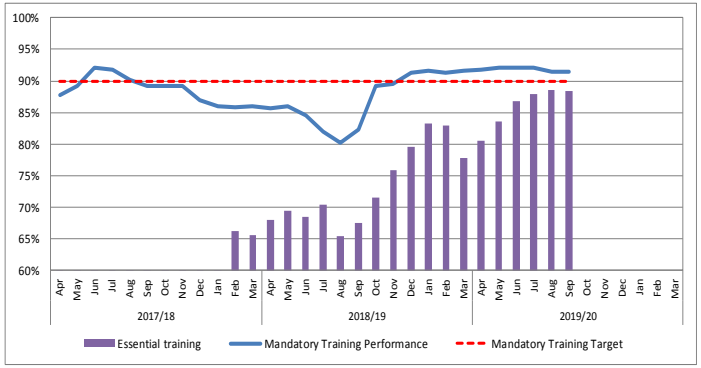


Period: 2017/18
WHHT 86% **Region 87%**
National 89%
Peers = Nightingale Group – acute multi-site trusts)

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 below target at 87.9%, this is however an increase compared to a year ago and is now just 4 percentage points from the target. The overall rate for medical staff (97%) includes all medics apart from Deanery posts. Mandatory training compliance is 91%, 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 Trust sickness rate is 3.49% against a 3.5% target, and so is below the target.

The current agency pay bill percentage is 4.2%. The overall target rate for 2019/20 is 5%, reflecting the reduced agency cost target envelope.

The 12 month turnover rate is 14.6%, amongst the lowest rates we have recorded. Generally, rates are now below the benchmark average.

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 -Sep 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	11.1%	12.1%	10.2%	10.5%	10.0%	0.5%	↗	5%
Band 5 Nurse Vacancy	11.3%	18.9%	9.0%	0.0%	9.0%	-9.0%	↘	-100%
Headline Turnover	15.0%	16.7%	15.2%	14.6%	13.0%	1.6%	↘	12%
Band 5 Nurse Turnover	16.3%	21.7%	17.0%	17.2%	16.0%	1.2%	↗	7%
Total Sickness	3.7%	3.2%	3.3%	3.5%	3.5%	0.0%	↗	0%
Non-Medical Appraisal	68%	84.0%	88.0%	87.0%	90.0%	-3.0%	↘	3%
Medical Appraisal		99.0%	99.0%	97.0%	90.0%	7.0%	↘	-8%
Core Skills Framework	91%	82.0%	92.0%	91.0%	90.0%	1.0%	↘	-1%
Agency as a % of Paybill	7.3%	4.7%	5.9%	4.2%	5.0%	-0.8%	↘	-16%
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 Q1 19/20 - Local Survey
Turnover	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 19/20 - Local Survey
Sickness	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 19/20 - Local Survey
Appraisal	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 19/20 - Local Survey
Core Skills Framework	Average of Bedfordshire and Hertfordshire NHS / FT Trusts Q1 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 Meeting
07 November 2019

Title of the paper	Delivery of 7 day services and the 7 day Board Assurance Framework
Agenda Item	12/76
Presenter	Dr Mike van der Watt Medical Director
Author(s)	Deborah Wadsworth Senior Business Manager
Purpose	*Please tick the appropriate box* *For approval* ✓ | *For discussion* | *For information*
Executive Summary	This paper presents the October 2019 7 Day Board Assurance Framework (BAF). It is attached as appendix 1and is due for submission to NHS Improvement by 29 November. The outcomes from the latest 7 day services self-assessment (September 2019) are also shared. The compliance target for all 4 priority clinical standards is 90%. At September 2019 compliance for the 4 priority standards was as follows: Standard 2 Time to first consultant review 84.2% Standard 5 Access to diagnostics 100% Standard 6 Access to consultant directed interventions 100% Standard 8 Ongoing consultant review: Once daily 94% Twice daily 100% Comparing April 2019 data, these figures demonstrate an increase in compliance with standard 2 of 1.2% and an overall increase in compliance with standard 8 of 4% The progress towards the other 6 standards are commented upon in the BAF. Enablers for 7 day service delivery include effective consultant job planning and electronic rostering. At the current time 87% of consultants have a fully compliant job plan, 12% have submitted job plans which are in the sign off process. The Medirota tool is being implemented across the Trust to support electronic rostering. 19 clinical teams have access to Medirota, and work is underway to ensure consistent, effective use and monitoring. The Quality Committee reviewed the paper and recommended it for presentation to the Board.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the*	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

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<table>
<tr><td>report)</td><td>
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<tr><td></td><td></td><td></td><td>Objective 10-12</td></tr>
<tr><td>✓</td><td></td><td></td><td></td></tr>
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</td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td>☐Is there the leadership capacity and capability to deliver high quality, sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td>
<table>
<tr><td>Committee/Group</td><td>Date</td></tr>
<tr><td>Quality Committee</td><td>31/10/2019</td></tr>
<tr><td></td><td></td></tr>
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<tr><td>Action required</td><td>The Board is asked to receive this report for approval on the delivery of 7 day services.</td></tr>
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Agenda Item: 12/76

Trust Board meeting – 07 November 2019

Delivery of 7 day services and the 7 day Board Assurance Framework

Presented by: Dr Mike van der Watt, Chief Medical Officer

1. Purpose

This paper shares the Trust's draft October 2019 7 Day Board Assurance Framework (appendix 1), which is due for submission to NHS Improvement on 29 November 2019. It provides information on Trust compliance with the 10 clinical standards for 7 day services and a progress update on the current round of Consultant and SAS doctor job planning. It also updates on the implementation of the e-rostering tool Medirota.

2. Background

2.1 Following publication of the 10 clinical standards (see appendix 2)**,** in *NHS Services, Seven Days a Week Forum, summary of initial findings (NHS England, 2013),* the Trust was required to conduct regular self assessments of compliance against the 4 standards identified as priority:

- Time to first consultant review *(within 14 hours of admission)*
- Access to diagnostics *(within 1 hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients)*
- Access to consultant directed interventions *(weekday and weekend access either on site or via formal network arrangements)*
- Ongoing consultant review *(weekdays and weekends for patients requiring once daily and twice daily reviews)*

The compliance target for each is 90%

2.2 Participation in the national survey began in September 2015. This survey was subsequently completed on a six monthly basis.

2.3 In November 2018, providers were notified that the national survey would be replaced with a board assurance framework (Board assurance framework for seven day hospital services: guidance for providers of acute services, NHS England and NHS Improvement, 2018).

It is recognised that effective job plans and rosters are of pivotal importance in mapping the workforce to ensure 7 day cover. For this reason, job planning and rostering updates have been included in this report.

3. Analysis/Discussion

3.1 Current position

3.1.1 Self-assessment of the 4 priority standards September 2019 (76 records)

3.1.1a Priority standard 2: time to first consultant review April 2018 to September 2019

Table 1

Assessment	% compliance with standard 2 (time to first consultant review)		
	Weekday	Weekend	Total
April 2018	79% (103 cases)	71% (29 cases)	77% (132 cases)
April 2019	86% (37/ 43cases)	76% (13/17 cases)	83% (50 cases)
Sept 2019	86% (49/57 cases)	79% (15/19 cases)	84.2% (64 cases)

Between April 2019 and September 2019, the Trust saw an increase in compliance of 1.2% with standard 2 overall. This was attributable to improvement in weekend time to first consultant reviews.

Lower than expected compliance with standard 2 is largely linked to poor documentation of consultant review time, in some specialties. The specialties concerned will be supported through further advice to achieve improvements in documentation.

The Trust is currently piloting a change to the way medical on-call is provided, offering wider availability of a multidisciplinary consultant team later into the evening. If embedded, this arrangement will close the gap between early evening and morning ward rounds, reducing the risk of patients missing the 14 hour target for first review when admitted after the current evening ward rounds.

3.1.1b Priority standard 8: ongoing consultant review

Ongoing consultant review April 2018 to September 2019

Table 2

Assessment	Compliance with standard 8 (ongoing review)					
	Once daily			Twice daily		
	Weekday	Weekend	Total	Weekday	Weekend	Total
April 2018	99%	78%	93%	75%	100%	83%
April 2019	96%	80%	90%	100%	100%	100%
September 2019	100%	79%	94%	100%	N/A (no twice daily reviews required)	100%

Between April 2019 and September 2019 compliance for standard 8, once daily ward rounds increased by 4% on weekdays to achieve 100 % and reduced by 1% on weekends to achieve 79%. Overall compliance was 94%.

For twice daily ward rounds, performance remained at 100% compliance. For the September 2019 audit, no patients in the sample required twice daily ward rounds at the weekend.

3.1.1c Priority standard 5: access to diagnostics

Access to consultant directed diagnostics September 2019

Table 3

Service	Weekday	Weekend
	September 2019	September 2019
CT	Yes	Yes
Echocardiograph	Yes	Yes
Microbiology	Yes	Yes
MRI	Yes	Yes
Ultrasound	Yes	Yes
Upper GI Endoscopy	Yes	Yes

Compliance with standard 5 remains at 100% for both weekdays and weekends

3.1.1d Priority standard 6: access to consultant directed interventions

Access to consultant directed interventions September 2019

Table 4

Intervention	Weekday	Weekend
Critical care	Yes on site	Yes on site
Primary percutaneous coronary inteverntion	Mix of on and off site	Yes off site
Cardiac pacing	Mix of on and off site	Yes off site
Thrombolysis for stroke	Yes on site	Yes on site
Emergency general surgery	Yes on site	Yes on site
Interventional endoscopy	Yes on site	Yes on site
Interventional radiology	Mix of on and off site	Mix of on and off site
Renal replacement	Mix of on and off site	Mix of on and off site
Urgent radiotherapy	Yes off site	Yes off site

Compliance with standard 6 remains at 100% for both weekdays and weekends

3.1.2 Progress towards the 6 non priority standards (please refer to appendix 2 to see standard requirements)

At the current time the Trust is required to provide updates on progress towards the remaining 6 standards. High level summaries on the following standards have been set out in the September 7 day BAF (appendix 1).

- Standard 1 Patient experience
- Standard 3 MDT review
- Standard 4 Shift handovers
- Standard 7 Mental health.
- Standard 9 Transfer to community, primary and social care
- Standard 10 Quality Improvement

Advances are being made towards achieving all of these standards, although with several, shift handover in particular, there is variability in practice and in availability of data. With standard 3, MDTs do take place, but the target time window is not considered to be uniformly achievable at present (appendix 2 pg. 4).

3.2 Consultant job planning

3.2.1 Effective consultant job planning is key to delivering consistent and safe 7 day services. This has been highlighted in the board assurance framework guidance, in particular for standards 2 and 8. For this reason, 7 day service updates will now include reference to job and team workforce planning performance.

3.2.2 Team Planning

In November 2018 team plan templates were sent to each Clinical Director for completion in line with the 2019/20 planning cycle. Team plans are required to include weekend consultant cover and make provision for compliance with the 10 clinical standards.

The following teams have sent a draft plan to the MDO Job Planning Manager for 2019/20;

- Acute Medicine
- Breast Surgery
- Ophthalmology
- Orthopaedics
- Radiology
- Vascular
- Neurology
- Haematology
- Gastroenterology
- Paediatrics/ Neonatal
- Dermatology

There is significant variation in the way these plans have been created and a programme is being developed to work closely with teams to ensure a more standardised approach.

3.2.3 2019/20 Job planning performance

Individual job plans should be created once team plans have been agreed and are subject to a validation process.

At 16th October 2019, 87% (254) of individual job plans were compliant (fully signed off). 12% (35) of job plans have been submitted and are in the process of sign off.

3.2.4 Job planning performance by Division at 16th October 2019

Division	Compliance
Clinical Support	94%
Emergency Medicine	100%
Medicine	75%
Surgery, Anaesthetics and Cancer	96%
Women's and Children's Services	76%

3.3 E-rostering

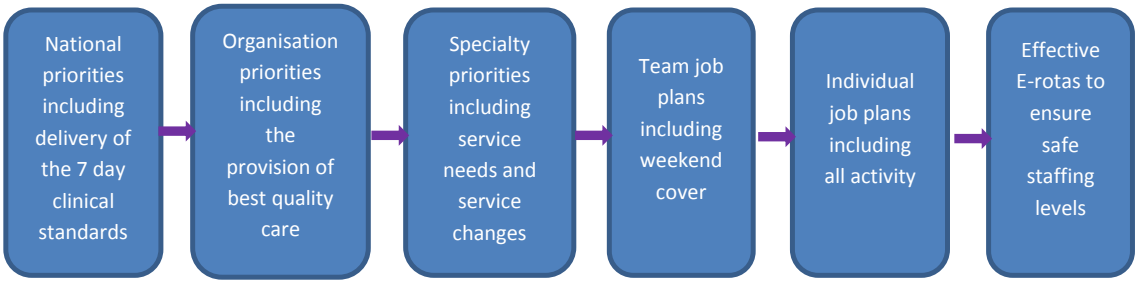
E rostering is another powerful tool to facilitate the delivery of safely staffed 7 day services.

A trustwide e-rostering tool Medirota is available to all teams and a plan is in place to achieve full implementation.

The current position is as follows:

19 clinical teams have full access to Medirota and training in its use
1 clinical team is mid implementation
2 clinical teams are in a queue to implement

Rotas should reflect what we would expect to see based on job plan submissions, which in turn should reflect team plans, which are built to ensure the delivery of national, organisational and specialty priorities.



A Medirota implementation task force has been established with membership including representation from:

- Executive Team
- Medical Staffing
- Medical Director's Office
- Clinical Leads
- Divisional Mangers
- Finance
- Project Support
- Rotamap

This group links closely with the more strategic Medical Resources Group and is tasked with not only overseeing implementation, but also ensuring that the Medirota is used to best effect from a service planning perspective.

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3.4 National Board Assurance Framework requirements

3.4.1 The Trust is required to submit the 7 day BAF (appendix 1) to NHSI to meet the 29th November deadline.

3.4.2 Plans for improvement include:

- Consultants to be asked to indicate clearly in patient notes where daily consultant reviews are not considered necessary and where delegation will not affect the patient's care pathway
- Encouraging improved documentation of consultant review
- Further development of team job planning and service mapping through the Medical Resourcing Group and the Medirota Implementation Group

- Expanding the use of the trustwide e-rostering tool Medirota
- Ensuring full capture of the good work taking place with 7 day service provision both in terms of business as usual and as part of wider quality improvement programmes.
- Evaluating the medical on-call pilot

4 Risks

4.1 The 10 clinical standards have been established to improve access to services across 7 days, improve patient safety and experience and reduce the variation between weekday and weekend mortality. Where it does not achieve these standards, the Trust is taking positive steps towards increasing compliance, thereby reducing risk.

5 Recommendation

5.1 The Board is asked to receive this report for approval.

Dr Mike van der Watt
Chief Medical Officer

November 2019

West Hertfordshire Hospitals NHS Trust 7 day self assessment October 2019

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The Trust is not yet compliant with this standard according to the last 7 day self assessment, which was conducted in September 2019. For clinical standard 2 compliance results were: Weekday 86%, Weekend 79%, Overall 84.2%. Lower than expected compliance with standard 2 is largely linked to poor documentation of consultant review time, in some specialties. These specialties have been identified and will be supported through further advice to achieve improvements in documentation. The Trust is currently piloting a change to the way medical on-call is provided, offering wider availability of a multidisciplinary consultant team later into the evening. If embedded, this arrangement will close the gap between early evening and morning ward rounds, reducing the risk of patients missing the 14 hour target for first consultant review when admitted after the current evening ward rounds	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The Trust is fully compliant with this standard	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	The Trust is fully compliant with this standard	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	For clinical standard 8, compliance during the last self assessment(September 2019) was: Weekday once daily reviews 100%, weekend once daily 79% , overall once daily reviews 94%. Weekday twice daily 100%, weekend twice daily not applicable (no cases in sample), overall twice daily reviews 100%. There are sufficient consultants within all specialities to ensure 7 day service provision and to meet each of the 4 priority targets. Consultant job plans are in place, most have been reviewed during the current year. The Trust has an electronic job planning tool which is used to manage the job plans of consultants and associate specialits doctors. As at 16 October 2019, 87% (254) of individual job plans were compliant (fully signed off). 12 % (35) of job plans have been submitted and are in the sign off phase. A Trustwide e rostering tool has been introduced and is currently being implemented across all specialities. To date 19 clinical teams have access and have received training, 1 clinical team is mid implementation and 2 clinical teams are in the queue to implement. Going forward, consultants will be asked to indicate clearly in patient notes where daily consultant reviews are not considered necessary and where delegation will not effect the patient's care pathway, this is of particular importance where patients are medically fit for discharge, but awaiting packages of care.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1 Patient Experience: The Friends and Family Test and the monthly Test Your Care audits span 7 days of the week. The quality of patient services is monitored across 7 days, including complaints and PALS interactions. The Trust has a 7 day volunteer service and 7 day spiritual services. Standard 3 MDT Review: patients do receive MDT reviews but at present the Trust is unable to consistently meet the 14 hour target for all emergency admissions. Standard 4 Shift handovers: Shift handovers between nurses in ED take place at 7.30am and 7.30pm, between doctors all staff handovers take place 8am, 4pm and 10pm. These handovers are documented the handover book. In AAU multidisplinary handovers take place at 9am, 12pm, 5pm and 9pm. For surgery there are consultant led handovers twice daily at 8am and 8pm, these are recorded on e-handover. There are two radiology consultants in AAU between 08.30 and 13.30 and between 13.30 and 18.30. Handover occurs at 13.30 and patient discussions are recorded electronically. Standard 7 Mental Health: The Trust has a formal contract with RAID (Rapid Assessment Interface and Discharge Team). There is a 24/7 service from the psychiatry liasion service and a mental health triage tool which is used to determine how quickly patients should be seen by the team. The standard response time (if not immediate) is within an hour. Standard 9 Transfer to community, primary and social care: The Integrated Discharge Team has a planned weekend rota for staff, that on a daily basis includes as a minimum : 1 Hertfordshire County Council Deputy / Head of Service on Call, 1 On site Hertfordshire County Council Deputy / Team Manager, 4 minimum social care staff with an option to increase assessment capacity dependent on demand, 1 Acute Facilitator providing access subject to capacity to home care provision (this can be assessed and commenced over the weekend, 1 or 2 Discharge Planning Nurses and / or Discharge Co-ordinators (Access to rehab pathways and assurance around discharge planning), 1 In-reach Worker (Saturdays Only – access to rehab pathways), Herts Help/Hospital Navigator Service to support access to voluntary service. Hertfordshire County Council continues to work with providers to increase the ability of providers to respond at weekends to support discharge activity. The Pharmacy, Therapy, Pathology and Radiology Teams provide a 7 day service, supporting weekend discharges and transfers. Standard 10 Quality Improvement: The Trust produces a bimonthly quality integrated performance report, which is reviewed by the Clinical Outcomes and Efficiency Committee and also by the Safety and Compliance Committee.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
The Trust is fully compliant with all clinical standards for urgent network clinical services

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Seven Day Services Clinical Standards

September 2017

11 September 2017

Gateway reference: 06408

No.	Standard	Adapted from source
Patient Experience		
1.	**Standard:** Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week. **Supporting information:** • Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times. • The format of information provided must be appropriate to the patient's needs and include acute conditions. • With the increasing collection of real-time feedback, it is expected that hospitals are able to compare feedback from weekday and weekend admissions and display publicly in ward areas.	NICE (2012): Quality standard for patient experience in adult NHS services (QS15) RCS (2011): Emergency Surgery, Standards for unscheduled surgical care
Time to first consultant review		
2.	**Standard:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. **Supporting information:** • A suitable consultant is a doctor who has completed all of their specialist training and has their CCT or equivalent and is therefore trained and competent in dealing with emergency and acute presentations in the specialty	NCEPOD (2007): Emergency Admissions: A journey in the right direction? RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical

No.	Standard	Adapted from source
	concerned and is able to initiate a diagnostic and treatment plan. • The standard applies to emergency admissions via any route, not just the Emergency Department, for example admissions via radiology, consultant clinic and direct admission to AMU. NOTE: if a patient is admitted from clinic, this consultation amounts to a first consultant review and meets this standard. • All patients should have a National Early Warning Score (NEWS) established at the time of admission. • All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor promptly, and seen and assessed by a consultant within six hours. • Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected), should be within one hour. • For emergency care settings without consultant leadership, review can be undertaken by appropriate senior clinician e.g. GP-led inpatient units. • Standards are not sequential; clinical assessment may require the results of diagnostic investigation. • Patients with a clear diagnosis on a well-defined pathway (e.g. midwife-led maternity, simple superficial abscess management) may have their clinical care delegated from a consultant to another clinician under the following circumstances: o there is a clear written local protocol for the pathway that has been agreed within the Trust clinical governance system and that is supported by the commissioners; o the protocol must describe actions to take in the event of clinical concern and that includes robust and rapid escalation to a consultant where	care RCP (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit

No.	Standard	Adapted from source
	appropriate e.g. a maternity patient who develops the need for an emergency Caesarean section or a patient with a superficial abscess who appears to be developing sepsis; and, o the patient's care is still recorded as being under a named consultant for the purpose of clinical governance (excluding patients specifically on midwife-led care pathways).	
MDT review		
3.	**Standard:** All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours. **Supporting information:** • The multi-professional team will vary by specialty but as a minimum will include nursing, medicine, pharmacy, physiotherapy and for medical patients, occupational therapy. • Other professionals that may be required include but are not limited to: dieticians, podiatrists, speech and language therapy and psychologists and consultants in other specialist areas such as geriatrics. • Reviews should be informed by patients existing primary and community care records. • Appropriate staff must be available for the treatment/management plan to be carried out.	RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical care NICE (2007): Technical patient safety solutions for medicines reconciliation on admission of adults to hospital

No.	Standard	Adapted from source
Shift handovers		
4.	**Standard:** Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week. **Supporting information:** • Shift handovers should be kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit. • Clinical data should be recorded electronically, according to national standards for structure and content and include the NHS number.	RCP (2011): Acute care toolkit 1: Handover RCP (2013): Future Hospital Commission
Diagnostics		
5.	**Standard:** Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients **Supporting information:**	RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical care AOMRC (2012): Seven day consultant present care RCR (2009): Standards for providing a 24-hour radiology diagnostic service

No.	Standard	Adapted from source
	• Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances. • The intention of the standard is to ensure that diagnostic tests are done within a specified period of time after the clinician in charge of the patient has requested them. • The standard requires that diagnostic services are made available for patients to access; it does not set an expectation that clinicians should order tests inappropriately early in the care pathway. There is a very important role for watchful waiting to see how a patient's condition progresses. • Unless it is clinically indicated, patients should not remain in hospital solely for the purpose of receiving the diagnostic test they require. • Critical patients are considered those for whom the test will alter their management at the time; urgent patients are considered those for whom the test will alter their management but not necessarily that day. • Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2. • Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker. • Seven-day consultant presence in the radiology department is envisaged.	NICE (2008): Metastatic spinal cord compression

No.	Standard	Adapted from source
Intervention / key services		
6.	**Standard:** Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy • Urgent radiotherapy • Stroke thrombolysis • Percutaneous Coronary Intervention • Cardiac pacing (either temporary via internal wire or permanent) **Supporting information:** • Standards are not sequential; if an intervention is required it may precede the thorough clinical assessment by a suitable consultant in standard 2. • The principle is that patients should receive urgent interventions within a timeframe that does not reduce the quality of their care (safety, experience and efficacy). Where there is evidence-based national clinical guidance regarding time to urgent treatment (e.g. thrombolysis for stroke, emergency laparotomy for peritonitis), trusts should implement systems to deliver to these standards and should monitor their performance. • Acute trusts should make a judgment through their clinical governance	NCEPOD (1997): Who operates when? NCEPOD (2007): Emergency admissions: A journey in the right direction? RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical care British Society of Gastroenterology AoMRC (2008): Managing urgent mental health needs in the acute trust

No.	Standard	Adapted from source
	processes and in discussion with their commissioners regarding which interventions their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. • Clear written protocols should describe any networked service arrangements, including a robust and transparent process for timely clinical assessment and patient transfer between sites. • Such processes should be regularly audited to ensure that transferred patients receive timely high quality care. • Trusts and their commissioners should have policies for managing a patient who is already in hospital and who develops another acute condition e.g. a general medical in-patient who then has a STEMI heart attack requiring primary PCI.	
Mental Health		
7.	**Standard:** Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week. Where an emergency* mental health need is identified in the Emergency Department or on an acute general hospital ward, a liaison mental health service should respond to the referral within one hour. Emergency referrals should be made at the earliest opportunity after a patient arrives in the ED. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment. Within four hours of arriving in an ED or being referred from a ward, the patient	NHS England, NICE, NCCMH (2016): Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults

No.	Standard	Adapted from source
	should: • have received a full biopsychosocial assessment, and • have an urgent and emergency mental health care plan in place, and • at a minimum, be en route to their next location if geographically different, or • have been accepted and scheduled for follow-up care by a responding service, or • have been discharged because the crisis has resolved OR • have started a Mental Health Act assessment. Where an urgent** mental health need is identified on acute general hospital ward, a liaison mental health service should respond to the referrer within one hour of receiving a referral to ascertain its urgency, the type of assessment needed and resources required for the assessment. The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should: • have received a full biopsychosocial assessment, and • have an urgent and emergency mental health care plan in place, and • at a minimum, be en route to their next location if geographically different, or • have been accepted and scheduled for a follow-up appointment by a responding service, or • have been provided with advice or signposted, where appropriate.	

No.	Standard	Adapted from source
	Supporting information: • In line with the commitment made by NHS England in response to the *Five Year Forward View for Mental Health*, all acute hospitals with 24/7 EDs should be working towards providing an all-age service and achieving as a minimum the core 24 liaison mental health service standard for adults and older adults. Where services are not currently operating on a 24/7 basis, outside the liaison services' hours of operation there may need to be effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call mental health staff, out-of-hours mental health services for children and young people etc). * An emergency is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response. ** An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.	
Ongoing review		
8.	**Standard:** All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. **Supporting information**	RCP (2007): Acute medical care: The right person, in the right setting – first time RCP (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit RCS (2011): Emergency Surgery, Standards for unscheduled surgical

No.	Standard	Adapted from source
	<u>Definition of a consultant for this standard</u> • Consultants in this context are defined as doctors on the Specialist Register, CCT-holders and those recognised as being equivalent in the view of the relevant Royal College. These senior decision-makers have a crucial role, not just in identifying and dealing with clinical issues but also in communication with patients and relatives, in taking active and appropriate decisions about discharge from hospital, and in providing support and supervision and education to junior clinical colleagues. • The term 'consultant' is maintained because it is believed that this is a term broadly understood by doctors and the public. This description of the consultant is included in this supporting information, to align the standard with professional opinion, and provide clarity on which senior doctors could provide ongoing review without compromising patient safety. <u>Purpose of consultant review</u> • The purpose of the consultant review is to see any patient who is not on a pathway, to address patient deterioration, to provide urgent important communication with patients and carers where appropriate, to speed flow and remove blockages in the care pathway. There should be clear escalation protocols so that if a patient deteriorates in-between daily ward rounds there is appropriate timely clinical escalation. ("Seeing the sickest quickest"). <u>Frequency of consultant reviews</u>	care AOMRC (2012): Seven day consultant present care AOMRC (2013): Implementing 7 day consultant-present care Intensive Care Society (2009) Levels of Critical Care for Adult Patients. Paediatric Intensive Care Society (2015) Quality Standards for the Care of Critically Ill Children

No.	Standard	Adapted from source
	• Clinical judgement should be used to determine frequency of consultant review required, but as a guide patients with Intensive Care Society levels of need of 2 (3 for paediatrics) and above may require twice daily review, and patients with needs of below level 2 (3 for paediatrics) may only require once daily review. The group of patients who need twice daily reviews should be based on the Intensive Care Society definitions of levels of illness and the Paediatric Intensive Care Society standards for the care of critically ill children rather than their geographical ward location in the hospital. <u>Use of Board rounds and delegation</u> • There should be consultant-led Board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan (based on written protocols for individual conditions) that is updated daily at the Board round. At the Board round the consultant decides which, if any of the patients' reviews that day can be delegated to another competent clinician, such as a specialist nurse or senior medical trainee. The following are considerations that may be used to exclude individual patients from requirement for daily consultant review: • The patient's physiological safety (low early warning score (EWS)). • The patient's level of need for further investigations and revision of diagnosis.. • The patient's level of need for therapeutic intervention. • The level of need for communication with patient, carers, clinical colleagues. • Their likelihood of imminent discharge. For example patients who are	

No.	Standard	Adapted from source
	medically fit for discharge and awaiting a social care placement (delayed transfers of care) may not need daily consultant review unless there are signs of clinical deterioration. The effective use of the skills and experience of a multidisciplinary team should be preserved, and this group will still need daily review with access to same day consultant advice. • The decision that the patient does not need a daily consultant review should be documented, along with the plan for how the patient will be reviewed each day by the multi-disciplinary team (MDT) to ensure any signs of clinical deterioration are acted upon.. Where a daily review is delegated the reviewer should feed back promptly to the consultant any concerns they have about a patient. Several examples exist of trusts that have segmented their inpatient population to facilitate the appropriate level of daily review. Typically the groups are described as 'medically active', 'medically optimised' and 'medically fit for discharge'. o The medically active group MUST be seen daily by a consultant and not delegated. This includes all patients causing nursing concern, all patients on end-of-life care pathways, all new admissions to a ward in the previous 24 hours and all patients in whom a potential same day discharge decision is required. o The medically optimised group need daily consultant input via the Board Round, to ensure there is an MDT discussion around progress on therapy and social assessments, then for some in this group the consultant may choose to delegate that day's face to face review to another member of the multidisciplinary team.	

No.	Standard	Adapted from source
	○ The medically fit for discharge group (including people who are Delayed Transfers of Care) may be excluded from daily consultant face to face review, and instead reviewed by a senior nurse or equivalent. There would still need to be a safety netting process in place so that if such a patient experiences unexpected deterioration there is a system that ensures that a consultant assesses them promptly. • There are concerns that a focus on Board rounds could disadvantage patients who are "outliers" and trusts should agree with their commissioners explicit strategies to mitigate this risk. Effective management of flow and bed occupancy should reduce the numbers of outlying patients. We know that outliers are often disadvantaged by typically not only missing out on daily consultant reviews, but also due to having less access to specialist nurses and allied health professionals. *The default position for outlying patients is that they should be seen face to face by a consultant every day.* <u>Role of the multidisciplinary team to support daily consultant reviews</u> • In units which are non-medical consultant led e.g. GP or midwife / therapist led units, it is acceptable for this consultant leadership to be provided by the GP, therapist, midwife or senior nurse. • Consultants need adequate support seven days a week from an appropriate team of healthcare professionals to ensure patients receive good quality care. Junior doctors involved in providing urgent and emergency care should have prompt access to consultant support and advice including a consultant presence on site every day to optimise opportunities for training and clinical supervision.	

No.	Standard	Adapted from source
	• Consultant ward rounds should be optimised for efficiency and effectiveness e.g. using specialist and senior nurses, pharmacists or physiotherapists to work with consultants and review specific patients. Appropriate administrative support is also needed every day and can be provided by other staff groups such as physician associates, doctors' assistants and ward clerks. The use of a standardised checklist on ward rounds can also improve efficiency. • A trust may agree with its commissioner to designate certain wards as non-acute rehab or intermediate care wards that don't require the level of daily consultant intervention described above. There would still need to be a clear escalation protocol for any patient in a rehab or intermediate care bed who deteriorates unexpectedly. <u>Optimising effective 7 day reviews</u> • Rota patterns which optimise continuity of care, such as consultants working multiple day blocks, should be designed; consultant review is likely to take less time if a patient is already known to the consultant. • A greater proportion of generalists (consultants with the skills to manage patients across different specialty areas) will increase the flexibility of the consultant workforce delivering daily reviews at weekends. • Patients, and where appropriate carers and families, must be made aware of reviews. Where a review results in a change to the patient's management plan, they should be made aware of the outcome and provided with relevant verbal, and where appropriate written, information. • Inpatient specialist referral should be made on the same day as the decision to refer and patients should be seen by the specialist within 24 hours. For high risk patients defined as where the risk of mortality is greater than 10%, or	

No.	Standard	Adapted from source
	where a patient is unstable and not responding to treatment as expected, consultant involvement should be within one hour. <u>Patient and family involvement</u> • Patients, and where appropriate carers and families, must be made aware of reviews. Where a review results in a change to the patient's management plan, they should be made aware of the outcome and provided with relevant verbal, and where appropriate written, information.	
Transfer to community, primary and social care		
9.	**Standard:** Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken. **Supporting information:** • Primary and community care services should have access to appropriate senior clinical expertise (e.g. via phone call), and where available, an integrated care record, to mitigate the risk of emergency readmission. • Services include pharmacy, physiotherapy, occupational therapy, social services, equipment provision, district nursing and timely and effective communication of on-going care plan from hospital to primary, community and social care. • Transport services must be available to transfer, seven days a week. • There should be effective relationships between medical and other health and	AOMRC (2012): Seven day consultant present care

No.	Standard	Adapted from source
	social care teams.	
Quality Improvement		
10.	**Standard:** All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week. **Supporting information:** • The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness. • Attention should be paid to ensure the delivery of seven day services supports training that is consistent with General Medical Council and Health Education England recommendations and that trainees learn how to assess, treat and care for patients in emergency as well as elective settings. • • All clinicians should be involved in the review of outcomes to facilitate learning and drive quality improvements.	GMC (2010): Generic standards for specialty including GP training

Trust Board Meeting
07 November 2019

Title of the paper	Annual Freedom to Speak Up Report and Update						
Agenda Item	13/76						
Presenter	Ginny Edwards, Non-Executive Director, FTSU Guardian						
Author(s)	Caroline Lankshear, Head of ER and Justine Powell, ER Manager						
Purpose		*For approval*		*For discussion*		*For information*	
		√				√	
Executive Summary	The purpose of this paper is to provide the annual update and assurance that the Trust's approach to Freedom to Speak Up is line with national guidance published by the National Guardians Office and NHS Improvement in July 2019. The revised guidance aims to support boards to create a culture that supports FTSU and where employees feel they have a voice and have a level of control and influence. This also supports the vision set out in the Interim People Plan. Effective speaking up arrangements help to protect patients and improve the experience of employees. Matters that speaking up highlight are also a good opportunity to learn and improve. Whilst Ginny Edwards, has been undertaking the role of FTSU Guardian since 2015, the new guidance requires a non-executive lead for FTSU, in addition to an FTSU Guardian. The guidance sets out clear expectations and individual responsibilities for the Board and Executive Directors. The Executive Lead for FTSU, Chief People Officer and Non-Executive lead for FTSU have reviewed the guidance and are currently working with the Board to ensure the Trusts approach to FTSU is in line with the guidance and have identified a number of actions that require implementation. The paper also refers to the numbers and types of FTSU cases that have been received either by the FTSU Guardian or in HR since reporting commenced in June 2016. The paper was received at the People, Education and Research Committee on 31 October 2019 and recommended to be presented to the Board.						
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*
			√				

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<table>
<tr><td>Links to well-led key lines of enquiry</td><td>☐Is there the leadership capacity and capability to deliver high quality, sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☐Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>People, Education and Research Committee</td><td>31/10/2019</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to:

• Receive the report for information and to provide assurance that that the 2019 guidance published by NHS Improvement and the National Guardians Office have been identified and are being implemented.

• Approve the recommendation that the board appoints Ginny Edwards as the lead NED for FTSU.</td></tr>
</table>

Agenda Item: 13/76

Trust Board Meeting - 07 November 2019

Annual Freedom to Speak Up Update

Presented by: Ginny Edwards, FTSU Guardian

1. Purpose

1.1 The purpose of this paper is to provide the annual update and assurance that the Trust's approach to Freedom to Speak Up is line with national guidance published by the National Guardians Office and NHS Improvement in July 2019. Where any gaps have been identified, a plan is now in place so additional actions can be implemented. The paper will also include a summary of cases that have been raised in the past 12 months.

2. Background

2.1 Revised guidance on FTSU in the NHS was published in July 2019 by NHS England & NHSI with the aim of supporting boards to create a culture that supports FTSU and where employees feel they have a voice and have a level of control and influence. This also supports the vision set out in the Interim People Plan.

2.2 Effective speaking up arrangements help to protect patients and improve the experience of employees. Matters that speaking up highlight are also a good opportunity to learn and improve.

2.3 All NHS trusts and NHS foundation trusts are required by the NHS Contract (2016) to nominate a Freedom to Speak Up Guardian (FTSUG). Ginny Edwards Non-Executive Director was appointed to this role in 2015. However, the new guidance requires a non-executive lead for FTSU, in addition to an FTSU Guardian.

2.4 Caroline Lankshear, Head of Employee Relations and Justine Powell, Employee Relations Manager they have been working with Ginny to raising the profile of FTSU and encourage employees to raise issues and know how to access support. This has included the appointment of 20 new Speak Up Champions, who provide support to colleagues in raising concerns including matters linked to harassment or bullying.

2.5 The July 2019 guidance sets out clear expectations and individual responsibilities for the Board. The Board are expected to:

- Include speak up and other related cultural issues in the board development programme
- Have an ongoing focus on reduction of B&H
- Send out clear and repeated messages that victimisation of those that speak up will not be tolerated
- Investing in sustained & continuous leadership development
- Ensuring there is a well-resourced FTSUG & champion model

- Supporting creation of an effective communication & engagement strategy that encourages and enables speaking up
- Openly discuss issues raised through speaking up with commissioners, CQC, NHSI

2.6 Executive Directors have a significant impact on the creation of a culture supportive of FTSU. To this end Executive Directors;

- are able to articulate both the importance of employees feeling able to speak up and the trust's own vision to achieve this
- speak up, listen and constructively challenge one another during board meetings
- are visible and approachable and welcome approaches from employees
- have insight into how their power could silence truth
- thank employees who speak up
- demonstrate that they have heard when employees speak up by providing feedback
- seek feedback from peers and employees and reflect on how effectively they demonstrate the Trust's values and behaviours
- accept challenging feedback constructively, publicly acknowledge mistakes and make improvements

2.7 The Executive Lead for FTSU, Chief People Officer and Non-Executive lead for FTSU have reviewed the guidance and are currently working with the Board to ensure the Trusts approach to FTSU is in line with the new guidance.

3. Analysis/Discussion

3.1 Analysis of the 2019 guidance has established the Trust is already implementing a number of the recommendations, which include:

- Exec Lead for FTSU and NED Guardian already in post
- Recruited 20 local Speak Up Champions
- Setting up 'Safe Space' meetings with Execs throughout the year
- Work is underway to publicise champions across 3 sites in time for Speak Up month in October
- Report on FTSU activity through PERC and an annual board paper
- Annual report to the Audit committee
- Ongoing discussions with Staff Side Chair and committee on strategy for engagement
- In line with 'Just Culture' replacing B&H and Grievance policies with a Resolution Policy and reviewing other key HR policies to introduce a more supportive approach to managing issues regarding absence and capability

3.2 A review of the guidance has also established a number of gaps that require further action. These include:

- Appointment of new FTSU Guardian - as the FTSU Guardian cannot be a NED
- An FTSU Strategy
- Guardian not currently responsible for report writing and does not formally triangulate all the data suggested for reports
- Lack of statistical expertise to support the triangulation of data

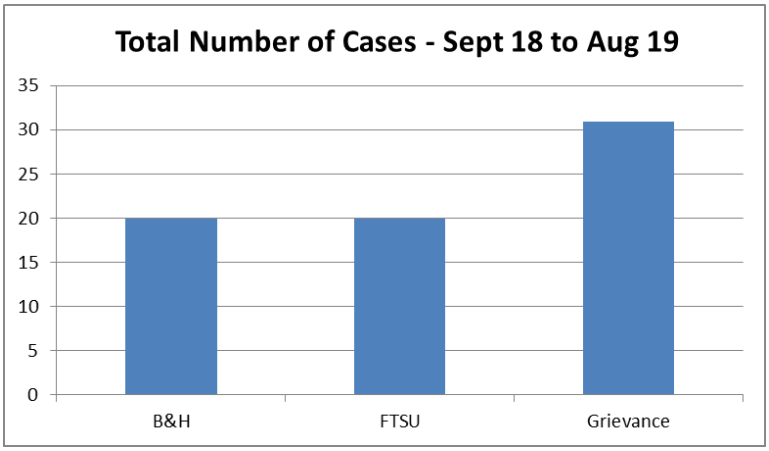
- Speak Up audits are not conducted
- Not all exec responsibilities are being met
- Sharing of lessons learnt is inconsistent

3.3 High level data: The Trust records and reports to the National Guardian Office all issues bought to the attention of the FTSUG. NHS Employers gives a useful definition on the distinction between whistle blowing and grievances - *"Raising concerns, also referred to as whistleblowing, is the term used when an employee speaks up about a possible risk, wrong-doing or malpractice that has a public interest aspect to it, usually because it threatens or poses a risk to others (e.g. patients, colleagues or the public). Raising concerns are different to grievances, which by contrast are about the staff member's own employment position and have no additional public interest."*

Number of FTSU Cases

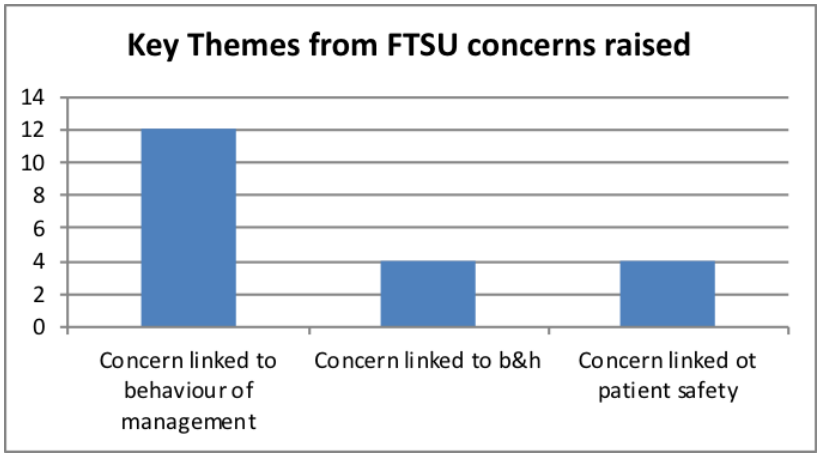
	2016/7	**2017/8**	**2018/9**
Number of cases in year (Sept – August):	10	15	20
Number of cases requiring formal investigation (total):	2	2	1
Number of cases resolved informally (total):	8	13	17
Current open cases:	0	0	2

In addition to FTSU cases the ER team also deal with individual employee grievances and complaints of bullying and harassment. A summary of the number of cases raised in the last 12 months can be seen in the chart below:

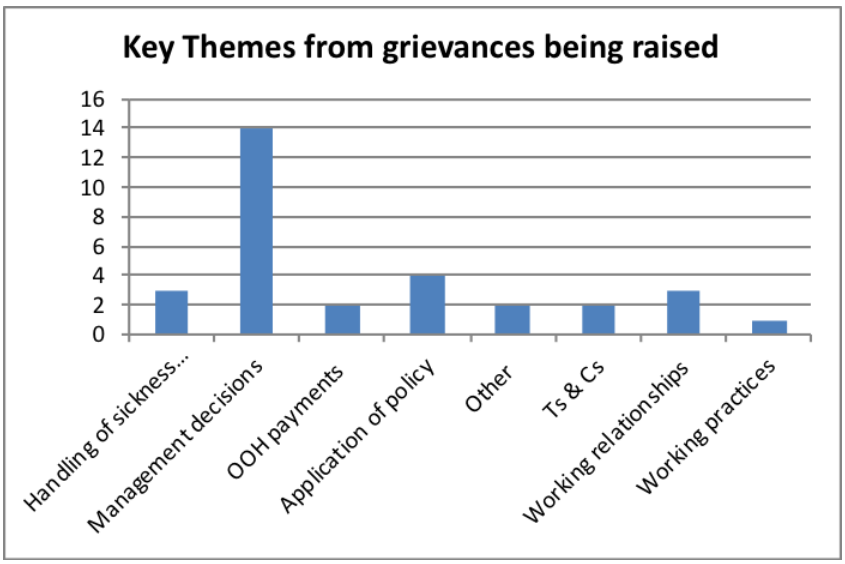


Compared with data from the same period in 2017/8, there has been a slight reduction in the number of bullying cases reported (26 compared with 20) and a more significant reduction in the number of grievances being reported (47 down to 31).

3.4 Summary of FTSU and grievance issues raised from September 2018 – August 2019:



Comparing the same data from the previous 12 months, there has been a marked increase in issues that are raised relating to the behaviour of management from 4 to 12 cases. It should be noted that all 12 cases have been resolved informally without the need for formal investgiaton or intervention. The data for concerns linked to bullying or patient safety remain low and is consistent with the data from the previous year.



The most significant reason for grievances in the past 12 months is linked to management decisions which include making reasonable adjustments, handling of redeployment, failure to pay expenses, recovery of an overpayment. 4 of these cases have been formally investigated with 2 being upheld with appropriate resolution. Whilst one of the girevances was not upheld, a satisfactory outcome has been reached by all parties.

4. Issues arising / Actions taken to address issues

4.1 Issues arising:

4.1.1 Since the introduction of FTSU and improved communications to employees regarding the importance of speaking up and promoting the role of FTSU Guardian, there has been an increase year on year in the number of concerns being raised. Given that employees have been using FTSU to raise issues linked to both bullying and more traditional grievance issues, the Trust took the decision to replace Harassment Advisors with Speak Up Champions and broaden their remit to encompass all things speaking up. This was in consultation with staff side who supported the title changing to Speaking Up Champions. This links to the 2019 guidance that suggests speaking up should be interpreted in the broadest sense and includes "raising concerns, complaining, raising a grievance or whistle blowing".

4.1.2 Further work is now required to implement the recommendations set out in the 2019 Guidance published by NHS England and NHSI.

4.2 Actions Update

4.2.1 The following actions have been completed since August 2018:

- Recruited and trained 20 new Speak Up champions - see Appendix 1
- Promoted the new champions in various communications as part of the Big 5's Protecting You month in May – Appendix 2
- Posters have been circulated to show staff the various ways to raise a concern
- The intranet page has been updated to ensure it is kept current and up to date and now includes the details of all the new Champions
- FTSU lanyards have been given to all the champions to make them more visible when walking around the site
- Capture data on contacts made with Champions to ensure more robust reporting of issues
- Submission of quarterly FTSU data to the National Guardians Office
- The FTSUG has participated in national conferences, regional meetings
- FTSU cases information included in Trust Annual Report
- Set up a support network for the Champions including pastoral care for their wellbeing, which meet quarterly – first meeting held in September 2019
- 3 Champions have been selected to attend the October Board to talk about why they have chosen to be a speak up champion

4.2.2 Further Actions needed to comply with the 2019 Guidance

- CEO to recruit new FTSU Guardian in line with the new guidance including ring fenced time with adequate resources
- Incorporate FTSU strategy in new people strategy
- Guardian will need to triangulate Speak Up issues with patient complaints, SI's, exit interviews, staff survey results etc. and report to the board every 6 months

- Speak Up audit to be established and completed every 2 years with focus on effectiveness of speak up channels and culture
- Board development
- CEO to approve confidentiality clause used in Settlement Agreements
- Benchmark how other Trusts are implementing the guidance
- Creation of behaviour standards to be communicated on recruitment and through other available channels such as induction, reconnection, appraisal etc.

4.2.3 Further actions needed to embed FTSU within the Trust

October is designated as Speak Up Month. The Trust will be undertaking the following actions:

- E-Update and Team Brief to promote Speak Up month
- FTSUG and Speak Up Champions to visit 3 sites to meet staff
- Produce posters of champions contact details to put up across the Trust including some which are site specific
- Review how learning from FTSU cases can be disseminated
- Re-issue a postcard for staff on FTSU which will include details of how to raise concerns and details of the local champions and Guardian
- Consider other methods of raising the profile of FTSU to encourage staff to speak up including a review of relevant training
- Amend the Speak Up policy to include the new 2019 guidance
- In conjunction with Staff Side communicate clear messages regarding protection in relations to Speaking Up, raising grievances and disciplinary matters
- Increase the number of Speak Up Champions with greater knowledge and experience from BAME/Disability backgrounds to support inclusivity
- Business case submitted to approve recruitment of Freedom to Speak Up Guardian in line with new guidance
- Seek Board approval for Ginny Edwards to be nominated as the NED lead for FTSU

5 Risks

5.1 If the actions recommended in the action plan are not implemented, and if appropriate support is not in place for staff who raise concerns, issues could escalate resulting in lower morale in the workforce and ultimately increasing turnover as existing talent will be lost if there is a perception that no action will be taken if staff raise concerns.

5.2 If a culture of speaking up does not exist and cases are handled badly, this will not give employees the confidence in future to raise concerns and this could ultimately impact on patient safety.

5.3 Whilst promotion of speaking up supports the development of an open culture, a consequence of this could be a significant increase in the number of cases that require investigation, which could lead to capacity issues for the Guardian, Champions and the Employee Relations team. This in turn can lead to additional costs where external providers need to be brought in to conduct the investigation on the Trust's behalf.

5.4 If the Trust does not comply with the 2019 guidance, the Trust will not meet the well led domain of the CQC inspection under Key Line of Enquiry 3.

6. Recommendation

The Board is asked to:

- Receive the report for information and to provide assurance that that the 2019 guidance published by NHS Improvement and the National Guardians Office have been identified and are being implemented.

- Approve the recommendation that the board appoints Ginny Edwards as the lead NED for FTSU.

Ginny Edwards
Non-Executive Director and FTSU Guardian

31 October 2019

Appendix 1 – Details of our New Speak Up Champions

Speak Up Champion Contact Details

Howard Borkett-Jones
Director of Medical Education & A&E Consultant
howard.borkett-jones@nhs.net

Richard Burridge
Guardian for Safe Working, Consultant Paediatrician
r.burridge@nhs.net
Tel:07967 752956

Alison East
Matron for Surgery & Cancer Services (based at SACH)
alisoneast@nhs.net
Tel: 07771 500781

Emma Purkis
Lead Nurse Endoscopy
emma.purkis@nhs.net
Tel: 07920 877490

Jo Sparrow
Senior Sister (HHGH)
joanne.sparrow1@nhs.net
Tel: 3312 2171

Anthony Curran
Chaplain
anthony.curran@nhs.net
Tel: 7994

Isabella De-Rosa
Administration Team Manager & Executive Assistant, UK NEQAS
isabella.de-rosa@nhs.net
Ext 3460

Kerri Bishop
PALS Officer
kerri.bishop@nhs.net
Ext 8186

Kirstie Allen
Staff Nurse - ICU
kirstie.allen2@nhs.net

Louise Devereux
Lead Superintendant Radiographer
louise.devereux@nhs.net
Tel: 7525 or 07342 035023

Adam Haspineall
Facilities Manager (SACH and HHGH)
adam.haspineall@nhs.net
Tel: 07423 331711

Sarah McLoughlin
Quality Governance Facilitator
sarah.mcloughlin@nhs.net
Tel: 07919 485320

Paula King
Head of Nursing (Surgery)
paula.king13@nhs.net
Tel: 07795 398759

Yvonne John
Haematology Services Manager, UK NEQAS
y.john@nhs.net
Tel: x7878

Joanne Scott
Radiographer
joanne.scott22@nhs.net
Tel: 3312 2339

Karen Bowler
Deputy Head of Nursing (medicine)
karen.bowler@nhs.net
Tel: 07979 457177

Chloe Field
Recruitment Specialist
chloe.field@nhs.net
Tel: 7031

Keri Flynn
ICU Sister
keri.flynn@nhs.net

Sue Barke
Assistant Divisional Manager
sue.barke@nhs.net
Tel: 07795127991

Bhavna Katwa
PALS Officer
b.katwa@nhs.net
Tel: 8185

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Appendix 2 – Examples of Communications to Promote Speaking Up in May

E-UPDATE

THE LATEST NEWS, EVENTS AND TRAINING FROM #TEAMWESTHERTS

team westHerts

THE BIG 5 2019 STAFF SURVEY

2 Protecting you

Keeping #TeamWestHerts safe

This month's BIG 5 theme in response to the staff survey is about **'Protecting You'** and during May there'll be lots going on to raise awareness around **staff safety** and the **support available**, such as:

- #ZeroTolerance – ensuring that staff, patients and visitors are aware that aggressive behaviour or violence towards our employees is **never** acceptable
- #Reportit – raising awareness about reporting **all** incidents of physical violence via Datix, regardless of severity
- #SpeakUp – encouraging staff to speak up if they have concerns about bullying and harassment and promoting the new 'Speak Up' champions
- #BeSafe – supporting all staff who experience violence at work and signposting further support and training available.

See **here** for further information.

Job vacancies

Looking for a change of scene or a promotion? Search and apply for jobs at West Hertfordshire Hospitals NHS Trust **here**.

Upcoming events

Celebrating midwives this Friday 3 May

Women's and Children's Services is celebrating the **International Day of the Midwife** this **Friday 3 May, 11am-2pm** in the Parent Education room at Watford. Staff are invited to wear international dress and bring dishes from around the world.

Grand Round Friday 3 May

Chief residents Dr Phillip Yee and Dr Alan Ansari are presenting on the **chief resident programme and service improvement in the NHS.**

2 Protecting you

Introducing our #SpeakUp champions

We have a number of #SpeakUp Champions as part of our commitment to eradicating bullying and harassment, and encouraging staff to raise concerns through the Freedom to Speak Up (FTSU) campaign.

#SpeakUp Champions are people with whom you can discuss and raise concerns. Champions can tell you about the options available, help you to take appropriate action or let you know where to seek support. They act as role models for creating an open, honest and transparent culture which values speaking up. To find out who our #SpeakUp champions are, please take a look at the **intranet**.

We are delighted to now have 15 #SpeakUp champions spread across our sites but we are always looking for more volunteers to support our Freedom to Speak Up Guardian and the bullying and harassment agenda. Further info about the role can be found **here**. We are looking for volunteers from any area, role or band within the organisation. If you would like to become a #SpeakUp Champion, please contact **Justine Powell,** ER manager, on WGH ext. 7149 for further details or complete the application form **here**.

Do you know how to #SpeakUp?

As part of this month's BIG 5 theme around 'Protecting You', staff are encouraged to **#SpeakUp** if they have any concerns around bullying and harassment. Lots of posters are going up across all sites to remind staff of how they can raise concerns by speaking to our **Freedom To Speak Up Guardian**, Ginny Edwards.

Speaking up about any concern you have at work is really important. In fact, it is vital because it will help us to keep improving our services for all patients and the working environment for our staff. You may feel worried about raising a concern, and we understand this but please do not be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

You can contact **Ginny** in confidence at **wherts-tr.speakup@nhs.net** or get in touch with the HR lead, **Caroline Lankshear** (pictured above) on 01923 436414. Further information is available on the Employee Relations page on our **intranet.**

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Trust Board Meeting
07 November 2019

Title of the paper	Annual report on guardian of safe working standards
Agenda item	14/76
Presenter	Paul da Gama, Chief People Officer
Author	Richard Burridge, Alex Sarkodie and Shamima Chowdhury
Purpose	***For approval*** : ; ***For discussion*** : √ ; ***For information*** :
Executive summary **(including resource implications)**	This report provides a summary of doctor rota gaps, shift fill rates, and exception reporting data for the year August 2018 – August 2019. There have been some rota gaps across the divisions with multiple recruitment attempts which are summarised in the report. Averaged over the year there have been around 22 WTE rota gaps within the trust. Missing shifts have been filled with bank and agency staff, with an average of 8 unfilled shifts per week across the trust. There have been 383 exception reports during the year. The vast majority were for additional hours worked with most being paid as compensatory pay rather than time off in lieu. This equates to around 1.3 reports per trainee per year. This is similar to other trusts in the region. The majority of exception reports come from the junior training grades, predominantly foundation doctors. This is reflected elsewhere in the region. There were three trainees who worked over the allowed average of 48 hours / week for one placement (Vascular Surgery) during the first part of the year. This led to a fine to the division of £770.94. An excellent response from the division led to changes being made to the F1 rota throughout surgery and the number of subsequent reports fell sharply. Included in the report is a brief summary of other dynamic changes that have been made or planned during the year covered by the report in relation to rota planning and doctor distribution amongst the specialties. Despite the rota gaps, on the whole, doctors appear to have been working safely within the terms and conditions of the contract during the year, and where an issue was identified, it has been rectified for subsequent placements. Further changes to the 2016 Terms and Conditions have been agreed in 2019 and these will be implemented during the year in line with the schedule set out by NHS Employers. The paper was received at the People, Education and Research committee on 31 October 2019 and recommended for presentation to the Board. Final approval is requested by the board.

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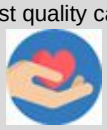
<table>
<tr><td>Aim 1
Best quality care
 
Objectives 1-5</td><td>Aim 2
Great place to work
 
Objectives 6-8</td><td>Aim 3
Improve our finances
 
Objective 9</td><td>Aim 4
Strategy for the future
 
Objective 10-12</td></tr>
<tr><td>√</td><td></td><td></td><td>√</td></tr>
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<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☐Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td>
<table>
<tr><td>Committee/Group</td><td>Date</td></tr>
<tr><td>People, Education and Research Committee</td><td>31/10/2019</td></tr>
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<tr><td>Action required:</td><td>The Trust Board is asked to receive the report for assurance.</td></tr>
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Agenda Item: 14/76

Trust Board meeting – 07 November 2019

Annual report on guardian of safe working standards

Presented by: Paul da Gama, Chief People Officer

1. Purpose

1.1 The below report provides a summary of rota gaps and shift fill for doctors in training as well as a summary of the exception reports received from doctors for the time period August 2018-August 2019.

2. Background

2.1 Overall the exception reporting rate amongst junior doctors equates to around 1.3 reports per trainee per year. This is comparable to other trusts in the region (383 reports August 2018 – August 2019).

2.2 Whilst there have been some persistent gaps in staffing, particularly at middle grade level across the divisions this has not been consistently reflected in the numbers of exception reports. This may be in part due to exception reporting behaviour; the higher training grades in general do not engage in the system. This reflects the trend in behaviour across the NHS in England. However, based on the exception reporting data only, the impact of the staffing levels does not appear to have had a significant detrimental effect on the safe working hours of junior doctors in the trust aside from within Vascular Surgery, where changes were made and things appear to have improved.

3. Analysis/Discussion

3.1 High level data

Number of doctors / dentists in training (total):	267
Number of doctors / dentists in training on 2016 TCS (total) (as of July 2018):	267

3.2 Annual data summary

The below table shows the rota gaps per division for the year August 2018-August 2019

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
Medicine	F1	0	0	0	1	0.25	15	0.3
	F2/SHO	0	2	3	4	2.25	34	0.65
	Middle Grade	5	0	0	0	1.25	25	0.48
Emergency Medicine	F2/SHO	2	2	1	0	1.25	40	0.77
	Middle Grade	4	4	3	3	3.5	79	1.51
Surgery & Anaesthetics	F1	0	1	0	0	0.5	15	0.29
	F2/SHO	4	4	5	7	5	53	1.02
	Middle Grade	3	3	2	2	2.50	45	0.87
WACS	F1	N/A	N/A	N/A	N/A	0.00	0	0.00
	F2/SHO	1.5	1.5	1.5	1	1.4	49	0.94
	Middle Grade	5	5	4	3	4.25	60	1.15
Total		**24.5**	**22.5**	**19.5**	**21**	**21.88**	**415**	**7.98**

3.3 Issues arising and actions taken to resolve issues *per division*

MEDICINE

Medicine Registrar Rota – Rolling Advert via NHS jobs to recruitment to fill middle grade positions. Recruitment unfortunately didn't yield any suitable applications via NHS jobs advertisement so the dept were forced to use external agency (Medacs) to help fill the middle grade gaps. We managed to fill 3 gaps at middle grade position with candidates starting in January 19, February and June respectively. This allowed the middle grade on-call rota gaps to be filled and lead to rota expansion from 1:15 to 1:19 from March 19.

- **Registrar Rota**: Due to Reg shortages in Care of the Elderly, Endo and one vacant slot in Respiratory, Rota was designed to 1:15.
- **Decision was made at Divisional Level around August to redesign Rota from 1:15 to 1:19 due to the increased number of doctors in Care of the Elderly following the local recruitment through Medacs.**
- This led to a change in pay for the doctors involved and also most importantly the frequency of the weekend and Night Shifts (lengthened)
- However, as a result of one of the Agency recruited doctors not initially confident in doing on-calls, we were instructed to ensure the doctor was partnered with any registrar for their designated on-calls.
- Any other gaps were due to sickness and agreed study leave provisions

- **Dermatology Registrar** who is not on the GIM rota went on maternity leave on 17th May which meant the dept had to recruit to fill day time cover. (Successful appointment following NHS Jobs advert. Previous CMT now covering the post effective from 7th August)

Medicine SHO Rota

August 18 – Dec 18: Endo and Rheumatology CMT Gaps but backfilled with LED (locally employed doctor) by Dr Matthew Knight.

Dec 18 - Apr 19:

- Endo CMT: vacancy due to maternity until December 18
- ITU CMT: gap due to trainee taking up ST3 position in another Trust
- LED Resignation in March for COE.

Apr 19 - Aug 19:

- X1 CMT and x2 GPST (Maternity and OH restrictions Gap in CoE)
- LED resignation gap in Respiratory and Endo

Care of the Elderly Ward doctors – Trust doctor gaps due to resignation and part time vacancies

- Recruitment campaign: 2.4 wte remained but further increased to 7 at the end of June 19. Advert on NHS jobs with 175 applications with interviews currently set for 6th Sept 19.
- X3 candidates were appointed via Matthew Knight recruitment on 27th July due to start within the next 4 weeks pending visa applications.

EMERGENCY MEDICINE

A&E: Rolling advert via NHS jobs:

- Three Recruitment adverts placed at Clinical Fellow Level and SHO levels
- X4 SHO level appointments - commenced in Feb along with 2 middle grades starting in March and June respectively.
- X2 middle grade doctors also appointed with start dates to be confirmed pending visa.
- We also had x4 new middle grade jobs approved at Vacancy control which went out to advert on 27th July.
- All shifts as a result of the rota gaps including Trust gaps were sent out for locum cover

WACS

O&G SHO:

- 1.5 wte GPST Gap from Aug – Dec 18 in Obs & Gynae
- Paeds had a gap at GPST level from April 19 – Aug 19
- Registrar 1.0wte vacancy until June 19 (Due to illness) which rose to 2.wte (Training gaps)

PAEDS SHO/Middles Grade

- One appointed doctor in Feb 19 at SHO level but delayed start date until August due to GMC registration.
- 5 recruitment episodes from 9th October 18 – 24th March 19 via NHS jobs which didn't held any suitable applicants at Registrar level.
- Paediatrics had on average of 2.5 Registrar vacancies including gaps due to Less than full time Trainees.

SURGERY AND ANAESTHETICS

Surgery: Recurring job adverts via NHS jobs: Breast Surgery appointed to x2 registrar level and x1 SHO level. Trauma and Orthopaedics had vacancies at Trust SHO Level. Advert on NHS Jobs between Dec 18 – March 19 lead to x5 appointed candidates from overseas who commenced in April, February and June 19.

Anaesthetics: Four episodes of adverts on NHS jobs at Clinical Fellow and Specialty Doctor Level since January 19. No appointment made due to shortlisting candidate withdrawing or unsuitable candidates following application review by Recruiting manager.

This job is been reviewed by the dept clinical lead.

Urology appointed to a Trust Registrar position via internal recruitment.

3.4 Exception Reporting

By Specialty

	August 2018-October 2018	November 2018-January 2019	February 2019- April 2019	May 2019 – July 2019
A&E	**1**	**(total3**	**2**	**0**
A&E	**1**	**3**	**2**	**0**
Medicine	**90**	**(total)75**	**40**	**58**
Acute	**2**	**0**	**1**	**18**
Cardiology	**10**	**0**	**2**	**3**
Endocrine	**5**	**0**	**0**	**16**
Gastroenterology	**15**	**28**	**11**	**11**
Geriatric	**10**	**9**	**9**	**3**
Respiratory	**40**	**19**	**9**	**0**
Stroke Medicine	**6**	**14**	**2**	**0**
Haematology	**2**	**0**	**0**	**0**
Rheumatology	**0**	**3**	**6**	**0**
ITU/Anaesthetics	**0**	**2**	**0**	**0**
Oncology	**0**	**0**	**0**	**7**
Surgery	**70**	**(total)32**	**12**	**0**
Lower GI	**5**	**4**	**6**	**0**
Orthopaedics	**1**	**0**	**0**	**0**
Vascular	**62**	**28**	**5**	**0**
Upper GI	**2**	**0**	**0**	**0**
Not stated	**0**	**0**	**1**	**0**
WACS	**0**	**(total)0**		**0**
Paediatrics	**0**	**0**	**0**	**0**
Grand Total	**161**	**110**	**54**	**58**

By Grade (totals)

	August 2018-October 2018	November 2018-January 2019	February 2019-April 2019	May 2019 – July 2019
CMT	34	5	5	22
F1	136	97	43	35
F2	1	6	5	1
Other SHO	0	2	0	0
ST4+	0	0	1	0
Grand Total	**161**	**110**	**54**	**58**

3.5 Guardian Fines during year- £770.94

There were a large number of reports from Surgery in the first two quarters. The majority of these occurred within Vascular Surgery. Following a series of meetings and discussions with senior members of the Surgical division, several changes were made and a new rota template was developed. The number of exception reports from within surgery has reduced significantly since this intervention with good engagement seen by the surgical division. Despite the changes made, there were breaches of the 'rota rules' from three F1 doctors who had been working within surgery and a guardian fine of £770.94 was applied to the division of surgery.

Changes made during the year from within Surgery include:

1. F1 doctors redistributed amongst the teams to better reflect the number of post take days. Feedback has been that this is working much better.
2. A late shift of one F1 per day on a twilight/late shift has been added every day, to enable the others to get away at 5pm, with someone to hand over their jobs to. This also appears to have worked well.
3. The division continue to have a locum F1 on Saturday and Sunday to help with the weekend ward rounds, and this also works well.

Within the division of medicine there have been a steady number of reports from across the areas. The agreement to offer compensatory payment for doctors working additional hours within some of the more intense medical specialties has continued and whilst additional hours have been worked and paid, no trainees have breached their 48 hours/week average during the year. Following concerns around work load in endocrinology a locally employed doctor was put in place for the last few months of the year to alleviate pressure in that area.

When any specific concerns have been raised by doctors within medicine there has been an excellent response from the division. Changes made during the year from within Medicine include:

1. PMOK FY1 weekday 5 – 9pm shift – 1 x extra FY1 doctor, taking the numbers of doctors for PMOK cover to 3 FY1 doctors and 1 SpR
2. AAU FY1 weekend cover – 2 x extra FY1 doctors for level 1 AAU cover, taking numbers of doctors for AAU from 2 to 4.
3. Tudor ward - in July 2019, an additional locum SHO was booked for Tudor to cover the 4 additional surge beds. From August there has been an additional doctor allocated to the Tudor team.

4. Cassio ward – additional SHOs allocated in response to exception reporting.
5. A “floater shift” is being introduced from August 2019 to respond to service needs when there are unpredictable staffing issues (sickness, unexpected capacity pressures)
6. In addition, SpR numbers are much better than this time last year (14 to 26 SpRs). This is due to the collaborative work with the deanery to ensure that all speciality SpR posts are filled. The clinical leads have established good speciality training programmes for SpRs which makes WHHT an attractive centre for trainees. We have also trialled an international recruitment programme for COE which has led to fewer COE SpR vacancies.

The majority of reports continue to come from junior trainees, mainly foundation doctors. This has been reflected nationally.

Looking forward into 2019/2020 there have been some changes agreed to the Junior Doctors Contract. Some of these relate to exception reporting and to guardian fines and it can be expected that there will be an increase in the number of and the value of guardian fines as the threshold for incurring fines has been lowered in the latest iteration of the contract.

NHS Employers have also released a provisional new template for the Guardian reports and once this has been finalised and agreed nationally, it will be adapted and adopted within WHHT for future reports.

4. Recommendation

4.1 The Board is asked to receive the report for assurance.

Paul da Gama
Chief People Officer

November 2019

Trust Board Meeting
07 November 2019

Title of the paper	Staff Seasonal Flu Vaccination Campaign update
Agenda Item	15/76
Presenter	Paul Da Gama, Chief People Officer
Author(s)	Kayleigh Rockett, Seasonal Influenza Project Manager
Purpose	*For approval*: *For discussion*: *For information*: √
Executive Summary	This paper is presented in order to meet the requirements as set out in a letter sent by Pauline Philip National Director of Emergency and Elective Care NHS England and Improvement sent on 17 September 2019 requiring all Trusts to complete a best practice management checklist for healthcare worker flu vaccination. In addition trusts were asked to publish a self-assessment against these measures as part of their trust board papers before the end of December 2019. This paper is intended to provide assurance that the Trust is fully compliant in relation to the NHS England Best Practise Management checklist. The paper was received at the People, Education and Research Committee on 31 October 2019 and approved to be presented to the Board. **Benefits to patients/staff from this project/initiatives** • Protection for WHHT staff and other closely linked service deliverers from seasonal influenza by offering them the flu vaccination. • Protection for patients from staff related transmission of seasonal influenza by immunising staff against the seasonal influenza virus. • To have healthy and well staff looking after our patients. • To minimise the risk of a flu outbreak to both staff and patients. • Investment in patient care using monies from CQUIN target achievement. **Risks attached to this project/initiatives and how these will be managed** Staff not vaccinated against seasonal influenza, leading to staff and patient illness, resourcing challenges and delivery pressures. Risk managed by: • Early detailed programme development. • 4 week intense programme of delivery. • Ongoing accessibility and convenience of being vaccinated. • Positive influence from other staff. • Simple and effective messaging. • Energetic, incentivised and sustained rollout of the programme. Income lost through non-achievement of CQUIN targets. Risk managed through: • Successful campaign • Accurate data collection and reporting.

15

<table>
<tr><td></td><td></td></tr>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<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>X</td><td>X</td><td>X</td><td>X</td></tr>
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</td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td>
<table>
<tr><td>Committee/Group</td><td>Date</td></tr>
<tr><td>Key elements have been discussed with stakeholders at the weekly Influenza Steering Group meetings</td><td>Weekly</td></tr>
<tr><td>People Education and Research Committee</td><td>31/10/2019</td></tr>
</table>
</td></tr>
<tr><td>Action required</td><td>The Board is asked to receive the paper as assurance that the Trust is compliant with the NHS England Best Practise Management checklist.</td></tr>
</table>

Agenda Item: 15/76

Trust Board Meeting - 07 November 2019

Staff Seasonal Flu Vaccination Campaign update

Presented by: Paul Da Gama

1. Purpose

1.1 The paper provides an overview of the measures the Trust is undertaking in order to ensure the Trust is doing everything possible as an employer to protect their patients and staff from seasonal flu. The trust has been asked to provide Board level assurance that it is meeting best practice guideline.

2. Background

2.1 In her letter of 17 September 2019, Pauline Philip, National Director of Emergency and Elective Care NHS England and NHS Improvement, sent a letter asking all Trusts to complete a best practice management checklist for healthcare worker flu vaccination. In addition trusts were asked to publish a self-assessment against these measures as part of their trust board papers before the end of December 2019.

In order to ensure the Trust is doing everything possible as an employer to protect their patients and staff from seasonal flu the Trust has completed a best practice management checklist for healthcare worker vaccination and published a self-assessment against these measures for the Board Committee to approve for public assurance.

3. The Trust's plan

3.1 The key elements of the Trust's campaign incorporate the following key elements:

Accessibility and Convenience	**Objective:** • Ease and convenience of being vaccinated. • Quick process for frontline HCW. **Action:** Drop in clinics: • Busiest time of day in high foot traffic locations. • Regular, consistent day/times. Area/department clinics: • Organised in advance with Area/Department manager at best time/day to capture maximum amount of staff. • Vaccinated by Influenza Nurse or Local Vaccinator
Education and Awareness	**Objective:** • Educate all HCWs of influenza to allow them to make an informed decision about being vaccinated. • Campaign to be seen and recognised. **Action:** • Availability of information – information about influenza online and distributed in area/department through various channels • Educational road show/presentations given to high risk low uptake area/departments prior to commencement of campaign. (High risk low uptake areas/department recognised for 2018/19 data). Speakers to be influential clinician in Trust or from

	external health body. • Simple and effective messaging. • Eliminate misconceptions/myth busting. • Increased publicity via marketing mediums – marketing collateral visual, emotive and repetitive. • Communicate clearly to HCWs the type of clinics available, date/time/locations of clinics and requirements.
Positive Influence from Staff	**Objective:** • Corporate/senior staff leading by example and positively influencing staff to be vaccinated. • Hierarchal flow of employees vaccinated to increase confidence in other staff with regards to safety of vaccines. **Action:** • Matron/Service Manager is the nominated Flu Champion who is responsible to communicate and distribute flu vaccination information to HCWs. Flu Champion is responsible to achieve CQUIN target of 80% vaccination. • Senior Sister/Nurse Specialist is the nominated Local Vaccinator with capability to vaccinate peers within their respective area/department. • Clinical Executives to sporadically vaccinate employees. • All corporate/senior staff (Chief Executive to Matrons) to be vaccinated Week 1 of Flu Campaign.
Data Management and Reporting	**Objectives:** • Accurate and detailed analytics and information provided weekly to help guide campaign delivery. **Actions:** • Weekly report to all staff from Trust Management • Weekly organisation and divisional report to key stakeholders • Regular connections made with all Flu Champions and other clinicians immunising staff to ascertain performance achievement, resolve issues and provide required support. • Weekly scheduled steering group meetings to gather feedback and adapt the approach accordingly, with 100% attendance (self or representative) for the period. • Feedback on campaign assurance to the Patient and Staff experience committee
Use of Incentives and Healthy Competition	**Objectives:** • Incentives used to get HCWs to engage in being vaccinated. **Actions:** • An incentive that benefits the individual when vaccinated. Confectionary, branded pen and coffee voucher. Coffee voucher expiry end of Phase 1, this is used to drive fast uptake. • An incentive that benefits the department when they achieve CQUIN target of 80% uptake of vaccines in department. • Weekly Trust wide targets set and publicly celebrated when achieved.

4. Analysis/Discussion

4.1 The Best Practise Management Self-Assessment below sets out those areas which the Trust is required to meet in order to meet NHSI and E requirements in the management of our flu vaccination programme. As can be seen the Trust is meeting all of the key requirements:

	Requirement	Status	Evidence
A	**Committed Leadership**		
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Compliant	'Staff Seasonal Influenza Vaccination Campaign 2018/19' presented by Paul Da Gama in June 2018 to TEC which provided an overview of the Trusts campaign approach to note and approved additional resource (1WTE Band 7 Project Manager, 1WTE Band 6 Flu Nurse, 0.53 WTE Band 6 Flu Nurse, 0.53 WTE Band 2 Data Administrator) to facilitate the100% Trust ambition of healthcare workers with direct patient contact.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Compliant	4500 quadrivalent (QIV) and 400 trivalent (TIV) vaccines were ordered and delivered to the Trust on 27th September 2019.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	Compliant	'Staff Seasonal Influenza Vaccination Campaign 2017/18' presented by Paul Da Gama in February 2018 to TEC which included approach, outcomes and learning.
A4	Agree on a board champion for flu campaign	Compliant	Paul Da Gama, Director of Human Resources and Organisational Development is board champion.
A5	All board members receive flu vaccination and publicise this	Compliant	Vaccinations given in the first 2 weeks of campaign at board meeting on 03-10-2019 and TMC on 09-10-2019. Imagery of this was published on Trust social platforms – Twitter and Facebook.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Compliant	Flu project manager, data administrator and nurse were assigned. Key stakeholders from all directorates, staff groups and trade union were assigned and represented. The flu campaign has been discussed at all Staff Side meetings since the summer.
A7	Flu team to meet regularly from September 2019	Compliant	Seasonal Influenza Steering Group meetings with key stakeholders held weekly on Monday at 1.00pm in various locations. This meeting is chaired by the Director of HR.
B	**Communications Plan**		
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Compliant	Independent marketing campaign created and distributed across all sites of the Trusts. Campaign to be emotive by expressing encouraging and positive emotions, educating by showing fact over fiction, stand out by using engaging messages and strong bold colour and type and relatable. Influenza myth-busting sessions rolled out by senior clinical leaders to area/departments.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Compliant	Drop in clinics, pre-planned department clinics and appointments available for all healthcare workers are publicised across various

	Requirement	Status	Evidence
			communications channels to ensure all staff are aware of the times and locations.
B3	Board and senior managers having their vaccinations to be publicised	Compliant	Imagery of Trust Executive Committee, senior managers published on Trust communication channels with aim to show staff that Senior management are leading by example.
B4	Flu vaccination programme and access to vaccination on induction programmes	Compliant	Consent forms included in Induction starter packs. Location of Flu nurse at drop in clinics, pre-planned department clinics or by appointment shared with all new starters during induction.
B5	Programme to be publicised on screensavers, posters and social media	Compliant	All information surrounding the Seasonal Influenza Campaign was publicised across various communication channels including; social, digital, printed and verbal platforms for maximum reach and engagement.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Compliant	Overview report sent weekly on Friday to all Executives, Directors, Divisional Managers and key stakeholders. Divisional report sent weekly on Friday to all Divisional and Managers and Service Managers/Matrons.
C	**Flexible Accessibility**		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Compliant	Peer vaccinator assigned for each area/department in the Trust who has undergone and completed Influenza Vaccinator training. Peer vaccinator provided all necessary equipment, consumables and information to successfully vaccinate staff. Weekly communication between Peer Vaccinator and Flu Team for updates and encouragement.
C2	Schedule for easy access drop in clinics agreed	Compliant	Regular drop in clinics organised across all Trust sites in high foot traffic locations at busiest time of day. Drop in clinics publicised throughout various communication channels.
C3	Schedule for 24 hour mobile vaccinations to be agreed	Compliant	Roaming vaccinator available 24 hours covering all staffing shifts – day, night and weekend.
D	**Incentives**		
D1	Board to agree on incentives and how to publicise this	Compliant	Staff receive badge and confectionary when they are vaccinated. Staff that are vaccinated before 31st October receive a NHS branded water bottle in efforts to drive fast uptake early.
D2	Success to be celebrated weekly	Compliant	Success celebrated weekly and publicised via communication channels, primarily Facebook, Twitter and e-Update. Trust wide targets celebrated FluShot500, Flu Shot1000, FluShot1500,

	Requirement	Status	Evidence
			FluShot2000. Department/Area that achieve 80% staff vaccination uptake receive celebration box.

5. Risks

5.1 Staff still not being vaccinated against seasonal influenza, leading to staff and patient illness, resourcing challenges and delivery pressures.

5.2 Income lost through non-achievement of CQUIN targets.

5.3 All resources are directed to the achievement of 100% vaccination uptake of healthcare workers with direct patient contact however it is likely that this ambition will not be achieved. The final staff vaccination uptake will determine the scale of the likelihood of the impact to the Trust.

6. Recommendation

6.1 The Board is asked to receive the paper as assurance that the Trust is compliant with the NHS England Best Practise Management checklist.

Paul Da Gama
Chief People Officer

November 2019

Trust Board Meeting
07 November 2019

Title of the paper	Report on long term financial planning
Agenda Item	16/76
Presenter	Don Richards, Chief Financial Officer
Author(s)	Don Richards, Chief Financial Officer
Purpose	*For approval* √ ; *For discussion* √ ; *For information* √
Executive Summary	The purpose of this paper is to update the Board on the process for developing the financial plans for 2019/20 and the following four years. The financial plan is a financial representation of the operational plans for the trust over the period concerned and is expected to be consistent with the STP Long Term Plan. The STP Long Term Plan is due to be finalised this month (November) and will act as a framework for our financial plan. The Trust has been issued with financial targets for the next four years (under cover of a letter from the NHSI[1] East of England Regional Office) which support the STP/ICS[2] providing services within the STP's spending control total. These targets assume the Trust will receive c£40m in each of the next four years to support balancing in-year income and expenditure by the 2022/23 year. This report (at appendix 1) provides updated analyses of the Trust's potential to achieve break-even by 2022/23 and to meet targeted maximum deficits on 2020/21 and 2021/22. Naturally, the need for borrowing will be significantly reduced if the plan is adhered to. Work continues regarding options to repay or re-structure the Trust's accumulated debt.
Trust strategic aims	Aim 1 Best quality care – *Objectives 1-5* – x Aim 2 Great place to work – *Objectives 6-8* – x Aim 3 Improve our finances – *Objective 9* – x Aim 4 Strategy for the future – *Objective 10-12* – x

[1] Ann Radmore to Christine Allen 7th October 2019 (see Appendix 3).
[2] Integrated Care System

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<tr><td>Action required</td><td>Updated financial trajectories and the process for developing financial plans having been agreed by the Trust management Committee and assured by the Finance and Performance Committee.

The Trust Board is asked to ratify acceptance of the financial trajectories for 2020/21 through to 2023/24.</td></tr>
</table>

Agenda Item: 16/76

Trust Board Meeting – 07 November 2019

Report on long term financial planning

Presented by: Don Richards, Chief Financial Officer

1. Purpose

1.1 The purpose of this paper is to update The Committees and the Board on:

(a) the process for developing the financial plans for 2019/20 and the following four years and

(b) the basis for accepting NHSE/I issued income and expenditure targets (trajectories) for the next four financial years.

2. Background

2.1 The financial plan is a financial representation of the operational plans for the trust over the period concerned and is expected to be consistent with the STP Long Term Plan. The STP Long Term Plan is due to be finalised this month and will act as a framework for our financial plan.

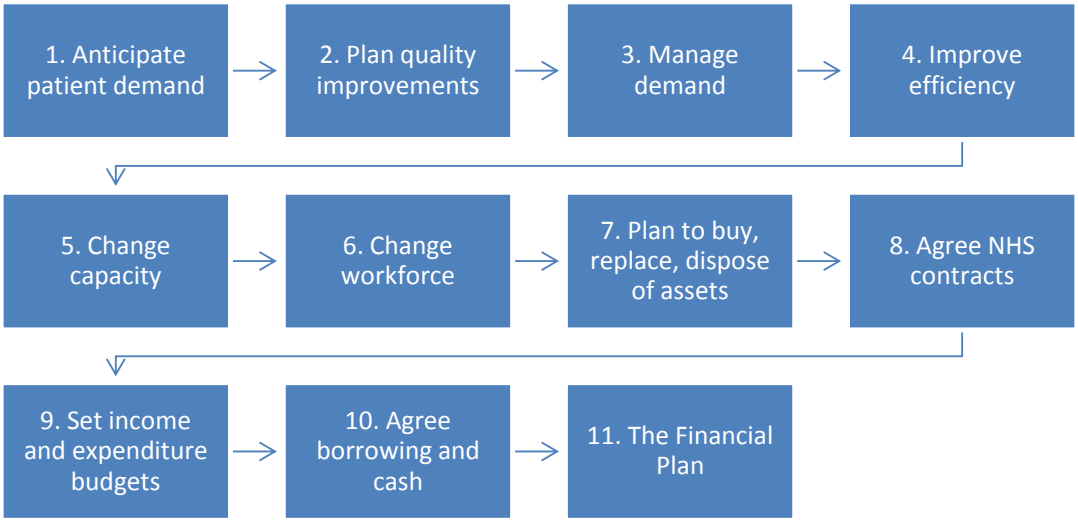
2.2 An important part of the Long Term Plan (LTP) is the need to operate within the spending constraint imposed by the System Financial Control Total. The Trust has been issued with financial targets for the next four years (under cover of a letter from the NHSI[3] East of England Regional Office) which support the STP/ICS[4] providing services within its financial control total.

2.3 In order for the Trust to deliver its objectives, in line with the LTP, the Trust's financial plan expects to represent the Trust's operational plans over the next four years. Therefore the financial plan takes into consideration:

(i) The anticipated demand for patient care,
(ii) How we intend to improve the quality of service,

[3] Ann Radmore to Christine Allen 7th October 2019.
[4] Integrated Care System

(iii) How we will work within the system to manage demand,
(iv) How we will improve efficiency,
(v) What capacity changes we will need to make,
(vi) What changes to workforce we intend to make
(vii) What assets we need to buy, replace, dispose of to support the plan
(viii) How the above is represented in contracts with NHS commissioners
(ix) What impact the above has on revenue income and expenditure and does this impact fit with mandated targets.
(x) What are the cash flow and borrowing implications of the plan.



3. Patient Activity Demand

3.1 At this stage in the planning process, activity projections for the 2020/21 year and future years are to be further developed.

3.2 An initial draft activity plan was submitted for the 5 years to 2023/24 as part of the STP Long Term Plan. This was in line with the planning guidance and used local assumptions agreed with the commissioners.

3.3 More sophistication will be incorporated in developing the 2020/21 plan. This will also respond to the expectations set out in the Long Term Plan Implementation Framework to reflect:

- Reduced waiting lists, improved elective treatments.
- Outpatient service transformation, including the use of digital tools to redesign how services are offered.
- Removing up to a third of face to face outpatient visits.
- Improved A&E performance
- Improved cancer treatment performance

4. Quality improvements

4.1 The Trust's Quality Commitment sets out the strategic plan for improving the quality of services. At the core of the plan is the need to invest in integrated care pathways and to reduce unwarranted clinical variation by working in partnership with the Royal Free London Group.

4.2 The Trust will also show its commitment to develop a digitised NHS.

4.3 Appendix 2 to this paper lists the LTP headline objectives.

5. Demand Management

5.1 In view of activity pressures and the need to provide high quality services within the constraints of the system control total, our financial plan will need to take into account plans to manage demand for services. These plans will be centred on a more integrated provision of services between different parts of the NHS.

5.2 Across Hertfordshire and West Essex, the Trust has agreed three key priorities for transformation and service change over the next three to five years: frailty, children and maternity, and planned care. These have been selected because of opportunities identified through benchmarking (Right Care, Model Hospital and GIRFT).

5.3 The Trust is also working collaboratively with other members of the STP to deliver the NHS Long Term Plan commitments to support the management of demand including changes to urgent care and cancer provision supported by improved tools to support total population health management.

5.4 However at this point in time, while detailed plans are being developed and agreed, assumptions are aligned with the demand management assumptions used to support the strategic outline case for the redevelopment of the WHHT estate.

6. Efficiencies

6.1 Even with optimistic demand management plans, the Trust will not be able to deliver services within the notified financial constraints, without developing new efficiencies. The Trust has been planning, for some time, that the Trust will develop recurrent efficiencies worth 4% of cost, for each year, up to and including the 2022/23 year.

6.2 The charts in Appendix 1 illustrate the potential to operate within the financial trajectories issued by NHSI after taking these efficiencies into account.

7. Capacity changes

7.1 After taking into account anticipated activity, growth, demand management plans and improved efficiencies, our financial and operational plans need to be underpinned by an understanding of the minimum bed, outpatient and theatre capacity available to support delivery. This is not a strong area for Trust due to software and hardware limitations. However we plan to improve our planning for necessary capacity in comparison to previous years.

8. Workforce changes

8.1 Activity, quality, capacity and efficiency demands drive the need to change the workforce. The financial plan needs to reflect these workforce changes.

8.2 The Trust is working closely with other members of the STP to refine and develop a five year workforce strategy. The plan will aim to clarify the workforce implications, using a modelling approach informed by STP clinical work streams. The plan will address planned workforce growth in different staff groups coupled with workforce efficiency plans. Initial analyses suggest a need for higher than standard growth of radiographers, consultants and midwives posts.

9. Capital expenditure

9.1 Providing the right service capacity while improving efficiency and quality will require investment in replacing, disposing and buying new assets. We anticipate dedicated funds to support the development of plans for the large scale redevelopment project but apart from this capital funds will be especially constrained in 2020/21. Recent announcements regarding targeted funding for ageing diagnostic equipment will ease capital spending constraints.

9.2 As in previous years initial outline strategic cases will be compiled during December to provide an outline for capital spending in January. We will aim to finalise the 2020/21 programme before the start of the financial year. At this point we will also aim to have a refreshed longer term headline programme in line with the Trust's estate strategy and the investment plan for transforming services with the use of digital technology.

9.3 The NHSE/I letter to the Chief Executive signals a move to improved certainty over capital funding in the future.

10. NHS contracts

10.1 The plans for the year, as far as they impact on patient care for different populations, will be reflected in contracts with Commissioners.

10.2 Significantly, this year, the plan will include the consequences of providing services as an integrated care provider within an integrated care system, regulated within a minimum income contract (MIC)[5].

10.3 The most important difference is that changes to funding from our host commissioner (HVCCG) will not vary in-year due to national tariff rules. Funding from this source once agreed is expected to be largely fixed, providing a greater incentive for all system partners to manage demand.

11. 'LTP' Funding

11.1 In addition to funds received via normal CCG contracts further revenue funding is likely to be made available to the Trust via the STP to enable targeted long term plan commitments. This funding to support cancer, stroke and maternity transformative changes is unlikely to exceed £0.8m in 2020/21. The funding will match projected costs.

12. Income and expenditure budgets

12.1 The process for translating the strategic financial plan into detailed budgets for every Division and Department in the Trust, will be set out in a Budget Setting Principles document. The document will be expected to provide managers with more clarity regarding how their detailed budgets have been set based on the strategic financial plan. This is expected to help support the delivery of services within the constraints of their delegated budget.

12.2 In developing the strategic financial plan, the Trust has used the financial assumptions set out in the framework for the years to 2023/24 as presented to the previous Finance Committee meetings. However the Committees should note the following material changes from previous reports discussed at FPC:

(a) The financial targets issued by NHSI, confirm FRF funding, that the Trust can plan on earning over the next four years. This funding, c£40m non-recurrently in each year, provides the Trust with a platform to break-even in-year by 2022/23 (see appendix 1).

[5] See separate paper and agenda item in the Part 2 agenda

(b) The assessment of the ability to meet the trajectory to break-even, now includes (i) the effect of changes to Market Forces Factor funding[6] and (ii) an assumption that tariff/ contract inflation will not fully fund expected increases to CNST costs.

12.3 Detailed income and expenditure budgets (when aggregated) will allow the development of an in-year 2020/21 income and expenditure, month by month trajectory. This will be monitored each month, to provide assurance that services are being delivered in line with the financial plan.

12.4 A material cost for the Trust in 2019/20 was the increase in pension contributions. LTP guidance states that any further changes required to pension contributions should be assumed to be funded separately.

13. Borrowing and cash flow

13.1 The financial plan anticipates small income and expenditure deficits in 2020/21 and 2021/22, therefore there will be a need to borrow to cover revenue expenditure during these years. In addition with limited internally generated cash and a large demand for capital expenditure to support the plan, the Trust will need to agree capital expenditure loans for the LTP period.

14. Next steps

14.1 The next update to Committees will set out the key actions needed to complete the financial plan for 2020/21 and the dates and risks associated with their completion.

15. Recommendations

15.1 The Board is asked to receive the updated financial trajectories and the process for developing financial plans which has been agreed by the Trust management Committee and assured by the Finance and Performance Committee.

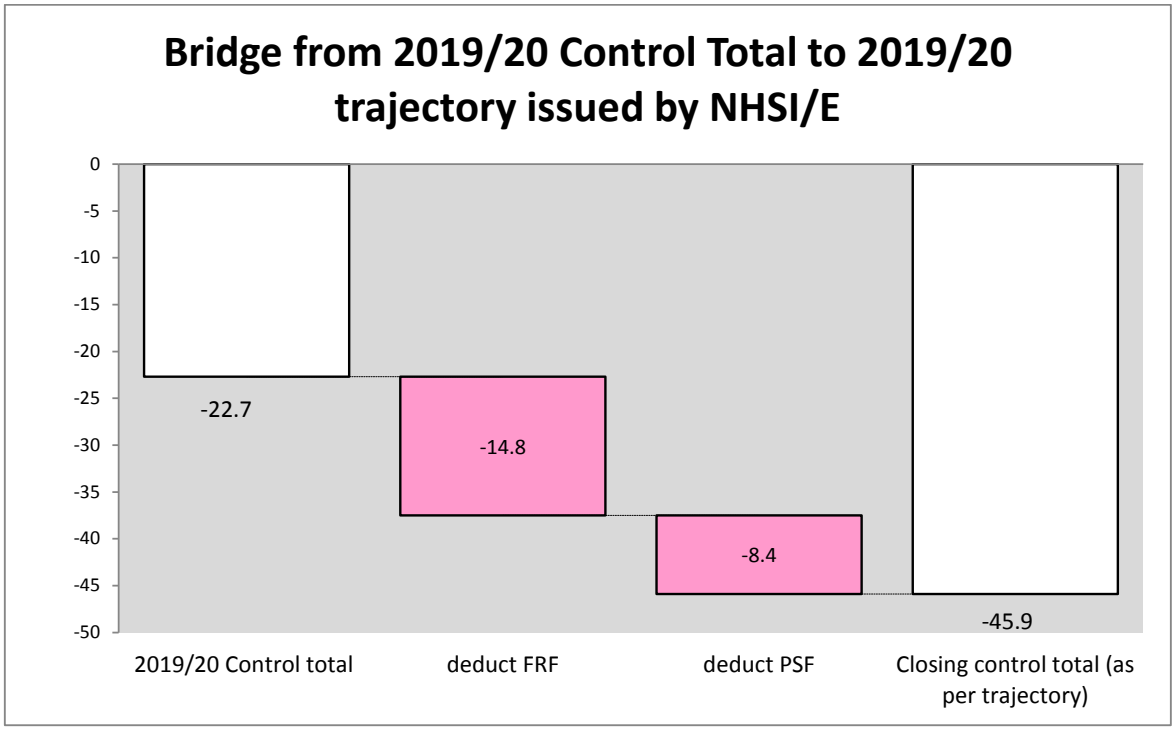
15.2 The Trust Board is asked to ratify acceptance of the financial trajectories for 2020/21 through to 2023/24.

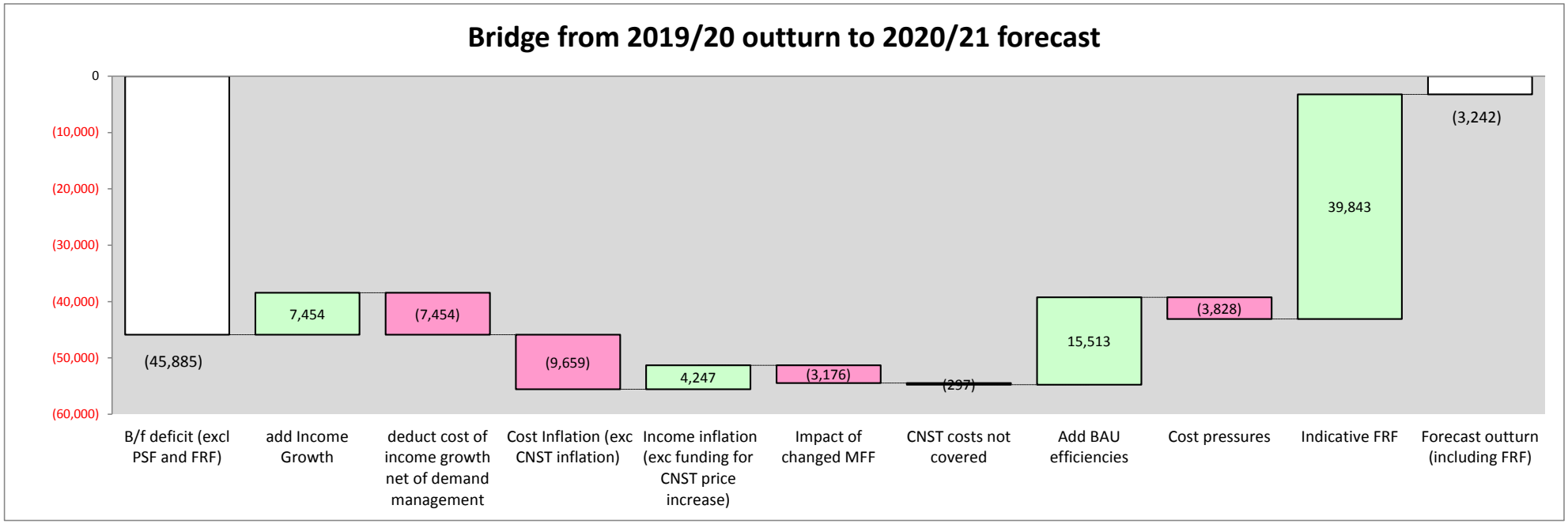
Don Richards
Chief Financial Officer

October 2019

[6] Assuming this is reflected in block contracts

Appendix 1 Income and Expenditure Bridges from 2019/20 forecast outturn to 2023/24 financial target

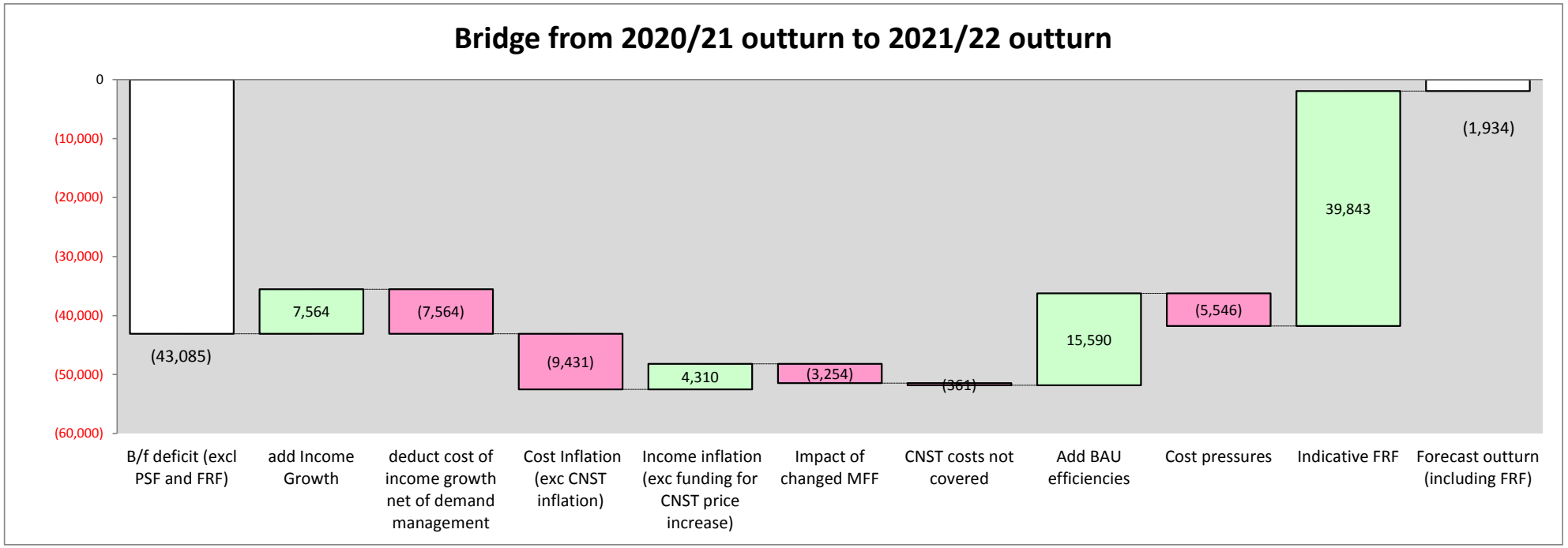


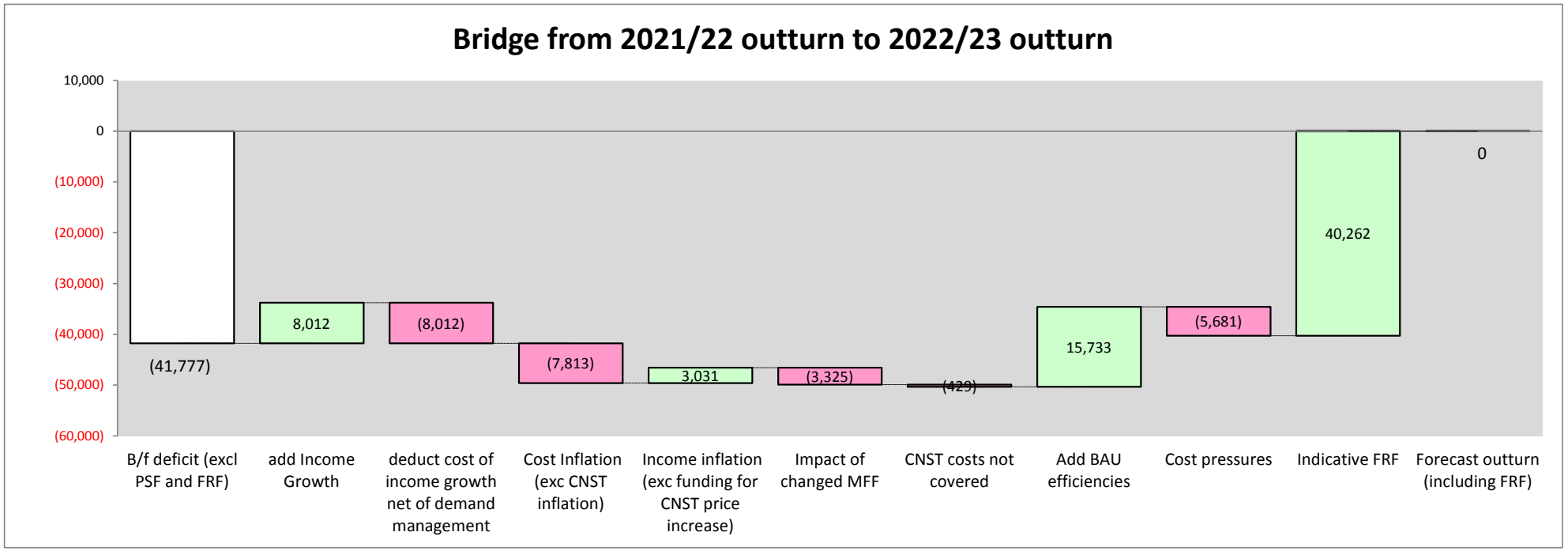


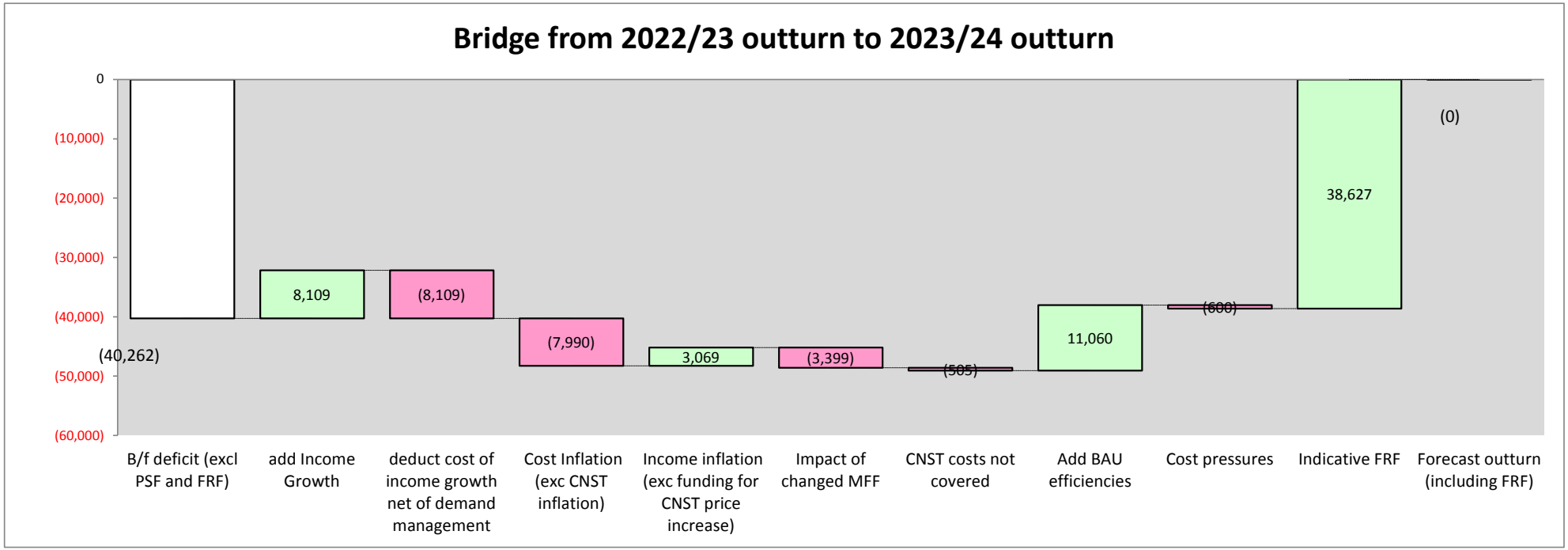
NB key differences from last FPC presentation:

(a) CNST inflation has been separated from cost and income inflation and an estimate made of the potential net difference between CNST funding increases and CNST cost increases.
(b) The Market Forces Factor funding distribution is changing from 2020/21. If this funding distribution change is reflected in contract structures in the same way as would be reflected under PbR contracts, the Trust will lose funding as shown in the bridge above.
(c) FRF allocations have been notified (eg £39.843m for 2020/21).
(d) The Trust is now required to end the 2020/21 year with a deficit no greater than £3.242m for 2020/21; £1.934m for 2021/22 and break-even thereafter.

(e) Assuming CIPs are delivered, it is assumed that there are funds available to meet cost pressures associated with eg capital charges on net capital expenditure in excess of depreciation (eg redevelopment spend), development costs not funded by Commissioners.




Bridge from 2021/22 outturn to 2022/23 outturn
10,000
0
(10,000)
(20,000)
(30,000)
(40,000)
(50,000)
(60,000)
(41,777)
8,012
(8,012)
(7,813)
3,031
(3,325)
(429)
15,733
(5,681)
40,262
0
B/f deficit (excl PSF and FRF)
add Income Growth
deduct cost of income growth net of demand management
Cost Inflation (exc CNST inflation)
Income inflation (exc funding for CNST price increase)
Impact of changed MFF
CNST costs not covered
Add BAU efficiencies
Cost pressures
Indicative FRF
Forecast outturn (including FRF)


Bridge from 2022/23 outturn to 2023/24 outturn
0
(10,000)
(20,000)
(30,000)
(40,000)
(50,000)
(60,000)
(40,262)
8,109
(8,109)
(7,990)
3,069
(3,399)
(585)
11,060
(600)
38,627
(0)
B/f deficit (excl PSF and FRF)
add Income Growth
deduct cost of income growth net of demand management
Cost Inflation (exc CNST inflation)
Income inflation (exc funding for CNST price increase)
Impact of changed MFF
CNST costs not covered
Add BAU efficiencies
Cost pressures
Indicative FRF
Forecast outturn (including FRF)

Appendix 2 - LTP headline metrics

A new service model for the 21st century

1. Primary and community services (extra £4.5 billion): annual implementation milestones for 5-year GP contract – more detail to be agreed: new community services response times and teams.
2. Comprehensive ICS coverage including a partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners.
3. Emergency care: on agreed trajectory for Same Day Emergency Care (SDEC) and Integrated Urgent Care Services (IUCS).

More NHS action on prevention and health inequalities

4. Prevention (1): increase uptake of screening and immunisation
5. Inequalities: inequalities reduction trajectory
6. Prevention (2): alcohol care teams, tobacco treatment services, and diabetes prevention programme

Further progress on care quality, access and outcomes

7. Maternal and children's health: on agreed trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025
8. Improve cancer survival: Improve one and five-year cancer survival; on agreed trajectory so that 75% of cancer patients diagnosed at stage 1 or 2 by 2028
9. Learning disability and autism: on agreed trajectory for halving inpatient rate by 2023/24 and increasing learning disability physical health checks to 75% of people aged over 14
10. Mental health: on track for locally agreed service expansion, and increase in investment for mental health services as a share of the NHS budget over the next five years, worth in real terms at least a further £2.3 billion a year by 2023/24
11. Implementation of agreed waiting times/clinical standards for urgent and emergency care, elective care, cancer and mental health, from April 2020, and the maintenance and improvement of performance for cancer treatment and A&E until that point.

NHS staff will get the backing they need

12. Workforce metrics will be agreed through development of the NHS People Plan but will include:
    - Staff retention: retention rate to improve by at least 2%
    - Leadership: CQC well led indicator, and staff engagement indicator
    - Diversity/inclusion: BME representation, gender, bullying/harassment

Digitally enabled care will go mainstream across the NHS

13. Outpatient reform: 30% reduction trajectory, outpatient digital role out
14. Empowering people: Summary care record roll out.
15. Access to online/telephone consultations in primary care.

Taxpayers' investment will be used to maximum effect

16. Test 1: The NHS will return to financial balance o proportion of NHS organisations in financial balance.

17. Test 2: The NHS will achieve cash-releasing productivity growth of at least 1.1% per year NHS Long Term Plan Implementation Framework I 41 o Annual cash releasing productivity growth of at least 1.1%
18. Test 3: The NHS will reduce growth in demand for care through better integration and prevention o With population health management delivering demand growth moderation in line with LTP activity model
19. Test 4: The NHS will reduce variation in performance across the health system o GIRFT/RightCare metric to be confirmed
20. Test 5: The NHS will make better use of capital investment and its existing assets to drive transformation of Metrics to support this test will be confirmed following the Spending Review and development of the new NHS capital regime

Trust Board Meeting
07 November 2019

Title of the paper	Strategy Update
Agenda Item	17/76
Presenter	Helen Brown, Deputy Chief Executive
Author(s)	Helen Brown, Deputy Chief Executive
Purpose	For approval: ; For discussion: ; For information: ✓
Executive Summary	The Board is asked to note the attached paper and M7 position on the 17 projects within the following programmes; Workforce; CIP, Digital, Interim Estates and Acute Redevelopment programmes. There is no movement on RAG ratings in month and 6 schemes remain green RAG rated meaning they are complaint with plan. Of the 10 amber rated projects, they are broadly behind schedule with identified risks and mitigations in plan. This month there is one exception report on the WGH Multi Storey Car Park which is in the main body of the paper.
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	TMC October 2019
Action required	The Board is asked to receive the M7 strategic programme delivery for year 2019-2020.

Agenda Item: 17/76

Trust Board meeting – 07 November 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 order to realise the vision of ***the very best care for every patient, every day***, the Trust aligns its priorities to the four strategic aims.

2.2 There are 11 programmes that align to the aims, within which 37 priorities projects are listed and report to their associated sub-committees. See Appendix A.

2.3 Section 3 below provides a RAG rated summary of compliance with plan of identified priorities in the 2019/20 work programme and provides detailed priority updates and/or exception reports on key areas.

2.4 A bi monthly reporting cycle was approved at Board in July 2019. Since then we have agreed to move the Strategy TMC closer to Board meeting dates to reduce the need for additional reporting and updates between the two. This will commence from 29th January.

3.

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: Month 7 - Year 1 – 2019-2020 Strategic Priorities

Strategic Aim	Programme	Active Projects 2019-20	Current Status (Oct 19)	Prior Status (Sept19)
Best Value	CIP	Private Patients	A	A
Best Value	*Financial Recovery Plan **	*Financial Recovery Plan*		
Great Place	Digital Programme	Electronic Patient Record (OBC)	A	A
Great Place	Digital Programme	Health Records Standardisation (Business Case)	A	A
Great Place	Digital Programme	Telephony Replacement (Business Case)	G	
Great Place	Digital Programme	Transition to Atos	G	G
Great Place	Digital Programme	New Local Area Network	G	G
Great Place	Digital Programme	Stabilising the IT infrastructure (Migration & Service Improvement)	A	
Great Place	Digital Programme	Cancer Information System (CIS) *(full implementation and benefits realisation)*	A	A
Great Place	Interim Estates	Consolidation of Orthopaedic Outpatients at SACH (Holywell)	G	G
Great Place	Interim Estates	Develop Interventional Radiology Service (OBC) *	A	A
Great Place	Interim Estates	Neonatal FBC *(Improve the environment on Woodlands Neonatal Unit)*	G	G
Great Place	Interim Estates	ED Development *(Wave 4 capital - FBC) Capital from NHSI*	A	A
Great Place	Interim Estates	Watford Theatre Reconfiguration *(Theatres FBC)*	A	A
Great Place	Interim Estates	WGH Multi-Storey Care Park FBC & approvals	R	R
Great Place	Interim Estates	Back Office Relocation (Staff Areas and Admin Space) *(to release space at WGH for key estate and IT priorities)*	A	A
Great Place	Interim Estates	2019-20 Winter Plans	A	
Great Place	Acute Redevelopment	Refresh Strategic Outline Case (SOC)	G	G

Note:
*** Progress against these programmes will be tracked and reported to their associated committees.*
** Verbal RAG rating provided. No written update available.*

3.1 Discussion

Exceptions this month:

The Watford MSCP project remains RED RAG rated and on-hold pending the outcome of a review of delivery options being undertaken by the Riverwell Development Team. An alternative option was presented to the Riverwell Partnership Board on 28 October 2019 with no further indication of response. All parties remain committed to delivering the project in line with the Letter of Intent signed in February 2019.

Items to note this month:

3.2 Best People

In month there has been a revision to the project names.

The Trust is developing a refreshed **People strategy** (2020-2023) which will update and replace the Workforce strategy for 2016-2019. The People strategy will reflect and support the STP 'One Workforce' strategy and the Interim NHS People Plan.

A first draft has been tested with the Executive and further engagement will now be undertaken.

A final draft is expected to be available at the end of November/December, to launch in January 2020, with implementation over the next three years.

To better reflect the workforce strategic aims the Workforce strategy project title has been revised to '**Develop the Trust's refreshed People Strategy (and supporting Implementation Plan)**'.

Occupational Health reprovision has been removed from the Strategic Programme for 2019-20, as this forms part of the wider People strategy work plan.

3.3 Best Value

The **Private Patient Policy** is now available on the intranet. There are also some additional related procedures which still need to be written/updated.

New pay rates for private patient work undertaken outside NHS hours (twice an individual's Agenda for Change pay rate) came into force on 01 October 2019. These new rates will ensure that staff pay for private patient work is fairer and more consistent across the Trust. Up to date prices have been sent to BUPA and the Trust is waiting to hear confirmation of their acceptance, after which a meeting will be arranged to agree a new contract. However, in the meantime, cardiology consultants have become aware that BUPA has advised patients not to come to WHHT because the Trust is in Special Measures. A letter was sent to BUPA to raise our concerns about this message and to challenge this message. The work to cost all private procedures is continuing and will be used to revise prices, prior to their presentation at TMC in January 2020.

A communications strategy is being developed and will be implemented once new contracts with insurers are in place. There is potential to procure some additional expertise to consider options for the further development of private work at the Trust. This is planned work for 2020/21. In view of

this, it was agreed to put the business case on hold and request that Medicine Division continues to support private patient administration for the time being.

3.4 Improve estate and digital IT

Stabilising IT infrastructure. The transition to Atos was successfully completed to plan at the start of September. The main applications moving to the tactical environment are nearly complete with some continued work on short term fixes which are improving functionality. A medium term improvement plan is being developed, starting with ED, taking us through to the end of the year.

Health Records Standardisation – (Business case). A tender to commission specialist expertise to undertake this work is now complete and subject to funding, the Trust is a position to award the contract. A paper will go to the next Capital Finance Planning Group in November to request the release of capital required to start consultancy work. The outcome of this work will include a set of options for the standardisation and management of medical records at the Trust. The business case options appraisal will determine the next steps in relation to the contract for off-site management of medical records and the feasibility of scanning paper records. The Trust is currently "out of contract" with its existing medical records management supplier and a decision needs to be taken to extend or replace the current contract.

Electronic Patient Record (EPR) – (Outline Business Case [OBC]). The external EPR costs & benefits review is complete and an update on progress will be provided to TMC in November.

A tender to commission specialist expertise for an EPR SOC, requirements gathering exercise and OBC is complete and subject to funding, the Trust is in a position to award the contract. A paper went to Trust Management Committee in October with a request to fund this case. While the request was supported in principle, in-year financial constraints lead to a decision to defer the request. Subsequently Trust Management Committee asked for a final attempt at sourcing external funding from NHSE/I. A request has been made and the outcome is expected in early November.

Discussions regarding the digital exemplar Fast Follower continue and following a number of cancelled meetings, a meeting is now in place with NHSE/I and the Royal Free; scheduled for the 6th November.

The existing **Cancer Information System (CIS)** is unable to meet the current NHS England and Cancer Registry reporting requirements. Therefore introducing a new CIS is recommended because it provides the best opportunity to realise a combined range of benefits aimed at reducing risk in data reporting in an expedited manner.

The original design for phase 1, to align the standards for V5 and V6 were completed by the supplier and made available to the project team in early September but were found to be not fully aligned with the specification. It was returned to the supplier (CIMS) for redesign and re-build. The redesign and rebuild V5 for Infoflex and V6 of the Web solution was then published to the team in mid-October 2019 by CIMS and is therefore currently in the testing phase. This is scheduled to be completed by 30/11/2019. It should be noted that currently the cancer resource is available and secured until 30/11/2019. Remaining Activities are:

- Publish cycle planned for CIMS on 03/01/2020
- Communication Strategy deployment planned for 03/01/2020
- Training planned for Mid-January 2020
- Go-live (phase1) planned 30/01/2020

The **WGH Theatres Reconfiguration Project Board** is now in receipt of a Guaranteed Maximum Price (GMP) for the Project from the Kier Consortium and is preparing a recommendation on a way forward for the TMC. An alternative, reduced scope option, concentrating primarily on the creation of a new theatre, additional compliant recovery spaces and supporting accommodation is being actively developed. A programme is being produced to reflect this new approach and it is anticipated that a revised business case could be ready for February 2020. The TMC have agreed to progress five enabling projects and all of these are targeted for completion before the end of the financial year.

The full business case for the development of improved **outpatient orthopaedic facilities at SACH** (Holywell) has been approved and refurbishment work has now commenced.

An outline business case to increase assessment capacity on the WGH site was approved by TMC, with TMC agreeing: That work proceed at risk given the need to help manage emergency care flow / as part of the **Trust's winter plans;** FBCs for each of the three required phases should be submitted separately, to support the pace of change needed. FBCs for the first two phases have now been submitted to TMC and once the third and final FBC has been completed, the over-arching business case will be submitted to FPC and then to Trust Board, given the total cost is anticipated to exceed the £1m delegated approval threshold for TMC. Some elements of this programme will be funded via national winter capital with the remaining elements of the programme funded from within this year's capital budget.

A full business case to **improve neonatal facilities** was submitted to TMC on 30th October 2019 and the request to commence enabling capital schemes (that are also of standalone benefit) during 2019-20, were agreed. A revision to paper requested around funding and to be brought back to TMC in February2020. The Full Business Case will then be presented to FPC and Trust Board in Q3 to enable early decision making in relation to next year's capital programme.

Work continues on the development of the FBC for the **redevelopment of ED** with an option appraisal workshop having taken place to assess options from a qualitative perspective and work now underway to consider the quantitative benefits and finalise the preferred option. Work to provide a CT within the ED footprint this financial year is progressing at pace, with the business case for this scheme now nearing completion.

Acute Redevelopment SOC. As previously noted by the Trust Board, discussions with regulators are ongoing in relation to the Trust's estate redevelopment Strategic Outline Case, to confirm anticipated next steps**.**

Trust Strategy Refresh. Work is underway to create a five year Trust Strategy that reflects the achievements 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 People, Best Value, Great People and Great Place*. The supporting strategies will be updated in 2020. (*Subject to change after engagement exercise concludes.)

The strategy was discussed in detail by the trust management committee in October and a further series of internal and external engagement events are planned through to the end of November with the aim of the Board receiving a draft for approval in December 2019.

4. Recommendation

4.1.1 The Board is asked to note the delivery status of strategic priorities.

Helen Brown
Deputy Chief Executive

November 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
Review CEPOD (emergency surgery) capacity & make recommendations
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
Access - Patient Flow Transformation
RTT & Cancer Programme Yr 1

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 v7.0 20191028

Trust Board
07 November 2019

Title of the paper	West Hertfordshire Hospitals NHS Trust and Herts Valleys Clinical Commissioning Group Urgent and Emergency Care Full Business Case (summary report)
Agenda Item	18/76
Presenter	Helen Brown – Deputy Chief Executive Officer
Author(s)	Clare Parker, Urgent Care Programme Consultant, NHS Herts Valleys CCG (FBC) Debbie Foster, Programme Director - Urgent and Emergency Care, West Herts Hospital Trust (Summary Report)
Purpose	*For approval* √ | *For discussion* | *For information*
Executive Summary	Following approval at Herts Valleys CCG's Board meeting on 17 October 2019, WHHT Trust Management Committee on 30 October 2019 and recommendation from the Trust Finance and Performance Committee on 31 October, this business case is presented to the Trust Board for further approval. If approved this will be subject to satisfactory finalisation of contractual arrangements between the Trust and Greenbrook Healthcare who is the preferred bidder selected to provide the Urgent Treatment Centre (UTC) at Watford General Hospital. The full business case can be accessed in the resources section of diligent.
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,

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<tr><td>Previously considered by</td><td>
<table>
<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>HVCCG Governing Body</td><td>17/10/2019</td></tr>
<tr><td>Trust Executive Meeting</td><td>17/10/2019</td></tr>
<tr><td>Trust Management Committee</td><td>30/10/2019</td></tr>
<tr><td>Trust Finance and Performance Committee</td><td>31/10/2019</td></tr>
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<tr><td>Action required</td><td>The Trust Board is asked to approve the paper, acknowledging that this will be subject to the satisfactory finalisation and signing of a contract between WHHT and Greenbrook Healthcare.</td></tr>
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Agenda Item: 18/76

Trust Board meeting – 07 November 2019

West Hertfordshire Hospitals NHS Trust and Herts Valleys Clinical Commissioning Group

Urgent and Emergency Care Full Business Case (summary report)

Presented by: Helen Brown – Deputy Chief Executive Officer

1. Purpose

1.1 The purpose of this business case is to seek approval for:

- The award of a contract for the provision of a UTC co-located with the ED at Watford General Hospital (WGH) following a procurement process to find a UTC provider to partner with the trust.
- The expansion of ambulatory emergency care services at WGH.
- In line with the new contractual arrangements, agreement by Herts Valleys CCG to provide transformation funding to support the shift from the existing clinical model to the new one as part of the new financial arrangements, recognising that the costs of delivering the service will increase in the short term before the transformation of urgent care reduces trust costs to at or below the current level of costs.

2. Background: Strategic context and case for change

2.1 This full business case has been prepared in response to the following key drivers for change:

- The need to improve access for patients and reduce Emergency Department (ED) waiting times.
- The need for a comprehensive front door primary care streaming service.
- The need to improve the Urgent Treatment Centre (UTC) at Hemel Hempstead General Hospital (HHGH) and the Minor Injuries Unit (MIU) at St Albans City Hospital (SACH) to meet best practice standards.
- The need to maximise ambulatory care to improve efficiency and improve patient experience and outcomes.

2.2 The business case also sets out a way in which the Trust and Clinical Commissioning Group (CCG) could work together differently to achieve common goals, which could become an exemplar for a future integrated care partnership.

2.3 This business case is underpinned by the move away from a payment by results contract to a minimum income contract (MIC) to enable the system benefits set out in the business case to be realised.

2.4 The business case also sets out the strategic context and case for change for:

- The recommissioning of the UTC at HHGH to better integrate the UTC with the co-located GP out of hours and GP extended hours services

- Further exploring the scope to extend the services of the MIU at SACH to meet the national requirements for a UTC and the recommissioning of the service to better integrate the UTC with the co-located GP out of hours and GP extended hours services.

3. Analysis/Discussion

3.1 Options Appraisal

Appraisal criteria	Option 1 – do nothing	Option 2 – do minimum Recruit x2 additional ED consultants, 4x Additional ED regs and expand ACU	Option 3 – do something Do minimum and implement UTC at WGH
Improved access and reduce ED waiting times	No improvement, maintains performance at 80.9% at best	Improves performance to 87.2%, slightly below national average of 88.0%	Improve performance to 92.8%
Comprehensive front door primary care streaming service	Does not deliver national requirement	Does not deliver national requirement	Delivers comprehensive model
Maximise ambulatory care	No improvement	Additional 1,040 patients treated through AEC year 1	Additional 1,040 patients treated through AEC, year 1
Workforce impact	No additional staff. Increased workload for existing staff, likely to cause recruitment and retention problems	Requires additional consultants and registrars to be recruited, may be hard to attract Should improve recruitment and retention	Requires additional GPs to be recruited, may be hard to attract depending on which provider is appointed Should improve recruitment and retention
Implementation timescales	No change	Depends on ability to recruit medics, minimum 6 months	Go live April 2020

The preferred option is option 3.

3.2 System approach to funding

The preferred option reduces income to the Trust, creating a financial pressure and an equal and offsetting benefit for the CCG. The business case takes a system approach based on the MIC agreement that assumes this impact is mitigated so that it does not become a disincentive to change.

The additional annual system costs are approximately £2.3m per annum. This business case proposes that:

- The costs of the increased ED consultants and registrars (£600k) will be met by the Trust; a business case has already been agreed and recruitment is underway
- That the additional costs of the UTC (£1.7m) are met by the CCG until March 2022, with a clear review point in March 2021 to ensure that the transformation plans are being delivered and to agree mitigating action if this is not the case
- That the system works together to realise the increase in AEC and length of stay reduction opportunities, releasing stepped costs within the trust, enabling a 'shape change' in the trust costs so that the overall costs of delivering non elective care are the same or lower by March 2022 than at present (all other things remaining equal)
- That a long term contract agreement between the trust and the CCG is put into place that mitigates trust income risk and a degree of CCG activity risk, enabling the system focus to be on delivering transformation and reducing trust costs.

Financial impact of a systems approach to funding for the Trust and CCG

	Do something					
	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	Total £001
Trust variance to do nothing	-546	-502	-506	-2,243	-2,335	-6,132
CCG variance to do nothing	-450	-1,699	-1,715	0	0	-3,864
System variance to do nothing	-996	-2,201	-2,221	-2,243	-2,335	-9,996

Note: The table does not include the value of any efficiency delivered by the Trust

3.3 Approach to identifying and delivering sufficient efficiency

A demand and capacity analysis has been undertaken of the Ambulatory Care Unit (ACU) and the impact of increased activity has been modelled. The core scenario being worked to shows that by treating this increased number of patients in ambulatory setting rather than admitting them to a core bed, the equivalent of 29.2 beds could be saved. If the opportunity is realised, this equates to £2.68m per full year - sufficient to fully offset the increase in the system costs. Detail of the methodology and rationale adopted in the modelling is included in section 5.3 of the paper.

In addition to the review of ACU there are other initiatives either planned or underway that are likely to support a reduction in the need to admit patients to the core bed stock. These are :

- A review of the medical take – pilot currently underway. This involves increased senior clinical presence in ED, leading to more timely and robust decision making facilitating admission avoidance.
- A review of the Frailty pathway and capacity decreasing number of frail patients admitted to a core bed and reducing LOS for those that are admitted.
- Centralisation and expansion of assessment areas – planned implementation February 2020. This will enable more efficient working and across departments. Increased capacity and the ability for more complex patients to be streamed away from ED.
- Review of surgical ambulatory care – second phase of ACU expansion work.

If the savings are delivered and are combined with a mechanism to protect trust income, the business case is neutral to both organisations while substantially improving performance and patient experience.

3.4 Benefits Realisation

Operational and clinical teams are committed to actively monitoring progress against delivery of improvements in performance and quality of care. The delivery of adequate efficiency by April 2022 to support the additional cost of the UTC at WGH will involve a re framing of the Trust's core bed capacity. A post winter review will be undertaken in March 2020 which will assess the impact of the initiatives described above. This will enable to development of a staged plan to reduce costs prior to April 2022.

4. Significant risk and associated mitigation

4.1 The most significant risk is that the additional increases in AEC and reductions in long stay patients are not realised, so costs do not reduce and the Trust faces a cost pressure in year 3. If this should be the case the transformational review will determine whether the UTC should be decommissioned or whether additional recurrent funding from the CCG will be required. The level of CCG funding will be determined in line with the wider MIC mechanism. There is an early break clause on the UTC contract for June 2023 – this would be the ultimate mitigation.

5. Recommendation

The Trust Board is asked to approve the paper, acknowledging that this will be subject to the satisfactory finalisation and signing of a contract between WHHT and Greenbrook Healthcare.

Helen Brown
Deputy Chief Executive

31 October 2019

Trust Board Meeting
07 November 2019

Title of the paper	Corporate Risk Register Report
Agenda Item	19/76
Presenter	Mike van der Watt, Chief Medical Officer
Author(s)	Dorothy Otite, Interim Risk Manager
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 Board meeting, the CRR has been reviewed by the Risk Review Group once (on 28 October 2019). Specific elements of the CRR have been reviewed through the committee structure during this period.
Action required	The Board is asked to review the corporate risk register and endorse the changes to the CRR (i.e. revised risk scores and closed/merged risks).

Agenda Item: 19/76

Trust Board meeting – 07 November 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 Board with an update on the status of the CRR including current risk scores, new, escalated, de-escalated and closed risks.

1.2 To provide the Board with assurance that the risks to achieving the strategic aims and objectives are being appropriately mitigated against and that progress is being made against fulfilling the actions as commissioned by each respective committee.

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 and above from each of the operational & divisional risk registers. The risk register is a 'live' document recorded on Datix; each lead for risk regularly reviews and updates the entries.

2.3 The Chief Medical Officer is the Trust's delegated lead executive for risk management.

2.4 The Quality Committee is a subcommittee of the Board which oversees assurance for risk management arrangements within the Trust.

3. Corporate Risk Register (CRR)

3.1 This report captures the decisions made by the Risk Review Group (RRG) on 28 October 2019. Data for this report was extracted from the CRR on 14 October 2019, a total of **24** open risks were registered.

3.2 **Appendix 1** provides a full summary of all corporate risks as presented to the RRG on 28 October 2019.

3.3 **Table 1** below presents the movement of risks by division, against each month since August 2018 to date as registered on the CRR.

Table 1: 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	
Clinical Informatics	3894	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**	→
	3899	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**	→
	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**	→
	4116											16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4125											16	→	16	→	16	→	16	→	12	↓										
	4197																											20		**20**	→
Clinical Support Services	3965	16	↑	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4082																					16	→	16	→	16	→	16	→	**20**	↑
	2755																					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**	→
	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**	→
	3120	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→
	4190																							15		15	→	15	→	**15**	→
	4191																							15		15	→	15	→	**15**	→
	4194																									15		5	↓		
	4207																											16		**16**	→
	4209																													**15**	
Emergency Medicine	4068			15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	20	↑	20	→	20	→	20	→	12	↓		
	3995																					15	→	15	→	15	→	15	→	**16**	↑
	4199																											15		**12**	↓
Environment	3958	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4135																	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4154																					16	→	16	→	16	→	16	→	**16**	→
	2795																					12	↑	20	↑	16	↓	16	→	**16**	→
Finance	3845	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**	→

	4205																										15		**15**	→
Medicine	4129												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** **Orange = De-escalated risk** **Blue = Merged**																														

3.4 **Risk Activity**

The following provides an overview of all risk activity since October 2019 Board as follows:

New risks – 0:

No new risk was approved by the Risk Review Group for addition to the CRR during this reporting period.

Revised current risk scores – 2:

Two current risk ratings were 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
Increased scores - 2					
4082	Clinical Support	16 ↑ 20	Potential shortage of spare parts to repair AAU CT scanner impacting on patient care	MVdW	Risk score increased at the request of the Quality Committee in September 2019 due to the increased frequency of breakdowns (3 were reported during that week). A centrally funded CT scanner is in the process of being installed in the fluid store.
3995	Emergency Medicine	15 ↑ 16	Challenges in Recruitment of Emergency Medicine Medical Workforce	MVdW	Current consequence score was increased to reflect the appropriate consequence score for the risk, taking into consideration the initial consequence score.

De-escalated risks – 3:

Three risks were 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	TC	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.
4137	Clinical Support	15 ↓12	Insufficient capacity on the WGH MRI scanner to offer a timely scanning service for all in-patient requests	ST	The risk score was reduced as out-sourcing has provided more in-patient capacity to accommodate in-patient scans.

ID	Division	Risk Rating	Risk title	Exec Lead	Rationale
4199	Emergency Medicine	15 ↓12	Inability to manage Patients attending the Emergency Care Pathway with mental health challenges	TC	This was presented to the RRG in September 2019 as a new risk and was agreed for de-escalation to the Division. It was noted that it was a lower risk as there are a number of controls in place to mitigate the risk. Score of 5 (L3xC4) was agreed.

Closed/Merged risks – 0:
There were no closed/merged risks during the reporting period.

Amendment to previous report:
The following amendments to the previous risk report are being brought to the attention of the Board. Both risks were not approved for addition to the CRR at the September Risk Review Group:

- **CRR 4197 (Missing Patches – ICT Server Estate)**: It was agreed that even though this presented a risk to the Trust, the absence of the full risk information (i.e. controls, assurances and planned actions) meant the RRG could not approve this risk. At the time of writing this report, the Clinical Informatics Division were in the process of updating the risk information. The risk will be brought back to the RRG for consideration in November 2019.

- **CRR 4199 (Inability to manage Patients attending the Emergency Care Pathway with mental health challenges)**: It was agreed that due to the strength of the controls in place to mitigate this risk it should be de-escalated to the Emergency Medicine Divisional Risk Register.

4. Risks

4.1 A 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 review the CRR and agree the changes made to the CRR during this reporting period.

Dr Mike van der Watt
Chief Medical Officer

October 2019

***Appendix 1* – Corporate risk register (by current risk level – Extreme to High)**

ID	OPENED DATE	DIVISION	RISK TITLE	INITIAL RISK RATING SCORE	PROGRESS NOTE	CONSEQUENCE (CURRENT)	LIKELIHOOD (CURRENT)	RATING (CURRENT)	EXECUTIVE LEAD
3894	12/06/2017	Clinical Informatics	ICT Applications reduced availability, poor reliability & performance	20	Up for eHandover by mid-November 2019. The current risk score will be reviewed in the coming months following observation.	Major	Certain	20	Paul Bannister
3899	12/06/2017	Clinical Informatics	ICT Trust Bleep System	20	The Telephony Business Case has been approved by CPFG and is currently going through the procurement process. The timeline for mitigation of this risk within 2019/20.	Catastrophic	Likely	20	Paul Bannister
4197	16/08/2019	Clinical Informatics	Missing Patches - ICT Server Estate	20		Major	Certain	20	Paul Bannister
4082	01/10/2018	Clinical Support	Potential shortage of spare parts to repair AAU CT scanner impacting on patient care	16	Risk score increased at the request of the Quality Committee in September 2019 due to the increased frequency of breakdowns (3 were reported during that week). A centrally funded CT scanner is in the process of being installed in the fluid store.	Major	Likely	20	Michael Van der Watt

3120	09/07/2014	Medicine	Lack of Storage facility for Patient Medical Notes leading to missing, poor condition and delayed location	20	Business case currently being written for Clinic Prep at SACH to move into area occupied by Orthopaedics who are due to move into new area. Multi volume tracking on Patient centre 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.	Major	Certain	20	Paul Bannister
3897	12/06/2017	Clinical Informatics	Cyber Risk	16	Work with a third party employed by the trust to analyse the results of a survey to assure our cyber security delivery and provide a plan for cyber essentials in progress. Delays due to recent change over of IT supplier. Mitigation will be addressed within 2019/20.	Major	Likely	16	Paul Bannister
4116	23/11/2018	Clinical Informatics	Delivery of the Trust's Digital transformation programme	16	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.	Major	Likely	16	Paul Bannister
3896	12/06/2017	Clinical Informatics	ICT Data Networks reduced availability, poor reliability & performance	20	Business case is going to the Trust Board for approval in November 2019.	Major	Likely	16	Paul Bannister
3965	11/12/2017	Clinical Support	Delays in imaging of patients requiring interventional radiology procedures	16	CT into fluid store progressing which will free up space to install IR suite. Radiology Manager met with new fundraising lead and Director of Communications to start fund raising campaign. Talks progressing with RFH to identify if a collaborative approach possible to provide an out of hours service for WHHT patients.	Major	Likely	16	Patrick Hennessey

2755	28/07/2011	Clinical Support	Risk of failure of the MRI scanner at HHGH and deterioration in image quality	16	Started to outsource some scans to OSD in Hemel Hempstead. Visit planned to look at modular option 30/09.	Major	Likely	16	Michael Van der Watt
4207	12/09/2019	Corporate	Inadequate post in-patient discharge appointment booking processes	20	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.	Major	Likely	16	Sally Tucker
3995	06/03/2018	Emergency Medicine	Challenges in Recruitment of Emergency Medicine Medical Workforce	20	Actively investigating joint consultant appointment for Respiratory ITU and ED ITU. Recruitment process continues, use of agency to support process under consideration. Current consequence score was increased to reflect the appropriate consequence score for the risk, taking into consideration the initial consequence score.	Moderate	Certain	16	Michael Van der Watt
4135	15/02/2019	Environment	Lack of A E & CP's across Safety Groups in accordance with HSE and DoH Managing safely guidance and accepted Codes of Practice	20	Plan to be agreed to address the higher level management aspects - AE responsibilities of LOLER/Fire/Confined space and pressure vessels.	Major	Likely	16	Patrick Hennessey
2795	15/12/2011	Environment	Management and control of - Asbestos Containing Materials (ACMs)	20	Capital team governance procedures implemented September 2019 – to be reviewed November 2019. Permit to work system and contractor induction to be reviewed by November 2019.	Major	Likely	16	Patrick Hennessey

4154	08/04/2019	Environment	Non-compliance with HTM00 (safe systems of work)	16	Risk remains static. Interim H&S Manager joined mid-October. Surveys for Statutory compliance related works have been funded and are underway, expected completion Nov 2019. Output will be used to write specifications and write business case for FY20/21 capital funding.	Major	Likely	16	Patrick Hennessey
3958	17/11/2017	Environment	Risk of condensate Tank failing - WGH Boiler House	16	Hot and Warmwell Replacement Project: The works progress on current programme with one of the two replacement condense receiver tanks now providing the service to the Watford site in a temporarily located position. Both existing receiver tanks have been removed from the Estates Power House making way for the first new tank to be moved to its final position for commissioning. Following a further minor steam shutdown for changeovers, the project is due to conclude 25th October 2019. This date was later than originally programmed, but was subject to additional works added including replacing the stainless steel pipework to the main boilers. These additional critical works were only identified during the current project. However, there is a possibility of improvement on this date and will update accordingly.	Major	Likely	16	Patrick Hennessey
4191	10/07/2019	Corporate	Risk of a financial liability to Trust following outcome of legal case 'Flowers'	20	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.	Moderate	Certain	15	Paul Da Gama

3710	20/04/2016	Corporate	Incomplete / Non-compliance with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) process	20	The DNACPR QI group took place on the 08/10/19 - minutes pending. The DNACPR form was reviewed and a draft copy will be shared across the Trust. Feedback will be discussed at the next meeting. Two audits were presented - one looking at the quality of the documentation on the DNACPR form and the second was a case law and future proofing audit. Next meeting 05/11/19 Dr Anna Wood and Fran Regal attended a 'Getting to Good' meeting to take part in a 'deep dive' into DNACPR issues. Dr Wood presented a summary of the DNACPR form audit and the 2 audits which were presented at the QI meeting on the 08/10/19. Dr Wood also presented data on the documentation regarding consideration of DNACPR orders and highlighted that a large number of patients are resuscitated inappropriately. The recommendations from the CEO were to: 1) Continue with the review of the DNACPR form, but ensure a thorough review is performed so the form is fixed for the future. 2) Bench mark KPI against other trusts - Dr Wood has asked the corporate team to action this 3) Explore the potential to add DNACPR form and documentation audit to test your care.	Moderate	Certain	15	Michael Van der Watt
4190	10/07/2019	Corporate	Senior medical staff may alter working arrangements resulting in the Trust being unable to maintain consultant led services	20	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 significant adverse impact has been identified.	Moderate	Certain	15	Paul Da Gama

4114	20/11/2018	Clinical Informatics	Delivery of the ICT Service Transition Programme	12	34 servers of 43 copied have been migrated using PlateSpin into the Atos WHHT Production environment (following a Hyper V to VMWare transfer). There has been a change to the technical design being used to deliver the transition, but this is positive step to assist the trust. Planning for the cut-over to Atos continues with an indicative date of 17th September.	Catastrophic	Possible	15	Paul Bannister
3828	09/11/2016	Corporate	Patients may come harm and have a poor experience due to long waits for elective care	20	Risk reviewed with Chief Nurse. Building on the success of 2018/19 long waits reduction programme, there is now greater focus on the quality, safety and patient experience associated with waiting times.	Catastrophic	Possible	15	Sally Tucker
4205	05/09/2019	Finance	Risk of not receiving Financial Recovery Fund as a result of failure to meet base criteria	20	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. 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.	Catastrophic	Possible	15	Don Richards

4204	05/09/2019	Finance	Risk of not receiving Provider Sustainability Fund income as a result of failure to achieve financial plans	20	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 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.	Catastrophic	Possible	15	Don Richards
4129	25/01/2019	Medicine	Unreliable functioning of central cardiac monitor	15	Clinicians preferred choice of monitors is Drager because of its superior telemetry and display screens. IT are recommending Philips. Business case is currently with Procurement awaiting for alternate pricing from Philips. IT will not be able to fully assess the cost and scale of the work involved until ATOS are engaged but it is known that areas the clinical areas where the monitors will be in use will have to be flooded with WAP.	Catastrophic	Possible	15	Michael Van der Watt

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Trust Board Meeting
07 November 2019

Title of the paper	**Progress report on well-led improvement plan**
Agenda Item	**20/76**
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 aim of this paper is to inform the Board on the progress being made 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. In addition, the plan includes improvements highlighted through a Board and the committees self-assessment programme. In June 2019 the Board approved an action plan to move the Trust forward on its improvement journey. Appendix 1 of this report provides an update on progress against this plan. 19 of the 32 actions on the improvement plan have been completed, with the remaining actions either on track to complete within the original or a revised timeframe. One key element of the plan was a review and restructure of the Board and committee structure. The refreshed committee structure came into operation in July 2019 – see appendix 2. Although still early days, anecdotal feedback on the new structure has been positive and will be formally reviewed in quarter four 2019 through the annual corporate governance self-assessment programme and a survey of the Board and committee members. The Audit Committee reviewed the improvement plan on 18 October 2019 and was assured that appropriate progress was being made to address the identified areas. It was recognised that two of the actions relating to quality improvement (action 5 and 32) would require a culture change in the organisation which would take a number of years to achieve. Therefore, these actions will continue to be ongoing and the RAG rating will remain at green.
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 receive this report as assurance that areas of improvement identified in a series of external observations and assessments under the scope of the national well-led framework are being addressed.

Agenda Item: 20/76

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Trust Board meeting – 07 November 2019

Progress report on well-led improvement plan

Presented by:
Phil Townsend, Chair
Christine Allen, Chief Executive
Jean Hickman, Trust Secretary

1. Purpose

1.1 The aim of this paper is to inform the Board on the progress being made 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.

2. Background

2.1 In-depth, regular reviews of leadership and governance arrangements are good practice across all industries. Rather than assessing performance, the reviews are intended to identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

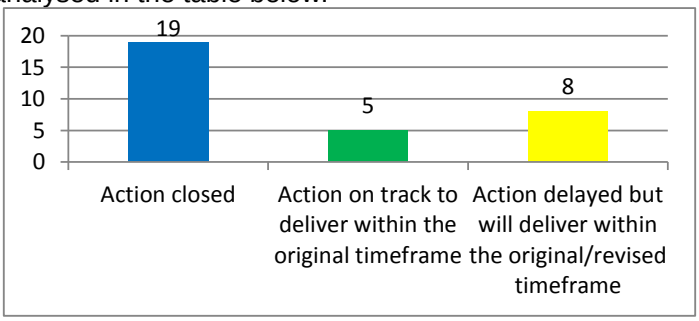
2.2 In 2018/19, the Trust received a number of external observations and assessments undertaken under the scope of NHS Improvement's well-led framework. In addition, between March and May 2019, the Board and the committees conducted a self-assessment of effectiveness against their terms of reference.

2.3 Overall, feedback from the observations and assessments was positive and reported that members of the Trust's senior leadership team generally had the appropriate range of skills knowledge and experience and there was an appropriate level of operational and financial experience and expertise across both non-executive directors and executives.

2.4 The key themes/recommendations from the reviews were analysed and collated into an overarching plan to address areas of further improvement, which was approved by the Board in June 2019.

3. Analysis/discussion

3.1 Progress towards achieving the 32 actions included in the improvement plan is detailed in appendix 1 and analysed in the table below.



3.2 There are no actions with a significant risk to delivery.

3.3 The Audit Committee reviewed the improvement plan on 18 October 2019 and was assured that appropriate progress was being made to address the identified areas. It was recognised that two of the actions relating to quality improvement (action 5 and 32) would require a culture change in the organisation which would take a number of years to achieve. Therefore, these will actions will continue to be ongoing and the RAG rating will remain at green.

3.4 An important element of the plan was a refresh of the committee structure (action 18 on the action plan). A review was carried out and a refreshed structure was put into operation in July 2019. The current structure can be seen in appendix 2.

3.5 The refreshed committee structure is being kept under continual review and will be updated as required. Overall, to date anecdotal feedback has been positive and will be tested formally in quarter four 2019 through the annual corporate governance self-assessment programme and a survey of the Board and committee members.

4. Risks

4.1 Failure to act on the recommendations arising from the external and internal well-led framework reviews could give rise to risk in a number of areas, including staff engagement and satisfaction, patient experience, influence with stakeholders and an inability to effectively identify and manage risk and incident trends.

5. Recommendation

5.1 The Board is asked to receive this report as assurance that areas of improvement identified in a series of external observations and assessments under the scope of the national well-led framework are being addressed.

Phil Townsend	**Christine Allen**	**Jean Hickman**
Chair	**Chief Executive**	**Trust Secretary**

November 2019

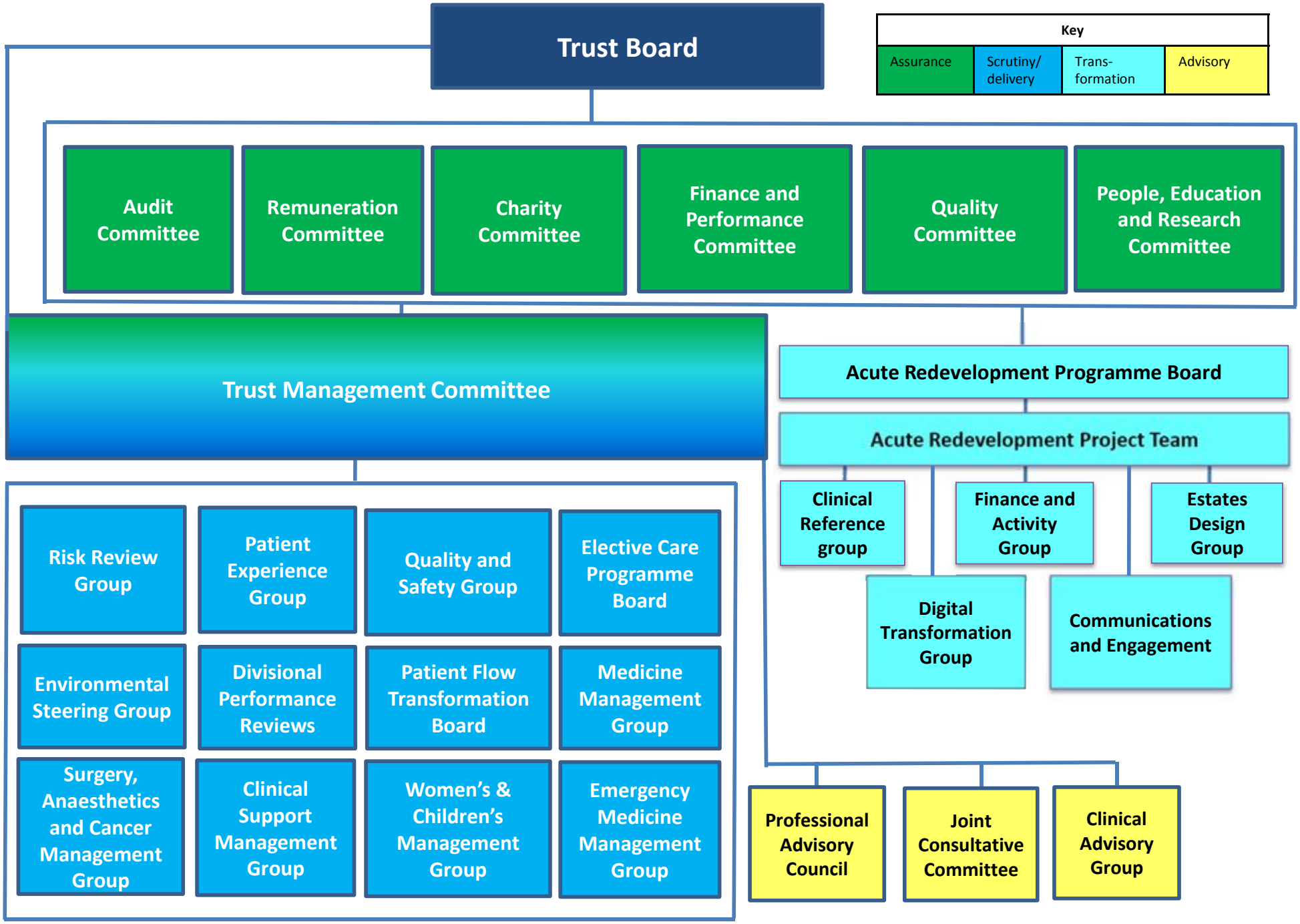
Well-led framework improvement plan

RAG rating	Meaning
Blue	Action closed
Grey	Action not yet due
Green	Action on track to deliver within the original timeframe
Amber	Action delayed but will deliver within the original/revised timeframe
Red	There is a significant risk to delivery of the action

Number	Key themes from feedback	Action	Lead committee/Board	Lead	Completion date	RAG ratings	Progress update
1	Participation in research and development is not fully developed	Research and development strategy to be developed	People, Research and Education	Chief Medical Officer	~~Sep-19~~ Jan-20		A research and development strategy has been developed and will be presented to the Board in January 2020.
2		Board to receive a presentation on the aims for the future of research and development	People, Research and Education	Chief Medical Officer	~~Sep-19~~ Jan-20		Board to receive a presentation on the future plans for research and development in January 2020.
3		A regular report on the work of the research and development department to be presented to the People, Research and Education Committee	People, Research and Education	Chief Medical Officer	Sep-19		The People, Research and Education Committee receives a report from the research and development steering group.
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	Trust Management	Deputy Chief Executive	Mar-20		An overarching five year strategy is being developed and will be presented to the Board for approval in December 2019.
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	Quality	Chief Nurse	Ongoing		A new QI lead took up post in June 2019. A roll out plan is being developed for review by the Board in November 2019. The Quality Hub is established with 2 sides to it: assurance and quality improvement. There is a quality lead nurse and 2 quality improvement facilitators. Eight clinical pathway groups have been established working in partnership with the Royal Free. A communication bundle has been introduced that incorporates QI methodology within all inpatient wards. An initiative that involves divisions and clinicians involved in incidents is being established which will use QI methodology – Swarming. 45 staff members have completed the modules of the IHI online Quality Improvement course. 70 nurse and AHP attended a clinical leader's event.
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.	Trust Management	Deputy Chief Executive	~~Oct 19~~ Mar-20		A joint engagement plan is being developed with Herts Valleys Clinical Commissioning Group in relation to the development of a west Hertfordshire integrated care partnership. A system leaders joint development session was held in September 2019 and a follow session is being scheduled for November 2019. A director's steering group has been established and is developing a comprehensive engagement and organisational development plan for roll out in quarter four 2019. Additionally an internal and external engagement plan has been developed to support the development of an overarching Trust strategy - key activities are scheduled for October and November prior to approval by the Board in December 2019.
7	The Board and committees receive too detailed performance data, which doesn't explain what the information is telling the Trust and how it links to actions and resolutions.	Review the existing integrated performance report to provide the Board with enhanced information and offer a deeper understanding of what the data means.	Trust Management & Finance and Performance	Chief Information Officer	Jan-20		Action completed. Integrated performance report has been refreshed and is received by the Board on a monthly basis from October 2019.
8		Streamline Board and committee reports to provide clearer executive summaries covering "what this tells us is…" along with proposals on next steps.	Board	Trust Secretary	Nov-19		Action completed. Board report and coversheet templates have been reviewed and updated.
9	The oversight of risk management is not fully embedded	Refresh the board assurance framework	Board	Trust Secretary	Sep-19		Action completed. The board assurance framework has been refreshed against the 2019/20 corporate objectives and new governance structure. The format has been reviewed against best practice and updated accordingly. Following approval by the Board in October 2019 the BAF is reviewed by the committees and Board on a monthly basis.
10		Introduce risk appetite process and risk statement	Board	Chief Medical Officer	~~Sep-19~~ Mar-19		The Board has had an initial discussion regarding risk appetite. A risk appetite statement has been drafted. Further work will continue over the remainder of 2019/20 to consider how to operationalise risk appetite.
11		Review corporate risks to ensure consistency of the narrative and scoring.	Quality	Chief Medical Officer	Jul-19		Action completed. All corporate risks have been reviewed and, where necessary, the narrative has been rewritten and the scoring changed to ensure consistency.
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	People, Research and Education	Chief People Officer	Nov-19		Senior workforce team are currently drafting the refreshed People Strategy for 2020 – 2023 and the OD strategy will form part of this. First draft to be completed by November 19 in readiness to receive feedback from colleagues across the organisation. The OD work will also be intrinsically linked to the work on quality and the QI approach as led by Chief Nurse.
13		Develop a comprehensive Board development programme which sets out time for the Board to focus on an improved collegiate understanding, develop partnerships and system thinking and get an external perspective on what others within and outside the NHS are finding success with.	Board	Chair/ Trust Secretary	Aug-19		Action completed. The Board has a comprehensive development programme, meeting 6 times a year, with agendas focusing on a wide range of topics.

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. Also the capacity and capability of senior leadership is insufficient to enable the Board and executive to step up.	Undertake a Board skills review to asses the capabilities of the current Board	Board	Chair/ Trust Secretary	~~Sep-19~~ Jan-20		A 360 degree appraisal programme of the Board is being arranged for November 2019, with the aim of receiving the analysis report by January 2020.
15		Develop a succession planning process which identifies and trains individuals who could take on future leadership roles within the Trust.	People, Research and Education	Chief People Officer	Nov-19		Succession planning process in place for Trust Executive Team and direct reports to the Executive. Individuals undertaking ADDS programme to develop into Executive roles. Next stage is to complete succession planning and talent management for the next level of leaders in the organisation (those reporting to Deputy Director roles etc). The approach will be outlined within the People Strategy 2020 – 2023
16		Re-launch a clinical leadership development programme	People, Research and Education	Chief People Officer	Sep-19		Action completed. Clinical Leadership Development programme has been re-launched for cohort of clinical leaders with first sessions taken place in October 2019.
17		Review and restructure to strengthen the divisional structure and leadership capacity	Trust Management	Chief Operating Officer	Oct-19		Action completed. A divisional restructure has been completed and the new structure is now in place with changes at both Divisional Director and Divisional Manager levels.
18	Strategic objectives are not fully embedded into the day to day work of the Trust and do not focus the work of the Board	Refresh the strategic objectives for 2019/20	Trust Management	Deputy Chief Executive	Jun-19		Action completed. The Board approved refreshed strategic objectives in June 2019.
19		The Board to receive a bi-annual report on progress towards achieving the strategic objectives	Board	Deputy Chief Executive	~~Nov-19~~ Dec-19		Bi-annual report on Board agenda for December 2019.
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	People, Research and Education	Chief People Officer	~~Sep-19~~ Mar-20		New Diversity and Inclusion Manager has been appointed and started in October 2019 following departure of previous post holder and will take responsibility for leading this work. Work has been completed on the Public Sector Equality Duty report that is to be published which sets out the Trust's implementation plan for improving the experience of the workforce in respect of diversity and inclusion. Engagement activities with staff networks underway with a focus on Black History month for October 2019, but more work to do to bring together a cohesive approach.
21	The accountability of each committee and individuals is unclear due a complicated committee structure	Undertake a review and refresh of the current committee structure including the frequency and membership	Board	Chair/ Trust Secretary	Sep-19		Action completed. A review was undertaken and a new committee structure was agreed. The new structure came into operation in July 2019.
22	The Board is not visible across all areas of the Trust	Develop a wide-reaching visible leadership programme, which includes non-patient facing areas	Board	Chief Nurse/ Trust Secretary	Jun-19		Action completed. A monthly Board visit programme was established in May 2019. The Board visit three/four areas each month and report feedback to the Board. A bi-annual paper will be presented to the Board, the first of which will be in December 2019.
23		Executive directors to undertake a number of ad hoc visits to all areas and sites of the Trust	Board	Chief Nurse/ Trust Secretary	May-19		Action completed. Executive directors regularly visit areas of the Trust and report them on a whiteboard in Trust Offices. A bi-annual report to the Trust Management Committee will include details on the visits undertaken.
24	All staff do not feel valued for their contribution to the Trust	Re-launch the monthly chief executive briefing programme.	People, Research and Education	Deputy Chief Executive	Jul-19		Action completed. A monthly chief executive briefing programme has been establshed.
25		2019 'Big 5' initiative launched in response to the results of the national staff survey with monthly themes	People, Research and Education	Chief People Officer	Apr-19		Action completed. Big 5 has run throughout 2019 with new themes and this has been positively received. Annual staff survey currently out with staff to complete until end November 2019.
26		Remind staff on the processes in place to raise concerns	People, Research and Education	Chief People Officer	May-19		Action completed. Freedom to Speak Up has been relaunched with new champions chosen from wide range of professions and backgrounds and significant communication has gone to staff to raise awareness of how they can raise concerns. Guardian of Safe-working role for junior doctors also well established and working well.
27		Appraisal targets not fully met	People, Research and Education	Chief People Officer	~~Oct-19~~ Dec-19		Work in progress – the appraisal compliance has been improving but is still not meeting the 90% target. This has been the subject of a deep dive recently and clear action plans have been developed by HR Business Partners to increase compliance and meet and sustain the target.
28		Develop a leadership and succession planning programme for executive and divisional directors	People, Research and Education	Chief People Officer	Oct-19		Action completed. Succession plans now completed.
29	Board agendas often focus more on operational issues rather than strategy	Review the Board and committee work plans to assess which reports are required to go the Board and which can be dealt with at committee level. The Board will receive regular updates on key strategic issues, such as redevelopment, digital strategy, integrated care partnerships and integrated care systems and the work with the Royal Free London NHS Trust	Board	Chair/ Trust Secretary	Sep-19		Action completed. The Board and committee work plans were reviewed as part of a wider Board and committee structure review and agendas have been streamlined as a result.

30	The senior leadership at St Albans and Hemel Hempstead hospitals is unclear	Strengthened clinical and managerial leadership at both sites	Trust Management	Chief Operating Officer/ Chief Nurse	May-19		Action completed. Matron leadership across both sites working effectively. Site meetings have seen improved staff engagement along with Executive's rotating their attendance
31	Service enhancements and improvements had not been sustained at the minor injuries unit (MIU) and urgent treatment centre (UTC)		Trust Management	Chief Operating Officer/ Chief Nurse	May-19		
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	Trust Management	Chief Nurse	Ongoing		A learning events programme has been established. Newsletters, posters and infographics are shared with staff. Mortality Reviews and structure judgement reviews are undertaken by medical examiners and divisional learning is shared at the quality safety group. Local resolution meetings focus on learning with families following complaints. Patient stories are shared at various meetings, including safeguarding panel and Board. Daily safety huddles are established within each ward area. The WHO 5 steps to safer surgery checklists are embedded within all theatre areas and used in every theatre case. Members of the Serious Incident Review Group monitor the implementation of actions taken.


Trust Board
Key
Assurance
Scrutiny/ delivery
Trans-formation
Advisory
Audit Committee
Remuneration Committee
Charity Committee
Finance and Performance Committee
Quality Committee
People, Education and Research Committee
Trust Management Committee
Acute Redevelopment Programme Board
Acute Redevelopment Project Team
Clinical Reference group
Finance and Activity Group
Estates Design Group
Digital Transformation Group
Communications and Engagement
Risk Review Group
Patient Experience Group
Quality and Safety Group
Elective Care Programme Board
Environmental Steering Group
Divisional Performance Reviews
Patient Flow Transformation Board
Medicine Management Group
Surgery, Anaesthetics and Cancer Management Group
Clinical Support Management Group
Women's & Children's Management Group
Emergency Medicine Management Group
Professional Advisory Council
Joint Consultative Committee
Clinical Advisory Group

Risk Review Group	Patient Experience Group	Quality and Safety Group		
• Divisional Management Groups	• Patients' Panel • Patient and Public Involvement Group	• Business Continuity and Emergency Preparedness Panel • Mortality Review Group • Medical Devices Panel • Medicines Use and Safety Panel • End of Life Care Panel	• Nutritional Steering Group • Policy and Guidelines Panel • Transfusion Panel • Infection Prevention and Control Panel • Fire Group • Serious Incident Review Group • Radiation Protection Panel	• Medical Gases Panel • Health and Safety Panel • Safeguarding Panel • Thrombosis Advisory Panel • Critical Care Delivery Group • Clinical Audit Panel • Divisional Governance Groups
Digital Transformation Group	**Surgery Transformation Group** *(to be established)*	**Workforce Transformation Group**	**Patient Flow Transformation Group**	**Planned Care Transformation Group**
• ICT Management Panel • Information Governance and Joint Security Group • ICT Infrastructure Finance Group	• St Albans Development Group	• Agency Steering Group • Education Group • Workforce Equality Group • Recruitment and Retention Group • Local Negotiating Committee	• Discharge Planning Group • Bed Configuration Group	

Agenda Item:21/76

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**07 November 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 09 October 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 held on 09 October

- The chief pharmacist and divisional director, clinical services provided an update on the private therapy service that had been operating from Jacketts Field, Abbotts Langley since February 2019.

- The committee approved business cases relating to:
  - Replacement of orthopaedic consultant
  - Appointment of a substantive consultant for neonatal service with extended responsibility for other areas of service (PAU – Paediatric Assessment Unit).

- The committee supported the expansion of the quality improvement education budgets 2019-2020 and 2020-2021, and the additional funding requested in principle, together with the clinical practice group programme request for funding. However, the timing of the funding is subject to the October performance reviews to ensure funding is available without putting achievement of our control total at risk.

- The committee discussed a paper on the development of an urgent treatment centre at St Albans City Hospital. It was noted that Herts Valley Clinical Commissioning Board had not approved the business case at their Board meeting in September 2019 as St Albans was not considered an area of high deprivation. NHS England and NHS Improvement have agreed to defer the deadline for an urgent treatment centre in St Albans.

- The committee discussed a business case to fund consultancy for the electronic patient record (EPR) programme. There was a strong steer from the committee that the overall EPR project should not be further delayed as it would enhance patient safety and quality of care. It was agreed that the Executive Team would consider approval of consultancy spend.

- Strategy updates were received on the following:
  - Car park.
  - Private practice.
  - Cancer information system.
  - Interim estate – awaiting official confirmation of amount of government funding.
  - Activity regarding winter planning.
  - CT scanner in the emergency department.

Risks to refer to the risk register None

Items to escalate to the Board None

Attendance

Don Richards	Chief Financial Officer (Chair)
Freddie Banks	Associate Medical Director, Clinical Strategy
Andy Barlow	Divisional Director, Women's and Children's
Laura Bevan	Deputy Director of HR
Howard Borkett-Jones	Associate Medical Director for Education
Sarah Cato	Lead Nurse, Emergency Medicine
Debbie Foster	Programme Director, Urgent and Emergency Care
Sean Gilchrist	Director of Digital Transformation
Louise Halfpenny	Director of Communications
Stephanie Johnson	Divisional Manager, Surgery,
Martin Keble	Divisional Manager and Chief Pharmacist
Colette Mannion	Director of Midwifery
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
Rodney Pindai	Director of Contracts, Efficiency and Commercial Development
Soheb Rafiq	Associate Director, Financial Management and Planning
Jane Shentall	Director of Performance
David Thorpe	Deputy Chief Nurse
Sally Tucker	Chief Operating Officer
Mike Van Der Watt	Medical Director
Karen Walker	Head of Nursing, Children's

	Fiona Wardil	Business and Contracts Manager
	Angela Wellman	Head of Nursing, Medicine and Emergency Medicine
	Simon West	Interim Divisional Director
	Laura Abel	Assistant Trust Secretary (minutes)
In attendance for specific items	Michelle Boot	Lead Nurse for Quality
	Patrizia Brown	Assistant Divisional Manager Paediatrics
	Vicky Flanagan	Divisional Head of Finance, WACS
	Shankara Narayan	Consultant Neonatologist & Service Lead
	Tejal Vaghela	Clinical Practice Group Programme Manager
	Martina Wade	Assistant Divisional Manager, Trauma and Orthopaedics

Report to:	Trust Board
Title of Report:	Assurance report from Finance and Performance Committee
Date of meeting:	07 November 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 31 October 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.

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Access Performance

The Committee reviewed the waiting time performances in September, for ED, ambulance handovers, cancer treatment, elective care referral to treatment (RTT) and diagnostic tests.

RTT

The RTT 18 week performance improved marginally from last month to 85.8% in September, which is close to both the recovery plan target of 86.0%, and the latest available national median of 85.5%. The Committee noted the continuous improvement since the April performance of 80.6%, and was assured that the Trust remained on track to achieve the Trust's recovery plan target of 90% by March, compared to the national standard of 92%.

The Committee noted that, in line with national guidance, both the total PTL (Patient Tracking List), and the backlog over 18 weeks were lower than at the start of the year.

The Committee also noted that at the end of September there were three patients whose waiting time has exceeded 52 weeks, and was assured that they were all due to patient choice to defer to after September.

The Committee was assured that an appropriate harm review process is in place for all patients exceeding the national waiting times.

A&E

The A&E 4 hour waiting time performance improved by 2.5% in September to 83%, but still remains the Trust's greatest access performance challenge in delivering its recovery plan target of 93% by March, en route to reaching the national standard of 95%. The Committee noted that the performance was closer to the latest national median of 85.2%, but was 5.4% lower than the Trust's recovery plan target of 88.4%.

The growth in attendances and the levels of acuity are the key factors in affecting performance. In September attendances at Watford were 11.4% higher than September 2018, with a greater percentage arriving by ambulance.

The national standard was met at the MIU in St. Albans and in the UTC in Hemel Hempstead. At Watford, minors and Children's were both just below standard at 94.9% and 92.9% respectively, whilst Majors, the most challenged area, improved by 3.3%, but was still well below standard at 57.3%.

The Committee reviewed the improvement plans underway, including the expansion of ambulatory care, creating a UTC at Watford and the pilot that started in October reviewing the patient intake from A&E into medical.

The Committee was assured that plans are taking shape with the aim of making a significant improvement to the 4 hour wait performance, and the resulting patient experience, but at this point was not assured that they will result in achieving the target of 93% by March.

Ambulance Turnarounds

The Committee noted that whilst there was a reduction in ambulance turnaround times of more than 30 minutes from 527 in August to 453 in September, this is still far too many. The Committee was assured that monthly handover improvement meetings are now in place with EEAST with a jointly owned action plan.

Cancer

6 of the 9 cancer waiting time targets were met in September. Compared to August two access performances improved from not meeting the national standard to achieving it.

The 2 week maximum wait target from GP referral for suspected cancer to first outpatient appointment was met, improving from 92.5% to 93.2%, achieving the 93% national target, and the 62 day maximum target from GP referral for suspected cancer to first treatment was also met, improving from 82.5% to 85.2%, achieving the 85% national standard.

The two access performances that fell below standard were the maximum 31 day waits from decision to treat to first treatment, and for subsequent drugs, the former falling from 96.5% to 94.1% against the standard of 96%, and the latter from 100% to 94.1% against the standard

of 98%. The Committee was assured that by the fact that both these standards have been met year to date, and that as the validation process for both is not yet complete improvement in the provisional performance is expected.

The Committee's main focus was on the standard that that was not met for the second successive month, the maximum 62 day wait from cancer screening to first treatment. Performance fell from 83.3% in August to 68.0%, which though provisional at this point is not expected to achieve the standard of 90%. Performance in the first four months of the year was ahead of standard at 93.4%, but is now below for the first half year at 79.6%. The Committee discussed the reasons for the drop in performance and the corrective actions in place to recover, and asked for a more detailed review at the November 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 6 weeks for diagnostic testing. Performance in September was 99.7%.

Financial Performance

i I&E

The Committee reviewed the September 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 month and the half year deficits were both in line with budget at £2.1m and £17.8m.

In September higher pay coasts of £0.6m were offset by higher revenues of £0.2m and lower non-pay costs of £0.4m. At the half year lower revenues of £1.2m and higher pay costs of £1.7m are offset by lower non-pay costs of £2.9m.

The Committee focussed on seeking assurance that the full year deficit budget would be met, and that progress had been made since last month on underpinning the £1.5m of required improvements to achieve this, identified at the September meeting.

The Committee noted that the prime reason for the lower revenue to date is lower use of high cost drugs, and that this has no impact on the deficit as the revenue loss is offset by lower non-pay costs. This together with the recently agreed minimum income contract for the year with HVCCG gives assurance that the budgeted income for the year is on track to meet budget.

The key challenge to meet the full year deficit is to reduce the rate of higher than budget pay costs, mainly in medical and nursing, without adversely impacting patient safety or experience. The Committee reviewed the actions in train to achieve this, and was assured that the Trust has fully embraced the drive to reduce these costs, but at this

stage, was not assured that the planned reductions were sufficiently underpinned to close the current £1.4m gap from the year end deficit forecast to budget.

The Committee commended the Trust's CIPs performance, with £6.2m delivered at the half year, £2.2m better than budget and well developed actions and plans in place to achieve the full year budget of £15.0m.

The Committee recommends that a paper on the forecast deficit for the year, including recovery plans and risks, is presented to the November Board.

ii Minimum Income Contract (MIC)

The Committee reviewed the proposed MIC agreement with HVCCG for 2019/20 which was approved by the HVCCG Board in October. The plan is for the Trust and HVCCG to prepare contract variations from the existing contract, and gain recommendation from the November Committee to the December Board for approval.

The Committee reviewed the proposed agreement, which essentially moves away from the current contract, which is mainly based on payment by results(PbR), to a fixed income contract for the year, based on the agreed plan activity.

This change in approach is consistent with NHS strategy and will be the basis for long term planning. It enables greater collaboration between commissioner and providers, working together within the system to improve both patients experience and improvements in productivity.

The Committee was supportive of the proposed agreement, and recommends that a briefing on the proposed MIC is given to the November Board with a recommendation that approval is given for the necessary contract variation documents to be prepared.

iii Capital Spend

Capital spend in the month of £0.5m brought half year spend to £3.6m. The Committee was pleased to note that an application for £1.0m of funding for the fuel efficiency programme using FLU-ACE technology, has been approved by NHSI, and is expected to deliver a significant return on investment. However the Committee was concerned that there is still no NHS approval on the application made earlier this year for £4.8m of essential funding for fire safety, theatres redevelopment and A&E transformation. Early approval for this spend is essential to enable the planned full year spend of £21m.

The Committee supported the planned spend for the year by project, and was assured again, that business cases supporting the spend would be completed in time to enable the full £21m to be spent.

iv Review of Surgery, Anaesthetics and Cancer Division

The Committee requested a follow up to last month's review to confirm

that actions agreed to improve controls over pay and annual leave management were in place. Compared to plan the Division has significantly lower revenues, but higher pay costs.

The Committee was assured that improved pay controls have been implemented, and noted that further savings in pay and non-pay of £0.4m are now forecast for the year.

v Long Term Financial Plan

The Committee reviewed the process for developing the financial plan from 2019/20 to 2023/24. The Committee was assured that the underlying income and expenditure trajectories, set by NHSI and ratified by the September Board, remained, and with increased central funding now advised by NHSI, would result in the Trust breaking even by 2022/23.

The key actions needed to complete the financial plan for 2020/21, and the timetables for Trust approval and submission to NHSI, will be reviewed at the November Committee.

The Committee recommends that an update on the plan process, covering the key operational and financial requirements, and timetable for review, approval and submission to NHSI, should be presented to the November Board.

Urgent and Emergency Care Full Business Case (FBC)

The Committee reviewed the FBC for the creation of a primary care led Urgent Treatment Centre(UTC) at Watford. This is a joint initiative between HVCCG and the Trust, and the HVCCG approved the FBC at a special meeting of its Board in October.

The FBC aims to improve patient waiting times, experience and outcomes in the Emergency Department at Watford. This requires investment in expanding ambulatory care, additional senior clinicians, and contracting with a third party primary care provider to operate the UTC.

The costs of running the UTC would be shared over time by the Trust and HVCCG, and the Trusts costs are expected to be offset by reducing bed requirements at Watford.

Following the review the Committee recommends the submission of the FBC to the November Board for approval.

Contract negotiations are underway with the preferred bidder, and the proposed contract is expected to be reviewed by the Committee in November. Once successful contract negotiations are complete, and the UTC is up and running the Committee has asked for regular updates on performance against contract , its contribution to the total A&E performance and subsequent freeing up of required bed space.

Interim Estates Strategy
The Committee was updated on the interim estates strategy for the period leading up to longer term Acute Development plans.

The Committee was assured that appropriate plans and actions are in place, and it was noted that the Board would receive an update on the plans for the multi-story car park at Watford at the November 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 was assured that there should be no additions or deletions to the risks approved by the October Board and by the updates on actions and mitigations.

The Committee recommended that the BAF and CRR, as reviewed, should be included in the Corporate report to the November Board for review and assurance.

Risks to refer to risk register

See above

Issues to escalate

The Committee recommends the following:

To Part 1 of the November Board:

For information and discussion:

- **Long Term Financial Plan**
  The Committee recommends that an update on the plan process, covering the key operational and financial requirements, and timetable for review, approval and submission to NHSI, should be presented to the Board.

For approval

- **Urgent and Emergency Care Full Business Case (FBC):**
  The Committee recommends approval of the FBC.

To Part 2 of the November Board:

For approval

- **Minimum Income Contract (MIC)**
  The Committee recommends that a briefing on the proposed MIC is given to the November Board with a recommendation that the necessary contract variation documents are prepared.

For information and discussion:

- **Financial Performance**
  The Committee recommends that a paper on the forecast deficit for the year, including recovery plans and risks, is presented to the Board.

Attendance record

Present
John Brougham, Non-Executive Director (Committee Chair)
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
Mr Jeremy Livingstone, Divisional Director, Surgery, Anaesthetics and Cancer
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 Divisional Surgery, Anaesthetics and Cancer financial performance review:
Jason McKee, Divisional Manager Surgery, Anaesthetics and Cancer
Nyasha Onyango, Head of Finance, Surgery, Anaesthetics and Cancer

Attended for WHHT and HVCCG Urgent and Emergency Care Full Business Case
Debbie Foster, Programme Director, Urgent and Emergency Care,

Attended for Interim Estates Strategy Development
Esther Moors, Acute Redevelopment Programme Director

Apologies
Christine Allen, Chief Executive Officer
Jean Hickman, Trust Secretary
Helen Brown, Deputy Chief Executive (Nominated reserve Executive)

NHS
West Hertfordshire Hospitals
NHS Trust

Report to:	Trust Board
Title of Report:	Assurance report from Quality Committee
Date of meeting:	07 November 2019
Recommendation:	For information and assurance
Chairperson:	Ginny Edwards, Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Quality Committee at its meeting on 26 September 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	**Clinical support quality assurance report** Work was on-going to improve the patient journey across all departments. Implementation of a new appointment system in the andrology department had reduced waiting times and a reduction in rejected specimens. Following a review of processes, roles and ways of working in respect of tablets to take away (TTAs), up to 50% of TTAs dispensed were now dispensed at the patient's bedside and pharmacist independent prescribers were available on certain medical wards to support timely TTA prescribing. Challenges included: Sustaining a financial balance versus providing a seven day service in Radiology with a limited budget at SACH. Retention of skilled staff within pathology following consultation regarding on call payment which impacted on service delivery across Microbiology and Blood Sciences. To mitigate this, fortnightly meetings were being held with all leads and Divisional General Manager to review establishment in preparation and readiness for when the consultation was completed and rolled out. Portering services in support of radiology and the impact for inpatients and A&E following the centralisation of services after a contract change. The service was working closely with the provider and facilities to

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address this and this was slowly improving.

The top risks related to equipment and are being addressed through the managed equipment services group. However, it was noted that the rolling equipment replacement programme cannot meet all departmental needs at once.

The sustainability of all services was being addressed by the Deputy Chief Executive and the clinical leads to ensure that robust plans were in place to meet demand in the context of the state of the estate overall and the facilities, including equipment.

Additional staff are being 'upskilled' to meet increased demand, and this is also being addressed at STP level, where workforce issues and clinical pathways are being reviewed to ensure that the system can meet growing demand within financial constraints.

Learning from experience continues to be embedded into business as usual; this was monitored by regular spot checks and audits. A programme of peer reviews is also being developed.

Quality Assurance Framework: 'Getting to Good and Beyond' implementation plan

The implementation plan provides an organisational overview of all existing quality improvements and initiatives currently in place against the CQC five domains. A robust governance approach across the divisions through to the Trust Board is in place.

The implementation plan is not a standalone area of work, but integrated and complimented by other workstreams, which when looked at holistically, provided an overview to ensure that each initiative is outcome focused, integrated, coordinated, intelligence led, and risk based.

Work was proactively ongoing to prepare for the Trust's PIR submission. Learning from previous inspections would ensure that the requested information was accessible and held within the correct format. This preparedness should reduce the clinical and executive burden and support a more comprehensive submission at the time of request.

A comprehensive executive led communication strategy was being finalised. The aim was to ensure the right approach first time, every time.

Areas of concern were noted to be in respect of:

- Consistency of approach across the Trust.
- The condition of the estate and the pace of improvements.
- Sufficient training and support for new staff.
- Expected timing of the inspection during winter pressures.

By being aware of these issues, the Trust could plan effectively to address them, although the planned improvements to the estate were mostly out of the Trust's control due to financial constraints.

Clear surge plans are in place, and the Trust Management Committee will shortly agree wider winter plans based on learning from previous years.

Risk management report and corporate risk register update following risk review group meetings held on 27 August and 19 September 2019

- Five new risks had been approved.
- Two risk ratings had been revised and approved (level of risk had been reduced).
- Six risks had been approved for de-escalation.
- There were no escalated risks.
- Three risks had been closed/merged.

All risks are discussed in detail at the divisional performance reviews.

Risk 4199 – inability to manage patients with mental health challenges attending ED.
The Trust is experiencing a significant increase in Mental Health patients attending ED. Whilst the rapid assessment interface and discharge team (RAID) are generally keeping up with assessments, those patients requiring further care were experiencing significant delays.

This is partly being addressed by the redesign of ED, with extra space being considered for Mental Health rooms. However, this issue reflected a national shortage of workforce to meet demand, and the complexity of these patients further complicated delivery of appropriate care in a timely way.

This is a 'system' issue, which was not exclusively within the responsibilities and capacity of the Trust to resolve; it is a standing item on the A&E System Resilience Group (SRG) in order to find system solutions to resolve.

Patient Experience Report
The inpatient FFT score was at 95.8% which met the target score, but the response rate remained below the 35% target as all comments need to be responded to before the form can be closed. An investigation was looking at why the response rate was not meeting the target.

The response rate is a national requirement to report on, and just one indicator, which is then triangulated with other patient experience feedback received, such as PALs and observational intelligence.

Feedback to patients following their comments is a difficult area, and work is in-hand to develop process to respond to themes and actions taken.

The percentage of volunteers under 25 years of age registered with the Trust was very important. There was no target for this, but at 26.9% this was to be commended.

The national Children and Young People survey results (Picker version) indicated that 95% of children felt staff spoke to them about their worries and that there was enough to do whilst in hospital.

Patients and ward managers had commented positively on the call back service for all adult inpatients discharged from hospital.

Night visits to wards and departments on the WGH site had been completed by senior staff to help gain an insight into the journey for patients and staff at night. Feedback had been positive.

Back to the Floor continued to be a positive experience for all involved.

DBS compliance for Volunteers had reached 80% and was on track to reach the 95% target by March 2020.

Environmental compliance report
This was discussed in detail by the Committee. Levels of Compliance and Assurance still require substantial improvement across the environment division; but there is now a robust methodology and process in place. Aa tool, **ARIDAD**, based on crisis management methodologies has been implemented to provide continuous improvement and track and report progress thereof.

Other industry recognised tools are being used to prioritise capital spend.

The Soft FM contract has delivered significant improvements across both the safety and patient experience. This has been facilitated by a clear and progressive specification, innovation of services and a robust set of KPI‘s.

Sustainability
A highly experienced Sustainability Manager has been employed.

A number of schemes have been identified, that, with investment, will generate annual year-on-year savings in excess of £1million, with a return on investment within 2.5years.

To provide support to staff during these changes, a number of mitigating actions have been put in place. These include:

- Engagement with staff;
- Regular communications; and
- Devolving accountability to staff to encourage them to take a more pro-active approach.

The Committee discussed the risk relating to asbestos (2795): Management and control of Asbestos Containing Materials (ACMs) which had been rescored from 20 down to 16. The Chief Medical Officer explained that the likelihood of people being harmed had been too high, therefore the level of risk had been reduced to reflect this.

The Committee ask the Board to note that there had been a robust discussion about the de-escalation of the risk relating to asbestos (2795) and were assured by the processes in place to manage the risk.

Annual Complaints and Patient Advice and Liaison Service (PALs) Report

There has been a significant decrease in complaints received by the Trust in 2018/19 compared to the previous two years.

The national target for acknowledgement within 3 working days has been achieved 100% of the time. Response rates have also significantly improved.

At the time of writing the report there was only one complaint over six months old, a significant drop from the same period last year.

All internal audit recommendations have been completed.

Complaint learning events were held three times during the reporting period where improvements were shared in a consistent way.

A weekly tracker to monitor all concerns at a Divisional level has been developed. This uses a RAG rating system (RED for breach, AMBER for nearing breach and GREEN for under investigation).

Standard Operating Procedures (SOP) have also been developed by PALS, resulting in improvements in quality of data collection due to robust management of recording of concerns accurately.

The Complaints Handling Policy has been updated.

Maternal new-born and infant clinical outcome review programme (MBBRACE)

There continue to be striking inequalities: black women are five times, and Asian women two times, more likely to die as a result of complications in pregnancy than white women. The Trust planned an awareness and engagement day during Black History month (October) to train both staff and the local population.

Although there was greater awareness of the importance of mental health during pregnancy and in the first year after birth, there is still a long way to go in recognising symptoms, supporting women with mental health problems and providing access to specialist perinatal mental health care.

Maternity services in the Trust were compliant with the majority of the recommendations, but one of the key issues was the need to update existing guidelines.

There is an audit programme to an audit programme to check implementation and adherence to the new policies and embedding these into BAU. This also links to the CNST 10 actions.

Briefing on future provision on Simpson Ward, Hemel Hempstead Hospital site

The division of medicine had welcomed the opportunity to take on the leadership of Simpson ward on the Hemel Hempstead site and appropriate governance processes would be implemented in line with Trust policies and procedures.

A senior band 8a matron has been recruited for a six month secondment to ensure a smooth transition from HCT to WHHT in a very tight timescale.

HCT had provided excellent handover support.

Previous concerns raised by the Care Quality Commission in their September 2016 inspection were being addressed.

Clostridium difficile attributed to the Trust

The CCG's infection control team had reviewed 21 of the 26 cases, 16 of which had been identified as no lapses in care (no identified lapse within WHHT care pathway leading to C diff infection).

The Committee noted the report and were assured by the progress of actions being undertaken to manage C. diff in the Trust.

Getting it right first time (GIRFT): Breast surgery progress report

The progress against the action plan was discussed. Of the 13 key actions:

- One was red rated;
- Three were amber rated;
- Four were green rated; and
- Five had been completed.

Progress against the action plan is discussed quarterly at breast unit meetings, and regularly monitored by the Clinical Lead for breast surgery and the Project Support Officer in the Strategy Delivery Office.

The coding issue was not restricted to the breast surgery team. It was noted that validation of data was a constant process. An IT system was the long-term solution.

Risks to refer to risk register

There were no new risks to escalate to the Board.

Recommendations to the Board

The following were reviewed, assurance provided and recommended to the board. These were verbally noted at the Trust Board Meeting on the 03 October 2019

CQC – Getting to good – assurance on progress and plans in place to deal with concerns.

Descalation of the Asbestos risk – assurance on reducing risk to patients and staff.

Risks – reviewed through appropriate governance and actions in place.

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
Alison Fuller, Interim Associate Chief Nurse
Fran Gertler, Director of Integrated Care
Martin Keble, Chief Pharmacist and Divisional Director Clinical Support Services
Colette Mannion, Director of Midwifery and Gynaecology
Mr Simon Thomson, Clinical Lead, Breast Surgery

Agenda Item: 24/76

Report to:	The Trust Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	07 November 2019
Recommendation:	For information and assurance
Chairperson:	Paul Cartwright, Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Audit Committee at its meeting on 18 October 2019.
Background	The Committee meets four times a year for regular business and has two additional meetings in relation to the year-end sign off process. It provides assurance to the Board: • on all aspects of internal audit and those aspects of external audit not reserved to the Audit Panel. The Audit Panel deals with the appointment and removal of the external auditor. • on the appointment of the internal auditor • that effective assurance controls, structures, systems and processes for integrated governance, risk management and internal controls are in place
Business undertaken	**Attendance** The committee was disappointed that three executive directors were absent from the meeting and requested for suitable deputies to be asked to attend in future in the absence of the director. **Assurance report from remuneration committee** The committee reviewed the work of the remuneration committee and was assured that it was working well and had improved over the last few years. The committee was assured that the remuneration committee regularly discussed all relevant VSM pay and other relevant issues which were identified by the management. The committee agreed that there was an appropriate scope of responsibilities between the remuneration committee and the people, education and research committee. In line with the Audit Committee handbook, it was agreed that in future the Board would receive a brief, appropriately worded assurance report in the private session of the Board meeting on the work of the remuneration committee.

Review of risk and governance arrangements

The committee received assurance that the Trust's risk and governance arrangements were broadly operating well. It was noted that over the coming months action would need to be taken to ensure that the Board was aware that all risks were properly understood, for example the target IT architecture against which IT risks can be understood and appreciated. The internal auditors confirmed that the risk and governance arrangements had significantly improved over the past few years.

Review of freedom to speak up policy

The Freedom to Speak Up (FTSU) arrangements were reviewed by the committee. It was noted that new guidance had been published in July 2019 and the committee was assured that the Trust had been meeting the original guidance; however there was still some work to do to meet all the requirements of the updated guidance. Assurance was received that FTSU had been impactful, thoughtful and energetic and sometimes a useful augmentation to the management. Concern was raised that the new guidance FTSU could potentially be used as a point of first contact for staff to raise concerns rather than retaining its traditional purpose of being a 'whistleblowing' function, thereby potentially reducing the effectiveness of it as a vital corporate safety feature for the organisation. The committee was in strong agreement with the approach of channelling normal day to day complaints and issues through established HR processes rather than through FTSU. It was however noted that there was a strong expectation by various external bodies that the Trust should follow the new guidance. It was agreed that the committee would receive an update on progress towards achieving the new standards in six months.

Updated standing financial instructions (SFIs), standing orders (SOs) and scheme of delegation (SOD)

The committee reviewed the changes and approved the updated SFIs, SOs and SOD for 2019/20. It was noted that the SFI's must be updated regularly to ensure they correctly reconciled with the developing ACO/STP/ICS/ICP systems.

Review annual clinical audit plan

The committee was assured that the clinical audit plan was being managed appropriately and progressing well.

Deep dive into losses and compensation register

The committee was updated on the controls in place to reduce the risk of losses and compensations. It was noted that, although the Trust was proactive in identifying overseas visits, including a training programme for A&E staff, £1.9m of revenue would be lost due to the inability to collect debt from overseas visitors. The committee was informed that private patient contracts were being finalised to mitigate overseas visitor debt write-offs.

Internal audit progress report

The committee reviewed an internal audit progress report and was concerned to be informed that the internal audit timetable was delayed and a large number of audits were scheduled to be undertaken at the end of the year. The committee stressed that internal auditors would need to take practical steps to get the final reports through the relevant committees and to the Audit Committee before the end of the financial year.

Local counter fraud service progress report

A lead investigator from the national counter fraud service provided a detailed update on a complex major fraud and theft investigation which had been ongoing for a significant length of time. The committee was pleased to note that the Trust had made improvements to its procurement process in order to reduce the risk of reoccurrence; however it was disappointed that the case may not be successfully concluded due to a lack of skilled anti-fraud resource centrally.

The following reports were noted:

- Waiver/tender register
- Staff salary overpayments
- Use of Trust seal
- Conflicts of interest register

Risks to refer to risk register

- Development of STP/ICS procedures may be inconsistent with the Trust's SFI's and timetable.
- Criminal investigations are not being completed within an appropriate timeframe.

Issues to escalate

- SFIs, SOs and SoD recommended to the Board for approval.
- Encourage FTSU focus on addressing 'Mid Staffs style' whistleblowing, which may not be in line with NHS guidelines

Attendance record

Attendees
Paul Cartwright, Non-Executive Director (Chair)
John Brougham, Non-Executive Director
Don Richards, Chief Financial Officer
Onali Mohamedali, Financial Controller
Jean Hickman, Trust Secretary
Clive Makombera (CM), Director, RSM
Gemma Higginson (GH), RSM Counter Fraud Lead
Ciaran McLaughlin (CO), Grant Thornton
Ade Oyerinde (AO), Grant Thornton

Apologies
Helen Brown, Deputy Chief Executive
Anna Wood, Deputy Medical Director and Director for Clinical Standards and Audit
Tracey Carter, Chief Nurse
Stephen Dunham, Assistant Director of Finance & Commercial Development

In attendance for specific items
Paul da Gama, Chief People Officer
Mark Howard, National Counter Fraud Services
Trisha McSkeen, Legal Services Manager

Agenda Item: 25/76

Report to:	Trust Board
Title of Report:	People, Education and Research Committee Assurance Report to Trust Board
Date of meeting:	07 November 2019
Recommendation:	For information and assurance
Chairperson:	Paul Cartwright, Non-Executive Director
Purpose:	The report summarises the assurances received, approvals, recommendations and decisions made by the People, Education and Research Committee at its meeting on Thursday 31 October 2019.

Background:

The Committee meets bi-monthly and provides assurance on:

- Workforce strategy
- Equality and diversity
- Induction
- Bullying and harassment
- Guardian of safe working
- Job planning
- Occupational health
- National surveys
- Staff health and wellbeing programme
- Revalidation
- Appraisals
- Fit and proper persons
- Whistle-blowing/Freedom to speak up
- Education and training
- Leadership development
- Talent management
- Flu vaccination programme
- Apprenticeships
- Staff engagement
- Relevant external review body reports
- Safe staffing

Research and development - Thought is being given about how to ensure appropriate prominence to research alongside work force issues.

Key Business Undertaken:

Work Plan 2019-20

The Committee received the revised draft work plan. Whilst it welcomed the changes made, it felt that there was opportunity to ensure work plan clearer still by showing 'fewer and summary level tasks at a consistent granularity'.

Workforce Performance Report

The Committee received an overview in relation to key workforce indictors and metrics. The summary is: the number of staff in post increased to 4,512wte in September. Turnover is currently 14.6%. Agency spend as percentage of the pay bill has reduced from 5.7% in July to 4.2%. Sickness absence is currently 3.49%, lower than the 3.5% target. The Trust appraisal rate increased from 77% in June 2018 to 87.9% currently. The OLM core training compliance is currently 91% and the rate for essential training is 88%. The Board Assurance Framework (BAF) scorecard is rated as ‘Green’ risk rating for the third time. In total, there are: 43 live ER cases, 66 long-term sickness cases, and 430 short-term sickness cases being managed by the ER team.

Whilst welcoming these improved metrics the Committee discussed without resolution why the work force metrics are positive with there still being apparent pressure on the wards and in ED and felt that much of the feeling of pressure was due to the increasing acuity of the patient population especially in relation to age and substance abuse. To be returned to.

The Committee also asked specifically that over time that research is given larger and more appropriate prominence in progress report alongside workforce matters.

Joint Corporate Risk Register and Board Assurance Framework
The Committee received a report on the joint corporate risk register and board assurance framework. There were three risks on the CRR aligned to the PER Committee. As this is the first review of the BAF since it was approved by the Board, no changes are suggested at this time.

Annual Freedom to Speak Up Report
The Committee received the annual Freedom to Speak Up report to provide the annual update and assurance that the Trust's approach to Freedom to Speak Up is line with national guidance published by the National Guardians Office and NHS Improvement in July 2019. Whilst welcoming the work being undertaken PERC agreed with the CPO that WHHT will aim to keep FTSU focused on detecting major issues (like the next Mid Staffs) rather than interfering with the more numerous issues more appropriately dealt with by the management line.
The Committee approved the report for submission to the Board.

Research and Development Strategy
The committee welcomed the initial draft of the Research and Development strategy and requested some further work prior to this being recommended for submission to the Board.

The Committee felt that the strategy should be augmented by adding a number of things including information on particular research focus areas, likely costs, workforce engagement and the basis by which the success of the strategy may be assessed. The Committee were keen to ensure that the strategy was presented to Board no later than January 2020.

Guardian of safe working Annual Report
The Committee received the guardian of safe working annual report which provided a summary of doctor rota gaps, shift fill rates, and exception reporting data for the year August 2018 – August 2019. The Committee took assurance that the quality of the WHHT lead Dr Burridge was considered by NHSE/I as the most effective and thoughtful lead in the region. The committee approved the report for submission to the Board.

Guardian of safe working Quarterly Report
The committee received the guardian of safe working quarterly report for the period May 1st 2019 – July 31st 2019 to provide assurance that doctors are working safely within the Trust.

Fit and Proper Persons Test
The Committee received the fit and proper person test report to provide an overview of the FPP requirements and provide assurance that the Trust is meeting the expected standard. The Committee were keen to ensure that for NED as well as Executive recruitment that comprehensive checks that at least the basic claims (e.g. education and qualifications) in all Board CV's are properly verified on recruitment in the future.

Flu Campaign Update
The Committee received the influenza campaign update report detailing the measures the Trust is undertaking in order to ensure it is doing everything possible as an employer to protect their patients and staff from seasonal flu. The Committee approved the report for submission to the Board.

Talent management Update
The Committee received the talent management update paper explaining the Trust's talent management and succession two-year plan which was developed in July 2018. The Committee agreed with the Chief Nurse the talent management programme would benefit from a comprehensive review at the next Trust Management Committee (not Board) away day.

STP Workforce Redesign Work
The committee received the STP workforce redesign paper to provide assurance that the Trust is activity involved with the development and implementation of transformational education and training activity to help achieve the Hertfordshire and West Essex STP workforce strategy, and to review progress against the priorities set out for the Role Re-Design and Development workforce work stream.

Appraisals update
The committee received a verbal update about appraisals.

Risks to refer to risk register:	None
Key decisions taken:	The Committee approved the following reports for submission to the Board: • Freedom to Speak Up annual report. • Guardian of safe working annual report. • Influenza campaign update.
Issues to escalate:	None
Challenges and exceptions:	None
Future exceptional items:	None

Attendees:
Paul Cartwright, Non-Executive Director (Chair)
Tracey Carter, Chief Nurse and Director of Infection Prevention and Control
Paul da Gama, Chief People Officer
Jonathan Rennison, Non-Executive Director
Paul Mendes, Head of Education, Learning and Development
Mike van der Watt, Medical Director
Laura Bevan, Deputy HR Director
Fiona Smith, Head of Research and Development
Laura Abel, Assistant Trust Secretary (minutes)

Apologies:
Natalie Edwards, Non-Executive Director

Agenda Item: 26/76

Report to:	Trust Board
Title of Report:	Charity Committee Assurance Report to Board
Date of meeting:	07 November 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 Charity Committee at its meeting 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	**Delivery of the charity strategy** The committee received an update on progress of delivery of the charity's strategy for 2019-2020 which was discussed. The Committee requested more clarification about the objectives, to include measures of success and measurable outcomes for donors. **Charity effectiveness**: The committee noted that there is a need to make progress on consolidation of funds, strategic alignment of funds and forward spending plans. The incremental consolidation of funds will ensure improved effectiveness of management of funds and the charity. **Lottery**: arrangements are being put in place to launch the previously agreed lottery. **Christmas appeal 2019:** the committee heard that, following the success of last year's 'Raise a Smile' campaign, there would be a similar campaign for 2020 which will have the same objective as the 2018 appeal – i.e. to provide gifts for inpatients over Christmas. It was also explained that the appeal will be managed in a way to record donor details. **Capital appeal**: the focus of the capital appeal is for an interventional radiology suite. **Recruitment**: a new charity director has been recruited and will take up post in December 2019. There had also been a successful candidate following the interviews for the post of fundraising officer. Discussions

were taking place prior to appointment.

Discretionary resources: there had been no negative reactions to the ruling that hospitality funds should no longer be spent on events such as Christmas parties.

The implementation of a customer relationship management system (CRM) will help with effective donor stewardship.

Terms of reference, workplan and self-assessment

The Committee received the terms of reference and work plan which had been reviewed as part of the review of the Trust's governance structures, and aligned to the Charity Commission's essential trustee guidance: .

The Committee recommend the terms of reference and amended work plan to the Trust Board, as Corporate Trustee, for approval.

Overview of Funds, including cash flow forecast

Income and spending projections through to 31 July 2020 suggest a maximum of £818,385 will be available for spending decisions, whilst still ensuring that the Charity maintains its reserve policy of always holding a minimum of six months expenditure. It was projected that the balance of the general fund at 31 July 2020 would be a surplus of £3,432.

Overview of donations and fundraising activity

The committee discussed the report; in particular the shortfall in the Starfish bathroom refurbishment. Officers explained that the age and condition of the Trust estate had added unforeseen cost pressures (e.g. safe removal of asbestos and other enabling works).

Annual Accounts & Report 2017/18

The Chair of the charity committee signed a letter of representation on behalf of the Corporate Trustee so that a signed audit opinion for the annual accounts for the charity would be provided by the auditors. The Financial Controller confirmed that this was part of tighter governance processes relating to charities.

Escalation to the Corporate Trustee

The Charity committee asks the Corporate Trustee to note:

- The new Charity Director will commence in post in December. Interviews have taken place for the fundraising officer role.
- An interim Charity Director (David Head) is in post and has set up (but not yet activated) a standalone website for the Christmas Raise a Smile Appeal with online donation functionality and GDPR compliant donor data capture.
  At the time of writing the charity committee is reviewing a short paper setting out the governance arrangements of the website (approved by the CIO) and PayPal.
- Income generation: starting lottery in early 2020.
- Terms of reference and workplan have been updated in line with essential trustee and the good governance code.

Attendance record

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
Laura Abel, Assistant Trust Secretary (Minutes)

TRUST BOARD MEETING IN PUBLIC
AGENDA

05 December 2019 at 12.30pm – 2pm
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	**Patient story**	Information	Chief Nurse	Present-ation	
INTRODUCTION TO THE MEETING						
	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						
	10/77	**Performance report on access standards**	Assurance	Chief Operating Officer	Paper	
	11/77	**Integrated performance report (month 7)** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Finance Officer	Assurance	Chief Operating Officer	Paper	
AIM ONE: BEST QUALITY CARE (OBJECTIVE 1 – 4)						
	12/77	**Annual report on infection prevention and control**	Assurance	Chief Nurse	Paper	
	13/77	**Annual report on complaints and the patient advice and liaison service**	Assurance	Chief Nurse	Paper	
	14/77	**Quarterly learning from deaths report**	Assurance	Deputy Medical Director	Paper	

	15/77	**Report on Board visit programme**	Assurance	Chief Nurse	Paper	
AIM FOUR: A STRATEGY FOR THE FUTURE (OBJECTIVE 10 – 12)						
	16/77	**Five year strategy**	Assurance	Deputy Chief Executive	Paper	
RISK AND GOVERNANCE						
	17/77	**Corporate risk register report**	Assurance	Chief Medical Officer	Paper	
	18/77	**2019/20 Board and committee meeting schedule**	Information	Trust Secretary	Paper	
ASSURANCE FROM COMMITTEES						
	19/77	**Assurance report from Trust Management Committee**	Assurance	Chief Executive	Paper	
	20/77	**Assurance report from Finance and Performance Committee**	Assurance	Chair of Committee/Chief Financial Officer	Paper	
	21/77	**Assurance report from Quality Committee**	Assurance	Chair of Committee/ Chief Nurse	Paper	
	22/77	**Assurance report from People, Education and Research Committee**	Assurance	Chair of Committee/Chief People Officer	Paper	
CORPORATE TRUSTEE						
	23/77	**Assurance report from Charity Committee**	Assurance	Chair of Committee/ Deputy Chief Executive	Verbal	
ADMINISTRATION						
	24/77	**Any other business previously notified to the chair**	N/A	Chair	Verbal	
QUESTIONS FROM THE PUBLIC						
	25/77	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal	
	26/77	**Questions from our patients and members of the public**	N/A	Chair	Verbal	
CLOSING						
	27/77	**Draft agenda for next meeting**	Approval	Chair	Paper	
	28/77	**Date of the next board meeting in public:** 09 January 2020, Executive Meeting Room, Watford	Information	Chair	Verbal	

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