TRUST BOARD MEETING IN PUBLIC
AGENDA

03 September 2020 at 9.30am – 12.15pm
Executive Meeting Room and via Zoom, Watford Hospital

Apologies should be conveyed to the Trust Secretary, Rod While on rod.while@nhs.net
or call 01923 436 283

Time	Item ref	Title	Objective	Accountable officer	Paper or verbal	Link to BAF
09.30	01/82	**Opening and welcome**	Information	Chair	Verbal	
	02/82	**Patient story**	Information	Chief Nurse	Verbal	
INTRODUCTION TO THE MEETING						
09.50	03/82	**Apologies for absence**	Information	Chair	Verbal	
	04/82	**Declarations of interest**	Information	Chair	Paper	
	05/82	**Board action log and decision log. Minutes of previous meeting on 2 July 2020**	Information	Chair	Paper	
	06/82	**Chair's and Chief Executive's report**	Information	Chair / Chief Executive	Paper	
	07/82	**Board Assurance Framework**	Information and assurance	Chief Executive	Paper	
PERFORMANCE						
10.05	08/82	**Performance report on access standards**	Information and assurance	Chief Operating Officer	Paper	
	09/82	**Integrated performance report** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Finance Officer • Chief Information Officer	Information and assurance	Chief Operating Officer	Paper	
AIM ONE: BEST CARE						
10.25	10/82	**Midwifery workforce planning bi-annual report 2020**	Information and assurance	Chief Nurse	Paper	
10.35	11/82	**Safeguarding Annual Report – May 2019 – April 2020**	Information and assurance	Chief Nurse	Paper	

10.45	12/82	**Annual assurance report on emergency preparedness, resilience and response**	Information and assurance	Chief Operating Officer	Paper	
AIM FOUR: GREAT PLACE						
10.55	13/82	**Strategic Priorities Update:** **13.1 Strategic Priorities Update** **13.2 Acute redevelopment Programme Directors update**	Information and assurance	Deputy Chief Executive	Paper x 2	
RISK AND GOVERNANCE						
11.20	14/82	**Corporate risk register report**	Approval	Chief Medical Officer	Paper	
11.30	15/82	**Great Place Committee Terms of Reference**	Approval	Trust Secretary	Paper	
ASSURANCE FROM COMMITTEES						
11.40	16/82	**Assurance report from Trust Management Committee**	Information and assurance	Chief Executive	Paper	
	17/82	**Assurance report from People, Education and Research Committee**	Information and assurance	Chair of Committee/Chief People Officer	Verbal	
	18/82	**Assurance report from Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper	
	19/82	**Assurance report from Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper	
	20/82	**Assurance report from Audit Committee, including Audit Committee annual report**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper	
ADMINISTRATION						
12.00	21/82	**Any other business previously notified to the chair**	N/A	Chair	Verbal	
QUESTIONS FROM THE PUBLIC						
12.05	22/82	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal	
	23/82	**Questions from our patients and members of the public**	N/A	Chair	Verbal	
CLOSING						
12.15	24/82	**Date of the next board meeting: 1 October** Executive Meeting Room and via Zoom, Watford Hospital	Information	Chair	Verbal	

NHS
West Hertfordshire Hospitals
NHS Trust

Acronyms and abbreviations

A

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

B

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

C

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

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

D

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

Declarations of board members and attendees interests
03 September 2020

Agenda item: 04/82

Name	Role	Description of interest
Phil Townsend	Chairman	• Son works for ATOS Sintel a separate legal entity wholly on work associated with the BBC
Christine Allen	Chief Executive	None
Paul Bannister	Chief Information Officer	None
Dr Andy Barlow	Divisional Director, Medicine	• Barlow Medical Services Ltd • Director, London & Hertfordshire Respiratory Diagnostics Ltd
John Brougham	Non-Executive Director	• Non-Executive Director and Chair of the Audit Committee of Technetix Ltd
Helen Brown	Deputy Chief Executive	None
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	None
Paul Cartwright	Non-Executive Director	• Member of Charity Committee, West Hertfordshire Hospitals NHS Trust • Member of Council of King's College London
Paul da Gama	Chief People Officer	None
Helen Davis	Associate Non-Executive Director	• Director and shareholder at Brierley Advisory LLP • Partner is senior civil servant at DHSC
Ginny Edwards	Non-Executive Director (Vice-Chair)	• Trustee Peace Hospice Care • Director of Edwards Consulting Ltd • Charity Committee for West Hertfordshire Hospitals NHS Trust • Executive coaching for Cross sector leadership exchange (CSLE)

Last updated: June 2020

Name	Role	Description of interest
		• Executive support Public Health England • Volunteer organisation 'Help Force' advisor (Ended April 2020) • In Touch networks - coaching consultant (Ended April 2020) • 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
Natalie Edwards	Associate Non-Executive Director	None
Louise Halfpenny	Director of Communications	None
Jonathan Rennison	Non-Executive Director	• Trustee of NHS Charities Together (formerly the Association of NHS Charities) • Change Management and strategy support with Kings College London • Director of Yellow Chair Ltd • Edgecumbe Consulting - Associate • The Teapot Trust - Coaching • 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 (Ended January 2020) • Organisational development, change management, leadership development with Quo Vadis Trust - mental health residential care and supported housing service. (Ended January 2020)
Don Richards	Chief Financial Officer	None
Sally Tucker	Chief Operating Officer	None
Dr Mike van der Watt	Chief Medical Officer	• Owner and Director Heart Consultants Ltd

Last updated: June 2020

Name	Role	Description of interest
Mr Simon West	Divisional Director of Surgery , Anaesthetics and Cancer – from 01 April 2020	• Director Northampton Hip and Knee
Dr Anna Wood	Director of Governance	None

TRUST BOARD MEETING IN PUBLIC
02 July 2020
Executive Meeting Room, Watford

Chair	Title	Attendance
Phil Townsend	Chairman	Yes
Voting members		
Christine Allen	Chief Executive	Yes
John Brougham	Non-Executive Director	Yes (virtual)
Helen Brown	Deputy Chief Executive	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	Yes (virtual)
Ginny Edwards	Non-Executive Director (Vice-Chair)	Yes (virtual)
Jonathan Rennison	Non-Executive Director (Senior Independent Director)	Yes (virtual)
Don Richards	Chief Financial Officer	Yes (virtual)
Non-voting members		
Dr Andy Barlow	Divisional Director, Medicine	Yes
Paul da Gama	Chief People Officer	Yes (virtual)
Helen Davis	Associate Non-Executive Director	Yes (virtual)
Natalie Edwards	Associate Non-Executive Director	Yes (virtual)
Sally Tucker	Chief Operating Officer	Yes
Dr Anna Wood	Director of Governance	Yes (virtual)
Dr Simon West	Divisional Director, Surgery, Anaesthetics and Cancer	Yes
In attendance		
Meg Carter	Hertfordshire Healthwatch	Yes (virtual)
Colette Datt	Lead Nurse Patient Experience and Public Participation	Yes – Item 02/81 (virtual)
Emma Pope	Matron for Medicine	Yes – Item 02/81 (virtual)
Rod While	Trust Secretary (notes)	Yes

Five members of the public and three members of staff were in virtual attendance

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/81	**Opening and welcome**		
01.01	The Chairman welcomed the Board and members of the public to the meeting and reminded virtual attendees to remain muted unless they wished to speak. He noted that the meeting room was COVID safe, hence attendees were appropriately socially distanced.		
02/81	**Patient stories**		
02.01	Collette Datt, Lead Nurse for Patient Experience noted that her role involved listening to patients, families and staff in order to maximise patient experience of Trust services. The COVID-19 pandemic had brought significant challenges and the visiting restrictions made it more difficult for families to remain in contact with their loved ones. The presentation would show how the Trust had kept communications open for families. Emma Pope, Matron for Medicine advised the Board that initially patients came to the isolation unit accompanied by family members and were able to say goodbye, however when visiting arrangements were curtailed patients had been arriving alone, often clearly daunted and frightened. At same time staff were having to adapt to new ways of working and were so busy they found it difficult to answer telephone calls. When they answered calls from relatives they found this difficult because they were unable to give relatives the time and information that was usually the case. The team however gave as much as they possibly could, given the very difficult circumstances Collette Datt informed the Board that it had been clear that something had to be done to support staff and relatives and initiatives were developed to do this. These included a visitors line, a family liaison hub, a volunteer response role, virtual visiting using iPads, a “message to a loved one” service and a “two hearts” initiative at the end of life. She explained that message to a loved one involved inviting relatives to send in messages by email and this then was transferred to a letter template and passed to the volunteer hub and delivered to the patient. The iPad initiative was put in place to maintain visual communication between patients and relatives; they are now in common use in all clinical areas. She then shared a number of anonymised but very moving messages from relatives and extremely positive feedback from the iPad initiative.		
02.02	The Chairman thanked Collette Datt and Emma Pope for the stories and noted that this was a timely reminder of what patients, families and the hospital had been going through during the pandemic.		
02.03	Ginny Edwards asked what elements of the services the Trust would maintain in the future. Collette Datt stated that it was the little things that mattered to families. The iPads would be used more extensively to support families and message to a loved one would continue to be used.		
02.04	Jonathan Rennison asked whether there were any core principles that the Board should adopt moving forward as the organisation was moving through a period of great change. Collette Datt noted that team working across teams had been excellent and it was possible to work at pace with fewer blocks in place. Bureaucracy had been noticeably less apparent and this was an important learning for the future.		

Agenda item	Discussion	Lead	Dead-line
OPENING			
03/81	**Apologies for absence**		
03.01	Apologies were received from Dr Mike Van Der Watt and the Chairman noted their condolences for his recent loss.		
04/81	**Declarations of interests**		
04.01	No changes were reported to the declarations of interest from those circulated prior to the meeting.		
04.02	There were no actions due for completion.		
05/81	**Chair's and Chief Executive's report**		
05.01	The Chairman stated a number of consultant interviews had been taking place and two consultant surgeons had been appointed on the previous day and two consultants for obstetrics and gynaecology the previous week. He noted that the Divisional Director, Medicine had appeared on the national TV news in relation to the virtual hospital. He advised the Board that a four week cycle with of meetings with MPs had been continuing. He informed the Board that work would be taking place to understand whether the December Board meeting could be held later in the month and the January meeting removed. Board members would be asked to approve any changes in the meetings schedule.		
05.02	The Chief Executive informed the Board that the number patients with COVID-19 in the Trust had reduced. It had become clear that restarting services was a major challenge and was a major focus at the moment. She acknowledged the excellent work that had been done by the Divisional Manager for Medicine and that the Trust wished her well for the future when she left. The brutal death of George Floyd brought in sharp focus the existence of racism in the UK. Almost 40% of Trust staff were from a BAME background and meetings had been taking place with the Connect BAME employee network to understand the practical actions that need to be taken. The Chief Executive advised the Board that the CQC report had been received following the visit in February. Whilst the report was "requires improvement" overall, it was important to note that all of the services at Watford and St Albans were now rated as "Good". This reflects the huge amount of work that had been done by staff.		
05.03	Paul Cartwright noted that the previous Board meeting had been held in private for reasons of safety but requested that minutes from the non-private discussions be published. The Chairman noted that this would be reviewed.		
PERFORMANCE			
06/81	**Performance report on access standards**		
06.01	The Chief Operating Officer introduced the report and informed the Board that performance against the A&E four standard had improved following an upward trend in activity following the COVID-19 peak. There had also been an improvement in performance against diagnostics standards which was a reflection of the restart arrangements in place. The rates of referral into cancer pathways had increased greatly and this had impacted upon waiting times.		
06.02	John Brougham asked about the timescale to return to full recovery. The Chief Operating Officer informed the Board that this was very difficult to predict as there are big constraints around face to face		

Agenda item	Discussion	Lead	Dead-line
	interactions with patients and currently the Trust is receiving more referrals than it is able to effectively manage. The Trust was maximising the capacity available from the independent sector. Once on a steady platform the Trust would be in a better position to understand the scope of the recovery phase.		
06.03	Jonathan Rennison asked about the status of risk assessments for longer waits in planned care. The Divisional Director, Surgery informed the Board that all patients on outpatients waiting lists had been subjected to harm reviews and prioritised based on the review. Patients awaiting surgery are prioritised based on criteria developed by the Royal College of Surgeons. He informed the Board that West Herts had been one of the national leaders in the utilisation of the independent sector for the treatment of cancer patients.		
07/81	**Integrated performance review**		
07.01	The Chief Operating Officer introduced the report and drew the Board's attention to a new COVID-19 dashboard within the paper which was a snapshot as of 15 June. This covered the inpatient position, testing status, nosocomial infections, staff testing status, staff absence and PPE supply.		
07.02	Paul Cartwright stated that the dashboard was extremely helpful and a useful addition would be an indication of whether specifically quoted outcomes were good or bad.		
07.03	Natalie Edwards asked whether there would be any inclusion of detail around BAME staff in the report. The Chief People Officer stated that the snapshot does not lend itself to a meaningful measure, though detail on risk assessments could be added. ACTION Chief People Officer to review feasibility of including staff risk assessments in the COVID dashboard.	PDG	August 2020
07.04	The Director of Governance suggested the consideration of medics in the staff absence element of the dashboard. The Chief Nurse urged caution in measuring absence for individual staff groups as all disciplines were essential in delivery a high quality service. People Officer		
07.05	The Chairman asked for each of the Chief's to provide a report on their areas.		
07.06	The Chief Operating Officer noted that there had been reductions in COVID-19 within the Trust, particularly within critical care. A great deal of work had taken place on social distancing and infection prevention and control. AAU continued to be the designated point of entry for asymptomatic patients pending the outcome of COVID tests. She informed the Board of a number of recent high calibre recruitments to divisional management structures		
07.07	The Chief Nurse informed the Board that the national focus had been the reduction of nosocomial infections. There had continued to be a great deal of work around training, communication, compliance with PPE and enhanced cleaning in all areas. This linked in with the Infection Prevention and Control Board Assurance Framework (IPC BAF) issued in May 2020. There had been an increase in COVID transmission in one area and this had now been effectively managed. Masks had been introduced across the site for all staff and patients attending the hospital.		

Agenda item	Discussion	Lead	Dead-line
	The Chief Nurse noted that in the absence of the Chief Medical Officer she was happy to take any questions. On caring and responsive, the Chief Nurse noted that the family liaison service was being adapted to support COVID and non-COVID wards in the context of visiting restrictions.		
07.09	The Chief People Officer informed the Board that so far 3,141 members of staff had been booked for antibody tests and 2,756 tests had been completed. New risks assessments of staff were being carried out and so far 2,816 had been carried out and 1,100 employees were from a BAME background. He noted that there would be a return to some mandatory training in July and a return of appraisals in September.		
07.10	The Chief Financial Officer informed the Board that finances were being managed under a temporary regime for the first four months of the year where commissioners were mandated to fixed amounts of funding, irrespective of activity. However divisional performance was being managed in line with the historical regime using the national tariff. The national expectation was for Trusts to breakeven and after two months the Trust had been able to meet this. He informed the Board that the capital expenditure plan was £24m for the year and after two months £2.5m had been spent.		
07.11	The Chief Information Officer informed the Board that May was a mixed month for performance metrics, not as good as April but broadly consistent with the post ATOS performance. In addition to the large strategic programmes being progressed there were a range of smaller projects in place which were highlighted in the report.		
07.12	Paul Cartwright noted that some measures of performance such as appraisals and cost improvement programmes were not included and asked whether this was due to reasons of cost. The Chief Executive stated that this was due to the availability of people who were focused on other work such as the restart programme.		
07.13	Ginny Edwards asked for an update on patient and family complaints. The Chief Nurse stated that COVID-19 had had a significant impact on complaints performance, though the complaints team had kept families up to date. Some virtual meetings and teleconferences had taken place and June performance was over 80% once more, following a dip during COVID-19.		
08/81	**Infection and prevention control board assurance framework**		
08.01	The Chief Nurse stated that the ICP BAF had been issued in May of this year and had been fully discussed at the Quality Committee on 25 June. The Quality Committee would continue to review the BAF on a bimonthly basis and report to the Trust Board in the committee assurance report. The IPC BAF would also form part of the biannual infection and prevention control report to the Trust Board. The IPC BAF also links in with the Trusts Board Assurance Framework reviewed at Board and the sub committees and is a key part of the restart plan.		
09/81	**Virtual hospital**		
09.01	The Divisional Director, Medicine presented an overview of the virtual hospital. He informed the Board that he had discussed the need for a virtual hospital with a colleague, Dr Matthew Knight, in March as there had been a concern about the impact of COVID-19 on the Trust. A spreadsheet had been developed alongside a virtual ward tracker together with a rudimentary protocol. The first patient was put through		

Agenda item	Discussion	Lead	Dead-line
	the virtual hospital on 14 March and is it likely that it was the first virtual hospital for COVID-19 in the country and is a reflection of the innovative culture that exists in West Herts Trust. By mid-April 300 patients had been seen and the service became a 7 day a week hospital, running from 9am to 7pm, but over time as case numbers dwindled, these hours were reduced. The virtual hospital was a major team effort with inputs from across the Trust and also some GPs. The key enablers were the availability of consultants unable to work on the front line, clinical support staff, the IT team, physiotherapists and others. The oxygen saturation probes were the focus of the ITN coverage in June. He showed a slide depiction of the patient pathway and noted that patients were stratified into a low or high risk group which would dictate the treatment received. Over a ten thousand virtual consultations have taken place since mid-March. He informed the Board that the virtual hospital would be extended to a broader range of patients in the future.		
09.02	The Chief People Officer informed the Board that the virtual hospital also benefited staff as any member assessed as being of high risk or tested positive were referred to the virtual hospital.		
09.03	Jonathan Rennison asked what pathways were being considered for the virtual hospital in the future. The Divisional Director, Medicine stated that work needed to be carried out to understand the appropriate pathways though he felt cardiology might be an appropriate fit.		
09.04	Natalie Edwards asked whether there was a feedback loop from patients that we could utilise in the future. The Chief People Officer noted that a qualitative survey had excellent results with a high level of satisfaction.		
09.05	Ginny Edwards asked how the Trust was providing staff with the skills to deliver the service in the future. The Divisional Director, Medicine noted that the programme had been required to move at such a pace that training was a little behind delivery in terms of time frames. The Chief People Officer stated that a training programme for the virtual hospital would be developed.		
10/81	**COVID-19 workforce update**		
10.01	The Chief People Officer introduced the paper noting that three new hubs created in response to COVID-19 were continuing to run. These were the general staff issues hub, enhanced absence management hub and a testing hub. The hubs had been set up very quickly and outcomes had been good. He informed the Board that for the future, the Trust is looking at how the hubs are resourced over the next 12 months and also where they would be located.		
10.02	Jonathan Rennison noted that the issues involved in diversity are wider than just COVID-19 and indicated wider racism in the NHS, he asked when there would be wider visibility in terms of work to address this within the Trust. The Chief People Officer informed the Board that a diversity dashboard is being created as part of the Integrated Performance Review and this would be reviewed by the Board on a monthly basis. There was also a much more proactive relationship with Connect and chairs from that group were invited to attend the Trust's Workforce Committee and the Staff Side Committee. Jonathan Rennison stated that the Trust should think through carefully who would present the dashboard as it was important for the key messages from that report to be authentic.		
11/81	**Staff wellbeing – looking forward**		

Agenda item	Discussion	Lead	Dead-line
11.01	The Chief People Officer introduced the paper, noting that it highlighted some of the current initiatives that had been developed and implemented as a result of best practice, feedback from staff and discussion with partners in the ICS. The initiatives described in the paper focused primarily on psychological support for staff, the physical environment and the infrastructure to support well-being. The paper demonstrated significant work that has been successful while at the same time having the flexibility to make changes that adapt to the different stages of the pandemic. The paper also made recommendations to start focusing on the period following the pandemic and how this plan could be developed to ensure consistency and sustainable support for staff in the future.		
11.02	The Chief Executive noted that the Trust awaited outcomes from a recent staff survey which covered what support staff wanted rather than what support the Trust thought they wanted.		
11.03	The Chairman noted that as there was not a Board meeting in August, Board members would welcome an email update on the initiatives described in the paper. ACTION email update on staff wellbeing to be circulated to the Trust Board	PDG	Aug 2020
12/81	**Strategy update**		
12.01	The Deputy Chief Executive informed the Board that as part of the Great Place element of the Trust strategy, a proposal for a Great Place Committee was being developed to provide the Board with assurance on the delivery of the redevelopment programme and the digital strategy. She confirmed that the Trust had received feedback from the regulators providing formal approval of the strategic outline case and permission to proceed to outline business case and to consider options that exceeded the £350m threshold. This was not an invitation to include any option that the Trust might want but this should include an option that replaces the main clinical block on the Watford site. Because there was no reference to a new hospital on a new site in the regulator letter, the discussion regarding this would be revisited and the Trust will be looking at a new hospital on a new site options as part of the long list and short list process. External advisory support had been commissioned to review four key sites to provide a formal view on feasibility.		
12.02	The Chief Financial Officer provided an update on the multi-storey car park. He reminded the Board that the Trust had struggled with the poor quality of car parking on the Watford site and NHSI had been supportive in allowing the Trust to work with local partners to make progress on this issue. Some enabling work on the car park had commenced and a full business case will be developed, which would be submitted to the September Board meeting.		
12.03	John Brougham asked about the business case for theatres which was being considered at the July Finance and Performance Committee (FPC) and noted that the Board would need to approve the delegation to FPC.		
12.04	**Resolution**: The Board delegated authority to the Finance and Performance Committee to approve the business case for theatres at its meeting in July.		
12.05	Paul Cartwright noted that there was an update in the paper on discharge to care home process and wanted assurance that the Trust		

Agenda item	Discussion	Lead	Dead-line
	was maintaining the momentum of suitable and rapid discharge. The Deputy Chief Executive noted that there had been a suspension of legislation with significant funding coming through local authorities and the Trust was working to ensure that the momentum continued		
13/81	**Corporate risk register report**		
13.01	The Chief Nurse informed the Board that the paper captured the discussions and decisions made at the Risk Review Group on 11 June. There were three new risks discussed and commentary was provided on this. The paper also highlighted and described escalated and de-escalated risks.		
13.02	**Resolution**: The Board approved the corporate risk register.		
14/81	**Assurance report from the Trust Management Committee**		
14.01	The chief executive informed the Board that the paper summarised discussions that had taken place at the May meeting including the operational impact of COVID-19, the CQC report and the specific work around IT.		
15/81	**Assurance report from People, Education and Research Committee**		
15.01	Natalie Edwards reported that the Committee received assurance on the COVID-19 workforce report, staff wellbeing and diversity. The Committee also discussed being clear on the Trust's research and development strategy in the future.		
16/81	**Assurance report from Finance and Performance Committee**		
16.01	No comments were made		
17/81	**Assurance report from Quality Committee**		
17.01	Ginny Edwards asked the Board to note assurances on quality and safety.		
18/81	**Assurance report from Audit Committee**		
18.01	No comments were made		
19/81	**Assurance report from Charity Committee**		
19.01	**Resolution**: The Corporate Trustee ratified the funding requests of over £25k as listed in the assurance report.		
20/81	**Any other business**		
20.01	No other business was reported.		
21/81	**Questions from Hertfordshire Healthwatch**		
21.01	Meg Carter asked whether the Trust had considered how to utilise urgent services in the future as a result of experiences during the COVID-19 pandemic. She also asked whether there would be further support from Watford FC for hospital staff in the future. The Deputy Chief Executive stated that on 1 July, the new urgent treatment centre opened, which was operated by Greenbrook Healthcare and the minor injuries unit at St Albans Hospital would remain closed until further notice due to workforce challenges and also the desire to make St Albans Hospital a green protected site so that planned care could continue there. She stated that Herts Valleys CCG was going to reflect on the strategy moving forward. The Chief People Officer noted that there are no definite proposals in place for further work with the football club but there was a desire from both parties to work together.		

Agenda item	Discussion	Lead	Dead-line
22/81	**Questions from the patients and members of the public**		
22.01	The Chairman stated that a communication "statement to the Boards of WHHT" by HertsValleysHospital.co.uk had been sent to and read by Board members. A member of the public raised a question regarding the Chief Financial Officer's report regarding spending on the outline business case (OBC). The Chief Financial Officer stated that the Trust was expecting to spend £7m on the OBC this financial year. Referring to the recent staff survey, the member of the public asked whether staff had been asked a question about whether they wanted a new hospital in a central location. The Chief Executive that the survey was particular focused on staff experience during the COVID-19 pandemic and not on anything wider than that. The Deputy Chief Executive noted that the Trust is setting up a professional reference group for the redevelopment programme with an open invitation to staff who wished to be part of this. The member of the public asked whether the Trust could state that the regulator had asked the Trust to consider the inclusion of an option of a new build on a Greenfield site. The Deputy Chief Executive stated that the regulators had not asked the Trust to look at an option of a new hospital on a Greenfield site but the Trust were looking at new site options as part of a long list.		
23/81	**Draft agenda for next meeting**		
23.01	The draft agenda was agreed, subject to necessary changes.		
24/81	**Date of the next Board meeting**		
24.01	The next Board meeting would be held on 03 September 2020 in the executive meeting room, Watford.		

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda item: 05/83

Action log Part 1 – 03 September 2020

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	07.03/81	Chief People Officer to review feasibility of including staff risk assessments in the COVID dashboard.	PDG	July 2020	An update is now included in the CPO Update section of the reports.
2	11.03/81	email update on staff wellbeing to be circulated to the Trust Board	PDG	August 2020	Update on H&WB provided to PERC and also a business case re. H&WB brought to TMC which was approved in principle subject to further funding considerations.

BOARD AND CORPORATE TRUSTEE
DECISION LOG

Board meeting/decision date	Decision reference (from minutes)	Item presented to Board for action	Comments/outcome
3/5/2020	13.03/80	2019 annual gender gap report	The Board approved the 2019 annual gender gap report.
3/5/2020	14.03/80	2019 annual equality report	The Board approved the 2019 annual equality report for publication.
3/5/2020	15.02/80	2018/19 medical appraisal annual audit report	The Board approved the 2018/19 medical appraisal annual audit report for submission
3/5/2020	17.02/80	Proposal to extend the patient administration system contract	The Board approved the extension of the contract and the completion of a waiver
3/5/2020	18.03/80	Corporate risk register report	The Board approved the corporate risk register
4/2/2020	07.05/81	Board Assurance Framework	The Board approved the draft Board Assurance Framework
4/2/2020	16.03/81	Outline business case for electronic patient record programme	The Board approved option C of the outline business case and to explore further approaches to deploy the EPR and other potential funding solutions.
4/2/2020	17.03/81	Business case for managed print service	The Board approved the business case to negotiate a six month extension to the current managed print service contract and to proceed to tender for a new contract.
4/2/2020	19.02/81	2020/22 corporate objectives	The Board approved the 2020/22 strategic objectives subject to the measures being re-based following the COVID-19 pandemic.
4/2/2020	20.03/81	Corporate risk register report	The Board approved the corporate risk register
4/2/2020	23.02/81	Assurance report from Charity Committee	The Corporate Trustee approved 1) the establishment of an urgent appeal to raise funds to support staff and volunteers working on the frontline to manage the COVID-19 virus and 2) the use of dormant funds for the purpose detailed above
5/7/2020	08.02/82	Board Assurance Framework	The Board approved the draft Board Assurance Framework
5/7/2020	08.07/82	Corporate risk register report	The Board approved the corporate risk register
5/7/2020	13.03/82	2020/21 budget	The Board approved the financial plan for the year, noting the potential to refresh in August pending NHSE/I advice.
5/7/2020	14.03/82	Contract for enabling works to support the multi-story car park at Watford hospital	The Board approved the use of emergency powers to make the contract award decision
5/7/2020	16.02/82	Annual statement of actions taken in 2019/20 to prevent slavery and human trafficking	The Board approved the annual statement on actions taken in 2019/20 to prevent slavery and human trafficking
5/7/2020	17.03/82	Board and committee governance: 2020/21 terms of reference and work plans	The Board approved the terms of reference and work plans for the Trust Board and committees
5/7/2020	22.02/82	Annual report and accounts	The Board approved the delegation of the approval of the final annual report and accounts to the audit committee.
6/4/2020	06.04/83	The replacement of two catheter labs	The Board ratified the urgent decision made in respect of the replacement of two catheter labs.
6/4/2020	16.03/83	Capital expenditure programme	The Board approved the capital expenditure programme for 2020/21
6/4/2020	19.07/83	Board self assessment of effectiveness	The Board approved the assessment of effectiveness subject to a small number of ammendments
7/2/2020	12.04/81(part 1)	Theatres redvelopment	The Board delegated authority to the Finance and Performance Committee to approve the business case for theatres at its meeting in July*
7/2/2020	13.02/81 (part 1)	Corporate risk register report	The Board approved the corporate risk register*
7/2/2020	19.01/81 (part 1)	Charity funding requests	The Corporate Trustee ratified the funding requests of over £25k as listed in the assurance report*
7/2/2020	11.02/84 (part 2)	Procurement of a design team and other specialist services to support the OBC	The Board approved the proposal to delegate authority to the Great Place Programme Board to confirm the appointment of a design team*
7/2/2020	13.03/84 (part 2)	Integrated Care System (ICS) governance	The Board approved the Trust's proposed feedback on the ICS governance proposals as outline in the paper*
7/2/2020	15.01/81 (part 2)	Electronic Patient Record business case	The Board approved that an extraordinary Board meeting be set up for the Board to review the business case*
8/13/2020	04.09/85 (Extraordinary Board meeting)	Electronic Patient Record (EPR)	The Board approved the following*: • The timetable set out for FBC and coming back to board for approval in October. • The spend through to December of £5.4m, subject to written confirmation of funding. • The risk related to procurement challenge, subject to confirmation that there was no risk to individual Board members. • The formal launch of the programme

Trust Board Meeting
03 September 2020

Title of the paper	**Chairman and Chief Executive report**
Agenda Item	**06/82**
Presenter	**Phil Townsend, Chairman and Christine Allen, Chief Executive**
Author(s)	**Rod While, 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.

Agenda Item: 05/81

Trust Board Meeting – 03 September 2020

Chairman and Chief Executive's report

Presented by: Phil Townsend, Chairman and Christine Allen, Chief Executive

1. PURPOSE

The aim of this paper is to provide an update on items of national and local interest/relevance to the Board. Please note that due to the current restrictions in place due to COVID-19 the September Board meeting is only open to members of the public via MS Teams.

2. NEWS AND DEVELOPMENTS

COVID-19

2.1. Since the end of July, the Trust has been accepting routine GP referrals for patients who are waiting for a non-urgent appointment with a specialist. The trust had stopped accepting referrals at the end of March, other than for urgent or suspected cancer cases, to focus efforts and resources on treating COVID-19 patients. With infection rates dropping and fewer patients now being treated for COVID-19, the Trust is working with Herts Valleys Clinical Commissioning Group (CCG) to restart services in a way that ensures safety for patients and staff. Hospital specialists and senior GPs have been working together to review patient lists, reassess patients' needs and agree the best course of action in every case – making sure that patients with the most urgent needs are prioritised. During the pandemic the Trust has been carrying out patient consultations by video or phone wherever possible and this will continue as appointments open up. As well as being more convenient for patients, reducing visits to hospital sites is in everyone's interests. For some patients, the best course of treatment may be for their GP to manage their care with advice and guidance from a hospital specialist. The Trust is managing the risk of infection to make sure that patients needing to go into hospital for an appointment or treatment, and staff working in hospitals, will be as safe as possible.

Appointments

2.2. Duane Passman joined the Trust on Monday 20 July as programme director for acute redevelopment. Duane brings 30 years' experience in major NHS investment programmes which will be put to good use helping us to deliver our redevelopment plans. His first major task is leading the development of our outline business case.

2.3 We are delighted to congratulate Dr Michelle (Shelley) Jacobs, consultant in paediatric emergency medicine, who has been appointed as postgraduate clinical tutor. She has spent the last three years in the deputy clinical tutor role. She will continue to have responsibility for doctors in postgraduate training including those who are working less than full time and who are returning to work after a break.

Dr Jacobs will also lead the trust's training for educational supervisors and support specialty faculty group meetings, research and development and innovative roles such as chief resident.

Other Trust News

2.4. The new Urgent Treatment Centre (UTC) at Watford General Hospital formally opened its doors in July. The new centre is located in the Minors area of the Emergency Department and will operate from 8am to 2am, 7 days a week. The blue ribbon was cut by our longest serving consultant Mr Howard Borkett-Jones who thanked all staff involved and welcomed our new colleagues Greenbrook Healthcare to our #TeamWestHerts family.

2.5. A number of digital visioning workshops have been held with members of staff to help develop the Trust's Digital Strategy for the future, which is a critical element of the Trusts plans for the future. The development of the strategy is now being progressed.

2.6. Plans to reconfigure the theatres in the main building (PMOK level 6) at Watford are well under way. There have been some delays and changes to the scope of what is being provided as we have worked out what can be achieved, given the exciting plans we have for new buildings opening in 2025/26. Our current theatres complex falls short in providing the 'best care for every patient, every day', despite the excellent care given by colleagues. The staff facilities are substandard and we currently have no separation between adult and paediatric patients in the recovery area. Whilst the life span of the reconfigured complex may be limited to five years, the improvements planned are incredibly worthwhile and will vastly improve the patient and staff experience, as well as enhancing infection control. The completed theatres complex will be wholly operational by late summer 2021, with some elements being ready sooner as this is a phased programme.

MP Updates

2.7. Successful meetings were held with MP for Dacorum Mike Penning and Gagan Mohindra MP for South West Hertfordshire.

Other Meetings

2.8 The Chairman has conducted the following business on behalf of the Trust

- Several meetings and Chair sessions on the future governance of the Integrated Care System (ICS)
- Board Development session on Diversity and Inclusion
- Chaired several Consultant Interviews with successful appointments
- Filmed a series of informative video's for our volunteers
- Chaired the extraordinary Board on 13 August
- Visited St Albans City Hospital and with Simon West explored the start up for Elective
- Attended Board Committees
- Attended the regional events on behalf of the Trust
- Spent time in A&E with Rachael Hoey, Consultant in Emergency Medicine
- Met with Nicolas Small, Chair of Herts Valleys CCG, on our CCG relationship
- Hosted Donna Nolan, Managing Director, Watford Borough Council, with Christine Allen.

National News

2.9. A phase 3 recovery letter has been sent from NHS England and NHS Improvement to all local leaders, with information on new marginal tariff rates for activity above or below the expected levels. It had been announced previously that systems would be expected reach 80% of their elective activity in September, rising to 90% in October. For systems failing to achieve these activity levels, penalties will be applied.

3. BOARD NEWS

Board meeting in private

3.1. An extraordinary board meeting was held in private (due to commercial in confidence information) on 13 August 2020 to consider an opportunity that had been evaluated regarding an acceleration of the Electronic Patient Record Programme (EPR) in which the Trust would join the Royal Free implementation of a new EPR. The Board approved the proposal to progress the offering to Full Business Case, which will be considered by the Board in October. If approved, a full EPR would be implemented 14 months earlier than had previously been assumed.

Board Development Meeting

3.2. A Trust Board development meeting was held on 9 of July to consider the Trust's clinical strategy and to take part in an inclusive leadership workshop.

Board visit programme

3.3. As part of the monthly Board visit programme, the Board visited three areas at Watford hospital in July 2020, namely Emergency Planning, Emergency Department and Patient Advice and Liaison Service (PALS). Verbal feedback from the visits was received in the private session of the Board meeting in July 2020 and will be included in a bi-annual engagement Board report.

Future Board meetings programme

3.4. The Trust has engaged with Board members on the potential removal of January Board meetings from the annual cycle of business and members have reviewed the advantages and disadvantages, concluding that January meetings can be cancelled on the understanding that any urgent business can still be addressed via an extraordinary meeting.

4. RECOMMENDATION

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

Phil Townsend	**Christine Allen**	**September 2020**
Chairman	Chief Executive	

Trust Board Meeting
03 September 2020

Title of the paper	Board assurance framework report
Agenda Item	07/82
Presenter	Christine Allen, Chief Executive
Author(s)	Rod While, 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 and now reflects the 2020/21 corporate objectives and the on-going impact of COVID-19
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

7

	improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	• Finance and Performance Committee – 30 July 2020 • Quality Committee – 30 July and 27 August 2020
Action required	The Board is asked to approve the Board Assurance Framework

Agenda Item: 07/82

Trust Board meeting – 03 September 2020

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 14 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.

3. Next steps

3.1 Once approved by the Board, the relevant elements of the BAF will be submitted to and discussed by the key committees overseeing the delivery of the four aims of the Trust:

- Aim 1 Best Care – Quality Committee
- Aim 2 Best Value – Finance and Performance Committee
- Aim 3 Great Team - People, Education and Research Committee
- Aim 4 Great Place – Great Place Committee

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

4. Risks

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

5. Recommendation

5.1 The Board is asked to approve the recommended changes made by the lead committees.

Christine Allen
Chief Executive

September 2020

Appendix 1 Board Assurance Framework

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Key Controls	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	The sub-committee	Risks scored 15 and above	CQC, NHSLA, HSE, etc.	Low/Medium/ High/	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	1. First line of assurance (divisional)	Where we are not	Actions to address control and assurance gaps.	Exec lead (to	Time scale	Update
AIM 1: BEST CARE																	
AMBITION 1. **Mortality (SHMI & HSMR): 'as expected' or 'better than expected' for HSMR and for SHMI.** **Avoidable Harm (harm free care): continuous improvement and better than national average for new pressure ulcers, falls with harm, new venous thromboembolism, urinary tract infections (in patients with a catheter) and e-coli**	**Reduce the gap between weekend and week day mortality** **To prevent Covid-19 outbreaks in a hospital setting** **To develop blue and green pathway staffing templates**	**% deaths reviewed by a medical examiner, evidence of learning from deaths (bi-annual report to QC)** **Definition of an outbreak of COVID in hospital settings: 2 or more confirmed cases in the same ward/clinical area in the preceding 14 days. (To be used in conjunction with the categories of hospital-acquired infection). The categories help to distinguish between hospital and community-acquired infections.** **Cluster: 2 or more confirmed cases of COVID-19 among staff / inpatients within 14 days** **Harm free care in line with or above national average and staff fill rate above 90%**	1a	Excess mortality due to COVID-19 and non-COVID-19 patients	Chief Medical Officer	Quality Committee	4272	CQC	High	1. Morbidity and mortality meetings 1. Structured judgement review process fully embedded 1. Divisional Governance meetings 1. Consultant coders and medical examiners fully established 2. Quality, Mortality review group 2. Quality Committee reports 3. Dr Foster Mortality reports	The effect of Covid-19 on mortality from non-Coved conditions is not precisely known. Furthermore, the reluctance of patients to attend ED is significant	1) Divisional governance meeting, 2) Quality Committee 3/ Dr Foster	As Covid-19 is a new disease, the medium term effects are unknown	No additional actions are currently possible	CMO	01/12/2020	
			1b	Failure to implement the IP&C Board Assurance Framework leading to the risk of nosocomial infection	Chief Nurse	Quality Committee	4287	CQC, HSE	High	Infection & Prevention control panel Recovery Governance Framework IMT Enhanced cleaning	Continually changing national guidance based on increasing evidence as we move through the pandemic	Gap analysis Quality Committee reporting CCG review/nosocomial reporting	As Covid-19 is a new disease, the medium to long term effects are unknown	Updating practice, education as evidence available Introduction of RCA process for all cases with a COVID positive result at 7 days and over Developing a project management approach to develop a repository for the evidence Staff & Pt testing programme Developing IPR reporting of key elements i.e. nosocomial infections, testing	AI/GB	01/10/2020	
			1c	Changes in pathways due to COVID-19 could prevent the Trust from meeting safe staffing ratios and impacts on harm free care	Chief Nurse	Quality Committee	4287	CQC, NQB	High	Daily staffing review meetings E-roster and KPI's with use of 'Safer Care' Senior clinical rota to review staffing until 2100 Mon-Fri and 0800 - 2000 Sat - Sun on site Quality Improvement programme	Continually changing national guidance based on increasing evidence as we move through the pandemic	Divisional Quality Summits Quality Improvement Forum (QIF) Bi-annual Quality Committee establishmmt reviews NHSE/I review and level 4 reporting and IPR attainment	None	Quality impact assessments to be undertaken of templates Staff training to support development of skills Trialling a night sister role to support and develop junior staff Overseas recruitment to begin now access to the country has changed.	DT	01/11/2020	
			1d	Failure to reduce the gap between weekend and weekday mortality	Chief Medical Officer	Quality Committee	4272	CQC	High	Adherence with 7 day working standards, SMART support to ED. Improved patient flow. Clinical Outreach service. Sepsis screening	The effect on COVID has been profound, and excess mortality has been seen throughout the UK. Reduction in outpatient capacity, access to primary care may further reduce our capacity to apply 7 day working standards, and a second wave of COVID would once again severely test our ability to provide timeous interventions	1) Divisional governance meeting, 2) Quality Committee 3/ Dr Foster	As Covid-19 is a new disease, the short and medium term effects are unknown, especially if we get another outbreak	None	CMO	Dec-20	
	25% reduction in e.coli by 2021	**Baseline 40 cases, aim to have no more than 30 cases in 20/21** **90% staff trained in correct PPE usage**	1e	Failure to reduce e.coli in line with agreed trajectory	Chief Nurse	Quality Committee		NHSE/I	Medium	RCA process for all cases Catheter passport Review of all patients admitted with a catheter	Oversight and management of catheter insertion across the trust	E.coli working group with the CCG IP&C	Reporting of all catheter insertion and use of passports	QI hydration project Audit catheter usage and trial catheter restriction programme Review and update catheter care plan	GB	Jan-21	
			1f	Failure to put in place appropriate training in line with PHE guidance and the use of PPE	Chief Nurse	Quality Committee			Medium	PPE training Communication campaign/posters for designated areas Donning and Doffing areas	Compliance with the wearing of PPE	IP&C panel Recovery governance reporting on PPE	Consistent compliance in the wearing of PPE	PPE audited as part of the 'code of practice' audits PPE campaign Risk assessing correct PPE usage PPE spot checks Safety message and check of PPE at handover Training films development	GB	Oct-20	
AMBITION 2. **Access to care (national waiting time standards): continuous improvement and top 25% of hospitals for emergency department 4 hour waits, 18 week referral to treatment and diagnostic waiting time and better than national average for cancer two week wait, 62 day urgent GP referral to first definitive treatment and the new faster diagnosis standard (maximum 28 days to communication of definitive cancer / not cancer diagnosis).**	**Implement primary care led urgent treatment model at Watford and procure UTCs and Hemel Hempstead and St Albans from 1 April 2021** **Deliver agreed improvement trajectories for key standards.**	**% of patients seen in primary care led UTC model**	2a	Impact of COVID-19 on emergency care demand may prevent delivery of emergency care access standards	Chief Operating Officer	Quality Committee	4269	NHS Constitution National waiting times standards	High	**Demand management** Promotion of UTC as an alternative to the acute COVID site Advice & guidance offer to primary care (acute admission avoidance) Virtual SMART (admission avoidance) Segregation of COVID / Non COVID pathways **Performance Oversight**	Inability to influence demand Capacity constraints due to social distancing requirements reduce flow IPC requirements impact on flow to diagnostics, cubicle utilisation and flow to correct designated bed base	Daily performance insight 2 hourly ED status report ED escalation, improvement and transition plans Discharge working group Patient Flow transformation Board ED team check ins with CEO Trust Management Committee Finance & Performance Committee	As COVID 19 is a new disease the short and medium term effects are unknown and the impact on demand for	No additional actions are currently possible	COO		
			2b	Impact of COVID-19 on capacity to meet planned care (diagnostics and RTT) and cancer demand in line with national standards	Chief Operating Officer	Quality Committee	3828 4269	NHS Constitution National waiting times standards	High	**Demand management** Collaborative working with commissioners on referral management and transformation of pathways **Recovery** Establishment of a phased service (including Diagnostics) restart plan, including new ways of	Inability to influence demand A second or subsequent wave of COVID-19 would result in the re-suspension of planned care to a currently unknown degree Capacity constraints due to social distancing requirements reduce flow	Enhanced governance framework in place, i.e. CDP, ODG Elective Care Programme Board RTT Performance improvement dashboard RTT Improvement Programme Cancer Improvement Programme Weekly RTT & Cancer Access meeting Divisional performance reviews Trust Management Committee	As COVID 19 is a new disease the short and medium term effects are unknown and the impact on demand for	No additional actions are currently possible	COO		
		Performance against trajectories	2c	Failure to deliver UTCs in line with planned delivery dates	Deputy Chief Executive	Quality Committee			Medium	1. Programme Director in post 2. Programme Plan for July start for WGH UTC in place	3. Programme plan for procurement of HHGH and SACH UTCs to be finalised	1. Urgent Care Programme Board - joint with HVCCG 2. updates to Board via Strategy Update		1. finalise programme plan for procurement of HHGH and SACH UTCs	HB	Jul-20	
AMBITION 3 **Patient Experience: improve our scores on the Friends and Family Test and national patient survey result to better than national average.**	**Improving communications with our patients and carers**	**25 Selected questions from 9 of the 12 sections from inpatient survey**	3a	COVID-19 outbreak negatively impacts on patient experience	Chief Nurse	Quality Committee	4269 4287	CQC	High	1. Patient Experience Group 2. Family Liaison line introduced as an extension of PALS 3. Visitors helpline 4. Use of technology to face time 5. Letter to a loved one introduced 6. Additional staff within patient affairs 7. Increase in establishment within Spiritual & pastoral care	The national and local visiting policy has the potential to have negative impact with no or reduced visiting Reduced visiting for end of life, LD, MH and dementia patients	1. Divisional Governance meeting 2. Patient Experience Group 3. Quality Committee 4. national inpatient surveys 5. Healthwatch report 6. Coproduction Board formed and project on visitation to gather feedback, codesign solutions, more informed community	FFT and national surveys within maternity and inpatients suspended	1.Monitor PALS, Complaints and thank you correspondence. 2. Compassionate conversation call back service to be reinstated which will gain valuable patient feedback. 3.Continue Healthwatch interaction to monitor their feedback intelligence from their members. 4.Coproduction work wiht Healthwatch and reporting to PEG and QC	DT	01/10/2020	
			3b	Failure to communicate effectively with our patients and carers and improve the experience of discharge.	Chief Nurse	Quality Committee	4207	CQC	Medium	1. Discharge working group 2. Discharge checklist 3. Divisional and ward level performance analysis at QIF 4. Compassionate conversation call back service 5. Electronic discharge letters 6. Communication bundle introduced	1. National PPE policy and the challenges that it brings with effective communication 2. Due to visiting restrictions reduced MDT communication with family	1. Discharge Working Group 2. Patient Experience Group 3. Quality Committee 4. Trust management Committee 5. Healthwatch reports		1. Reinforce the communication bundle to improve collaborative planning of care and goal setting using QI methodology. 2. The coproduction board will reach out to members to enable engagement and involvement and codesign work to support planning and evaluation	DT	01/10/2020	
	Implementing new outpatient pathways to improve patient experience	**Dropped call rate / local patient survey**	3c	New outpatient model fails to improve patient experience	Chief Nurse / Chief Information Officer	Quality Committee		CQC	Medium	1. A milestone plan has been developed for the completion of the digital telephony programme. 2. Expert telephony resource has been secured. 3. Regular progress meetings are held between our ICT and outpatient administration teams to ensure alignment in activities.	1. A potential lack of alignment between the technical and administrative enablement and the operational and clinical development of new pathways	1. Outpatient Transformation Group. 2. Trust Management Committee 3. Patient surveys		1. Centralisation of outpatient administration support, standardising and simplifying process as we go. 2 Production of an outpatient specific clinical plan - this should emerge out of the restart plans and the clinical strategy for the new hospital 3. The coproduction board will reach out to members to enable engagement and involvement and codesign work to support planning and evaluation	PB TBC DT	31/03/2021 31/12/2020 31/12/2020	

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Standards	Rating of risk to delivering objective	Key Controls	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	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	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	Time scale /review date	Update
AIM 2: BEST VALUE																	
AMBITION 4 Deliver our annual control totals and reach breakeven by 2023. Achieve a 'cost per weighted activity unit' that places us in the top 50% of acute trusts for efficiency (using the NHS Improvement Model Hospital metrics).	**Ensure that revenue income balances with revenue for each of the next two years**	**Deliver financial plan for 2021 and ensure that all clinical Divisions are able to either demonstrate costs are within 2020/21 budget or an improvement in patient care productivity.**	4a	Costs of responding to COVID-19 and restarting COVID-19 activity exceed available budget	Chief Financial Officer	Finance and Performance Committee	N/A	N/A	High	Chief sign-off of all Covid-19 related costs. Regular updates on criteria and processes by which costs may be recorded and reimbursed.	Possibility that postings may be made to dedicated Covid-19 centre outside of this process.	Submission of revenue and capital returns re Covid-19 and subsequent payments. Internal scrutiny at Finance and operational levels.	Timing delays confirming success of a given submission.	Regular scrutiny of all transactions within the dedicated Covid-19 centre. Regular communication with NHSEI and others to ensure timelinesss of response and rapid resolution of queries.	CFO	01/07/2020	
	Ensure that there is an improvement in costs per weighted activity unit in comparison to other acute trusts	**Improved controls to ensure that there is a direct link between agreed staff deployment patterns and staff expenditure.**	4b	Impact of COVID-19 on operational efficiency	Chief Financial Officer	Finance and Performance Committee	N/A	N/A	High	Where services remain operational, ringfence resources to maintain.	Advancement of Covid-19 outside of existing control measures, and subsequent drain on resources otherwise devoted to non-Covid activity.	Maintenance and improvement of operational efficiences per existing measurement mechanisms.	Current systems geared towards business-as-usual operation, and while appropriate workarounds have been enacted, sufficienctly flexible systems are not yet in	Post-Covid assessment of systems and operational requirements in response to a future pandemic or other prolonged major incident.	CFO	31/12/2020	

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Key Controls	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	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective	Actions to address control and assurance gaps.	Exec lead (to deliver specific	Time scale /review date	Update
AIM 3: GREAT TEAM																	
AMBITION 5 **We want to be one of the best hospitals in England for staff engagement and in top 20% of acute hospital Trusts in the country for NHS national staff survey results.**	**Ensure that all of our staff feel engaged and included (equality, diversity and inclusion)**	**Equality, diversity and inclusion domain of the staff survey - improvement to above national median**	5a	Impact of COVID-19 on staff morale and wellbeing (in the context of west Herts being a badly affected community)	Chief People Officer	People, Education and Research Committee	3422		Medium	1. H&WB programme with psychological support is in place to support staff. 2. Continuing to provide reduced cost lunch and encouraging people to take breaks 3. Pastoral team offering support	1. More work required on compassionate leadership. 2. Need join up our package of support. 3. Need to decide how we replicate the Sanctuary	1. Divisional Performance Meetings. 2. PERC 3. Staff survey (including F&FT)	It is still unclear as to the precise impact of COVID19 upon our staff	1. Implementing a programme of compassionate leadership. 2. Increase access to clinical psychologists 3. Work on STP H&WB proposal 4. Agree proposal regarding using charitable funds for staff H&WB	CPO	01/11/2020	
		Trust wide vacancy rate less than 10%	5b	The differential impact of COVID-19 on BAME staff adversely affects the engagement of BAME workforce	Chief People Officer	People, Education and Research Committee	4292	HSE	Medium	1. Clear plan in place to deal with issues: Employee risk assessment Admitting BAME COVID positive staff into virtual hospital Working with Connect Helping to create and resource an STP BAME telephone support line	Completing employee risk assessments Increasing the voice of BAME staff within senior decision making bodies Encouraging BAME staff to check their vitamin D levels Reviewing our approach to our WIRES action	1. Divisional Performance Meetings. 2. PERC 3. Staff survey (including F&FT)	A number of the initiatives are still in development	1. Continue with roll out of employee risk assessments 2. Continue to work with Connect. 3. Look at external best practice and see what we can learn from this.	CPO	01/11/2020	
	Reduce vacancy rates in hard to recruit "hotspots"	**Reduced vacancy rate in hotspots vs. baseline**	5c	There is a risk that vacancy rates will increase as a result of COVID-19	Chief People Officer	People, Education and Research Committee			Medium	1. We have an on-going recruitment campaign in place. 2. We have an overseas nurse recruitment plan in place. Turnover rates have fallen and vacancy rates are below our target of 10%	We need a strong proposal to encourage students to remain working at the Trust There are roles within the Trust where it will be likely that we will need an additional incentives for joiners and this is not in place.	1. Divisional performance Reviews 2. TMC/PERC	N/A	1. Nedd to have clear plans in place for how we recruit to hard to fill roles such as ED	CPO	Oct-20	
			5d	Increased staff absence as a result of COVID-19	Chief People Officer	People, Education and Research Committee			Medium	1. Have in place the Enhanced Absence Management Hub. 2. Clear reporting is in place. 3. Point of mental health support are in place to help support staff	Whilst there is good absence control across many of our staff groups more work is required in relation to managing the absence of medical staff, particularly our junior doctor population	1. Divisional performance Reviews 2. TMC/PERC	N/A	1. Business case being prepared to make our Enhance Absence Management Service a permanent service. 2. A number of H&WB initiatives are being put into place to help our staff	CPO	Oct-20	

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Key Controls	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	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	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 /review date	Update
AIM 4: GREAT PLACE																	
AMBITION 6 Ambition 6: Paperless hospital by 2025 New Hospital facilities - building work to commence 2023	**IT infrastructure: increased time to care**	**Reduced log in times, reduced downtime**	6a	Failure to deliver planned improvements to IT infrastructure and releasing time to care	Chief Information Officer	Trust Board	3896; 3894; 3899	CQC	Medium	1. Detailed programme plan and weekly reporting of progress. 2. Interim recruitment of infrastructure expertise. 3. Closer working relationships with Atos.	1. Hybrid model - gaps in knowledge and control of infrastructure. 2. Lack of complete network diagrams		Definitive evidence of improvements in stability and performance	1. Post completion of the network upgrade we will compile feedback from users plus monitor the number of network related incidents. 2. Establishment of the Great Place subcommittee	PB PB PB	Sep 20 Dec 20 Mar 21	
	Redevelopment OBC approved	**Key milestones**	6b	Failure to progress redevelopment OBC in line with the programme plan	Deputy Chief Executive	Trust Board			Medium	1. RFL & PA advisory support commissioned. 2. Detailed programme plan, workstreams established and PMO reporting in place.	Programme Director post in recruitment phase.	1. Great Place Programme Board (TMC) 2. Monthly regulator calls 3. Partnership Board convened on ad hoc basis		1. Establish formal Board sub-committee 2. Programme Director in post 3. External assurance arrangements TBC (e.g. Gateway reviews)	HB HB HB	Sept 20 Oct 20 Dec 20	
			6c	Insufficient engagement of clinical staff and stakeholders in planning for the new hospital results in a sub-optimal solution	Deputy Chief Executive	Trust Board	Reflected in programme risk register		Medium	1. Clinical Workstream established. 2. First draft clinical packs developed and clinical & technology brief in progress. 3. activity and capacity workstream updating demand assumptions.	1. Clinical engagement limited by COVID - increased dedicated clinical sessions required. 2. Team capacity - vacant posts. 3. User Groups not yet established 4. Clinical Brief to be finalised.			1. Appoint clinical leads with dedicated time. 2. Appoint to vacancies in programme team. 3. Establish User Groups.	HB HB HB	Sept 20 Oct 20 July 20	
	EPR secure funding and FBC mobilised	**Key milestones**	6d	Failure to secure funding for EPR	Chief Information Officer	Trust Board	4116	CQC	High	communications established with CEO of NHSX cross checked with Regional Director of Digital transformation at NHSE 2 Cross referencing of NHSX and HIP 1 communications 3 SFI's and board governance that ensure EPR programme cannot commence until funding	1. Inability to influence national leaders to decide on route and amount of technology funding. 2. Inability to have an effective conversation on internal commitment to technology funding.	1. IT Digital Strategy steering group. 2. Trust Management Committee. 3. External assurance from technology partners, Deloitte, Atos, Berkely partnership	Certainty of progress, the nature of this risk and its impact on our progress is not linear and will test our risk appetite	1. Appointment of external technology partners for both EPR provision and longer term technology delivery 2. Establishment of the Great Place subcommittee	PB PB PB	Sep 20 Dec 20 Mar 21	The accelerated EPR programme was approved by the board on 13/08 and a programme launch meeting has been held. Verbal support has been received from NHE/I and NHSX at regional and national level. The accelerated proposal goes to national Joint Investment Committee on the 4th August, post that we will sign contracts that take the programme to Christmas 2020. An FBC is being developed with the expectation that this will go to October board and national JIC in Novemeber with the aim that we contractualise a ten year agreement by December. The current plan shows that EPR and PAS go live in Nov 21 and clinicals at the end of Jan 22.
	Multi-storey car park - FBC completed, approved and works commenced	**MSCP key milestones - FBC/work on site / completion date**	6e	Failure to complete FBC for MSCP	Chief Financial Officer	Finance and Performance Committee	N/A	N/A	Medium	Construction of business cases in accordance with established guidance	Resource and knowledge constraints regarding what is needed within the project team.	Regularly updated criteria by which the FBC can be measured. Official communications from NHSEI to the effect that an application has been successful, or the additional conditions which must be met to ensure success.	Timeliness of NHSEI and other communications. Inconsistency of interpretation re business case criteria.	Continued regular communication with NHSEI and other relevant bodies in order to be continualy aware of the latest guidance and the Trust's duties in relation to them.	CFO	Sep-20	

Trust Board Meeting
3 September 2020

Title of the paper	ED, RTT, Cancer & Diagnostics Access Performance Update (July 2020 reporting period)
Agenda Item	08/82
Presenter	Sally Tucker Chief Operating Officer
Author(s)	Jane Shentall Director of Performance
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary	This paper provides assurance on the monitoring of compliance with national Access standards in July 2020, identifying factors affecting performance and the actions to ensure a return to compliance. Performance data is provisional at the time of writing (18/8/2020) and for a number of indicators, is expected to change until closure of the formal submission period.

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	85.9%	↓
Diagnostic waits	99%	73.3%	↑
RTT incomplete pathways < 18 weeks	92%	51.0%	↑
52 week waits	0	484	↓
2 week wait referrals	93%	98.5%	↑
2 week wait breast symptomatic referrals	93%	98.1%	↑
28 day Faster Diagnosis standard (Shadow)	70%	80.5%	↓
31 day first definitive treatment	96%	97.0%	↔
31 day subsequent - surgery	94%	94.1%	↓
31 day subsequent - drug	98%	100.0%	↑
31 day subsequent - palliative	94%	100.0%	↔
62 day referral to first treatment	85%	80.5%	↓
62 day screening referral to first treatment	90%	0.0%	↓

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

Performance against the A&E 4 hour waiting time standard was worse than the previous month (87.1%) at 85.9% but it should be noted that attendances increased by 17% both overall and at Watford. It should also be noted that Watford UTC opened at the beginning of July 2020.

Diagnostics has improved further, to 73.3%.

RTT performance has also improved, up from 47.7%, to 51% this month, as a result of the new and shorter pathways associated with the increasing volume of referrals being received. However, there has been a further significant increase in 52 week waits, now at 484.

The two week wait, breast symptomatic, 28 day faster diagnosis and 31 day pathway standards have all been achieved. The standard has not currently been met for 62 day first pathways although this is likely to change prior to formal submission. None of the five 62 day screening pathways were

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	compliant with the standard this month.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	<table><tr><td>Aim 1 Best quality care *Objectives 1-5*</td><td>Aim 2 Great place to work *Objectives 6-8*</td><td>Aim 3 Improve our finances *Objective 9*</td><td>Aim 4 Strategy for the future *Objective 10-12*</td></tr><tr><td>✓</td><td></td><td></td><td></td></tr></table>
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	<table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Management Committee</td><td>26 August 2020</td></tr><tr><td>Finance & Performance Committee</td><td>27 August 2020</td></tr></table>
Action required	The Board is asked to receive this report for information.

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Trust Board Meeting
03 September 2020

Agenda Item: 08/82

Finance & Performance Committee Meeting – 03 September 2020

ED, RTT, Cancer & Diagnostics Access Performance Update
(July 2020 reporting period)

Presented by: Jane Shentall, Director of Performance

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 when non-urgent elective care is reinstated.

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

2 Suspension of non-urgent elective care

2.1 This continues although attention is now moving to phased recovery planning.

3 Indicators not achieved in the reporting period

3.1 At the time of reporting the following waiting times standards were not achieved in June 2020.

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	85.9%	↓
Diagnostic waits	99%	73.3%	↑
RTT incomplete pathways < 18 weeks	92%	51.0%	↑
52 week waits	0	484	↓
62 day referral to first treatment	85%	80.5%	↓
62 day screening referral to first treatment	90%	0.0%	↓

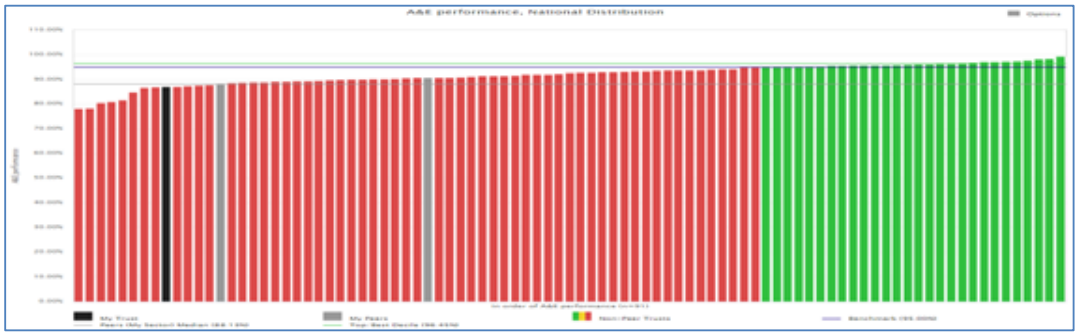
↑ improved non-compliant	↓ deteriorated non-compliant	↔ no change non-compliant	↑ improved compliant	↓ deteriorated compliant	↔ no change compliant

4 A&E 95% target

4.1 Performance fell slightly in July, at 85.9% when compared with the previous month's 87.1%. Demand continues to grow, with 11,742 attendances overall (an increase of 17.5%) although this is still below the pre COVID levels of activity. CED performance (95.7%) was better than the standard but Majors performance was lower this month at 66% (from 71.1%). The Minor Injuries Unit at SACH remains closed but UTC at Hemel Hempstead achieved 100% compliance.

4.2 The Watford Urgent Treatment Centre opened at the beginning of July 2020. WGH UTC performance in July was 99.3% (3028 type 3 attendances). When this is combined with the WGH type 1 activity performance was 81.2%. However, type 1 only (Majors) was 71.7%.

4.3 Model Hospital benchmarking (June 2020 performance at 87.1%) shows the Trust (the black bar) in a marginally better position, while still at the lower end of the national range, with a national median of 88.1% and a regional median of 90.7%.



5 Ambulance Handover Delays

5.1 May saw 2659 patients arriving in an East of England ambulance (previous month 2453), an increase of 8% on June. There were 268 (previously 245) over 30 minutes and 89 (was 53) delays over 60 minutes.

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6 RTT Incomplete pathways

6.1 Performance has improved slightly, to 51% (from 47.4% in June) although the backlog has increased further (7519 from 7031) with 1614 patients waiting over 40 weeks (up from 1128).

6.2 Referral levels have increased, and there were 7833 pathways below 18 weeks at the end of July, in comparison to 6423 in June, an increase of 22%. This has been the biggest factor in performance improvement.

6.3 Model Hospital benchmarking (May 2020 performance at 56.5%) shows the Trust (the black bar) has moved in to the lowest quartile, but it should be noted that lowest performance in quartile 3 was 61.5% and no organisation achieved the standard, the highest performance being 80%. The regional median in May was 57.6%, and above the national median 61.5%.

7 52 week waits

7.1 The number of patients waiting more than 52 weeks continues to increase significantly, with 484 pathways waiting a year or more, and the highest number of these long waits remains in Oral Surgery.

Service	Jul-20
ORAL SURGERY	167
ENT	103
TRAUMA & ORTHOPAEDICS	57
UROLOGY	56
OPHTHALMOLOGY	50
GENERAL SURGERY	21
VASCULAR SURGERY	8
PAIN MANAGEMENT	8
ORTHODONTICS	6
PAEDIATRIC UROLOGY	6
COLORECTAL SURGERY	2
Total	484

Service	Jun-20
ORAL SURGERY	114
ENT	61
UROLOGY	41
TRAUMA & ORTHOPAEDICS	31
OPHTHALMOLOGY	28
GENERAL SURGERY	10
PAIN MANAGEMENT	6
VASCULAR SURGERY	4
COLORECTAL SURGERY	2
ORTHODONTICS	2
PAEDIATRIC UROLOGY	2
GYNAECOLOGY	1
Total	302

8 Cancer Waiting Times Performance

8.1 The 2 week wait and breast symptomatic standards were achieved in July. As were all 31 day standards.

8.2 Performance against the 62 day referral to first treatment standard is currently below the 85% target at 80.5% but the reporting period is still open and validation is ongoing at the time of reporting. There are currently 14.5 breaches (19 pathways) in 60 pathways. Urology and Lower GI have incurred the most breaches at present.

8.3 A rolling 12 month summary of performance against the cancer waiting time standards is included in appendix 3.

8.4 Model Hospital benchmarking (May 2020 performance at 74.7%) shows the improving position at WHHT (the black bar). Performance was better than the national median of 70.7%, and the regional median of 67.2%.

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9 Diagnostic waiting times performance

9.1 The standard for diagnostic waiting times was not achieved, although current performance at 64.7% is better than the previous month (39.7%) with most modalities below the standard.

Description	< 6 weeks	> 6 weeks	Total	%
W01: Imaging - Magnetic Resonance Imaging	772	287	1059	72.9
W02: Imaging - Computed Tomography	696	66	762	91.3
W03: Imaging - Non-obstetric ultrasound	646	56	702	92
W04: Imaging - Barium Enema	4	0	4	100
W05: Imaging - DEXA Scan	809	154	963	84
W06: Physiological Measurement - Audiology - Audiology Assessments	131	98	229	57.2
W07: Physiological Measurement - Cardiology - echocardiography	208	357	565	36.8
W08: Physiological Measurement - Cardiology - electrophysiology	0	0	0	
W09: Physiological Measurement - Neurophysiology - peripheral neurophysiology	153	26	179	85.5
W10: Physiological Measurement - Respiratory physiology - sleep studies	0	0	0	
W11g: Physiological Measurement - Urodynamics - pressures & flows (Gynae)	27	0	27	100
W11s: Physiological Measurement - Urodynamics - pressures & flows (Surgical)	7	2	9	77.8
W12: Endoscopy - Colonoscopy	189	82	271	69.7
W13: Endoscopy - Flexi sigmoidoscopy	109	107	216	50.5
W14: Endoscopy - Cystoscopy	89	71	160	55.6
W15: Endoscopy - Gastroscopy	328	203	531	61.8
Total	**4168**	**1509**	**5677**	**73.4**

9.2 Model Hospital benchmarking (May 2020 performance at 39.7%) shows the Trust (the black bar) was in line with the national median, also 39.7% and slightly better than the regional position at 39.3%. It should be noted that the highest performing organisation achieved 79.3% and the worst was 22.9%.

10 Harm Reviews

RTT harm review tracking has been reset to March 2020 onwards in recognition of the increasing long waits resulting from the suspension of routine elective care and the reduced throughput associated with service re-starts.

The cancer harm reviews have now been extended to include any pathway over the 62 day cancer waiting times target and these are also subject to an RCA style review.

The last available updates for RTT and Cancer are as follows.

Referral to Treatment

Reporting Month: July 202	Tracking		Outcome		
Specialty	Reviews in progress	Reviews completed	Number of patients with harm identified	Degree of harm	Notes/Comments
ENT	5	409	0		In progress RCAs with clinician for sign off
Ophthalmology	16	283	0		In progress RCAs with clinician for sign off
Oral Surgery		430	0		
Orthodontics		10	0		
General Surgery	15	359	0		In progress RCAs with clinician for sign off
Urology	41	264	4	tbc	In progress RCAs with clinician for sign off
Orthopaedics	111	74	0		22 patients have TCI date
Pain	48	33	2	tbc	

Cancer 62 day

Reporting Month: July 2020	Tracking		Outcome		
Specialty	Reviews in progress	Reviews completed	Number of patients with harm identified	Degree of harm	Notes/Comments
Urology	18	106	2	tbc	
Colorectal	6	44			
Head & Neck	24	6			Tertiary provider RCAs outstanding at NWP, L&D
Upper GI	1	27			
Breast	0	18			
Gynaecology	8	20			Tertiary provider RCAs outstanding at ENHT, L&D
Lung	0	89			
Haematology	15	22			
Dermatology	1	10			
Sarcoma	1	0			Tertiary provider RCA outstanding at RNOH

8

11 Service re-starts and recovery

11.1 Referral rates continue to increase as patient confidence grows and services re-start. The number of cancer and urgent referrals received in July is in line with the pre-COVID monthly average, but there is still some way to go before routine referrals are at their previous levels.

Description	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	20/21 Total
(1) Routine	12994	11661	8576	3191	4248	6208	7183	3597	24427
(2) Urgent	3130	2779	2143	1075	1442	2099	2285	1070	7971
(C) Cancer	1873	1694	1284	569	1005	1416	1740	812	5542
Total	**17997**	**16134**	**12003**	**4835**	**6695**	**9723**	**11208**	**5479**	**37940**

12 Risks

12.1 Risk 3828 remains on the corporate risk register with a score of 20 in light of the COVID-19 pandemic and the suspension of elective care. The rapid rise in long waits has increased the likelihood of patient harm and the rate of recovery is likely to be slower than that seen in 2018/19 – 2019/20.

13 Recommendation

13.1 The Board is asked to note the contents of this report.

Jane Shentall
Director of Performance
18 August 2020

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 3

Specialty level RTT performance against 92% open pathway standard – July 2020

Description	Total	Less than 18 Weeks	18 Weeks Plus	% Under 18 Weeks
PAIN MANAGEMENT	550	74	476	13.45%
ORAL SURGERY	931	158	773	16.97%
VASCULAR SURGERY	127	26	101	20.47%
ORTHODONTICS	47	10	37	21.28%
PAED CARDIOLOGY	45	12	33	26.67%
TRAUMA & ORTHOPAEDICS	1772	480	1292	27.09%
OPHTHALMOLOGY	1505	411	1094	27.31%
PAED OPHTHALMOLOGY	144	46	98	31.94%
ENT	1431	533	898	37.25%
GENERAL SURGERY	1055	431	624	40.85%
GERIATRIC MEDICINE	115	49	66	42.61%
UROLOGY	1175	646	529	54.98%
PAED UROLOGY	80	44	36	55.00%
HEPATOLOGY	53	30	23	56.60%
COLORECTAL SURGERY	313	193	120	61.66%
GYNAECOLOGY	909	582	327	64.03%
CARDIOLOGY	1309	869	440	66.39%
RHEUMATOLOGY	264	192	72	72.73%
ORTHOTICS	20	15	5	75.00%
GENERAL MEDICINE	9	7	2	77.78%
RESPIRATORY MEDICINE	279	219	60	78.49%
NEUROLOGY	422	340	82	80.57%
CLINICAL HAEMATOLOGY	149	121	28	81.21%
UPPER GI SURGERY	107	88	19	82.24%
ENDOCRINOLOGY	169	139	30	82.25%
NEPHROLOGY	18	15	3	83.33%
CLINICAL ONCOLOGY	22	19	3	86.36%
GASTROENTEROLOGY	974	847	127	86.96%
PAED ENDOCRINOLOGY	18	16	2	88.89%
DERMATOLOGY	690	614	76	88.99%
DIABETIC MEDICINE	43	39	4	90.70%
PAEDS	284	258	26	90.85%
PAED EPILEPSY	13	12	1	92.31%
MEDICAL ONCOLOGY	14	13	1	92.86%
PAED DERMATOLOGY	38	36	2	94.74%
BREAST SURGERY	192	184	8	95.83%
OTHER	2	2	0	100.00%
CRITICAL CARE MEDICINE	2	2	0	100.00%
PAED GASTROENTEROLOGY	26	26	0	100.00%
PAED CLINICAL HAEMATOLOGY	16	16	0	100.00%
STROKE MEDICINE	2	2	0	100.00%
GYNAECOLOGICAL ONCOLOGY	17	17	0	100.00%
Total	**15351**	**7833**	**7518**	**51.02%**

Appendix 4
Cancer waiting times performance – update (at 18/8/20)

Standard	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 YTD (latest)
2ww	93.0%	92.5%	93.2%	94.1%	96.3%	96.8%	97.0%	97.6%	98.0%	95.1%	99.0%	97.7%	98.5%	97.7%
2ww 28 day FDS	75.0%	N/A	N/A	71.1%	75.2%	76.8%	75.8%	84.7%	77.0%	68.8%	85.6%	82.1%	80.5%	80.3%
2ww breast	93.0%	98.4%	100.0%	100.0%	96.3%	98.4%	94.2%	98.6%	98.5%	100.0%	87.9%	87.9%	98.1%	94.3%
31 day 1st	96.0%	96.5%	95.0%	94.3%	98.0%	99.4%	96.3%	97.2%	97.1%	98.5%	92.1%	97.2%	97.0%	96.4%
31 day surgery	94.0%	100.0%	100.0%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	93.8%	87.5%	100.0%	94.1%	94.7%
31 day drug	98.0%	100.0%	94.4%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%	98.1%
31 day palliative	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day radiotherapy	94.0%	N/A	N/A	N/A	N/A	N/A	100.0%	100.0%	N/A	NA	NA	NA	NA	50.0%
62 day	85.0%	83.9%	88.0%	79.4%	77.9%	82.9%	84.8%	80.1%	83.1%	70.3%	76.9%	86.4%	80.5%	79.5%
62 day screening	90%	83.3%	64.0%	66.7%	92.3%	100.0%	72.0%	80.0%	92.0%	85.7%	64.3%	100.0%	0.0%	59.6%

NB:

- Performance is provisional at the time of writing

Trust Board Meeting
3rd September 2020

Title of the paper	**Integrated Performance Report** ***(August 2020 reporting period – July 2020 data at 26/8/20)*** ***In addition the IPR for the July 2020 reporting period – June 2020 data is included in the pack, this IPR was reviewed by the Finance and Performance Committee on the 30th of July.***
Agenda Item	09/82
Presenter	**Sally Tucker** **Chief Operating Officer**
Author(s)	**Jane Shentall** **Director of Performance**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary	**Best Care / Great Team – COVID-19 snapshot** • More COVID-19 positive at 25 (was 19) and an increase in suspected at 16 (was 12), and no change in ITU COVID-19 positive patients (slide 3, 29-31) • Results awaited has increased (June 63 / July 128) (slide 3, 29-31) • Increase in COVID-19 negative inpatients, now 480 (was 415) (slide 3, 29-31) • No change in COVID-19 negative patients in ITU - remains at 10 (slide 3, 29-31) • Staff absence indicators show a decrease in both COVID-19 sickness 93 (was 163), and staff self-isolating 60 (was 133) (slide 3) • No nosocomial infections were reported again in this months snapshot (slide 3, 31) • PPE RAG rating indicates amber status in supply of gowns, gloves, FFP3 face masks and aprons but fluid resistant face masks were green in terms of days' supply (slide 3, 30) **Safe Care & Improving Outcomes** • Mortality indicators remain stable, and within the as expected range – SHMI 99.1 (99 last period), HSMR 103 (from 101) (slides 6, 26) • There was 1 hospital apportioned clostridium difficile case (previous month 0) with a year to date total of 6 (slides 6, 27) • The overall C-section rate has risen to 35.3% (from 32.8%) and remains above target (28%); the elective rate has increased to 19.7% (was 16.1%), above the local target (11%), but the emergency rate is lower at 15.6% (was 16.7%). The year to date rate for all C-sections is 33.6% (slides 6, 33). • Reporting for safe care, nursing shift fill, remains suspended as a result of the COVID-19 pandemic (slides 6, 34) • Patient safety incidents that are harmful is lower (better) at 7.2% and year to date 8.5%) (slides 6, 35) • Safety thermometer new harms remains suspended as a result of the COVID-19 pandemic (slide 6) • VTE risk assessment is better (higher) than target (95%) at 96.1% and year to date the rate is 95.8% (slides 6, 40) • Stroke indicator performance is similar to the previous month, with 26.1% (previously 28.3%) of patients admitted to the Stroke unit within 4 hours (target 90%, national average 54%), and 83.3% (was 54.1%) of patients spent 90% of their admission on the unit (target 80%, ytd 69.1%, national average 82.7%) (slides 6, 41) **Caring & Responsive Services** • Ambulance turnaround delays increased, with 268 (was 245) between 30 and 60 minutes and 89 (was 53) over 60 minutes (slides 7, 42) • ED 4 hour performance dropped to 85.9% (from 87.1%) with a year to date position of 84.5% (slides 7, 42) • Reporting requirements for delayed transfers of care (DToCs) remain suspended

as a result of the covid-19 pandemic (slides 7, 44)

- Friends & Family testing has also been paused for COVID-19
- Complaints response times remain better than target (80%) at 92.3% with no reactivated complaints received in the month (slides 7, 47)
- RTT (incomplete) performance is better at 51% (from 47.7%) (ytd 56.9%). There were 484 x 52 week breaches (previously 302) (slides 7, 49)
- Diagnostic waiting times performance is improving and although below the standard (99%) is better than the previous month (64.7%) at 73.3% (slides 7, 49)
- 2 week wait (98.5%) is better (higher) than target (93%), 2 week wait breast symptomatic is compliant with the standard (93%) at 98.1% (previously 87.2%) (slides 7, 50)
- 28 day faster diagnosis standard (2ww) performance shadow reporting against the recently announced target of 75%, is compliant at.82.4% (slides 7, 50)
- The 31 day standard is at 97.1% (target 96%). 31 day subsequent drug 100% and 31 day subsequent surgery have met their targets 94.4% (target 94%) (slides 7, 51)
- Performance against the 62 day urgent referral to first treatment is currently below target (85%) at 82% (slide 7, 52)
- No 62 day screening pathways were compliant with the 62 day screening standard this month (slides 5, 49)
- Short notice appointment cancellations remain above (worse than) target, at a similar level to the previous period, at 16.2% (from 16.3%) (slides 7, 53)
- Outpatient DNA rates remain better (lower) than target at 6.5% (previously 6.1%) (slides 7, 53)

Workforce & Finance

- 12 month turnover rate is lower than previous months at 13.6% (previously 13.8%) and is just above target (13%); the vacancy rate is similar to last month, at 9.1% and remains better (lower) than target (10%) (slides 8, 54)
- Sickness absence rates continue to improve at 4% (from 4.1%) but still worse than target (3.5%) (slides 8, 54)
- All staff appraisals rates are temporarily suspended (slides 8, 54)
- Mandatory training and Essential training are temporarily suspended (slides 8, 55)
- Bank pay is better (lower) than the target (12%) but higher than previously (10%) at 10.8% (ytd 10.1%) but agency pay has increased above target (4.7%) AT 4.9% (slides 8,18)
- In line with national guidance, income continues to be matched to expenditure therefore an actual breakeven position was reported in month. This resulted in a performance which was £0.79m worse than plan. This is linked to seasonal factors and the number of working days allowing for additional income generation within a business as usual scenario. The YTD actual breakeven position is now £1.6m better than plan.
- Due to the ongoing covid-19 pandemic, the efficiency programme has been temporarily suspended. However, it is anticipated as part of the trusts' plan to resume normal operations, more efficient ways of working will be retained. The in-month target was to deliver efficiencies of £0.8m. The YTD CIP ask of £2.0m has been mitigated by the interim reimbursement arrangements.
- A range of activity counts are now included for information (slide 8):
  Activity RAG ratings are shown in the context of the minimum income contract where the primary objective is to match capacity to demand. Therefore, non-elective activity above plan/expectations would be rated red. Births are classified as non-elective activity and so activity below plan is rated green. Elective spell underperformance against expectations is rated red in the context of waiting list management.

NB: Data correct at the time of reporting – 26/8/2020

Trust strategic aims

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

Aim 1 Best care	Aim 2 Great team	Aim 3 Best value	Aim 4 Great place
Objectives 1-4	*Objectives 5-8*	*Objective 9*	*Objective 10-12*
✓		✓	

Links to well-led

☒Is there the leadership capacity and capability to deliver high quality, sustainable

9

<table>
<tr><td>key lines of enquiry</td><td>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>Finance and Performance Committee</td><td>27 August 2020</td></tr><tr><td>Trust Management Committee</td><td>26 August 2020</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for information, assurance and discussion.</td></tr>
</table>

NHS
West Hertfordshire Hospitals
NHS Trust

Integrated Performance Report

July 2020

Reporting Period: June 2020

Trust Board: 3rd September 2020

Performance data updated on: 27th July 2020

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

How Are we Doing?

Safe Care & Improving Outcomes	Caring & Responsive Services	Workforce & Finance
Safety Thermometer New Harm Free Care Suspended Target 95%	**Complaints response times** 82.4% Target 80%	**Mandatory Training** 93.9% **Appraisal Rates** 87.0% Target 90%
Clostrioides Difficile cases 0 Target 2	**ED 4 hour standard** 87.1% Target 95%	**Agency pay** 2.6% Target 4.7%
VTE assessment 96.6% Target 95%	**RTT 52 week waits** 302 Target 0	**Vacancy rate** 9.1% Target 10%
Inpatient Friends & Family positive scores Suspended Target 95%	**CWT: 62 day referral to first treatment** 86.4% Target 85%	**I&E forecast** (Full year) £0 **I&E actual** (YTD actual & YTD plan) £0 Target -£ 2,341

2

6

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COVID-19 SNAPSHOT - 15 July 2020

BEST CARE

INPATIENTS

C-19 positive	C-19 suspected	ITU C-19 positive
19	12	2
C-19 result awaited	**C-19 negative**	**ITU C-19 negative**
63	415	10

PATIENT TESTING

Non-elective C-19 positive	Non-elective C-19 negative
0	72
Elective C-19 positive	**Elective C-19 negative**
0	1

NOSOCOMIAL INFECTIONS

Hospital definite	Hospital probable
0	0
Hospital indeterminate	**Community**
0	0

GREAT TEAM

STAFF TESTING

C-19 positive	C-19 negative
0	1
Antibody test positive	**Antibody test negative**
6	13

STAFF ABSENCE

C-19 sickness absence	C-19 self isolating
163	133
C-19 shielding	
TBC	

PPE ESTIMATED STOCK DURATION (DAYS)

Fluid resistant face masks	FFP3 face masks
34 (Green)	13 (Amber)
Gloves	**Gowns***
11 (Green)	9 (Red)

*Red status due to sterile reinforced gown Theatre requirements, plans currently in progress to mitigate

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Essential Measures – Executive Summary

NHS
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NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Remains within as expected range	SHMI 99.0 HSMR 103.0	**Complaints response times** Above target (80%) and higher than previous month	82.4% YTD 59.2%	**All staff appraisal** Unchanged from previous month Below target (90%)	Suspended
Infection Control – clostrioides Difficile (hospital & healthcare) No cases this month	0 (Cat1: 0) YTD 5	**Inpatient Friends & Family Test** Positive scores mainly compliant but variable, ED just below target (95%)	Suspended	**Mandatory training** Consistently achieved (target 90%) and stable	Suspended
Serious incidents & Never Events (NE) Variable – 1 SI in reporting period	SI 1 YTD 6 NE 0 YTD 1	**Mixed sex accommodation** None in reporting period but usually low number when breaches occur	Suspended	**Turnover at 12 months** Worse than target (13%) and similar To previous month	13.8% YTD 14.1%
Patient safety incidents which are harmful Unchanged from previous month	8.4% YTD 9.0%	**Outpatient DNA rates** Below target (8%) but higher than previous month	6.1% YTD 5.5%	**Income & Expenditure** Breakeven position for June	£0.00m YTD £0.00m
Combined Caesarean Section Standard (28%) not achieved Lower than previous month	32.8% YTD 32.9%	**ED waiting times** Better than previous month Target (95%)	87.1% YTD 83.9%	**Capital Spend** £0.85m Capital spend in June against a target of £2m	(£0.85)m YTD (£3.48)m
VTE assessments Above target (95%) and better than previous month	96.6% YTD 95.5%	**RTT waiting times** Lower than the target (92%) Increase in 52 week waits	47.7% YTD 59.1% 302 YTD 490	**CIP Efficiency**	Suspended
Stroke Indicators Admission to Stroke Unit within 4 hrs – target (90%) not achieved 90% admission spent in the Stroke Unit – target (80%) not achieved	4 hr 28.3% YTD 37.5% Adm 54.1% YTD 65.6%	**Cancer waiting times** 2ww achieved consistently 62 day above target (85%) and better than previous month	2ww 97.7% YTD 97.7% 62 day 86.4% YTD 77.2%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 0 Elec 1271 vs 4148.37 Non-Elec 3394 vs 4925.79
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**	

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West Hertfordshire Hospitals NHS Trust

COVID19 – SNAPSHOT - Indicator Summary

Domain	Theme	Trend	Jun-20	Jul-20
COVID 19 Snapshot	**Inpatients**			
	C-19 positive	Improving	32	19
	C-19 suspected	Worsening	10	12
	C-19 result awaited	Stable	62	63
	C-19 negative	Improving	364	415
	ITU C-19 positive	Stable	2	2
	ITU C-19 negative	Improving	6	10
	Staff Testing			
	C-19 positive	Improving	1	0
	C-19 negative	Improving	3	1
	Antibody test postive		73	6
	Antibody test negative		149	13
	Patient Testing			
	Non-elective C-19 positive	Stable	0	0
	Non-elective C-19 negative	Improving	3	72
	Elective C-19 positive	Improving	2	0
	Elective C-19 negative		38	1
	Staff Absence			
	C-19 sickness absence	Improving	171	163
	C-19 self isolating	Worsening	129	133
	C-19 shielding		N/A	N/A
	Nosocomial Infections			
	Hospital definite	Stable	0	0
	Hospital probable	Improving	1	0
	Hospital indeterminate	Stable	0	0
	Community	Improving	1	0
	Estimated duration of PPE stock (days)			
	Fluid resistant face masks	Improving	14	34
	FFP3 face masks	Improving	8	13
	Gloves	Worsening	13	11
	Aprons	Improving	15	21
	Gowns		N/A	9

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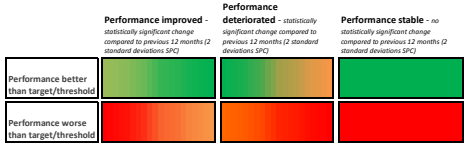
Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Apr-20	May-20	Jun-20	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)	26	100	Performance stable and better than target	100.1	99.7	99.0			Jan-20	National	100	Jan-20
		HSMR - Total (Rolling three months)	26	100	Performance deteriorated and worse than target	97.4	101.0	103.0			Mar-20	National	100	Mar-20
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	27	n/a		3	2	0	5		Jun-20	National	n/a	
		Clostridioides Difficile - Healthcare associated (Cat 2)	27	n/a		0	0	0	0		Jun-20	National	n/a	
		Clostridioides Difficile - Hospital and Healthcare associated Total	27	2	Performance improved and better than target	3	2	0	5	6	Jun-20	National	n/a	
		Hand Hygiene Compliance	28	95%	Performance stable and better than target	99.7%	95.0%	98.0%	97.6%	95%	Jun-20	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	32	4.5%	Performance stable and better than target	3.7%	3.8%	3.9%	3.7%	4.5%	Dec-19	National	4.5%	Dec-19
		30 Day Emergency Readmissions - Emerg *	32	13.9%	Performance deteriorated and worse than target	14.6%	13.5%	15.1%	13.8%	13.9%	Dec-19	National	13.9%	Dec-19
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	32	28.0%	Performance stable but worse than target	32.0%	34.1%	32.8%	32.9%	28.0%	Jun-20	Local	28.0%	2017/18
		Caesarean Section rate - Emergency*	32	15.0%	Performance stable but worse than target	14.6%	18.4%	16.7%	16.6%	15.0%	Jun-20	Local	16.0%	2017/18
		Caesarean Section rate - Elective*	32	11.0%	Performance stable but worse than target	17.4%	15.7%	16.1%	16.4%	11.0%	Jun-20	Local	12.0%	2017/18
		Patient Safety												
		% nursing hours (shift fill rate)	35	95.0%	Performance stable and better than target	suspended				95.0%	Jun-20	National	n/a	
		Serious incidents - number*	35	0	Performance stable but worse than target	3	2	1	6	0	Jun-20	National	n/a	
		Serious incidents - % that are harmful*	35	0.0%	Performance improved and better than target	0.0%	100.0%	0.0%	33.3%	0%	Jun-20	National	n/a	
		% of patients safety incidents which are harmful*	35	0.0%	Performance stable but worse than target	10.6%	8.4%	8.4%	9.0%	0%	Jun-20	National	n/a	
		Never events	35	0	Performance stable and better than target	1	0	0	1	0	Jun-20	National	n/a	
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	-	95.0%	Performance improved but worse than target	0.0%	Suspended			95.0%	Jun-20	National	93.7%	Mar-20
		Safety Thermometer % New Harm Free Care (acquired within Trust)	-	95.0%	Performance improved but worse than target	0.0%				95.0%	Jun-20	National	97.8%	Mar-20
		Category 4 pressure ulcers - New (Hospital acquired)	37	0	Performance stable and better than target	0	0	0	0	0	Jun-20	Local	n/a	
		Category 3 pressure ulcers - New (Hospital acquired)	37	0	Performance stable and better than target	1	0	0	1	0	Jun-20	Local	n/a	
		VTE risk assessment*	38	95.0%	Performance stable and better than target	93.9%	95.7%	96.6%	95.5%	95.0%	Jun-20	National	95.3%	Q3 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	39	90.0%	Performance improved but worse than target	60.9%	26.4%	28.3%	37.5%	90.0%	Jun-20	National	54.0%	Mar-20
		Stroke patients spending 90% of their time on stroke unit	39	80.0%	Performance deteriorated and worse than target	86.0%	54.8%	54.1%	65.6%	80.0%	Jun-20	National	82.7%	Mar-20

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



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Indicator Summary

NHS
West Hertfordshire Hospitals

Domain		Theme	Page	Target	Trend	Apr-20	May-20	Jun-20	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Caring & Responsive Services	Effective	**Patient Flow: Emergency Department**												
		Ambulance turnaround time between 30 and 60 mins		0	Performance deteriorated and worse than target	321	192	245	758	0	Jun-20	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	27	6	53	86	0	Jun-20	National	n/a	
		% Patients admitted through A&E - 0 day LOS		n/a		21.6%	27.1%	31.6%	27.2%		Jun-20	National	n/a	
		Patient Flow: In hospital flow												
		Discharges between 8am and 12pm (main adult wards excl AAU)		33.0%	Performance stable but worse than target	11.8%	12.9%	14.1%	13.0%	33.0%	Jun-20	National	n/a	
		Mixed sex accommodation breaches	41	0	Performance stable and better than target	suspended				0	Jun-20	National	59 Trusts breaching	Feb-20
		LOS > 21 days	42	65	Performance stable and better than target	31	61	53	53	65	Jun-20	National	n/a	
		Delayed Tranfers of Care (DToC) beddays used in month	42	n/a		Suspended				n/a	Jun-20	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	42	n/a						n/a	Jun-20	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	-	95%	Performance improved but worse than target	suspended				95%	Jun-20	National	85.0%	Feb-20
		Inpatient Scores FFT % positive	-	95%	Performance improved but worse than target					95%	Jun-20	National	95.9%	Feb-20
		Daycase FFT % positive	-	95%	Performance improved but worse than target					95%	Jun-20	National	n/a	
		Maternity FFT % positive	-	95%	Performance improved but worse than target					95%	Jun-20	National	96.9%	Feb-20
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	45	80%	Performance stable and better than target	58.3%	38.9%	82.4%	59.2%	80%	Jun-20	National	n/a	
		Reactivated complaints	45	0	Performance stable but worse than target	0	1	2	3	0	Jun-20	National	n/a	
		Patient Experience: End of life care												
		New indicators to be included in Q4												
	Responsive	**Access to Services**												
		ED 4hr waits (Type 1, 2 & 3)	40	95.0%	Performance improved but worse than target	78.9%	83.9%	87.1%	83.9%	95.0%	Jun-20	National	92.8%	Jun-20
		Referral to Treatment - Incomplete*	47	92.0%	Performance deteriorated and worse than target	71.1%	56.5%	47.7%	59.1%	92.0%	Jun-20	National	72.2%	May-20
		Referral to Treatment - 52 week waits - Incompletes	47	0	Performance deteriorated and worse than target	53	135	302	490	0	Jun-20	National	26029 (all Trusts)	May-20
		Diagnostic (DM01) <6 weeks		99.0%	Performance improved but worse than target	26.5%	39.6%	64.7%	41.3%	99.0%	Jun-20	National	41.5%	May-20
		Cancer												
		Cancer - Two week wait *	48	93.0%	Performance stable and better than target	95.1%	99.0%	97.7%	97.7%	93.0%	Jun-20	National	91.6%	Q4 19/20
		Cancer - Breast Symptomatic two week wait *	48	93.0%	Performance deteriorated and worse than target	100.0%	87.9%	87.2%	89.1%	93.0%	Jun-20	National	85.6%	Q4 19/20
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	48	75.0%	Performance stable and better than target	68.9%	85.5%	82.4%	80.3%	71.7%	Jun-20	National	n/a	
		Cancer - 31 day *	49	96.0%	Performance stable and better than target	98.5%	92.1%	97.3%	96.1%	96.0%	Jun-20	National	95.9%	Q4 19/20
		Cancer - 31 day subsequent drug *	49	98.0%	Performance deteriorated and worse than target	100.0%	100.0%	88.2%	98.8%	98.0%	Jun-20	National	98.7%	Q4 19/20
		Cancer - 31 day subsequent surgery *	49	94.0%	Performance stable and better than target	93.8%	87.5%	100.0%	94.7%	94.0%	Jun-20	National	91.0%	Q4 19/20
		Cancer - 31 day subsequent radiology *	49	94.0%		-	-	-	-	94.0%	Jun-20	National	96.0%	Q4 19/20
		Cancer - 62 day *	50	85.0%	Performance stable and better than target	70.3%	76.9%	86.4%	77.2%	85.0%	Jun-20	National	75.6%	Q4 19/20
		Cancer - 62 day screening *	50	90.0%	Performance stable and better than target	85.7%	64.3%	100.0%	78.4%	90.0%	Jun-20	National	80.5%	Q4 19/20
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	51	5.0%	Performance stable but worse than target	36.7%	26.2%	16.3%	26.8%	5.0%	Jun-20	Local	n/a	
		DNA rate	51	8.0%	Performance deteriorated but better than target	4.7%	5.5%	6.1%	5.5%	8.0%	Jun-20	National	n/a	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Apr-20	May-20	Jun-20	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)	52	13.0%	Performance improved but worse than target	14.4%	14.2%	13.8%	14.1%	13.0%	Jun-20	National	15.0% (Beds and Herts orgs)	Q1 19/20
		% staff leaving within first year (excluding medics and fixed term contracts)	52	n/a		17.0%	16.7%	15.7%	16.5%	n/a	Jun-20	National	n/a	
		Vacancy rate	52	10.0%	Performance improved and better than target	9.7%	9.6%	9.1%	9.4%	10.0%	Jun-20	National	11.1% (local survey)	Q1 19/20
		Sickness rate	52	3.5%	Performance stable but worse than target	11.6%	6.3%	4.1%	7.3%	3.5%	Jun-20	National	3.7% (EoE orgs)	Q1 19/20
		Developing Staff												
		Appraisal rate (Total)	53	90.0%	Performance stable but worse than target	87.0%	87.0%	87.0%	87.0%	90.0%	Jun-20	National	n/a	
		Mandatory Training	53	90.0%	Performance stable and better than target	93.9%	93.9%	93.9%	93.9%	90.0%	Jun-20	Local	91.0% (local survey)	Q1 19/20
		Essential Training	53	90.0%	Performance stable and better than target	90.8%	90.8%	90.8%	90.8%	90.0%	Jun-20	Local	n/a	
		Finance overview												
		Financial Risk Rating	14-24	3	Performance improved but worse than target	0.00	0.00	0.00			Jun-20	Local	n/a	
		Income & Expenditure Actual	14-24	-£174	Performance stable and better than target	£0	£0	£0	£0	-£2,341	Jun-20	Local	n/a	
		Income & Expenditure forecast	14-24	£0	Performance improved and better than target	£0	£0	£0	£0	£0	Jun-20	Local	n/a	
		Cash balance at the end of the month	14-24	£4,036	Performance deteriorated but better than target	£40,789	£51,142	£48,307	£48,307	£4,036	Jun-20	Local	n/a	
		Capital expenditure	14-24	-£2,008	Performance stable but worse than target	-£2,500	-£125	-£852	-£3,477	-£6,017	Jun-20	Local	n/a	
		CIP delivery against plan	14-24	£1,153	Performance improved but worse than target	suspended				£3,458	Jun-20	Local	n/a	
		% Bank Pay**	14-24	12.0%	Performance stable and better than target	10.8%	8.9%	10.0%	9.9%	12.0%	Jun-20	Local	n/a	
		% Agency Pay**	14-24	4.7%	Performance stable and better than target	4.2%	2.8%	2.6%	3.2%	4.7%	Jun-20	Local	7.3% (local survey)	Q1 19/20
		Activity (chargeable)												
		GP referrals		8,027	Performance deteriorated but better than target	1,455	2,497	3,775	7,727	24,081	Jun-20	National	n/a	
		A&E attendances		15,092	Performance deteriorated but better than target	6,553	8,645	9,876	25,074	39,236	Jun-20	National	n/a	
		Elective spells (overnight)		492	Performance improved but worse than target	137	141	190	468	1,365	Jun-20	National	n/a	
		Elective daycase		3,656	Performance improved but worse than target	391	435	1,081	1,907	10,137	Jun-20	National	n/a	
		Total elective spells		4,148	Performance improved but worse than target	528	576	1,271	2,375	11,502	Jun-20	National	n/a	
		Non-elective spells		4,926	Performance deteriorated but better than target	2,680	3,031	3,394	9,105	14,942	Jun-20	National	n/a	
		Births		322	Performance stable but worse than target	355	362	356	1,073	977	Jun-20	National	n/a	
		Outpatient attendances		21,481	Performance improved but worse than target	7,025	7,434	9,452	23,911	59,561	Jun-20	National	n/a	

* No official cash target
** Straight line target

Activity RAG ratings are shown in the context of the minimum income contract where the primary objective is to match capacity to demand. Therefore, non-elective activity above plan/expectations would be rated red. Births are classified as non-elective activity and so activity below plan is rated green.
Elective spell underperformance against expectations is rated red in the context of waiting list management.

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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Safe Care & Improving Outcomes

Chief Medical Officer

As Covid numbers reduce, the trust is now cautiously restarting elective work. This has required significant oversight from the executives, with regards PPE requirements, space, theatre utilisation, patient flow, and logistics. We are anticipating the number of pathways re-opening to escalate significantly, as staff get used to working in new ways.

The possibility of an earlier launch of an electronic patient record, and the new hospital design project, has meant that clinical engagement has never been more important. With this in mind, we are currently recruiting staff across all divisions who are able to dedicate a significant amount of time every week, to support these projects. All staff groups will be represented.

The Clinical Advisory Group continues to meet weekly, but importantly, has a wider membership fortnightly. This includes the divisional triumvirates, and other senior colleagues, ensuring that strategic advice is discussed and agreed by all staff groups.

Finally, the mediation project in Women's services is due to conclude shortly, having been significantly delayed by the Covid pandemic. There has already been a significant improvement in engagement and culture, and I am confident this will improve further.

Chief Nurse

Infection, prevention control continues to be a high priority as we manage and recover from Covid to manage nosocomial infections, testing and implementing new guidance on self isolation prior to planned procedures. The planning of the reopening of St Albans elective care as a green site supported by national guidance to provide covid protection for the planned care pathway i.e. using testing and education on social distancing and hand hygiene. The business case for testing has now been completed and will be discussed at Trust management committee for a 12 month period for staff and patient testing.

The ward scorecard review is complete and will recommence in July and be included in the September Trust Board IPR. Harm free care presentation of data using SPC charts and an improvement methodology will feed into the ward scorecard, the quality IPR and Trust Board IPR.

I am pleased to announce the commencement of our associate chief nurse for shared decision making and the plans to launch our leadership council in September with our first councils in place by November. We will report on this further at Trust management committee and quality committee in October.

Finally we are planning to recommence quality improvement work that was suspended in March due to Covid.

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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Caring & Responsive Services

Chief Nurse

We have continued to focus on adopting and adapting the good practice for patient experience learnt during Covid. We have some clinical leaders events with this focus planned in August to ensure a wide range of nurses, midwives, AHP's and support workers involved. The events will be smaller to support social distancing.

The Co-production work with Health watch is recommencing in August with the first board meeting.

We have now begun to see an increase in formal complaints numbers after a reduction during March/April/May, some of the themes reflect the early weeks of Covid around patient property, patient affairs and clarification of clinical care.

Chief Operating Officer

The Trust has continued to see a reduction in the total number of Covid-19 patients being cared for by the Trust. Testing on admission has continued. Based upon an upward trend in activity that has included conversion to admission further bed capacity has been utilised for those asymptomatic patients admitted and awaiting swab results.

Good progress is being made with service recovery across the Divisions with plans in place for a phased restart of activity on the St. Albans Hospital site towards the end of July 2020.

The Urgent Treatment Centre went live on 1st July and is located within the minors area of ED. This new service is being managed by Greenbrook Healthcare.

Key posts out to advert for recruitment include the Deputy COO/Divisional Manager for Emergency Medicine and Head of Emergency Planning & Resilience

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief People Officer

- Vacancies - It is pleasing to see that our vacancy rates continues to fall at 464 wte or 9.1% of the establishment (9.6% last month). The target rate is 10%.
- Sickness – the June rate is 4.3% against a target of 3.5%. The 12 monthly sickness rate averages 4.7%. Naturally these absence figures have been effected by COVID and whilst they are still high by traditional standards, they are considerably reduced from their high of nearly 20% at the height of the pandemic.
- Labour Turnover –This is 13.8% (last month 14.2%). The target is 13%. This is the lowest rate recorded since October 2013. Turnover for staff who leave within their first year of is now 15.7% (21% in Aug 2019). The target rate is 15%. Turnover for Band 5 Nursing and Midwifery staff is 16.0% (16.1% last month). The target is 16%, which means that this is the first time we have achieved this since it was set in May 2017, and is a significant reduction when rates were approx. 30%.
- COVID staff Survey – We received the results of our COVID19 Staff survey which was completed by 25% of our employees. Whilst there were some areas where the Trust performed well, there were a number of areas where it failed to do as well as comparator organisations. Whilst this is disappointing it is important to note that in many respects the Trust was a 'hotspot' organisation and this clearly impacted the experience of our staff. A comprehensive plan is being put into place to address some of the issues identified by the survey.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief Finance Officer

June signals the end of Q1 and we continue to progress the financial year managing finances under a temporary system, designed to minimise the risk that any NHS organisation limits its response to the COVID-19 pandemic, due to money constraints. Revenue flows from Commissioners continue to be guaranteed regardless of patient numbers. The Trust continues to follow internal processes to ensure all costs incurred in relation to the pandemic are captured. These processes follow national guidance to ensure full reimbursement of the additional costs. This applies both to revenue and capital expenditure.

In line with the temporary system, the Trust reports that accrued income matches the £34.8m of expenditure incurred in the month. Within the £34.8m, the COVID-19 pandemic created an extra £2.5m of revenue costs. The trust expects additional income to cover these costs. Before the pandemic, the trust had budgeted for expenditure in June to exceed income by £0.2m. The 'full reimbursement' regime has allowed the trust to perform £0.2m better than the plan that was set at the time despite the pressures arising from treating COVID patients. Year to date, the Trust is £2.3m better than plan at the end of Q1.

In terms of patient numbers, footfall has continued to increase in June. This is linked to various operational restarts. Despite this, overall patient numbers continue to fall significantly lower than the plan.

Elective admissions were 29% of the original plan in month, compared to an average of 16% for April & May.
Outpatient attendances were 58% of the original plan in month, compared to a 52% average for April & May.
A&E attendances 77% of plan compared to a 62% average for April & May.

The Trust spent £0.85m on buildings and equipment assets in June. Cash flow is healthy, at this stage supporting the trust's efforts to pay suppliers as quickly as possible.

As the trust looks to re-start normal service provision, the forecast begins to take into account additional costs associated with enhanced protection needed for patients and staff, and the revised productivity profiles based on the organisations first phase of Restart. Based on the existing funding regime and current cost profiles, it is anticipated that in addition to the existing Covid-19 top up, the Trust could require up to £8.1m worth of additional funding.

The Trust is looking to spend c£24m on developing and buying new assets in 2020/21. Some of this spend is dedicated to the wider hospital redevelopment programme.

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Key Messages for the Board

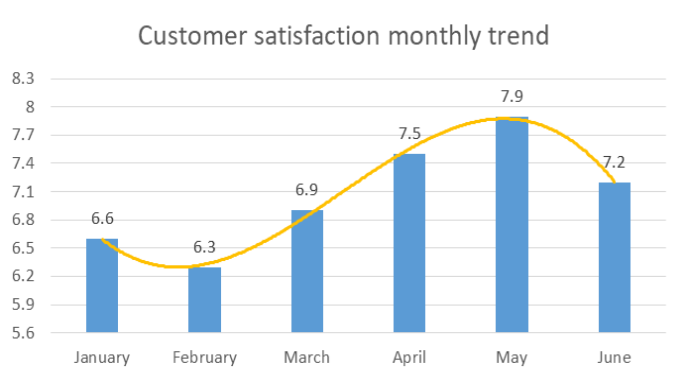
Corporate - ICT

Chief Information Officer

The month of June saw a mixed performance in respect of service metrics. There were four Priority 1 incidents in the month (three in the previous month) and seventeen Priority 2 incidents (25 in the previous month). The four priority 1 incidents were as follows:

- 3rd June – External telephony failure
- 3rd June – Above drove a failure in inter-site telephony
- 18th June – Network issues for clinic prep at St Albans
- 20th June – Sunquest ICE application performance issues

Atos continued to meet the majority of the metrics within our SLA during June. Further progress was made in reducing the Incident backlog which at the end of June totalled 350 (down from 392 in May), however there was a disappointing reduction in the Customer Satisfaction score as shown below:



The customer satisfaction trend is likely explained by the hospital starting to return to a more normal state and the expectations around IT service performance increasing. This is supported by the increased number of contacts to the service desk, reaching a record high in June:

Volume by Contact type	Jan	Feb	Mar	Apr	May	June
Phone	4,019	3,442	3,706	3,844	3,915	4,287
Self-service	164	76	74	79	107	90
Email	933	805	949	1,328	1,050	1,131
Total	**5,116**	**4,323**	**4,729**	**5,251**	**5,072**	**5,508**

The major strategic projects (Local Area Network, Windows 10, EPR preparation, Digital Strategy for the new hospital) all continued to progress to plan and in the month the team did a significant amount of work to ensure our connection to the National Pathology Exchange was as robust as possible.

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Workforce & Finance: Income and Expenditure June 2020

Trust Definition	Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance		YTD Budget	Actual	Variance	
Income	Divisional Income	80,923	6,744	7,663	919	Bii	20,231	21,806	1,575	Fii
	NHS Revenue	335,141	28,186	27,123	(1,063)	Bi	82,536	81,651	(886)	Fi
	Income Unallocated CIPs									
Income Total		**416,065**	**34,929**	**34,785**	**(144)**	**B**	**102,767**	**103,457**	**689**	**F**
Pay	Medical Pay	(81,414)	(6,763)	(6,503)	261		(20,513)	(19,964)	549	
	Non-Clinical Pay	(63,182)	(4,863)	(4,209)	655		(14,545)	(12,439)	2,106	
	Nursing Pay	(79,663)	(6,637)	(6,398)	239		(19,915)	(19,130)	785	
	Other Clinical Pay	(29,645)	(2,470)	(2,629)	(159)		(7,411)	(7,705)	(294)	
	Scientific, Technical & Profes	(27,267)	(2,272)	(2,330)	(58)		(6,816)	(6,955)	(139)	
	Pay Unallocated CIPs	9,386	361		(361)		722		(722)	
Pay Total		**(271,786)**	**(22,645)**	**(22,069)**	**576**	**C**	**(68,478)**	**(66,192)**	**2,286**	**G**
Non Pay	Clin Supp Serv	(31,253)	(2,717)	(2,186)	531		(7,535)	(6,586)	950	
	Drugs	(21,424)	(1,863)	(1,424)	439		(5,166)	(4,803)	363	
	OTHER (NON CLIN)	(81,315)	(6,739)	(7,752)	(1,013)		(20,270)	(21,770)	(1,500)	
	Non Pay Unallocated CIPS	6,257	241		(241)		481		(481)	
Non Pay Total		**(127,734)**	**(11,078)**	**(11,363)**	**(284)**	**D**	**(32,489)**	**(33,159)**	**(670)**	**H**
Recharges	Recharges				()				()	
Recharges Total					**()**				**()**	
Financing Charges	Depreciation	(10,948)	(911)	(895)	17		(2,734)	(2,717)	16	
	Trust Debt Redemption	(5,570)	(466)	(464)	2		(1,399)	(1,392)	7	
	Unwinding Discount	(27)	(2)	5	7		(7)	5	12	
Financing Charges Total		**(16,545)**	**(1,380)**	**(1,354)**	**26**	**E**	**(4,140)**	**(4,105)**	**35**	**I**
Total			**(174)**	**()**	**174**	**A**	**(2,341)**	**()**	**2,341**	**J**

A – As the interim arrangements set out by NHSE/I continue, the Trust delivered an actual breakeven position for the month of June.
The performance to plan was better by £174k. The planning process for the first 4 months of 20-21 has been suspended and the plan shown represents the pre-covid business as usual plan. This could be subject to change if the Trust choses to amend its annual plan when existing planning restrictions are lifted.

B- In line with block arrangements for the month, the income position saw a small underperformance in month of £144k.
Bii – With the interim reimbursement arrangements in place, key points to note within divisional income include reduced MRET, PSF and car parking income within the month. This was mitigated by the national top up payment and claims for additional covid related costs which are captured on slide 9.
Bi- NHS Revenue generated a total of £27,123k in month. This represented temporary block arrangements with all CCGs, regardless of activity performance. This guarantee of income saw an underperformance against the business as usual plan. This is where block arrangements did not cover our original expectations of the activity to be performed in June. The underperformance was £1,063k. Operationally, all points of delivery saw significant underperformances in month as a result of the Covid-19 situation. However, Actual activity levels continued to grow in month 3.

C – The overall pay bill for the month was £22,069k which was £576k underspent. Within the pay position, an additional £629k was spent in relation to covid-19 and is offset by income. Reduced activity levels in month contributed to the underspend.

D – The non pay position reported an overspend of £670k. This includes an additional £1,898k spent in relation to covid-19 . This also has been offset by income. Reduced activity levels in month contributed to the underlying underspend.

E – Financing charges broke even in month with a small over performance of £26k.

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Workforce & Finance: Finance overview dashboard

Financial Overview 30 June 2020

Month 3 Income & Expenditure

£m	Plan	Actual	Var
Surplus / (Deficit)	(0.2)	0.0	0.2

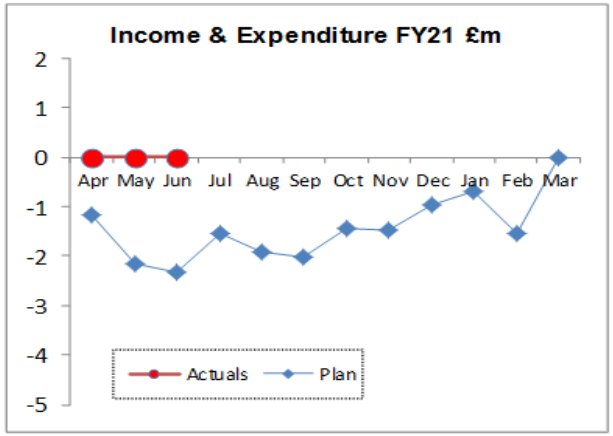
£m	YTD M3 20/21		
Surplus / (Deficit)	(2.3)	0.0	2.3

Statutory / Regulatory Duties

Breakeven	The trust achieved break even in month 3 and has a break even plan for FY21.	G
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 30/6/20 equated to 48 days' spend.	G
BPPC	Month 3 performance - 85.0% on number, 88.3% on value (95% target)	A

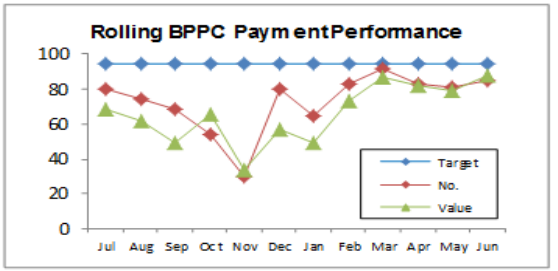
Financial Risk Rating	FY21	2

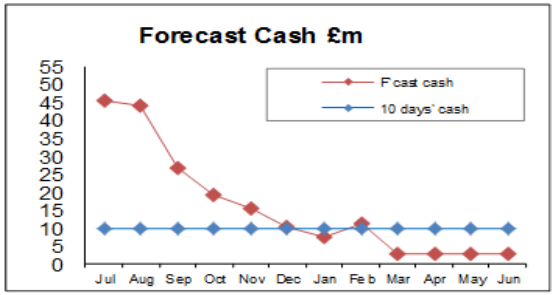
Risk rating on a scale of 1 to 4, with 1 being best and 4 being worst.

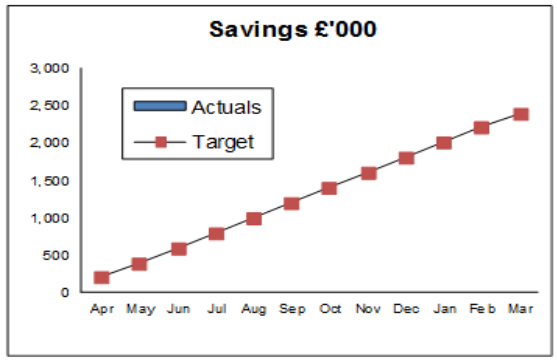


YTD Variance by Division £m

Medicine	(6.1)
Unscheduled Care	(4.9)
Surgery	(10.1)
Women's	(2.6)
Clinical Support	(1.7)
Estates & Facilities	(0.3)
Corporate	0.1
Other	28.1
Total	**2.3**







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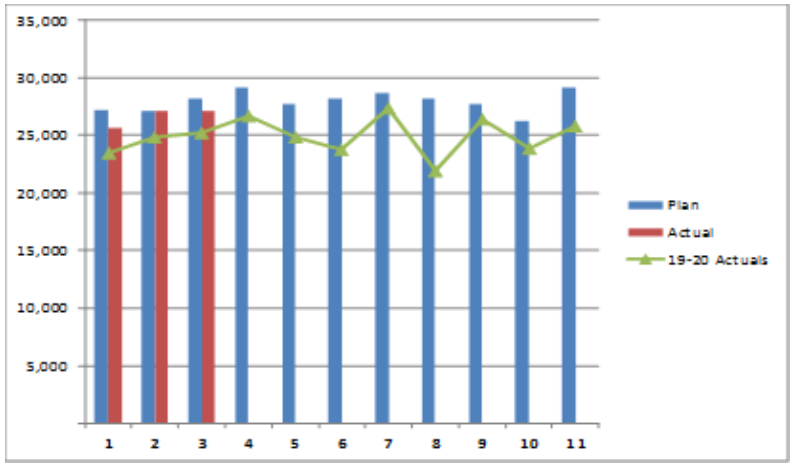
Workforce & Finance: Trust Income - June 2020

NHS Revenue: Performance by Month (£s)

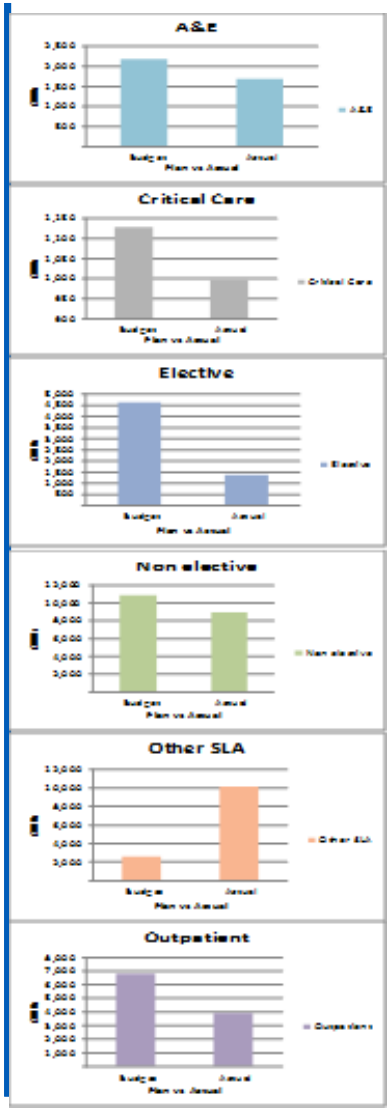


In line with national guidelines, NHS revenue continues to be set at a block amount of £27.12m for the month of June. This resulted in an underperformance against the business as usual plan.

All points of delivery showed underperformances as a result of the Covid-19 outbreak:

Despite increases in activity from previous months, A&E continues to underperform against plan by £0.5m
In June, the number of covid patients requiring critical care facilities reduced. This resulted in a £0.13m under performance against plan.
The cessation of all routine Elective cases led to an underperformance of £3.3m in month. This is predominately within the Surgery division.
For Non Elective the in month position showed under performance of £1.9m.
Despite an increase in virtual interactions, the overall fall in Outpatient attendances meant performance was £2.8m away from plan.

The adverse variances above were offset by other SLA income being favorable to plan by £7.5m. This reflects the interim block reimbursement arrangements.



In Month Performance (£s)

Expense Type	POD	Annual Budget	In Month (£000's) Budget	Actual	Variance
NHS Revenue	A&E	26,486	2,181	1,678	(502)
	Critical Care	13,664	1,128	996	(133)
	Elective	53,207	4,627	1,349	(3,278)
	Non elective	132,024	10,851	8,999	(1,852)
	Other SLA	31,040	2,630	10,179	7,548
	Outpatient	78,721	6,768	3,922	(2,846)
	NHS Rev Unallocated CIPs				
NHS Revenue Total	Total	335,141	28,188	27,128	(1,060)

In Month Performance (spells)

Expense Type	POD	Annual Budget	In Month (Activity) Budget	Actual	Variance
NHS Revenue	A&E	156,535	15,356	10,806	-4,550
	Critical Care	14,572	1,195	1,025	-170
	Elective	47,705	4,145	1,301	-2,847
	Non elective	64,255	5,290	3,730	-1,560
	Other SLA	2,774,705	226,226	216,309	-111,926
	Outpatient	479,534	47,639	28,077	-19,562
NHS Revenue Total	Total	4,566,020	325,997	255,251	-140,616

Divisional Income

Divisional income delivered a £919k surplus in month. Reduced MRET, PSF and car parking income was mitigated by the national covid top up payment. In addition to this the Trust submitted £2.5m worth of claims for additional covid related expenditure. This is included within the position.

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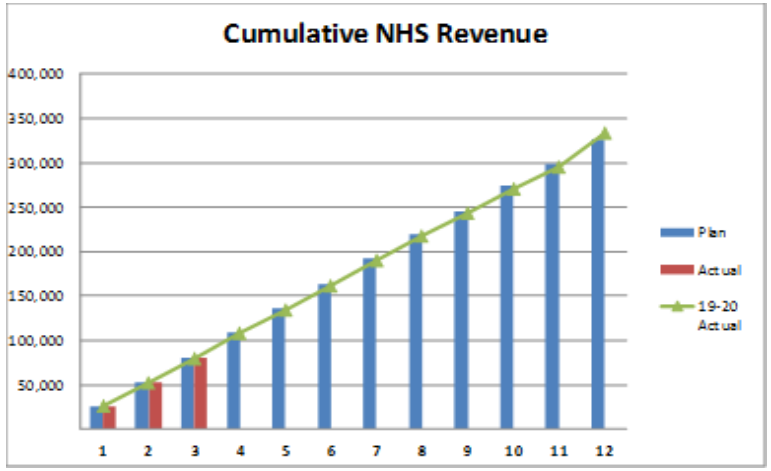
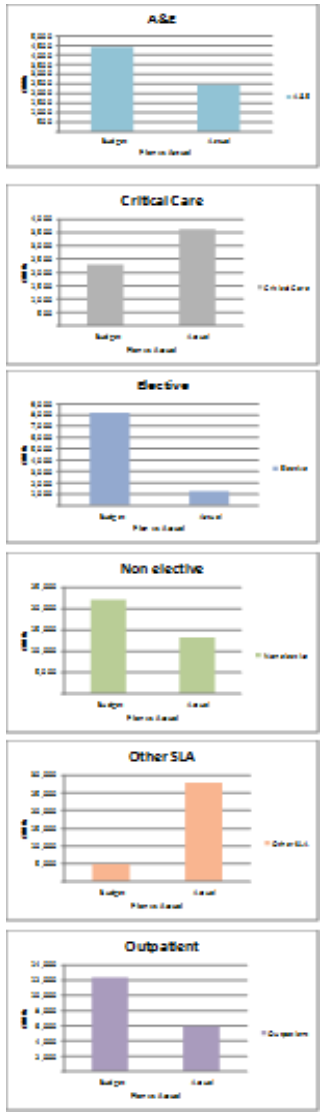
Workforce & Finance : Year To Date (YTD)– Trust Income

NHS Revenue: Performance by Month (£s)



Month 3 YTD shows Income under performance of £0.87m. £81.7m has been generated against plan of £82.5m.

A&E has a YTD under performance of £2.48m which is linked to a price and volume variance.
Critical care is £1.22m better than plan and has seen an average occupancy rate of 75%. The increase is linked to the Covid-19 pandemic.
Elective performance is £10.19m away from the YTD plan. This is mostly driven by underperformances across the Surgery division linked to a reduction in the volume of procedures performed and a reducing complexity of procedures.
Non Elective activity has a deficit against plan of £10.7m. This is predominately centred around the Emergency division and is linked to a reduction in emergencies throughout the pandemic.
YTD Outpatient performance shows £9.22m under performance.
Other SLA income is £30.45m above plan. This is driven by a central adjustment to take into account the impact of current interim reimbursement structure.



YTD Performance (£s)

POD	YTD (£000's) Budget	Actual	Variance
A&E	6,606	4,128	(2,478)
Critical Care	3,410	4,631	1,222
Elective	12,829	2,638	(10,191)
Non elective	32,916	22,254	(10,661)
Other SLA	7,653	38,100	30,447
Outpatient	19,124	9,900	(9,225)
NHS Rev Unallocated CIPs			
Total	**82,536**	**81,651**	**(886)**

YTD Performance (spells)

POD	YTD (Activity) Budget	Actual	Variance
A&E	46,581	26,799	-19,782
Critical Care	3,635	4,374	739
Elective	11,502	2,417	-9,085
Non elective	16,046	10,163	-5,883
Other SLA			
Outpatient	115,839	50,085	-65,754
Total	**193,602**	**93,838**	**-99,764**

Divisional Income

The YTD divisional income position is now better than plan by £1.6m. This is driven by claims for Covid -19 revenue reimbursement from the centre.
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Workforce & Finance: Trust Pay June 2020

Trust Pay Performance

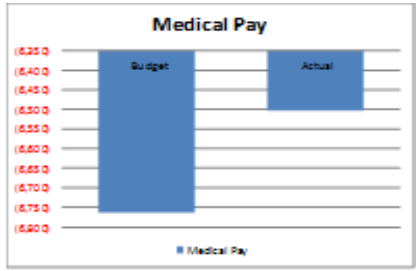
Expense Type	Annual Budget	In Month (£000's)			WTE		
		Budget	Actual	Variance	Budget	Actual	Variance
Medical Pay	(81,414)	(6,763)	(6,503)	261	711.37	781.60	-70
Non-Clinical Pay	(63,182)	(4,863)	(4,209)	655	1,270.89	1,199.87	71
Nursing Pay	(79,663)	(6,637)	(6,398)	239	1,629.40	1,525.08	104
Other Clinical Pay	(29,645)	(2,470)	(2,629)	(159)	1,018.42	1,047.42	-29
Scientific, Technical & Profes	(27,267)	(2,272)	(2,330)	(58)	511.40	517.50	-6
Pay Unidentified CIPs	9,386	361		(361)	0.00	0.00	0
Total	**(271,786)**	**(22,645)**	**(22,069)**	**576**	**5,141.48**	**5,071.47**	**70**

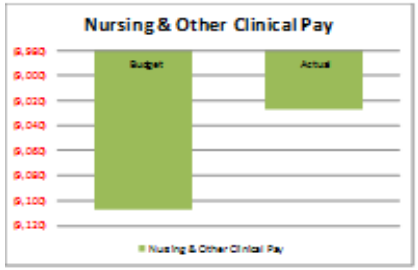
The Trust reported an in month underspend of £0.58m. This is linked to reduced activity levels performed in month. There was also £0.63m worth of cost captured in relation to Covid-19.

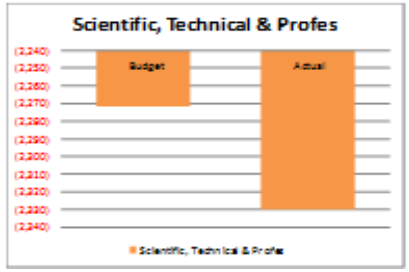
Key areas to note include;

Medical pay was £0.26m underspent, this is linked to operational changes in dealing with the covid-19 outbreak.
Non Clinical Pay- was underspent by £0.66m. This represents unspent growth reserves across divisions.
Nursing and other clinical pay showed a combined underspend against plan of £80k. This was driven by a lower bank and agency spend in month due to unfilled shifts.
Agency premium to cover scientific and professional vacancies across clinical support, theatres and cardiology generates the £58k overspend in month.
Expected pay efficiencies in month were not achieved and this caused a £0.36m adverse movement against plan.

Additional work is ongoing to understand any future cost implications of implemented hospital zoning versus existing funded establishment.







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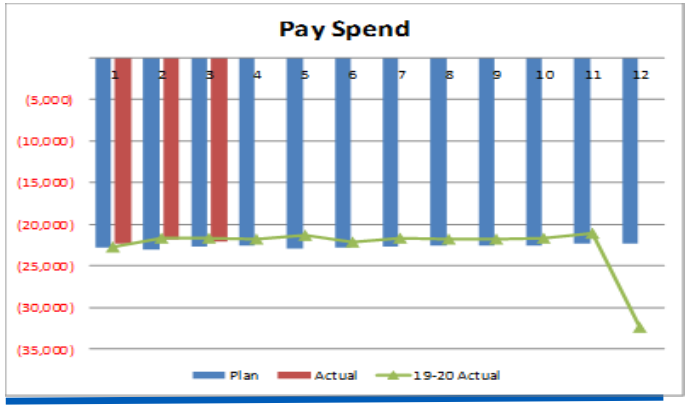
Workforce & Finance: Trust Pay June 2020



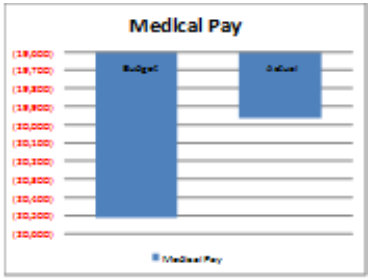
The year to date reported position shows an underspend of £2.23m.
Key year to date themes to note are:

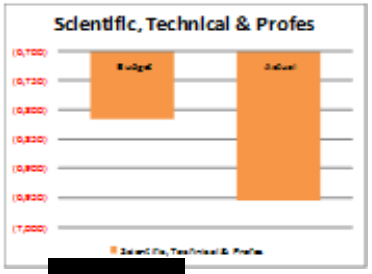
Medical pay – is showing an underspend of £549k. This reflects operational changes made during the covid-19 pandemic.

Nursing and other clinical pay has a combined underspend of £0.49m YTD. This is driven by a lower bank and agency fill rate and operational changes made to deal with Covid-19 (zonal deployment).

Scientific & therapeutic agency premium to cover vacancies across clinical support, theatres and cardiology are causing £0.14m YTD overspend.
The above overspends are buffered by unutilised growth monies sitting on the non clinical pay line.

Unachieved CIPs due to the temporary suspension of the efficiency programme account from a £0.72m overspend.
Total Pay costs which have been spent in relation to the Covid-19 pandemic total £2.1m.overspend.





YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(81,414)	(20,513)	(19,964)	549
Non-Clinical Pay	(63,182)	(14,545)	(12,439)	2,106
Nursing Pay	(79,663)	(19,915)	(19,130)	785
Other Clinical Pay	(29,645)	(7,411)	(7,705)	(294)
Scientific, Technical & Profes	(27,267)	(6,816)	(6,955)	(139)
Pay Unallocated CIPs	9,386	722		(722)
	(271,786)	**(68,478)**	**(66,192)**	**2,286**

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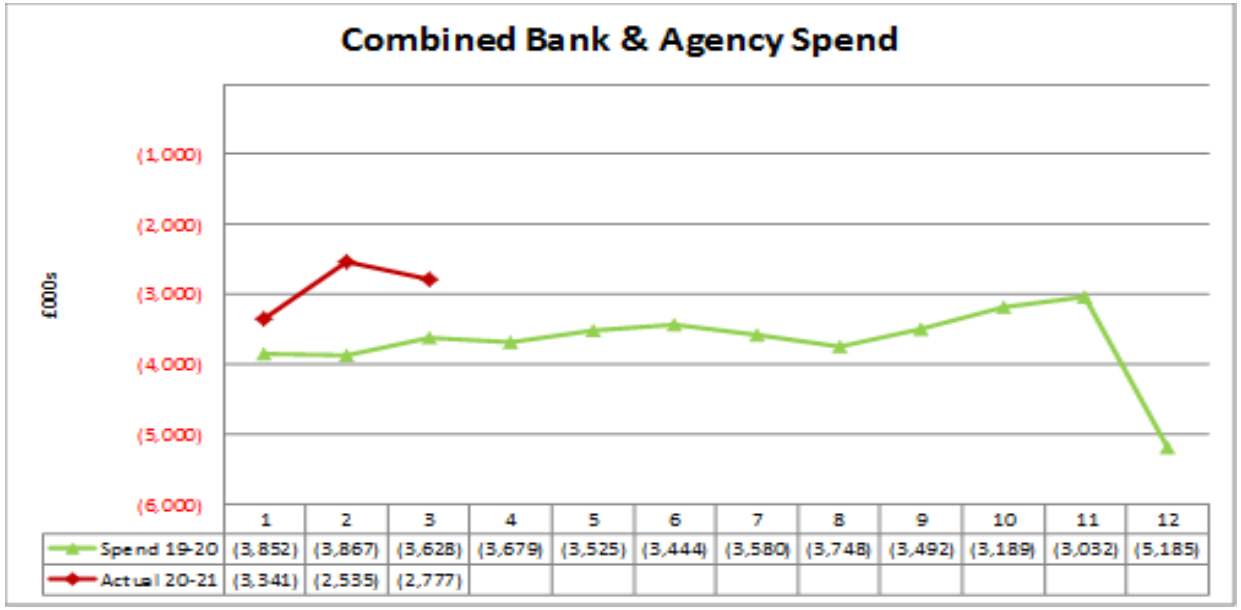
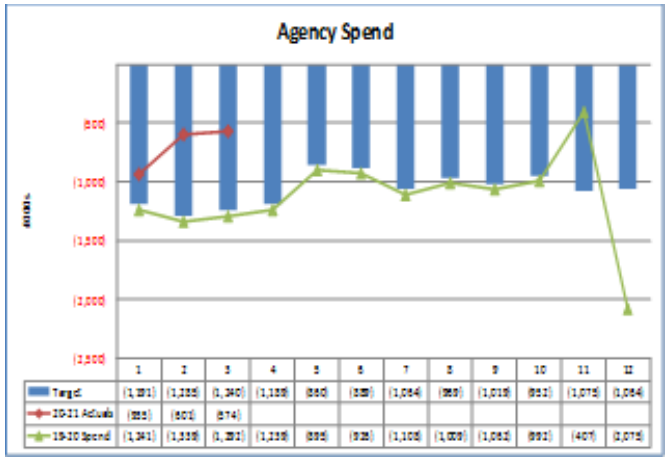
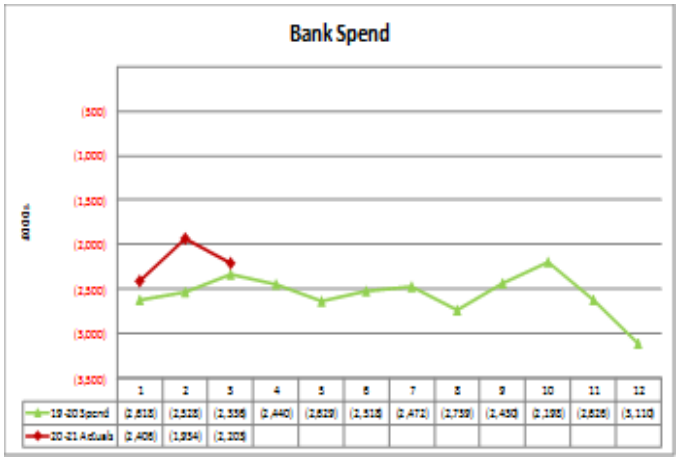
Workforce & Finance: Bank & Agency Spend June 2020



	1	2	3	4	5	6	7	8	9	10	11	12
Spend 19-20	(3,852)	(3,867)	(3,628)	(3,679)	(3,525)	(3,444)	(3,580)	(3,748)	(3,492)	(3,189)	(3,032)	(5,185)
Actual 20-21	(3,341)	(2,535)	(2,777)									





Agency

The Trust has set an internal target of £12.8m for 20-21.

This is £0.2 lower than the internal target set last year.

Agency expenditure in the month totaled £0.57m. This is lower than previous months and reflects unfilled agency shifts and operational changes within the Trust.

Of the £0.57m in month spend, £0.19m has been spent in relation to covid.

Bank

Bank spend for June was £2.2m. This is broadly in line with the average spend for months 1 and 2.

Of the £2.2m spend, £0.27m has been spent in relation to covid.

When comparing to the same month last year, the Trust has spent £0.85m less on temporary staffing.

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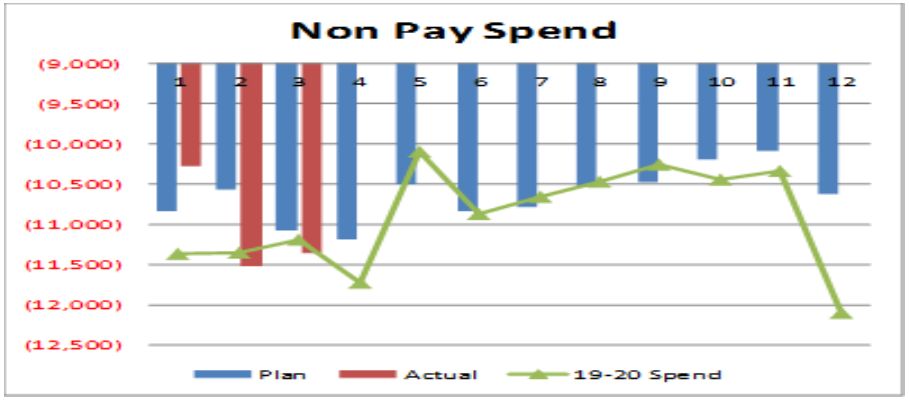
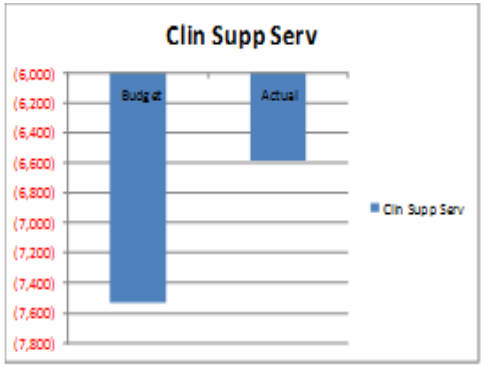
Workforce & Finance: Non Pay June 2020

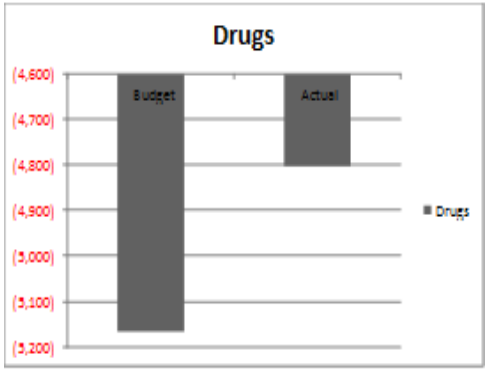
Non Pay Performance

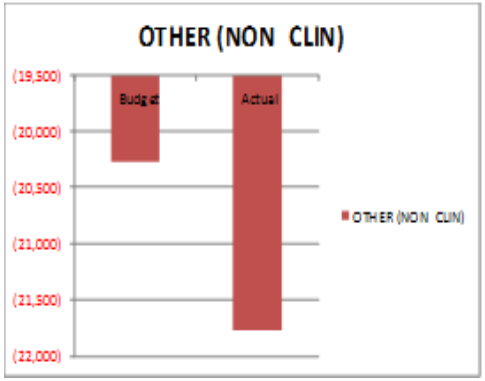
Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	YTD Budget	Actual	Variance
Clin Supp Serv	(31,253)	(2,717)	(2,186)	531	(7,535)	(6,586)	950
Drugs	(21,424)	(1,863)	(1,424)	439	(5,166)	(4,803)	363
OTHER (NON CLIN)	(81,315)	(6,739)	(7,752)	(1,013)	(20,270)	(21,770)	(1,500)
Non Pay Unallocated CIPS	6,257	241		(241)	481		(481)
Total	**(127,734)**	**(11,078)**	**(11,363)**	**(284)**	**(32,489)**	**(33,159)**	**(670)**



YTD Performance







The in month non pay position reported an overspend of £0.28m. Actual Spend was £11.36m against a budget of £11.08m.

The main drivers of the position include:

Clinical supplies were £0.53m underspent in month. This was driven by lower activity numbers in June. Fewer elective cases in month resulted in underspends against high cost devices.
Drugs were underspent by £0.44m. This reflects the volume and complexity of patients seen in month.
Other non clinical supplies were overspent by £1m. The majority of this relates to covid related infrastructure costs.
The position includes a total spend of £1.9m in relation to covid-19 in month.

YTD the position is £0.67m overspent. This includes total YTD covid non pay costs of £4.9m.

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Workforce & Finance: Covid-19 Cost Capture June 2020

Principles

Two main financial control principles are used to ensure relevant Covid-19 costs are charged:

All expenditure to the central code must be signed off by a Chief officer.
Divisional expenditure is collated through finance managers within each division, and then assessed for relevance, backup etc before being submitted for Chief approval.

Month 3

In month 3 the following costs have been captured:

£629k pay
£1,898k non-pay

This has been offset with £2,527k worth of central income.

Major equipment purchases will be largely non-recurrent, while staff costs will be ongoing and increasing as the number of patients peaks.
.

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Pay	Medical Pay	175	476
	Non-Clinical Pay	243	444
	Nursing Pay	99	606
	Other Clinical Pay	12	221
	Scientific, Technical & Profes	100	367
Pay Total		**629**	**2,114**

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Non Pay	Cleaning supplies & materials	19	53
	Computer expenditure	53	53
	Consultancy	31	127
	Drugs		374
	Estates expenditure	111	565
	Laboratory expenses	312	714
	Medical & Surgical Equipment	335	1139
	Other non-pay	828	1492
	Printing & stationery	4	21
	Provisions	99	184
	Staff Uniforms	106	137
Non Pay Total		**1,898**	**4,858**
Grand Total		**2,527**	**6,972**

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Workforce & Finance: Efficiency Programme

WHHT - FY21 CIP Efficiency Covid 19 impact

FY21 Efficiency Strategy Themes
Covid 19 impact (as of 14.05.20)

Division	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	Total £000
A&C Establishment Review (WTE Reduction)	4	8	12	15	19	23	27	31	35	38	42	46	**300**
A&C Establishment Review (Skill Mix)	1	3	4	5	6	8	9	10	12	13	14	15	**100**
Medical Establishment Review (WTE Reduction)	13	26	38	51	64	77	90	103	115	128	141	154	**1,000**
Medical Establishment Review (Skill Mix)	3	6	10	13	16	19	22	26	29	32	35	38	**250**
Nursing Establishment Review (WTE Reduction)	13	26	38	51	64	77	90	103	115	128	141	154	**1,000**
Nursing Establishment Review (Skill Mix)	6	13	19	26	32	38	45	51	58	64	71	77	**500**
Senior Manager Establishment Review (WTE Reduction)	3	6	10	13	16	19	22	26	29	32	35	38	**250**
Senior Manager Establishment Review (Skill Mix)	1	3	4	5	6	8	9	10	12	13	14	15	**100**
Non-Pay Procurement initiatives	26	51	77	103	128	154	179	205	231	256	282	308	**2,000**
Non-Pay Divisional Targets	60	119	179	238	298	357	417	476	536	595	655	714	**4,644**
Outpatients - Service Development	26	51	77	103	128	154	179	205	231	256	282	308	**2,000**
Contracts & Commercial opportunities	19	38	58	77	96	115	135	154	173	192	212	231	**1,500**
Non-SLA Income opportunities	26	51	77	103	128	154	179	205	231	256	282	308	**2,000**
Total	**201**	**401**	**602**	**802**	**1,003**	**1,203**	**1,404**	**1,605**	**1,805**	**2,006**	**2,206**	**2,407**	**15,644**
	Covid 19 April - July impact			**2,006**									

FY21 CIP Efficiency Divisional Target
Covid 19 impact (as of 14.05.20)

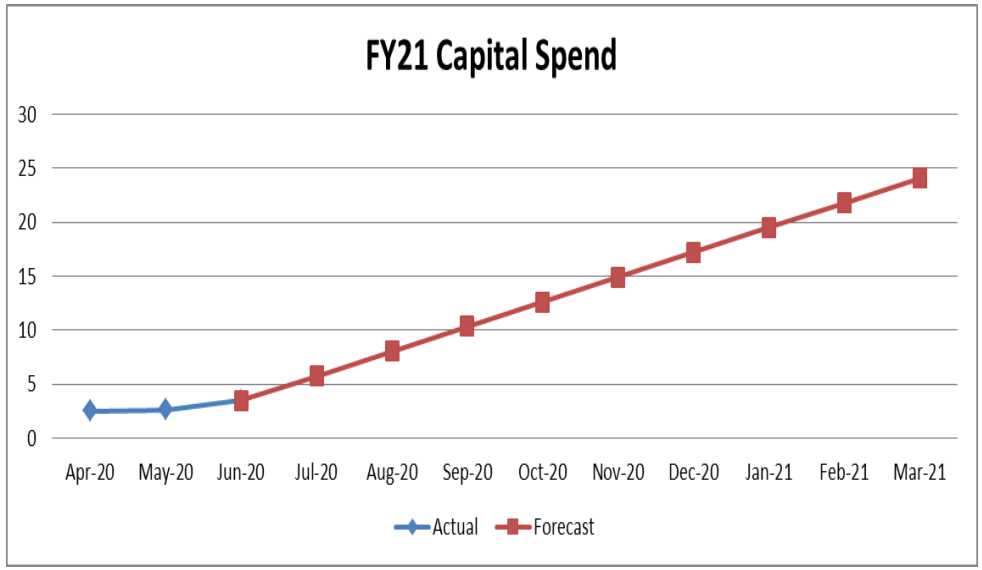
Division	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	Total £000
Clinical Support	18	35	53	70	88	105	123	140	158	175	193	210	**1,367**
Corporate	24	48	72	97	121	145	169	193	217	241	266	290	**1,883**
Medicine	43	86	130	173	216	259	303	346	389	432	476	519	**3,372**
Surgery & Anaesthetics	53	106	159	212	265	318	371	424	477	530	583	637	**4,137**
Emergency Medicine	21	43	64	86	107	128	150	171	192	214	235	257	**1,667**
Womens & Childrens	22	44	66	88	110	131	153	175	197	219	241	263	**1,709**
Environment	19	39	58	77	97	116	135	155	174	193	213	232	**1,508**
Total	**201**	**401**	**602**	**802**	**1,003**	**1,203**	**1,404**	**1,605**	**1,805**	**2,006**	**2,206**	**2,407**	**15,644**
	Covid 19 April - July impact			**2,006**									

At the time of writing NHSI guidance is that the first 4 months of the Trust's FY21 efficiency program have been suspended, it is anticipated that NHSI guidance around impacts beyond July will be provided imminently.

WHHT FY21 April to July impact is £2m

West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Capital Expenditure June 2020



YTD Capital spend by Scheme

Month	Scheme	Spend (£m)
1	**Your Care Your Future**	**0.3**
1	**LED Lighting**	**0.2**
1	**Medical Equipment**	**0.6**
1	**Backlog maintenance**	**0.1**
1	Covid-19 related projects	1.3
	Month 1 Total Spend	**2.5**
2	Your Care Your Future	0.06
2	Covid-19 related projects	-0.49
2	Fire Safety	0.31
2	Backlog maintenance	0.25
	Month 2 Total Spend	**0.13**
3	Your Care Your Future	0.08
3	Medical Assessment Unit	0.31
3	Endoscopy Equipment	0.29
3	Replacement of Pharmacy Robot	0.06
3	Theatre Project	0.08
3	WAN Infrastructure- IT	0.03
	Month 3 Total Spend	**0.85**
	YTD Spend	**3.48**

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Safe Care & Improving Outcomes: Mortality Indicators

In this reporting period:
The latest available (February 2019 to January 2020) Summary Hospital Mortality Indicator (SHMI) was 99.0 and within the 'as expected' range (band 2). For the 12 month period (April 2019 to March 2020), the Trust's overall HSMR of 100.7 was within the 'as expected' range. The COVID diagnostic code will not be part of the HSMR primary diagnostic bundle and has a separate SMR code and as such effects on mortality indicators are currently predicted to be minimal although will be observed closely.

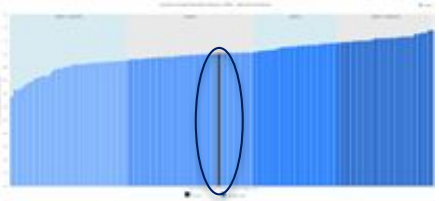
Quantitative aspects of Mortality :
A case note deep dive review is undertaken for each 'outlying' primary diagnostic SMR group with a speciality or senior trust consultant and the coding manager. This process is consistent and has not highlighted any lapses of care to date in those outlying groups. Current outlying groups include secondary malignancies but as the SMR has recently shown a downward trajectory, this will be kept under close observation.

Qualitative aspects of Mortality:
Monthly specialty/departmental Mortality Review meetings have restarted as well as the process for Structured Judgement Review (SJR) both of which had been suspended. There have been 35 cases allocated to reviewers since restart (with a residual backlog of 28) and 22 cases returned and completed by reviewers. The level tier 2 work for judgements of potential avoidability of death has resumed.

In Q1 20/21 4 cases were considered to have received suboptimal care and the rest, the majority, care of an appropriate standard.

Performance stable
Better than target/threshold

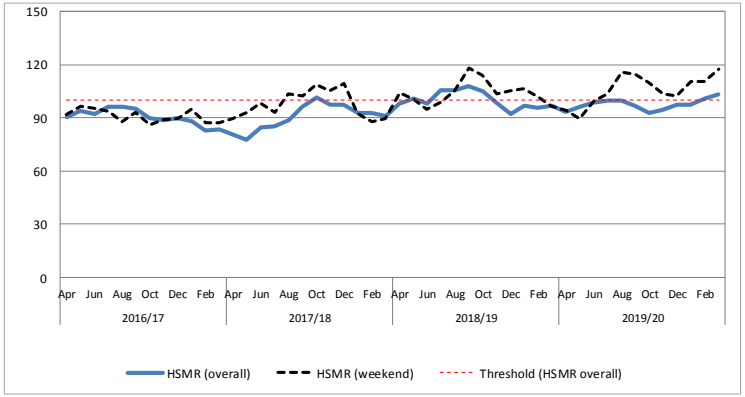
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



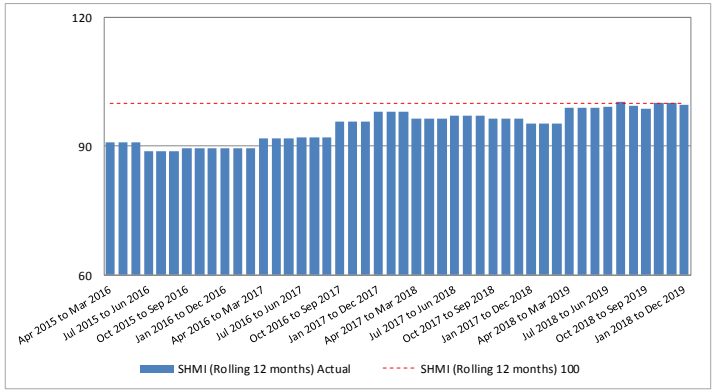
Period: Jan 2020

WHHT 1.01 **Sector: 1.01**

HSMR – rolling 3 months



SHMI – rolling 12 months



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	1a / 1b / 2a / 3a / 4a

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

In this reporting period:
Clostrioides difficile Infection (CDI) objectives for 2020/21 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 (CAT1). 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 continues in 20/21. The continuation of work around the CDI action plan has included visits to clinical areas to support patient reviews and raise awareness regarding learning from CDI. This includes PPE compliance and embedding the basics of IPC. In June 2020 0 cases of C diff infection were attributed to the Trust . Total number of Trust apportioned cases April to June is 5 cases (all cat 1). RCA's have been undertaken on all of these cases, with a plan for re starting review meetings with CCG/ICS in the near future.

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 June 2020. With over a year since the last post 48 hour (trust) cases .

Outbreaks/ Covid19: The IPC team supports the management of the Covid19 Pandemic through daily clinical visits and reviews, PPE training in clinical areas. Advice and support regarding management of Covid19 in both clinical and non clinical areas. Work is undertaken in the analysis of positive Covid19 test results , for managing any Hospital Acquired cases (in line with NHSE definitions) , all patients are now tested on admission and screening on day 5 -7 of their admission. During June x2 outbreaks were identified and a full Outbreak meeting and investigation has been undertaken with an SI process commenced. .
Hand hygiene (HH): Hand hygiene compliance for the month of June is above the 95% target across the trust. HH training on ward visits is routine, staff now reminded of importance of washing to the elbow in clinical areas. IPC undertakes daily clinical visits to observe and provide support to ensure compliance with hand decontamination and PPE compliance.
Water Management, Ventilation and Decontamination: The Trust has groups in place to monitor all of these areas. Water Safety Group meetings have been undertaken and ventilation/decontamination discussed as part of covid management structure.

Performance stable
Better than target/threshold

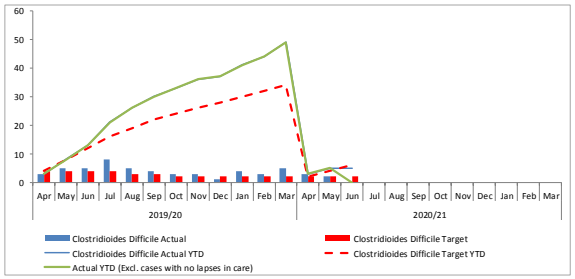
Benchmarking: MODEL HOSPITAL
Rolling 12 month trust apportioned Cdiff infections / 12 month avg occupied bed days

Period: to March 2019

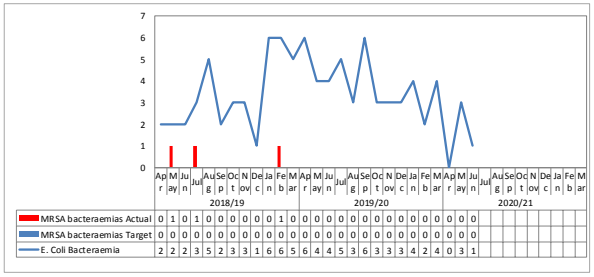
WHHT 6.42 Peer 13.68
National 11.11

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

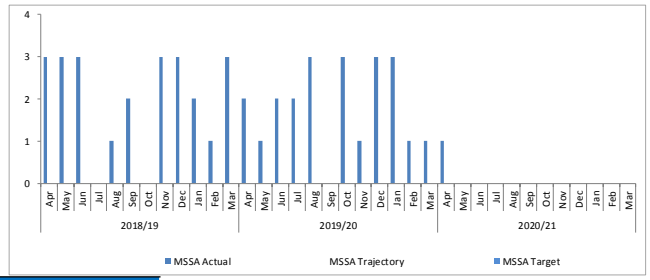
Clostrioides Difficile Infection (CDI)



MRSA



MSSA



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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

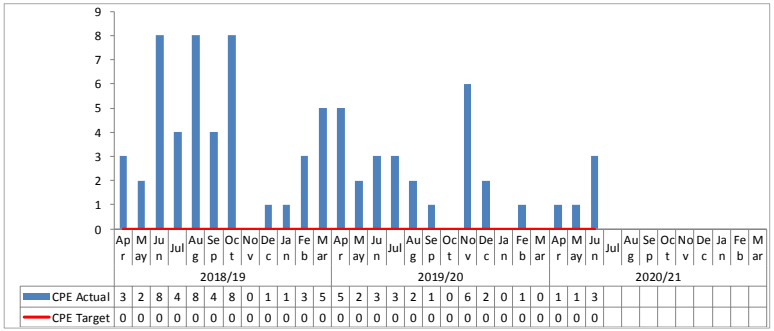
In this reporting period:
E. Coli bacteraemia (E colib):
There was 1 post-48hr cases and 14 pre-48 hour cases (non-trust) reported in June 2020. This is a reduction on previous month. There is no externally set target for the trust but the national target is to deliver a 25% reduction by 2021 and 50% by 2024; this is reflected in the quality indicator which is monitored by the CCG. Thematic data is gathered for post-48 hour cases and reviewed alongside microbiology review of the pre-48 hour cases. Work around this is to be recommenced as part the recovery plan.

Methicillin-sensitive Staphylococcus aureus (MSSAb):
There was 0 post-48 hour case and 2 pre-48 hour cases of MSSAb in June 2020. Each case is usually reviewed by a microbiologist using an RCA tool to identify and share learning and is to be picked up as part of the Covid19 work. No MRSAb has been recorded (post 48hr) for over a year.

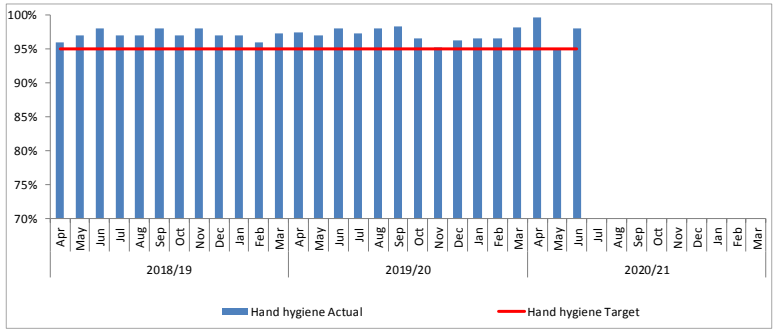
Carbapenemase-producing Enterobacteriaceae (CPE):
The trust routine management and compliance process for CPE continues, including screening, enhanced cleaning and isolation. This is being re-embedded as the trust recovers from the Covid19.

IPC Progress Update: The IPC Code of Practice (CoP) audits have been reviewed to incorporate Covid19 IPC guidance & the BAF. Divisions and wards have recommenced their CoPs audits in their departments, and IPC Team are supporting. . During June work on the use of PPE continues for Covid19, . The IPCT have been providing practical support to clinical areas . There is continued monitoring of water quality, ventilation, decontamination, antimicrobial stewardship and cleaning across the trust. There is ongoing discussion from IPC with Facilities, Estates, Mitie and the clinical team to ensure we work together to improve the standard of cleanliness of the environment which is fundamental in the prevention of Nosocomial infections in Covid.
Next steps: The work of the IPCT is to support the Divisions in all aspects of IPC supporting the prevention of health care associated infections including COVID in all areas. There is continued focus on cleaning, hand decontamination and PPE compliance to ensure safety of our staff and patients, particularly focusing on Covid19 and other key HCAIs such as CDI, CPE and Gram Negatives Rods.

Carbapenemase-producing Enterobacteriaceae (CPE)



Hand hygiene compliance



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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Safe care & Improving Outcomes: COVID-19 (Slide 1 of 3)

Learning from COVID-19

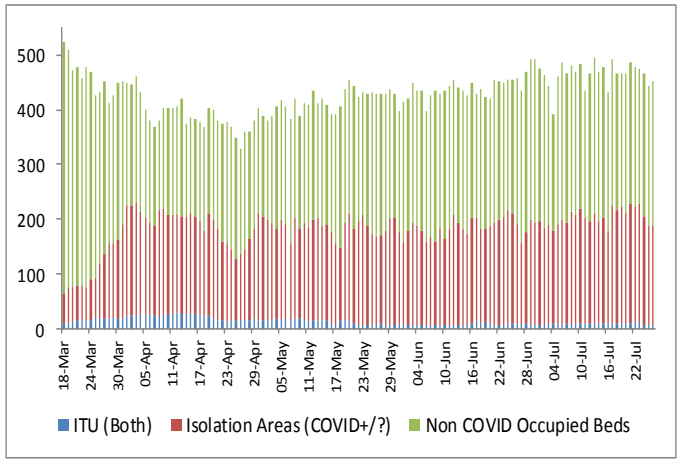
Implementation of improved testing to support the reduction of movement of patients. Increased operational oversight of results and patient tracking to ensure timely result management, and patient transfers. Focus on documented PPE training for all staff working in Covid and non-Covid areas as well as Don & Doffing. Re design of audit tool to support BAF and general IPC standards with feedback and support for clinical areas.

A COVID RCA tool has been developed to support the review of Hospital-Onset Probable & Definite Heatlhcare-Associated cases. The learning identified through the RCA process will be shared across the divisions and along with audit data/feedback the data will be analysed for any areas requiring improvement

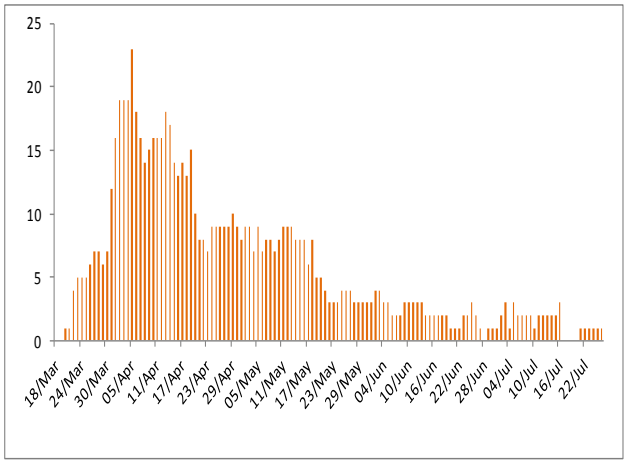
C19 Isolation Wards (including ITU) - discharge status

%	Discharged	Died
18-31 Mar	77%	23%
Apr	66%	34%
May	87%	13%
Jul	95%	5%
Jun to date	96%	4%

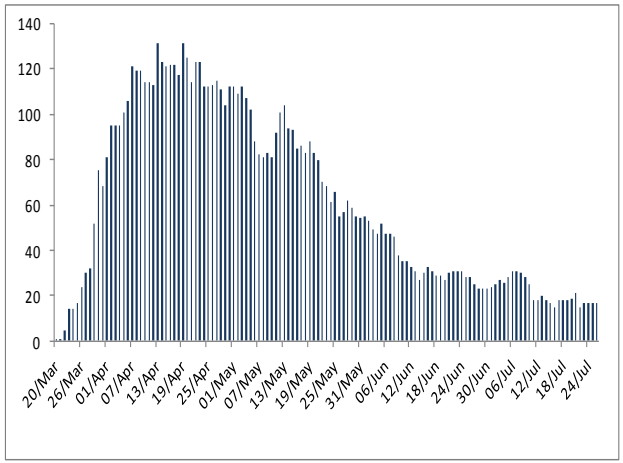
Occupied beds all areas at 0800



COVID-19+ve patients in ITU at 0800



COVID-19+ve patients in other beds at 0800



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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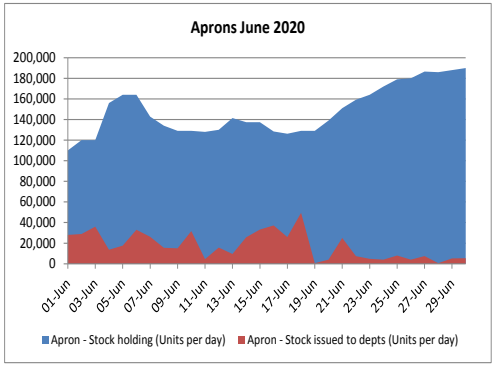
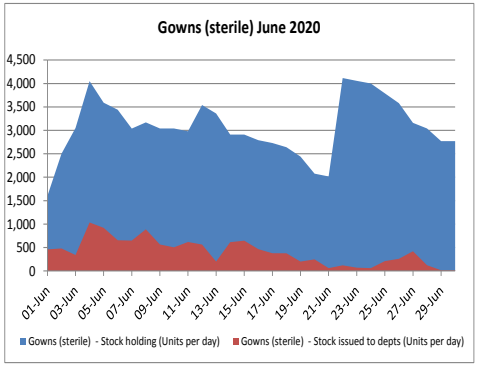
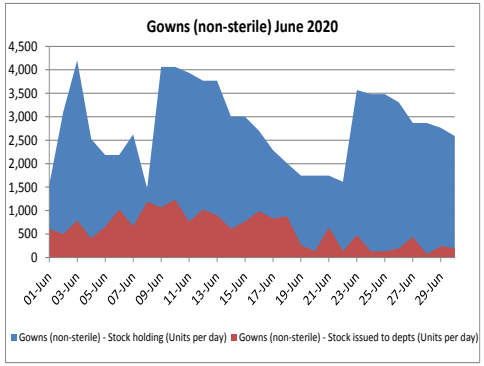
Safe care & Improving Outcomes: COVID-19 (Slide 2 of 3)

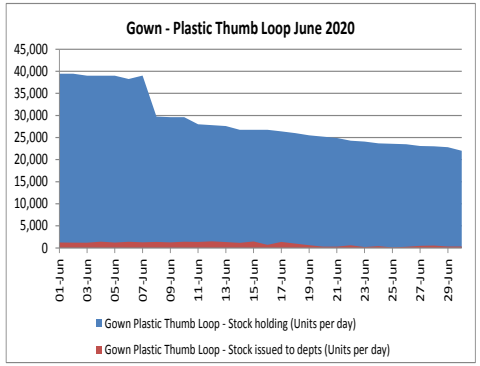
PPE

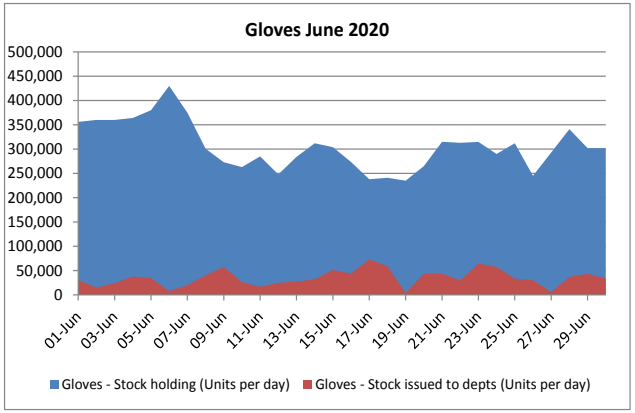
- Central DHSC control of supply and delivery of items from the National Pandemic stock continues.
- The graphs below show at a summary level usage (red block) has remained below stock level although during May stock levels for gowns were under pressure.
- The main current concern remains that National Pandemic stock levels are low on certain (preferred) types of FFP3 masks. This has lead to repeated fit tests on different products that are now being supplied..
- Risks around quality of goods supplied is managed by local examination undertaken by the NHS Herts Procurement clinical product specialist.
- Stock levels for different PPE items are reported to Chief Officers and the IMT every day. This allows Chief Officers to escalate further action at Regional level or seek mutual aid from other organisations.
- PPE use forecasts are being collated and compared to anticipated supply to support the re-start of normal activity.

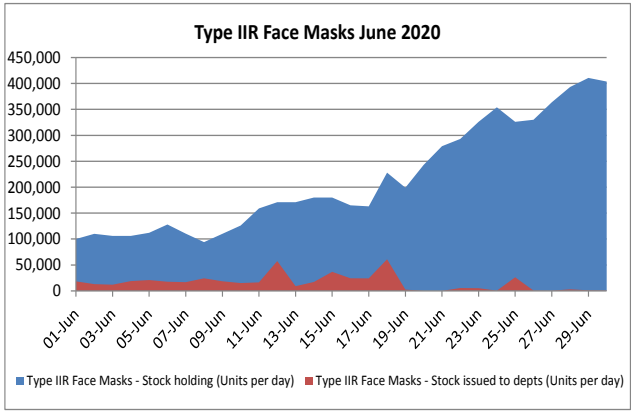


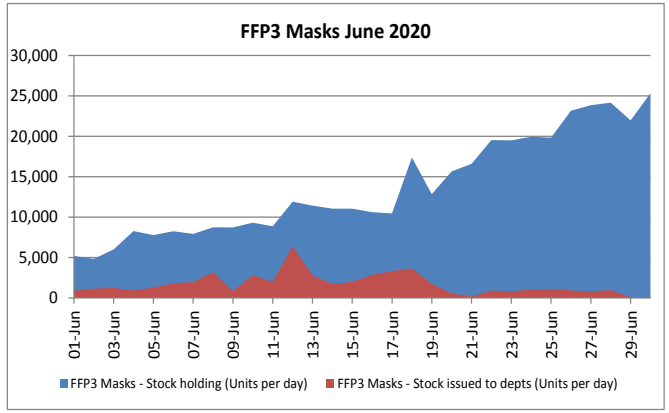












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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Safe care & Improving Outcomes: COVID-19 (Slide 3 of 3)

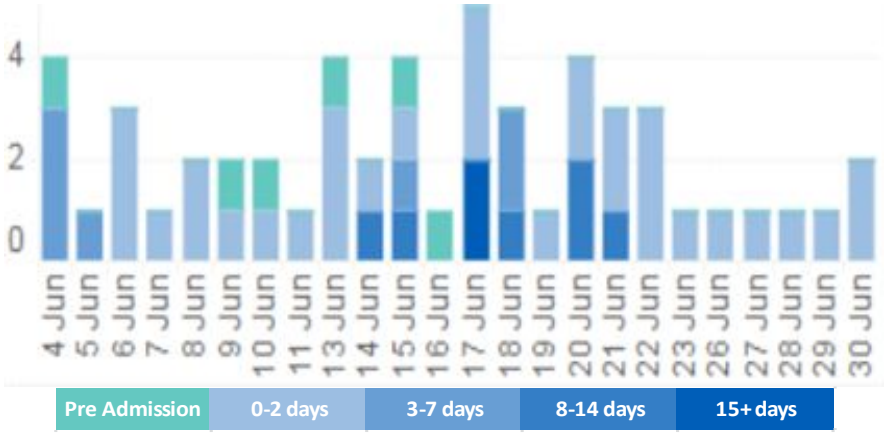
Nosocomial infection cases

COVID19 positive in-patient cases are routinely reviewed by Respiratory & Microbiology team. Cases reviewed prior to national Nosocomial infection definitions did not identify cause for concern.

On the 19th May 2020 four defined categories for COVID Nosocomial Infection was confirmed nationally. The 4 categories of Nosocomial Infection are based on date of patients sample in relation to their date of admission. The 4 categories are 0-2 days (Hospital-onset community Healthcare-Associated), 3-7 days (Hospital-onset indeterminate Heatlhcare-Associated), 8-14 days (Hospital onset probable Healthcare-Associated) and 15+ days (Hospital-onset definite Healthcare Associated). Emergency management and IPCT is working with Information Team to collate and capture this data for reporting to PHE.

A COVID19 RCA has been developed locally to support the clinical review of all Hospital-Onset Probable & Definite Heatlhcare-Associated cases. The RCA process will be supported by the divisions, and learning identified will be shared across the organisation.

Nosocomial infection cases



Staff testing – Drive-through data covers the period 1st June to 30th June

Drive-through testing					
Days from initial contact to drive-through test*			Days from swab taken to result received*		
No of Days	Tests	%	No of Days	Results	%
0	376	10.1%	0	2	0.5%
1	522	14.0%	1	15	3.9%
2	584	15.6%	2	100	26.1%
3	539	14.4%	3	137	35.8%
4	570	15.2%	4	42	11.0%
5	299	8.0%	5	47	12.3%
6	231	6.2%	6	3	0.8%
7	161	4.3%	7	3	0.8%
8+	458	12.2%	8+	34	8.9%

*excludes DQ issues eg -ve days between

Drive-through - All Results Received	Positive	Negative	Invalid Test	Total Results	% Positive
Staff – All (WHHT + Bank/Agency/Mitie)	15	285	2	302	5.0%
Total (Staff + Household + Other)	21	374	3	398	5.3%

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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Safe care & Improving Outcomes: Emergency Readmissions

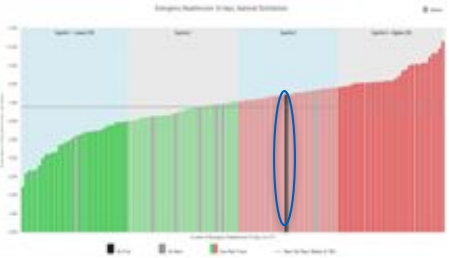
In this reporting period:
The readmission rate, benchmarked against the most up to date national position (December 2019) was above the national average overall, and for readmissions following an elective and emergency (original) admission.

There has been a increase in emergency readmissions, to 15.1%, which is 1.2% more than the national average of 13.9%.

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

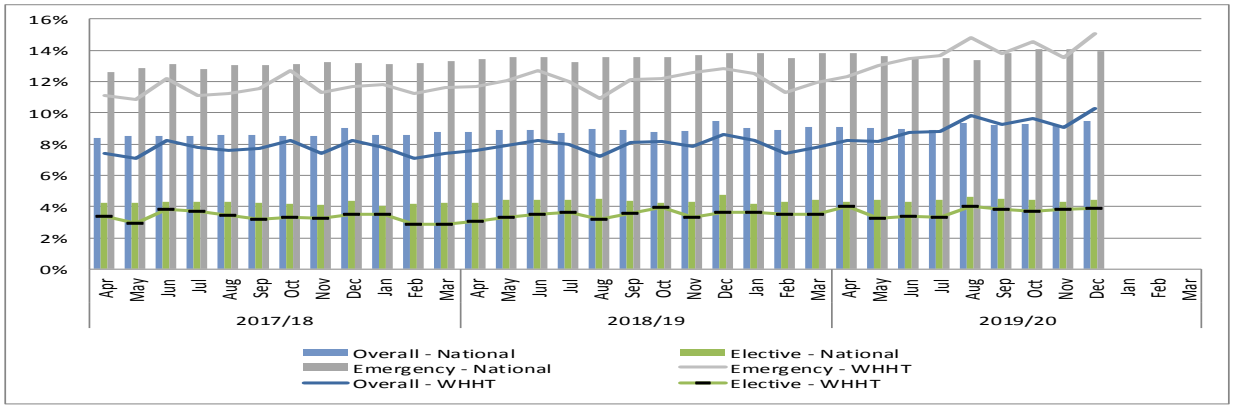


Period: Q4 2019/20

WHHT 7.46% Peer 6.76%
National 7.09%

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

Emergency Readmissions



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	2a / 2b / 2c / 3a / 4c

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Safe care & Improving Outcomes: Caesarean Section rates

C-section rate
The elective and emergency combined rate is 32.8%. CMIS data shows Elective CS rate of 14.4(LMS 18.6) and Emergency rate of 18.3(LMS 15.6).

Women's choices for mode of birth are facilitated as per the NICE guidance.

C-sections have been reviewed daily by the incoming teams on call and the data will be presented at the next Governance meeting and learnings embedded.

The central foetal monitoring system has enabled the on call teams to monitor women more closely especially in isolated patients. The foetal monitoring team has been actively supporting staff to monitor babies.

Training in Instrumental delivery and foetal monitoring are now being offered via virtual platforms. Operative delivery is increasingly consultant led/ supervised . The next course of instrumental deliveries is scheduled for September.

VBAC uptake rates have consistently been the best in the LMS at 60%(Average 25.8)and the efforts to enable women to take an impartial informed choice is ongoing.

Performance stable
Better than target/threshold

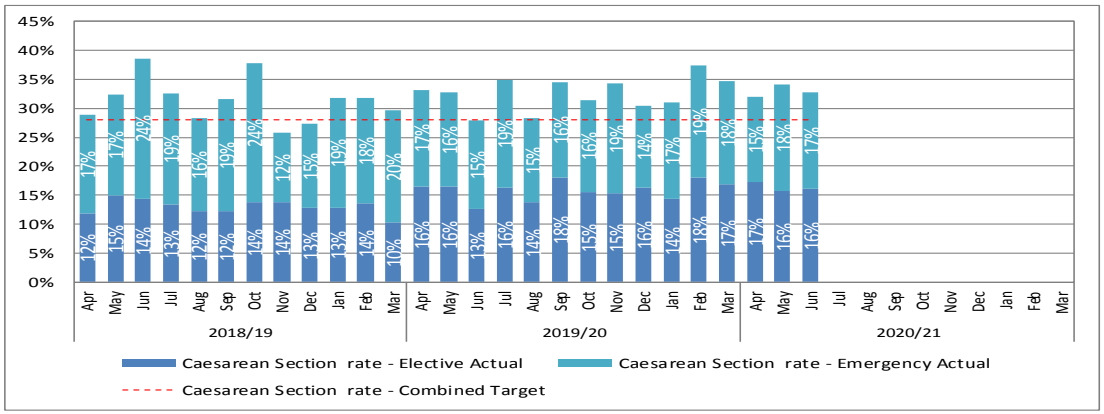
Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate

Period: March 2020

WHHT 18.40% Peer: 16.83%
National: 16.63%

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

Caesarean section rates



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	2a / 2c / 3a / 4c

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Submission suspended

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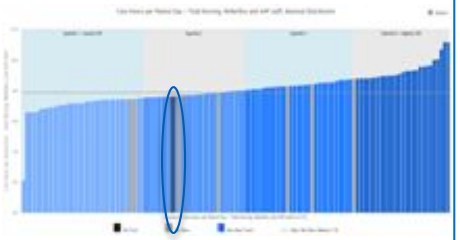
Safe care & Improving Outcomes: Workforce and CHPPD

In this reporting period:
On the 8 June staffing templates reverted to pre-COVID establishment templates. Staffing is reviewed as part of the operational site meeting and at the workforce safe staffing hub at 0830 and 1430, where senior nursing staff support, guide and amalgamate workforce resources using patient dependency and acuity recorded on safe care and professional judgement. During June the fill rate was 107.8%; (103.2% registered and 106% unregistered). Zone A – Granger: overall staffing was 101.2% to cover four wards (Red, Bluebell, Winyard and Winter). During this period bed occupancy for isolation was significantly reduced due to low numbers of COVID positive/COVID suspected patients. ITU overall fill rate was 119.1% and during this period ITU had high levels of unregistered redeployed staff supporting the registered team with a number of activities day and night. Overall 89.1% shifts were RAG rated green, down 0.6% from last month. 11.5% were rated amber, down 1.5.% from last month and no red shifts were reported. Ward leaders' supervisory time was 77.7%, down 0.4% from last month and focused on promoting patient safety**,** developing and supporting junior staff and managing the ward, 22.3% lost represents annual leave and redeployment to clinical areas supporting safe staffing. Bank and agency total demand hours continues to be significantly reduced. This is due to reduced service provisions and a reduction of patients in both isolation and ITU, which allowed substantive staff to be redeployed. A total of 52,185 demand hours were requested (1,774 less than last month) of which 81.5% were bank and 4.8% agency. Any request for additional shifts within hours must be authorised by HoNs and out of hours by the senior nurse, in discussion with the on call manager. At the June workforce meeting chaired by the Deputy Chief Nurse, KPIs indicated good management of e-rostering. Since March, ie during COVID the realignment of medicine beds has resulted in there being no designated dementia unit. There has been a significant increase in enhanced care usage to 7951.34 hours, an increase of 2,447.63 from last month. CHPPD rate overall was 10.01 (5.59 registered and 4.42 unregistered). This increase is in part due to staff redeployments, students forming part of the workforce and reduced bed occupancy in some clinical areas. Current band 5 nursing vacancy is 6% and the turnover is currently at 16%, meeting the original target set by NHSEI. Overseas recruitment paused during COVID but HR are in discussion with the agency to resume this. WHHT has 20 overseas nurses working on the temporary register. The Trust is actively working to recruit its students currently working as Aspirant Nurses and Midwives.

Performance stable
Better than target/threshold

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



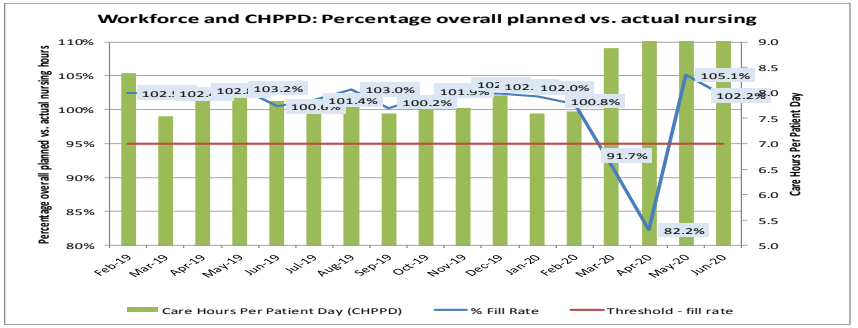
Period: February 2020

WHHT: 7.6 **Peer: 7.9**
National: 8.0

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

Factors/ Themes:

- Increase usage Enhanced care, business case to go to TMC in August.
- COVID staffing is on the risk register (risk 4273) and following review at RRG on 11 June the risk score was de-escalated to 12
- In addition to the 5 daily operational meetings, two workforce safe staffing hub meetings have been established to review staffing based on demand and acuity. These are chaired by the Deputy Chief Nurse and HONS.
- Staff are supported out of hours (incl BH and weekends) by band 7 bleep holders and by a Senior Nurse. In addition, overnight the senior night sister role has been put in place. Following review in July the role will has now been extended until 31st March.
- To support recruitment and retention of our students in July an incentive package has been offered .
- 20 July NMC announced opening of the OSCE test centres – 10 of our OSCE nurses have now been given dates to undertake, and the others are waiting on dates from the centres.



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1b / 4c / 7a / 7b / 8c

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Safe Care & Improving Outcomes: Patient Safety

In this reporting period – June 2020:

Never events
There were no Never Events reported in June 2020.

Serious Incidents
One (1) serious incident was declared in June 2020. At the end of June 2020 the Trust had 8 ongoing SIs; Of these 8, 1 was overdue and 6 were within date; an additional 1 investigation was being undertaken by HSIB.

There were 5 completed reports submitted to the commissioners during June 2020.

7 of the 8 overdue Serious incident reports were completed by the end of June 2020, leaving 1 report overdue.

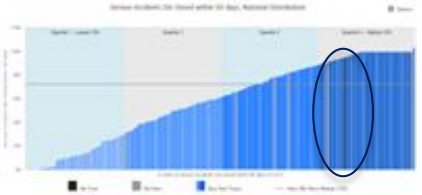
% of patient safety incidents which are harmful
7.5%(9) of incidents reported in June 2020 were recorded as having caused harm to the patient, compared to 8.4% in May 2020. This demonstrates a slight decrease compared to the May data which could be in part as a result of the relatively decreased pressures from the COVID pandemic.

There were 9 incidents reported in June 2020 with a moderate or above level of harm.

There was 1 incident reported in June 2020 with a harm level of Death/Catastrophic;
1. This incident relates to a Delay in transfer of the patient to ITU. The patient received 5 cycles of resuscitation before he died. The incident has been discussed at the SI panel meeting. The cause of death is awaited from the Coroner and is being followed up.

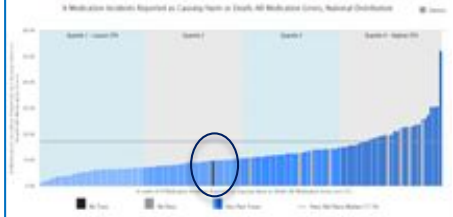
Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



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

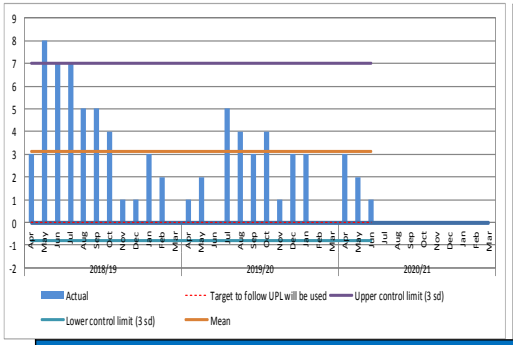
Benchmarking: MODEL HOSPITAL
% medication incidents reported as causing harm or death/all medication errors



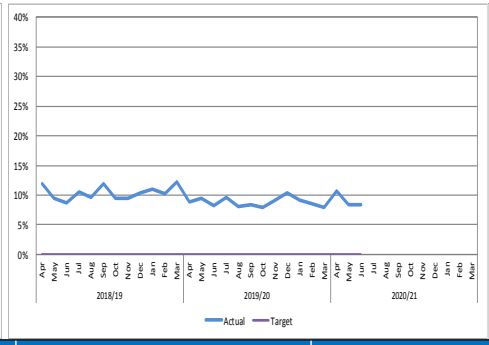
Period: 31/03/2019
WHHT 10.0% **Peer: 17.1%**
National: 10.7%

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

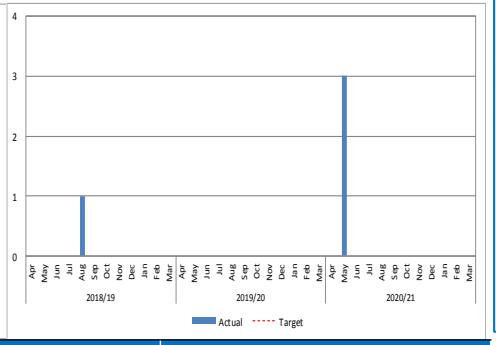
Serious Incidents



Safety incidents (% harmful)



Medication incidents causing serious harm



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1a / 1b / 2a / 3a / 4a / 4b / 4c

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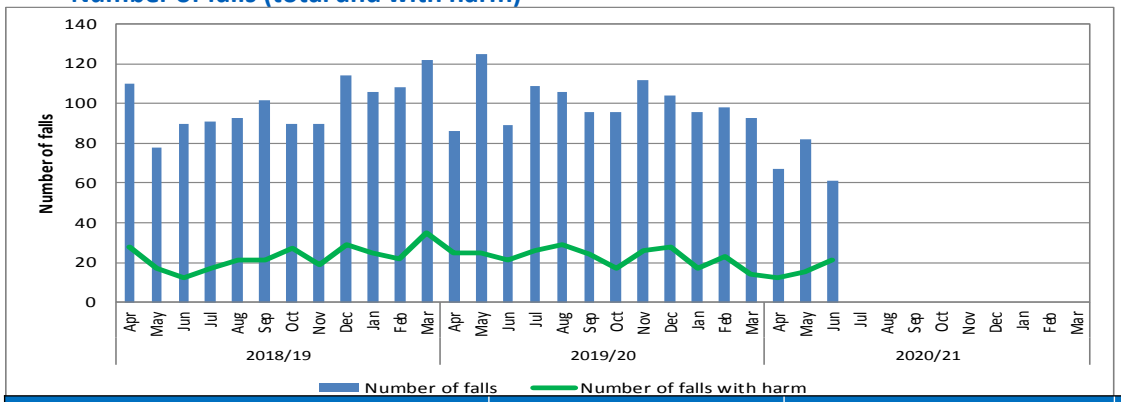
Safe Care & Improving Outcomes: Falls & Falls with harm

In this reporting period:
In June there were 59 inpatient falls in total, 21 with low harm.
13 (61.9%) falls were not witnessed, 8 (38.1%) falls were witnessed. 15 occurred during the day shift and 6 during the night shift. 9 (42.9%) incidents with harm involved patients with cognitive impairment. Of these, 5 patients reported as having dementia. Most falls 12 (57.2%) occurred around the bed area. Falls with harm remain low in comparison to the number of falls reported locally and nationally. Of the 86 falls reported in May, there were 3 recurrent fallers accounting for 7(11.8%) of incidents – a significant improvement when compared with previous months). In June fewer clinical areas reported high numbers of falls; Croxley 8, Aldenham 7

Actions:
- Falls awareness, prevention and management sessions on clinical staff development days
- Ward based bite size teaching with focus on iidentifying and managing adults at high risk of falls, effectively documenting falls preventative interventions and reporting harm levels for falls
- Spot check and challenge to improve patients' visibility by ensuring curtains are kept drawn back unless there is a clinical indication for use is ongoing – feedback from the wards have been positive.
- Using falls per 1000 occupied bed days to monitor and help clinical areas understand their falls rate as well as identify and manage areas for improvements.
- Continue to use QI methodology to test Swarming in Tudor Ward to help reduce falls
- Using QI methodology to reduce inpatient falls on Croxley ward;
    - Coloured wrist band to help identify high risk fallers and prompt effective management to reduce risk factors
    - BP management – aimed at reducing drug induced hypotension in elderly patients at risk of falls

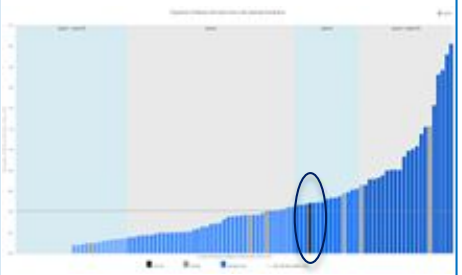
Number of falls (total and with harm)



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1b / 2a / 3a / 4c

Performance stable
Better than target/threshold

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



Period: December 2019

WHHT 0.5% **Peer: 0.4%**
National: 0.4%

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

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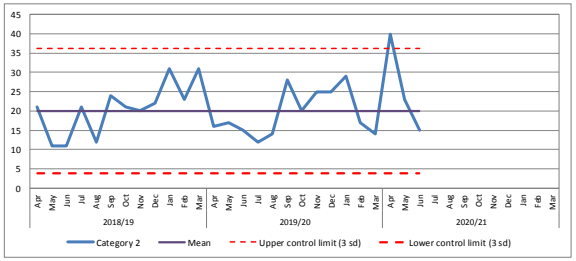
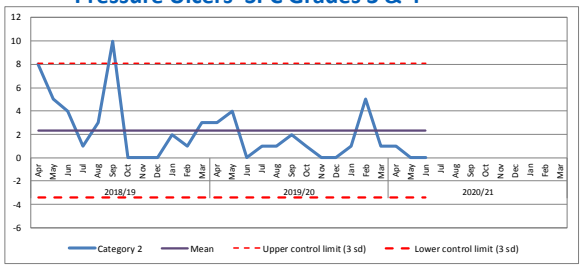
Safe Care & Improving Outcomes: Pressure ulcers (HAPUs)

Reportable HAPU (June 2020)			
Categories	**HAPU**	**Medical Device Related Pressure Ulcer**	**Total HAPU**
Category 2	8	8	16
Category 3	0	0	0
Category 4	0	0	0
Unstageable (possibly category 3 or 4)	1	2	3
Total reportable (affecting 14 patients)	9	10	**19**
Non-Reportable HAPU			
Category 1	7	2	9
Suspected deep tissue injury (SDTI)	6	2	8
Total non- reportable (affecting 18 patients)	13	4	17

Pressure Ulcers SPC Grade 2

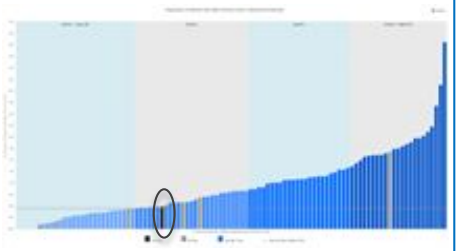


Pressure Ulcers SPC Grades 3 & 4



Stable

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



Period: December 2019

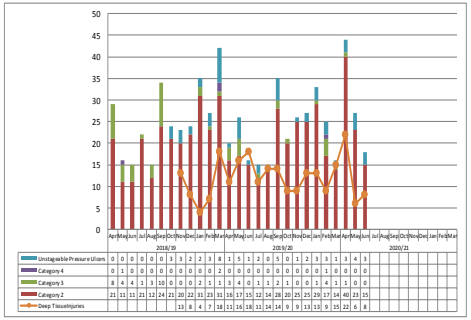
WHHT 0.5% **Peer 0.4%**
National 0.8%

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

The SPC demonstrates that the number of HAPU is within normal variation for the month of June.
However, there was an increase in the numbers of medical device related pressure ulcers - 10 reportable compared to 8 in May.
Widespread differentiation in location of pressure damage and anatomical location does not evidence specific causation, apart from the need for increased effective repositioning.

Actions:

Continue to raise awareness during the safety huddles regarding the precautionary and preventative approaches , recommended in the Pressure Ulcer Prevention and Management Policy for patients using medical devices .
Medical device related Pressure damage poster produced and distributed to all clinical areas
Effective repositioning being highlighted to clinical areas in wards. TVN team continue to undertake check and challenge exercise across clinical areas, and supporting wards experiencing repositioning challenges..
Meetings were arranged with the Matrons ,ward managers and the TVNs to identify possible related issues .Action plans to be confirmed.
Weekly ward based 30 minute," bite size" Tissue Viability training sessions ,on the Admission areas ,to continue and to be expanded throughout the Trust as requested.
Additional support to be arranged for the matrons and update training to be arranged for the band 7 nurses ,who validate pressure ulcers for the clinical areas.
Updated Pressure Ulcer Prevention Policy to be distributed once ratified
Review and reintroduce the Tissue Viability Resource Folders on all clinical areas. Suggestions are being invited to inform the contents of the proposed Revised Tissue Viability Resource folder.



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1b / 2a / 2c / 3a

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Safe care & Improving Outcomes: VTE risk assessment

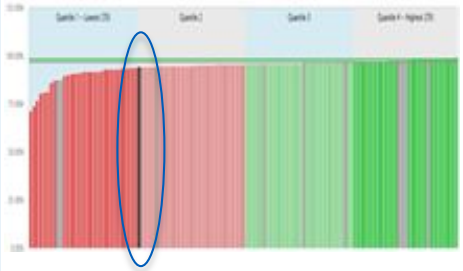
In this reporting period:
The target was achieved this month.

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

Next steps:
- Regular reporting is being provided to all wards where VTE risk assessments are below threshold
- 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

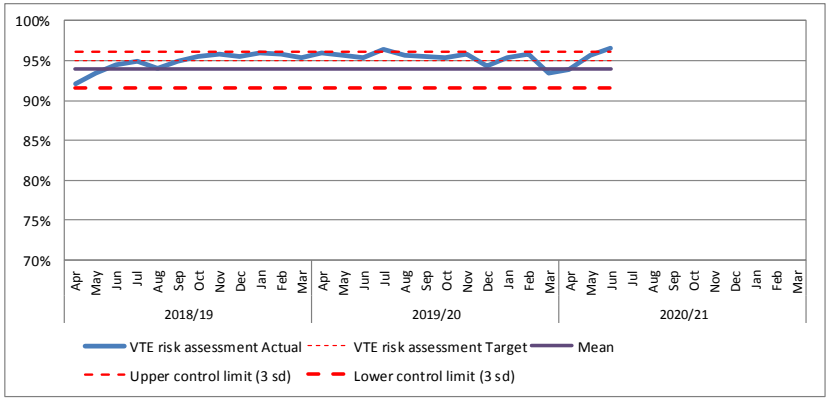


Period: Q3 2019/20

WHHT 94.38% Peer: 94.43%
National 95.99%

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

VTE risk assessment



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	1a / 1b / 2a / 2c / 4c

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Safe Care & Improving Outcomes: Stroke

In this reporting period:

Admission to Stroke Unit within 4 hours – 25.5%

Admission to the unit within 4 hours is not always possible, some patients do not present with standard symptoms and diagnosis is therefore later in the pathway and at times of increased demand capacity constraints affect "right bed" availability. There is also a delay as a result of COVID screening and patients awaiting swab results. Patients have to go to a holding ward and await results, which can take up to 72 hours to come through. Positive COVID stroke patients will not be admitted to the stroke ward. However patients continue to receive Stroke specialist care and input while they await transfer to the Stroke unit.

90% stay on Stroke Unit (target 80%)

54.1% achieved 90% stay on the Stroke ward, lower than last month. One factor is patients being moved due to the COVID segregation of patients. As mentioned previously, patients have to go to a holding area to await swab results or to a positive ward so cannot spend as much time as previously on the stroke ward.

Thrombolised within an hour – (SSNAP target 55%)

100% achieved: 8 patients were thrombolised and completed within 1 hour.

SSNAP data is reviewed quarterly.
These figures will change as more patients get discharged as the pathways cannot be updated until the patient is discharged

Performance stable
Better than target/threshold

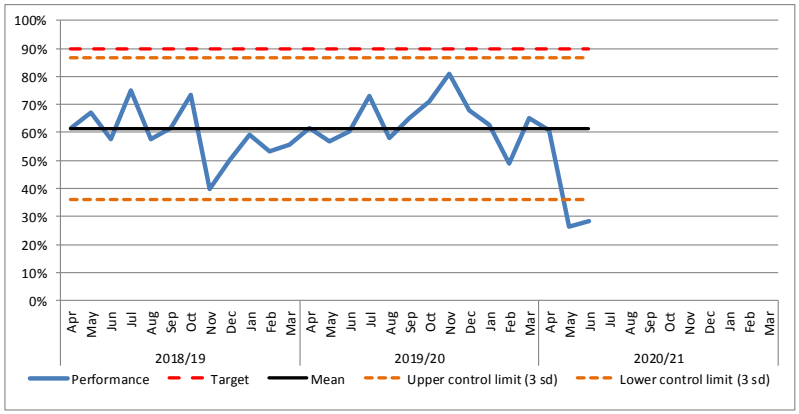
Benchmarking: SSNAP

Period: October to March 2020

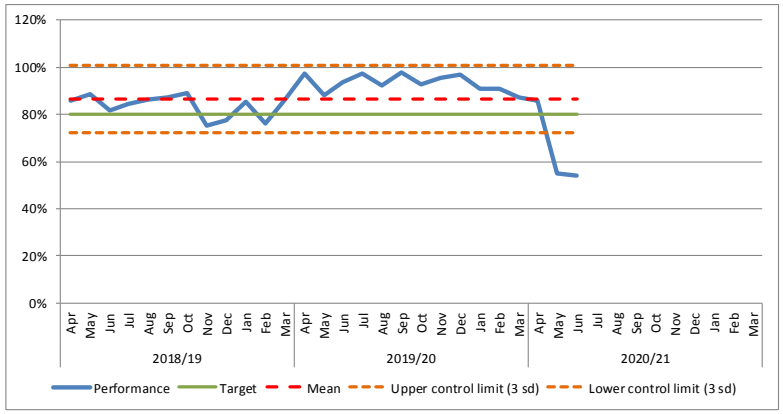
Admission within 4 hours: 54.0%

90% admission on Stroke Unit: 82.7%

Stroke: Admission within 4 hours



Stroke: 90% of admission on Stroke Unit



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	1a / 1b / 2a / 2b / 2c / 3a / 4a / 4c

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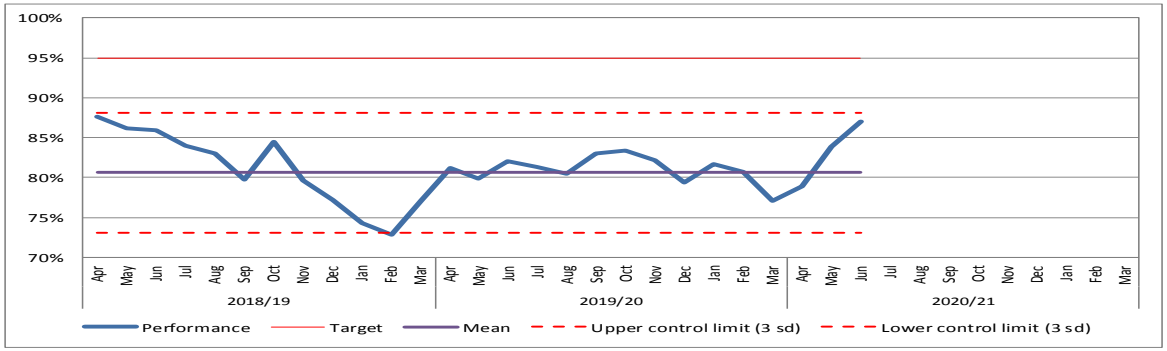
Caring & Responsive Services: Emergency Department

In this reporting period:
At 87.1%, overall performance is better than the previous month (83.9%). Compliance with the 95% standard was maintained at UTC (100%). Minors performance was maintained at 99.3%. Processes for COVID pathways hinder established pathways mainly due to capacity constraints in ED and staff are challenged with working in isolation environments in PPE. Type 1 attendances were up on the previous month by 12.3%, Hemel UTC attendances were up 14.4% meaning a total increase in attendances across the Trust at 12.8%. MIU remains closed.

May was the best performing month for a whole year for ambulance handover delays. In June 38% of ambulances were offloaded within 15 minutes (previous month was 41.6%) and the average handover time was 22 minutes (previous month 20 minutes). The number of patients waiting over 60 minutes to handover increased to 52 in June from 6 in May. There are multiple reasons for offload delays including the process for offloads for the COVID protocol which changed at the beginning of March meaning that ambulances needed to offload those patients with COVID symptoms into majors 2 creating 2 streams of patients. A loss of cubicles in STARR for the non-COVID pathway meant loss of offload capacity. Loss of cubicle capacity, an increase in attendances, interrupted bed flow due to swab result delays and changes to AAU and assessment areas impacted on flow within ED.

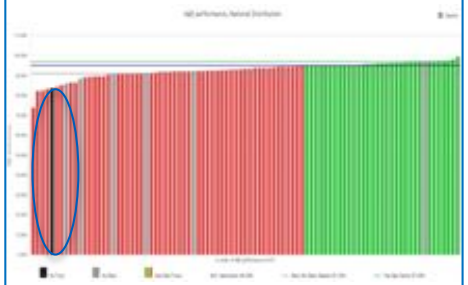
Next Steps:
- The regular check in meetings between the service team and Executive colleagues have been stood down temporarily in the light of the COVID pandemic.
- Work with system partners is ongoing to develop the urgent care strategy which includes the development of Urgent Treatment Centre (UTCs) across all 3 trust sites. The start date of the UTC was delayed to 1 July due to Greenbrook staffing issues caused by COVID
- The monthly programme board meetings oversee the ambulance work stream with a joint action plan between EEAST and the Trust restarted in May.
- A recruitment plan for medical staffing is in place; The middle grade rota is to be rewritten to accommodate 16 MGs from August 2020. Due to COVID we are still awaiting the arrival of 2 MGs due to Visa issues. Consultant recruitment has not been as successful. The department is reviewing the possibility of joint posts and being supported by recruitment agencies.
- SMART has been limited due to the new COVID pathway.

A&E: Attendances within 4 hours



Performance deteriorated
Worse than target/threshold

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



Period: May 2020

WHHT: 83.91% Peer: 91.03%
National: 95.0%

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

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee	1a / 1b / / 2b / 2c / 4a / 4c / 12b / 12c / 12d

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Caring & Responsive Services: Mixed sex accommodation breaches

Last reported position February 2020:
The submission has been suspended since March

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

Next steps:
The monitoring and management of patients requiring step down from ITU is reviewed daily as part of the regular operational management meetings. Privacy and dignity is maintained at all times. Full length curtains are used and patients are offered the use of the toilet/shower if they are able.

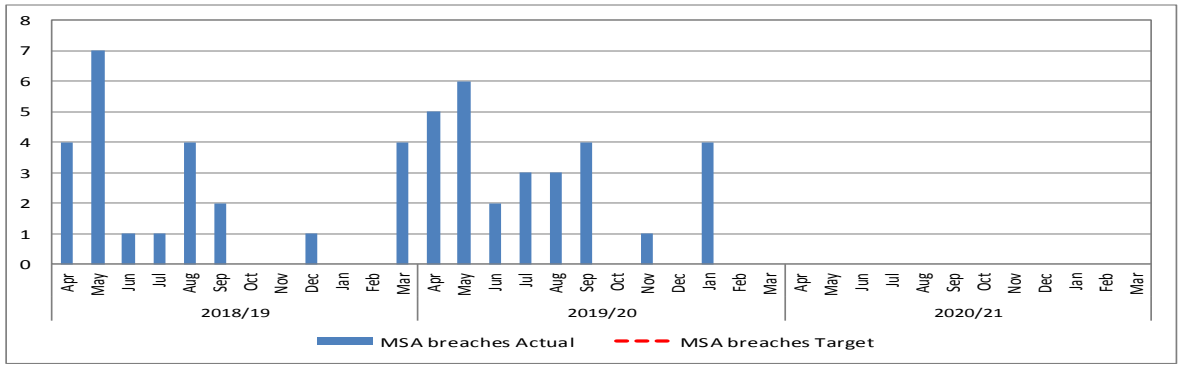
Performance stable
Better than target/threshold

Benchmarking:

Not currently available

Submission suspended

Mixed sex accommodation breaches



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Effective	Chief Nurse	Quality Committee	4a / 4c / 12b / 12c

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Caring & Responsive Services: Delayed Transfers of Care

In this reporting period:
The average number of discharges have risen from 12.5 per day to 13.6, but as a percentage of the daily declared Medically Optimised (MO) list, performance has deteriorated significantly. In June the average percentage of MO patients being discharged was 36%.
Current processes still operate without the deployment of Assessment and Discharge Notification and the inherent delay that this builds in (72 hours).

The current challenges for the team are:

- Delays with swabbing; which has indirectly contributed to some patients being discharged incorrectly without a reportable discharge swab result available
- Ward MDT's not routinely setting EDD's
- Limited capacity of domiciliary, residential and nursing home care providers. SCAH whom are commissioned to provide care at short notice through DH2A are running at capacity.

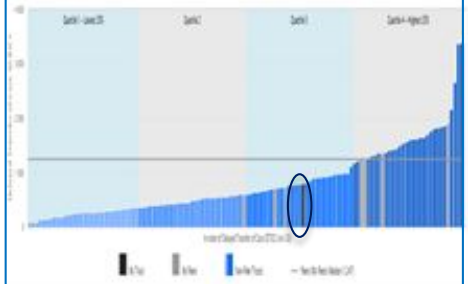
High demand for swabbing patients returning home with home care continued, as well as for patients moving on to IMC facilities and both residential and nursing homes. Due to the volume of new service users referred for new POC's, there are now delays with POC requests equivalent to TDS and higher. There are also delays in allocation of DTA beds as the majority of commissioned beds have been filled; HVCCG are now routinely turning to higher-cost care providers in order to commission beds.

Accurate EDD's remains an issue although through the Care Home PTL a return to best practice is emerging. Patient Flow Manager is working with Informatics to provide the wards with a clear platform for daily submission of EDD and 'reasons to reside'. This is important as the suspension of national data submissions could be lifted.

The Herts Valley COVID Discharge Cell is currently working up cross system plans to develop this model longer term to support patients home safely and provide assurance around pace and flow for the wide system.

Performance deteriorated
Worse than target/threshold

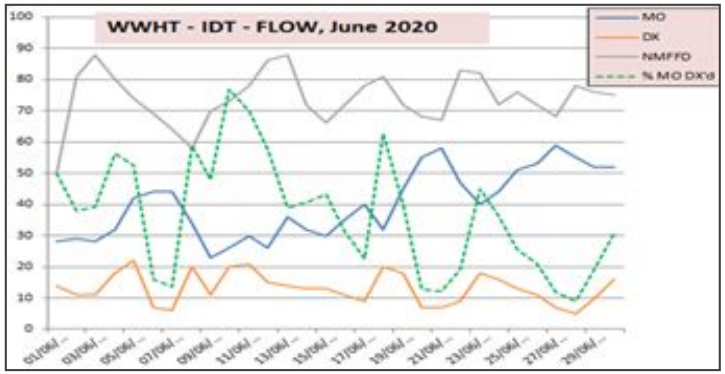
Benchmarking: MODEL HOSPITAL
Total number of bed days lost due to patients not being transferred to a more appropriate care setting

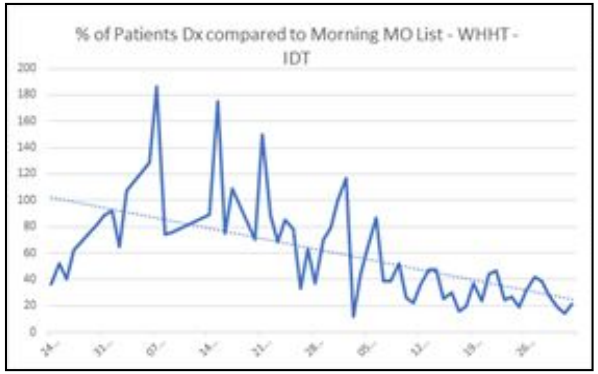


Period: December 2019

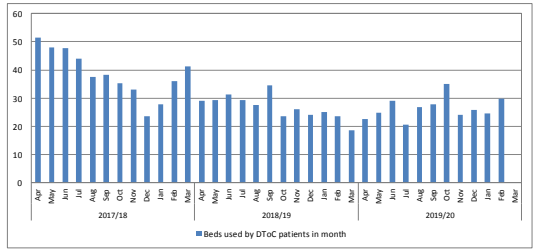
WHHT: 799 Peer: 1247
National: 610
(Peers = Nightingale Group – acute multi-site trusts)

Submission suspended





Delayed Transfers of Care



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Effective	Chief Operating Officer	Finance & Performance Committee	1b / 2b / 2c / 4a / 4c / 11a

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Family Liaison Line and Visitors Helpline

Family Liaison Line (FLL)
12 members of staff cover the FLL, 7 days a week between 8am and 8pm.
Staff call relatives of patients categorised green and amber in Isolation wards (when requested) at least once a day and provide an update. (Calls made by ITU and palliative care are not included in this data). The service was piloted on 30 March and started on 31March 2020. It was paused between 1-2 April for further training.

2244 relatives have been contacted at least once from 1 June – 30 June 2020
I-Reporter is utilised to ensure enquiries are logged and managed. There is a reduction in the number of wards that have Covid 19 patients and this is demonstrated in the graph

Staffing for the FLL
Staff who have been redeployed from other areas are being taken back to their own teams, this has reduced the amount of staff available to make the calls, however with the reduction in patients, this has not currently a concern. A request has been submitted for additional staff.

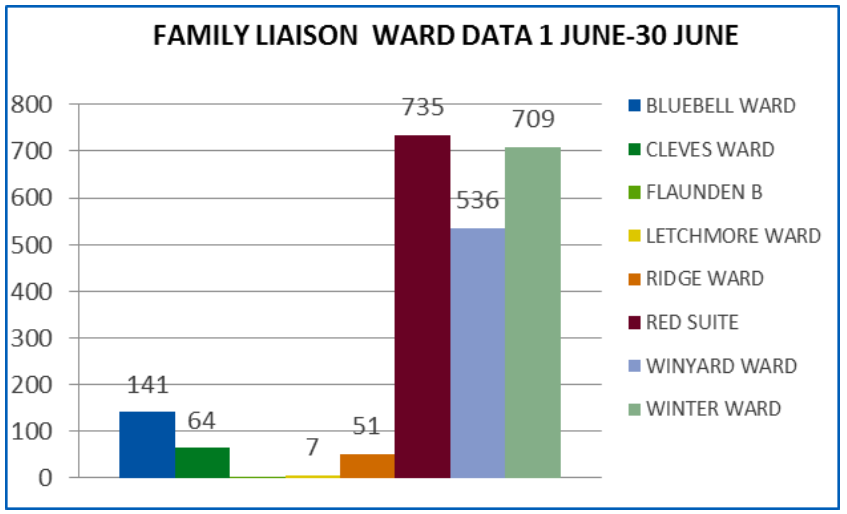
Feedback from relatives
'NOK said we are a lovely service, very helpful especially during these hard times'
So grateful for all the up dates, has really helped and been informative. ICU has been a great team.

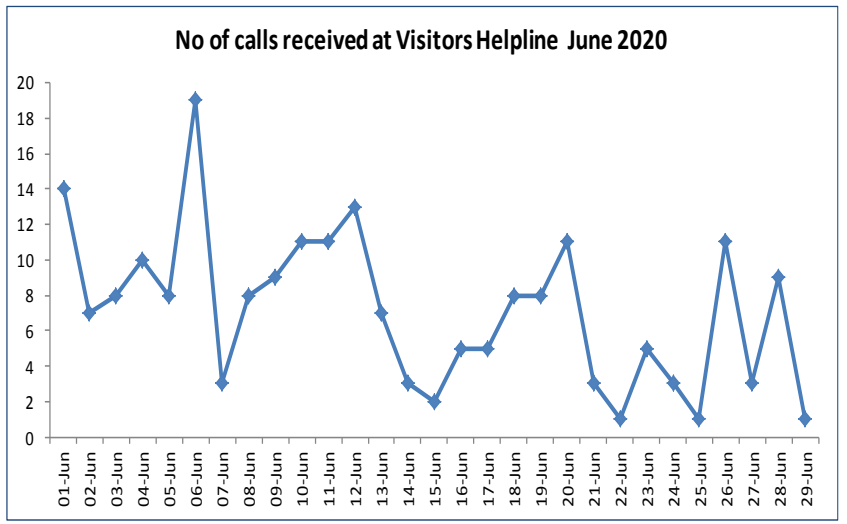
Visiting Helpline (VHL)
Continues to operate 7 days a week with a reducing service (Due to reduced calls) running from 8-4 (week) and 9-5 weekends. 6-7 staff managing the service during the week and 4-5 over the weekends.

Primary contact point for enquiries from family and friends of COVID-19 patients (but do receive enquiries for other wards).

207 calls were received from 1 June - 30 June 2020
Themes of enquiries includes update requests around patients' medical status, messages to loved ones, property, facetime requests. Works in partnership with Family liaison team, PALS and wards to manage/respond to enquiries.
Emotionally challenging environment dealing with bereaved/concerned families.
Continue to utilise I-Reporter to ensure enquiries are logged and managed.

Messages to loved ones up to 30th June
235 have now been forwarded to patients. The emails are being copied onto template and delivered via volunteer hub to wards , who ensure patient receives the message.





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Family Liaison Line – Intensive Care Unit/FFT Update

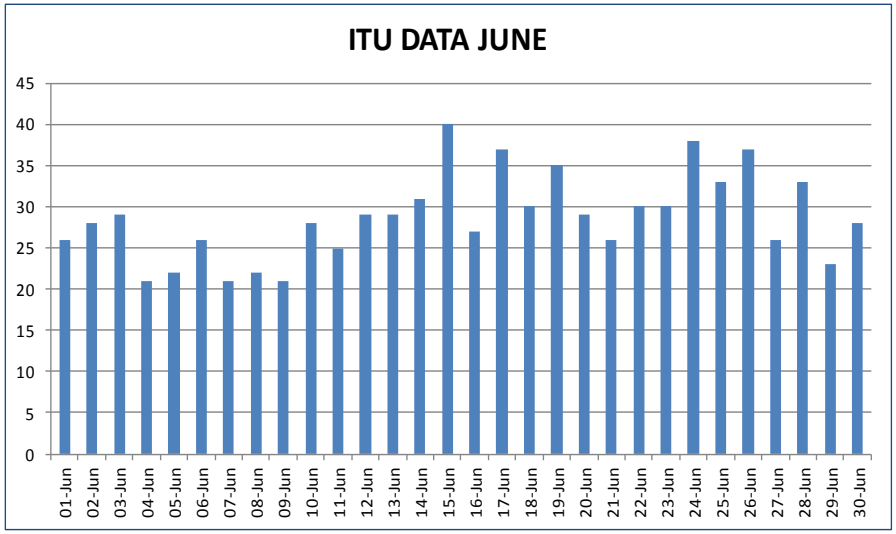
West Hertfordshire Hospitals NHS Trust

Family Liaison Line (FLL) (ITU)
Currently 2 members of ITU staff (nurses) cover the FLL, for ITU, 7 days a week between 8am and 8pm.

The staff link directly with ITU for updates. They call relatives of patients giving detailed updates at least once but often twice a day (Calls made by palliative care or ITU medical staff are not included in this data). The service was piloted on 30 March and continues.

Calls made from 1 May – 31 May.
546 calls were made which was, on average , 2.9 calls per day

Calls made from 1 June – 30 June
776 calls were made in the month of June, which is a slight increase in the amount provided by the FLL staff.



The Friends and Family Test
The friends and family test is still nationally paused.
We are currently running a PILOT, which commenced 6th July, using IPADS to collect feedback.
The pilot areas are Maternity, OPD WGH, Cleves and A&E,.
The Phase 2 and Phase 3 of the roll out of the IPADS for collection will commence in August across the trust.

Nationally the aim is to recommence collecting data at the end off September with National reporting at the beginning of October

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Caring & Responsive Services: Complaints

In this reporting period:
The Trust's monthly target of 80% was achieved - 83% in June.
25 new complaints were received as follows:

- 16% (4) relate to Surgery, Anaesthetics and Cancer (SAC)
- 32% (8) Medicine
- 20% (5) Women's & Children's (WACs)
- 20% (5) Emergency Medicine
- 8% (2) Corporate
- 4% (1) Other

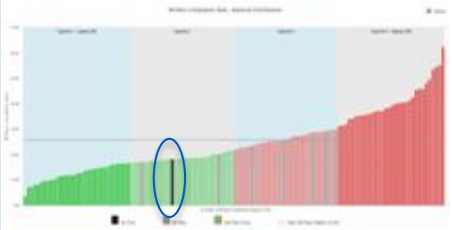
At month end there were a total of 50 live complaints (62 at end of previous month).
32 complaints were closed in the month. 2 complaints were re-opened in June 2020 (both Medicine)

Improvement plan:
Complaints have begun to increase again with 25 new complaints, up from 22 the previous month, although this is still below the 27 complaints received in June 2019. Surgery have reduced their open complaints to 12 (from a high of 38) of which 7 are overdue, they have the only open complaint over 6 months+, which is actively being worked upon. Emergency Medicine had 5 overdue complaints out of 12 open complaints. Complaints team continue to work with SAC and EM to address the backlog and improve performance. The deputy DM for SAC continues to take primary responsibility for SAC complaints within the Division to facilitate responses are completed. Emergency Medicine have weekly meetings with the complaints advisor to discuss complaints performance and responses.

Factors/Themes:
Trust wide, common themes remain all aspects of clinical care (incl. clinical care and treatment) 48% (12); attitude of staff and communication at 16% (4), admissions 24% (6), appointments 8% (2) and 4% (1) other. No specific themes or trends have been identified although communication remains a consistent factor throughout all complaints received.

Performance improved
Better than target/threshold

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

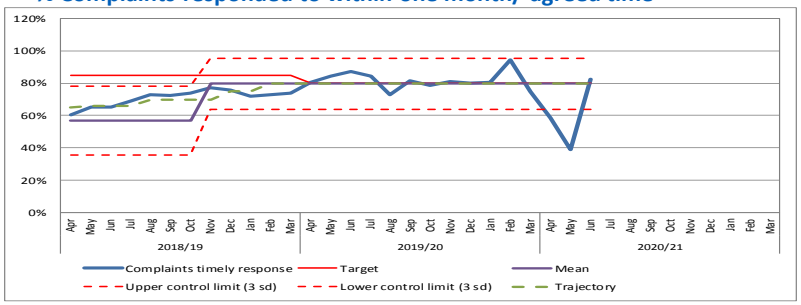


Period: December 2019

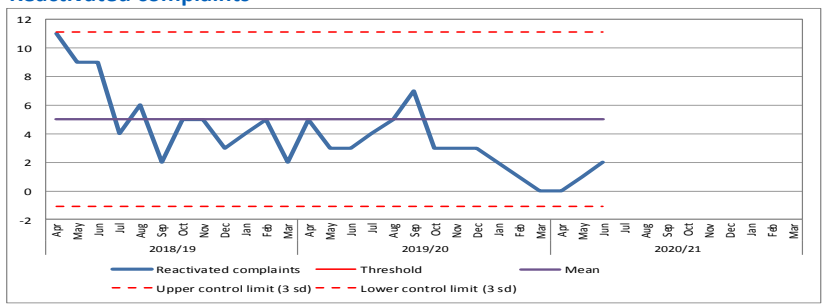
WHHT 18.36 Peer 25.90
National 21.95

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

% Complaints responded to within one month/ agreed time



Reactivated complaints



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee	1b / 2a / 2c / 3a / 4a / 4b / 4c / 10e / 10f / 11a / 12c

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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 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 June 2020 85 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 (PPD) was not achieved
There were 5 patients in June 2020 who died in a setting that was not their preferred place of death (PPD). In 2 cases this was due to the patients' physical symptoms not permitting their transfer home, in one case there was no hospice bed available and in 2 cases the patients' physical symptoms did not allow their safe transfer to a Nursing Home.

Patients on an Individualised Plan of Care for the Dying Person (IPCD) & Treatment Escalation Plans (TEP)
Of the 7 patients whose deaths were reviewed in June, there was only one patient who did not have an IPCD; It was deemed appropriate that this person was not placed onto the IPCD. Learning from the audit will be fed back to ward areas to support the identification of patients appropriate for an IPCD.

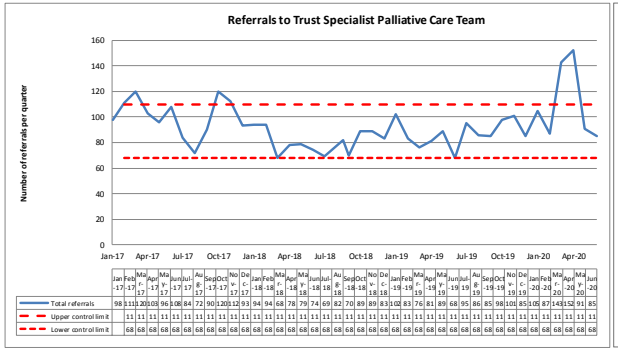
Treatment Escalation Plans (TEP)
Treatment Escalation Plans ensure that every patient's care is reviewed, individualised and their levels of care are considered, in line with the Trust's guidelines.
Of the 7 patients whose notes were reviewed, who died in June 2020, 5 patients had a TEP in place; All of those patients had had their TEP reviewed as needed and they were appropriate. There were 2 patient s without a TEP.

Stable

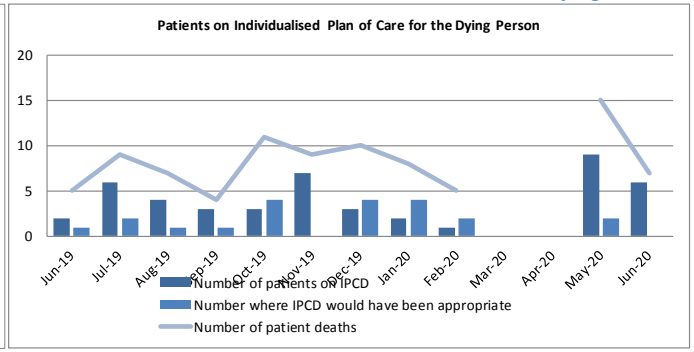
Benchmarking:

Not currently available

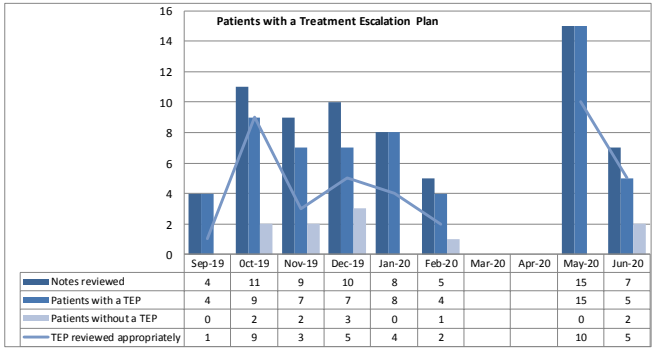
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Notes reviewed	4	11	9	10	8	5			15	7
Patients with a TEP	4	9	7	7	8	4			15	5
Patients without a TEP	0	2	2	3	0	1			0	2
TEP reviewed appropriately	1	9	3	5	4	2			10	5

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee	2a / 2b / 2c / 3a / 4c / 11a

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Caring & Responsive Services: RTT Open pathways

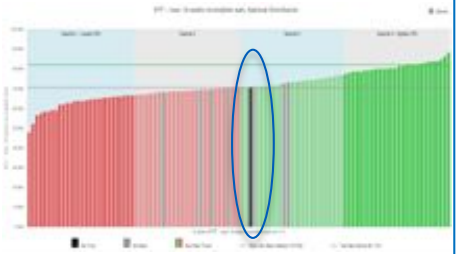
In this reporting period:
The deterioration in performance (47.7%) continues as the backlog of patients waiting more than 18 weeks continues to grow at a faster rate than patients can currently be treated, The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was worse than the national position (16.4 vs 15.3 weeks) and the 92nd percentile wait time was worse also (37.1 vs 34.3 weeks). Service re-starts are ongoing in a controlled and limited form and so the number of very long waits continues to grow as cancer and clinically urgent treatments are prioritised. At the end of the month there were 302 patients whose waiting time exceeded 52 weeks wait.

Next steps:
In addition to the cancer and urgent procedures previously being outsourced, some non urgent activity is now being undertaken via the national independent sector provider contract, but this is not an option for all services.

Diagnostics
There has been further improvement in diagnostic performance, at 64.7% but most modalities remain non-compliant although with increasing activity levels. Endoscopy is a significant area of challenge where there was previously high volume and throughput and the service is in the process of restarting activity at Watford, Hemel Hempstead.

Performance improved
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

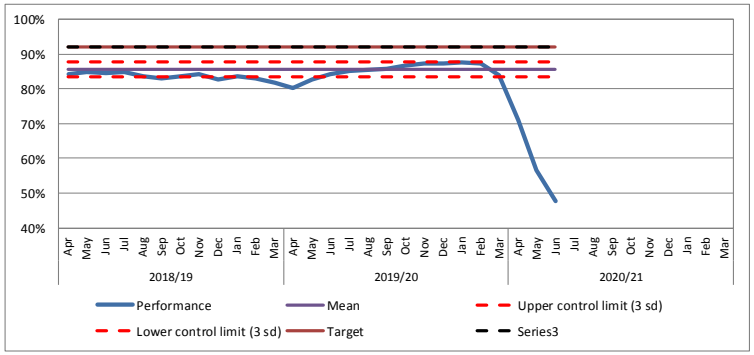


Period: April 2020

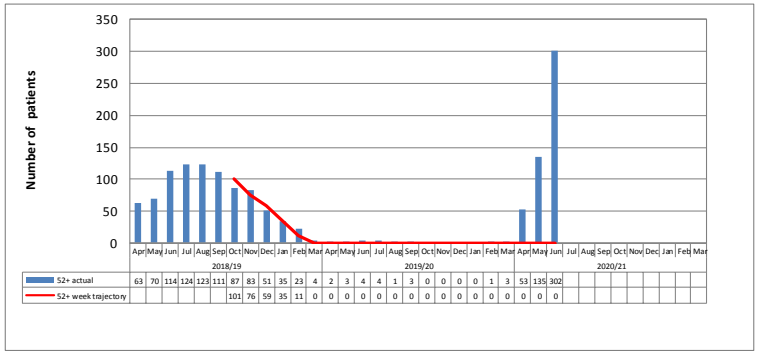
WHHT: 71.11% Peer: 70.53%
National: 70.64%

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

RTT - % within 18 weeks



Number of 52 week waits



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

2 week waits

The provisional position for June is compliant at 97.7% with 1141 referrals of which 26 were seen beyond 14 days. Of the 26, there were 5 x LGI and 15 x breast

The referral numbers have steadily increased since a significant drop in April but still below average. The average in 2019/20 was 1625 per month

The Trust are monitoring the referral numbers and the numbers of patients diagnosed with cancer. Currently the Trust's conversion rate is lower than usual at 4.1% in June. (Benchmark taken in Oct 2019 is 6.9%)

2 week wait breast symptomatic

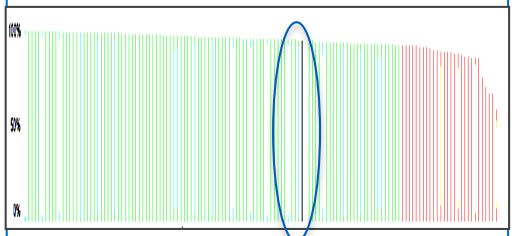
The provisional position for is non-compliant at 87.2%. There were 78 referrals and 10 patients were seen beyond 14 days. This is attributable to the fact that the Breast team were using the COVID regional guidance that rejected referrals for patients under 25 years and also deferred some patients by 3 months.

28 day Faster Diagnosis Standard

The provisional position is: 2ww - 82.1% Screening –66.7%% Breast Symptomatic – 88.3%%

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

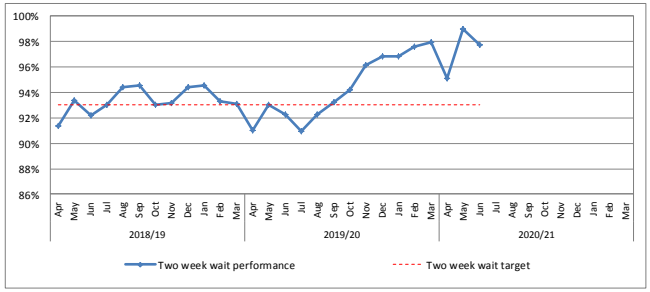


Period: May 2020

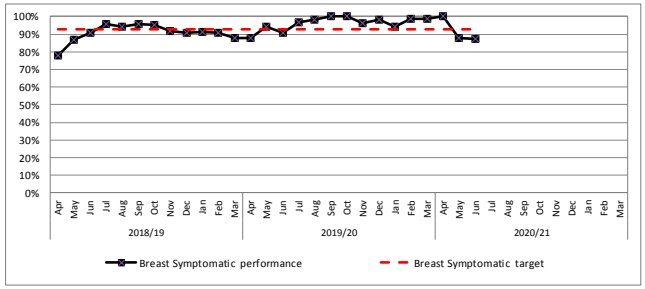
WHHT: 98.9% Peer: 95.0%
National: 94.2%

(Peers = East of England region)

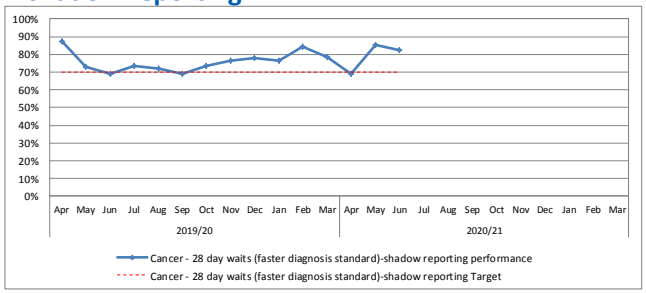
Two week waits: % within target time



Breast symptomatic patients: % within target time



Cancer - 28 day waits (faster diagnosis standard)-shadow reporting



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Quality Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services: Cancer 31 day

In this reporting period:

31 day referral to first definitive treatment
The position for June is provisionally compliant at 97.3% with 104 pathways with 3 breaches (2 x breast and 1 x LGI).

31 day subsequent surgery
The provisional position for June is provisionally compliant at 100%, with 14 pathways

31 day subsequent Drug
The position for June is provisionally non-compliant with 88.2% . There were 17 pathways with 2 breaches (both urology BCG)

31 day subsequent palliative and other
The provisional position for June is compliant at 100 % with 14 pathways

Next steps:
Review the influence of covid on cancer pathways as part of the Trust's recovery plans

Performance improved
Better than target/threshold

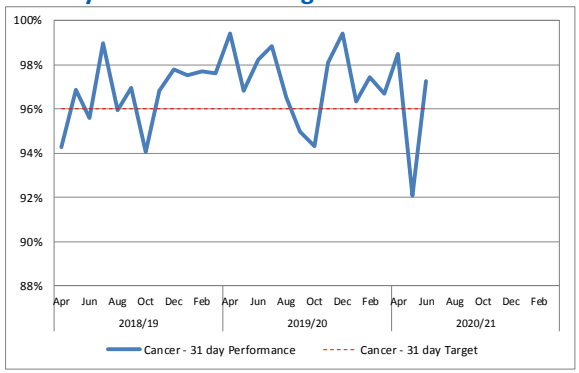
Benchmarking: NHSI Analytics Hub

Period: May 2020
31 day first:

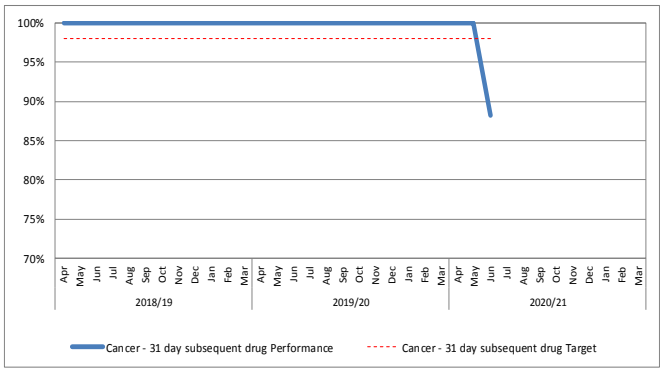
WHHT: 92.1% **Region: 91.5%**
National: 93.9%

31 day surgery:
WHHT: 87.5% **Region: 83.9%**
National: 88.5%

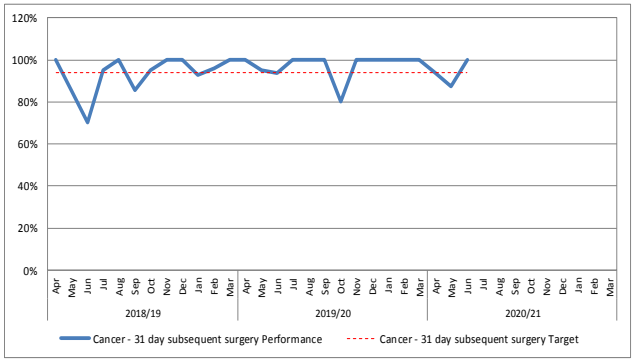
31 day first: % within target time



31 day subsequent drug: % within target time



31 day subsequent surgery: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services : Responsive	Chief Operating Officer	Quality Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services: Cancer 62 day urgent GP referral

In this reporting period:

62 day referral to first definitive treatment - The provisional position for June is compliant at 86.4% Provisionally there are 59 treatments (69 patients) with 8 breaches (11 patients). This include 3 x urology, 2 breaches for both H&N and Lung and then one UGI, LGI, breast and gynae breach.

The number of treatments is lower than usual and lower than last month. In 2019/20, the Trust submitted an average of 90 treatment pathways (equating to 105 patients) per month. This is attributable to fewer patients being referred in March and April and fewer patients progressing through the diagnostic pathways.

A provisional review of the breaches indicate more breaches attributable to outpatient capacity issues than previous months. This is on account of the fact that in previous covid months, more patients were further through their diagnostic pathway than those treated in June. Four are attributable to tertiary delays, two that were on account of patient being unwell and only one patient causing delay.

62 day screening referral to first definitive treatment - Performance is provisionally compliant at 100% with 1 pathway in target.

62 day consultant upgrade The provisional June position is 100% with 8 patients all in target.

104 day breaches

Open pathways: In June's submission of open pathways over 104 days, there were 101 open pathways which is significantly higher than usual. Of the 101 open pathways, 73 were LGI. (73 x LGI, 9 x urology, 5 x H&N, 3 x haem, 1 x brain, 1 x breast, 1 x gynae, 2 x lung and 6 x UGI). There were some complex pathways and pathways delayed by patients being reluctant to attend, but most were delayed on account of Covid changes.

Closed – Provisionally the Trust has closed 4 pathways over 104 days (including consultant upgrades and screening)

Performance improved
Better than target/threshold

Benchmarking: MODEL HOSPITAL
62 day wait from urgent GP referral

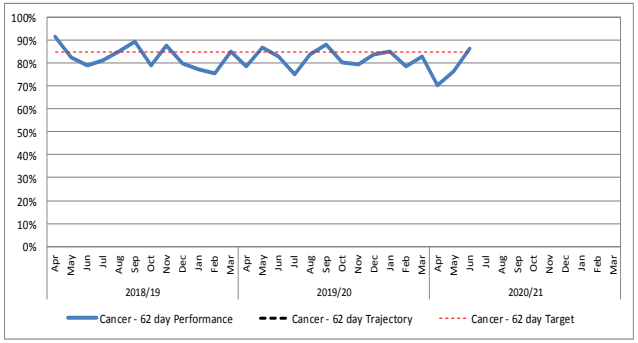
Period: April 2020
WHHT: 68.79% Peer: 77.99%
National: 73.93%

Peers = Nightingale Group – acute multi-site trusts

Benchmarking: NHS Analytics Hub
Period: May 2020
WHHT: 74.1% Peer: 68.2%
National: 69.9%

Peers = East of England Region

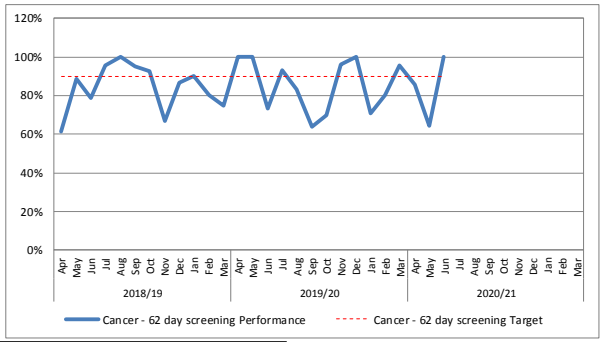
62 day GP: % within target time



62 day GP: Tumour Site

Tumour type	April	May	June
Breast	78.6	90.5	90
Gynaecological	78.9	90.9	84.6
Haematological	25	20	100
Head and Neck	22.2	33.3	0
Lower Gastrointestinal	85	36.4	50
Lung	83.3	0	62.5
Skin	100	100	100
Upper Gastrointestinal	77.8	85.7	71.4
Urological	60	66.7	66.7
Testicular	0	100	100
Other	100	0	0
Total	70.3	76.3	86.4

62 day screening: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Caring	Chief Operating Officer	Finance & Performance Committee	2c / 4b / 4c / 12c

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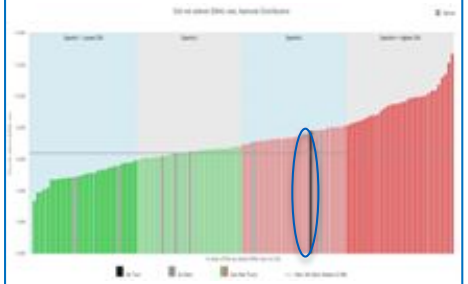
Caring & Responsive Services: Outpatients

In this reporting period:
Standard Operating Procedures have been ratified and circulated for clinical reinstatement and referral management.
New work flows have been established to support service reinstatement and clinic template revision, these are performing within agreed parameters of a 7-10 day turn around
Working on ensuring OPD communications are live and current with the addition to Attend Anywhere communications inc Letter, text and access link to virtual waiting rooms.
Telephone services created with ERS to continue electronic booking throughout and to support full RAS service
Pilot of electronic clinic outcome form underway within Infoflex and pilot is now to be expanded to 3 services prior to full roll out estimated by mid Sept 2020. This will support all activity and is in line with remote working practices going forwards.
Medical Records to introduce new ways of working to mirror all 3 site working practices to support new programme manager.
Work has commenced to initiate PIFU for Breast Service this is to align with current pilot of drive through /car park waiting room that has been successful implemented for the Breast Service.

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Did not attend rate



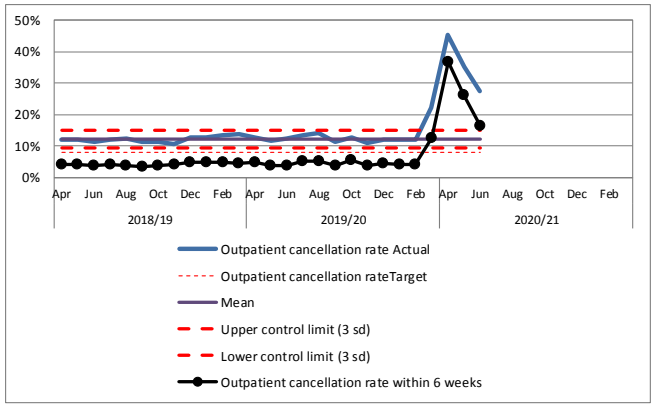
Period: Q4 2019/20

WHHT 7.80% **Peer: 6.38%**
National: 6.91%

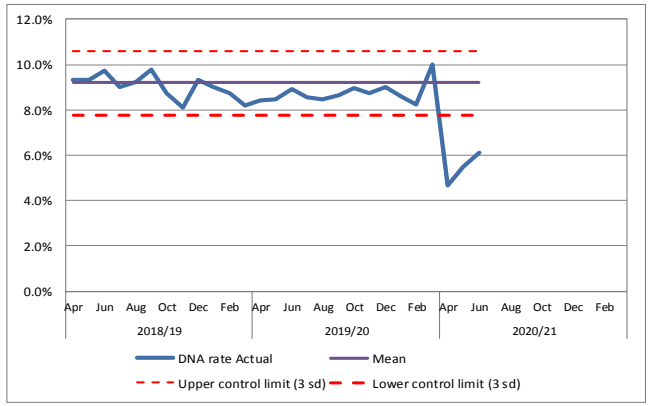
(Peers = Nightingale Group – acute multi-site trusts

Total cancellations: 25.2%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
12.3%	4.3%	10.2%	9.6%

Outpatient cancellation rate



DNA rate



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee	3a / 4b / 4c / 10e / 10g / 11a

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Recruitment & Retention

In this reporting period:

Staff in Post and Vacancies

Contracted wte staff in post is 4,659 (4,596 wte last month) (+23wte), or + 169wte over 12 months. NB – some of this increase is due to COVID staffing arrangements such as employing aspirant nurses.

Vacancies (the difference between the ledger establishment and contracted wte on ESR) is 464 wte or 9.1% of the establishment (9.6% last month). The target rate is 10%. For the fifth month in a row the Trust has met its vacancy target of less than 10%. For Band 5 nurses the vacancy rate is currently 6% (7.5% last month). Vacancy rates for Band 6 & 7 staff have remained almost constant too at 1.5% and 0.2% respectively. The Band 5 Nurse vacancy wte figure includes overseas transitional nurses who are currently working towards their NMC registration. There are ongoing plans to recruit both in the UK and abroad to reduce these vacancies to maintain the vacancy rate at under 5% or as close to this as possible, although overseas recruitment is paused during the COVID outbreak.

Sickness Rate :

Sickness – the June rate is 4.3% against a target of 3.5%. The 12 monthly sickness rate averages 4.7%. The figure was 6.3% last month, and over 11% for April, the highest rate recorded over the last 10 years.

Labour Turnover and Number of staff leaving within first year

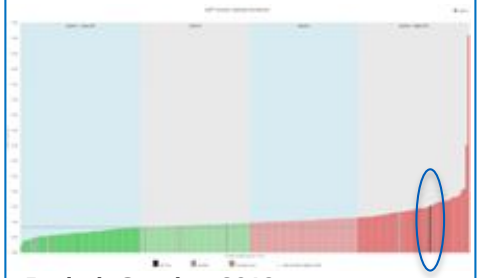
This is 13.8% (last month 14.2%). The Trust target is 13%. This is the lowest rate recorded since October 2013. All TUPE related leavers have been excluded from the calculations, as have staff who were on fixed term contracts or have re-commenced working for the Trust. The voluntary rate (excluding retirements / dismissals etc) is 11.3%. The rolling 3 monthly turnover rate is 10.8%. Turnover for staff who leave within their first year of is now 15.7% (21% in Aug 2019). The target rate is 15%. Turnover for Band 5 Nursing and Midwifery staff is 16.0% (16.1% last month). The target is 16%, which means that this is the first time we have achieved this since it was set in May 2017, and is a significant reduction when rates were approx. 30%.

Next steps:

At the start of the year, overseas nurse new joiners rose from 5 to 10 for February and 15 for March and April. The COVID situation has meant a reduction in overseas recruits, with 9 in March and 1 out of the 15 planned for April. Since then, all overseas joiners are now on hold , although it is hoped that this recruitment will begin again in September / October. 20 existing transitional nurses who have not yet taken their OSCE exam have been invited to join the temporary register and work as band 4's during the pandemic. Final year student nurses have also been employed on fixed term contracts as aspirant nurses , including midwives and children's nurses. Initiatives are being made to employ permanently as many as possible of these staff.

Performance stable
Worse than target/threshold

Model Hospital benchmarking:
Proportion of staff leaving each month

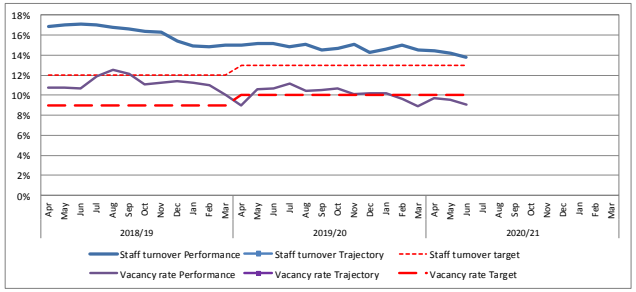


Period: October 2019

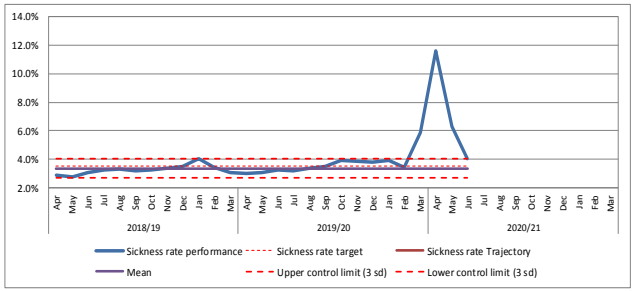
WHHT: 1.54% Peer: 0.83%
National: 0.98%

Peers = Nightingale Group – acute multi-site trusts)

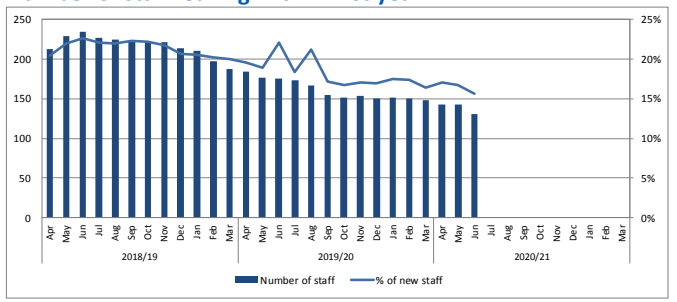
Staff turnover and vacancy performance



Sickness absence performance



Number of staff leaving within first year



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Workforce & Finance: Well Led	Chief People Officer	People, Education & Research Committee	3a / 6a / 6b / 7a / 7b / 12c

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Developing Staff

Submission suspended

In this reporting period:

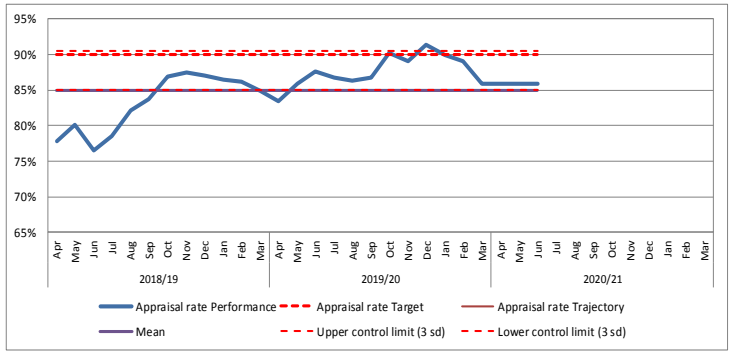
Appraisals

- Current compliance is at 87% (target 90%) for March. In view of the outbreak, for compliance purposes the rate will be kept at 87% until reviewed, based on future circumstances. This figure includes medical staff. The figure is slightly below the target, as COVID19 pressures are impacting on the compliance rate. Medical appraisal rates are 97%, non medical rates are 85%. HRBP's are now working with managers over the next few months to September in order to ensure as many staff as possible have up to date appraisals.
- The Trust will need to implement the national 2018 NHS pay award which agreed to end automatic incremental pay progression for all staff. Instead, this has been replaced with a requirement for staff to be up-to-date with any statutory or mandatory training (providing that this has been made available to them), not have a live formal disciplinary / capability sanction on their record, and have completed appraisals in line with the organisation's appraisal process and standards. The implementation of this agreement is gradual, and there will be increasing numbers of our staff required to undertake this process from April onwards . However, given the current exceptional circumstances that we find ourselves in, it has been decided NOT to implement this agreement at the current time. Instead, we will continue to implement incremental progression automatically to at least September after which implementation will be reviewed. For local benchmarking for appraisals, within Herts Beds and Essex Trusts, the Trust ranks equal 4/13 local Trusts (Q4, 19/20)

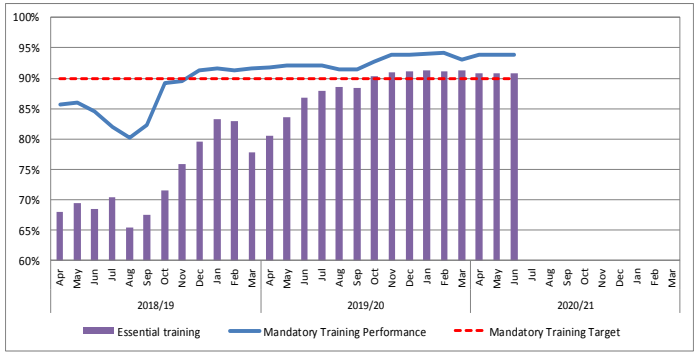
Mandatory / Essential training

- The all Trust mandatory training rate remains above target at 94%. Compliance in the low 90's has now been consistently maintained since November of 2018. For local benchmarking, the Trust also ranks equal 2/13 local Trusts (Q3 9/20).
- Essential training compliance is now also at 91% or above since October 2019.

Appraisal performance



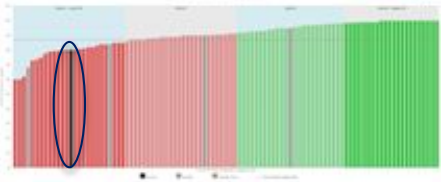
Essential training and mandatory training performance



Performance improved
Better than target/threshold

Benchmarking: Model Hospital

Trust staff with appraisal completed by the required date

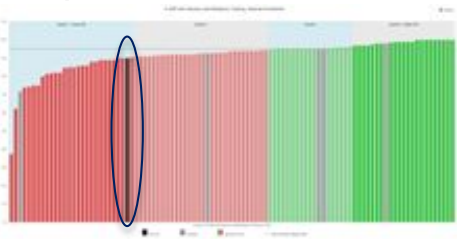


Period: 2018/19
WHHT: 80% **Peer: 87%**
National: 91%

Performance stable
Better than target/threshold

Benchmarking: Model Hospital

Statutory & Mandatory training compliance rate



Period: 2018/19
WHHT 90% **Region 95%**
National 94%
Peers = Nightingale Group – acute multi-site trusts)

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Workforce & Finance: Well Led	Chief People Officer	People, Education & Research Committee	3a / 5c / 6a / 6b / 8b / 8c

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West Hertfordshire Hospitals NHS Trust

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 are being monitored, including 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. The turnover of band 5 nurses is currently at 16.0% vs 12.5% overall for all registered midwives/nurses. This represents a decrease from last month and means that the Trust has now achieved its target of under 16%. It is a significant reduction from nearly 30% turnover in May 2017. For Band 5 nurse vacancy rates, these are currently 6%, an increase from rates of 3.2% 4 months ago, but reduced from 7.5% last month. This in turn is a significant decrease from 123wte or 17.2% in March 2018 and 32% in 2015. Nurse vacancy rates for Band 6 and 7 staff have also reduced over the last few months. NB – the Band 5 Nurse vacancy wte figure includes 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 20/21 and beyond to maintain the vacancy rate at under 5% or as close to this as possible. Final year student nurses have been recruited on fixed term contracts as aspirant nurses.

When measured at month end, combined appraisals rates at March were slightly below the compliant target of 90%, due to the impact of the COVID pandemic. As set out previously the rates have been held at this rate over the COVID period. The overall rate for medical staff (97%) includes all medics apart from training posts. Mandatory training compliance is 94%, and is now consistently above the 90% target. The monthly Trust sickness rate is 4.1% against a 3.5% target much reduced from the 11.3% at the height of the pandemic. Staff who are off sick as a result of COVID related absence will not enter half pay should they exhaust their sickness pay entitlement over this period. The average 12 month sickness figure reported to NHSI is 4.7%. The 12 month turnover rate is 13.8%, and the lowest since 2013. The Trust is ranked 9 / 12 nearby NHS organisations.

Staff survey - Response rate : Trust response rate 42% (against average of 43% for acute Trusts and 46% nationally) ; Engagement score : Overall WHHT staff engagement score 2019 - 7.02 (2018 – 7.02).

The current agency pay bill percentage is 2.6%. This is a significant reduction compared to any historic comparisons, and is expected to change as services transition to BAU. The 19/20 year expenditure was £13.6m, or 5.2% of the paybill. Without the influence of COVID, the target of £13m or 5% would have been achieved.

Workforce Indictors - Progress Table

Progress against target - June 2020

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	10.4%	11.2%	8.9%	9.1%	10.0%	-0.9%	↗	-9%
Band 5 Nurse Vacancy	11.3%	1.0%	3.4%	6.00%	9.0%	-3.0%	↗	-33%
Headline Turnover	14.0%	14.9%	14.5%	13.8%	13.0%	0.8%	↘	6%
Band 5 Nurse Turnover	16.3%	13.3%	17.3%	16.0%	16.0%	0.0%	↘	0%
Total Sickness	4.8%	3.2%	5.9%	4.1%	3.5%	0.6%	↘	17%
Non-Medical Appraisal	78%	85.0%	87.0%	87.0%	90.0%	-3.0%	→	3%
Medical Appraisal		99.0%	99.0%	97.0%	90.0%	7.0%	↘	-8%
Core Skills Framework	89%	92.0%	93.0%	94.0%	90.0%	4.0%	↗	-4%
Agency as a % of Paybill	7.3%	5.7%	6.4%	2.6%	4.7%	-2.1%	↘	-45%
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

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		✓	✓	✗	✓
		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 between 8am and 12pm (main adult wards excl AAU)	WHHT	COO		✓	✗	✗	✓
		Mixed sex accommodation breaches	WHHT	COO		✓	✗	✗	✓
		LOS > 21 days	WHHT	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 Q4	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		✓	✗	✗	✓
		Diagnostic (DM01) <6 weeks	WHHT	COO		✓	✗	✗	✓
		Cancer							
		Cancer - Two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - Breast Symptomatic two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent drug *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent surgery *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent radiology *	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		✓	✗	✗	✓

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	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		✓	✗	✗	✓

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

August 2020

Reporting Period: July 2020

Trust Board: 3rd September 2020

Performance data updated on: 24th August 2020

The very best care for every patient, every day

NHS
West Hertfordshire Hospitals
NHS Trust

How Are we Doing?

Safe Care & Improving Outcomes

Safety Thermometer New Harm Free Care

Suspended

Target 95%

Clostrioides Difficile cases

6

Target 2

VTE assessment

96.1%

Target 95%

Inpatient Friends & Family positive scores

Suspended

Target 95%

Caring & Responsive Services

Complaints response times

92.3%

Target 80%

ED 4 hour standard

85.9%

Target 95%

RTT 52 week waits

484

Target 0

CWT - 62 day referral to first treatment

82.0%

Target 85%

Workforce & Finance

Mandatory Training

93.9%

Appraisal Rates

87.0%

Target 90%

Agency pay

4.9%

Target 4.7%

Vacancy rate

9.1%

Target 10%

I&E forecast

(Full year)

£0

I&E actual

(YTD actual & YTD plan)

£0

Target -£ 1,551

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West Hertfordshire Hospitals NHS Trust

COVID-19 SNAPSHOT - 17 August 2020

BEST CARE

INPATIENTS

C-19 positive **25**	C-19 suspected **16**	ITU C-19 positive **2**
C-19 result awaited **128**	C-19 negative **480**	ITU C-19 negative **10**

PATIENT TESTING

Non-elective C-19 positive **0**	Non-elective C-19 negative **30**
Elective C-19 positive **0**	Elective C-19 negative **0**

NOSOCOMIAL INFECTIONS

Hospital definite **0**	Hospital probable **0**
Hospital indeterminate **0**	Community **0**

GREAT TEAM

STAFF TESTING

C-19 positive **0**	C-19 negative **31**
Antibody test positive **1**	Antibody test negative **2**

STAFF ABSENCE

C-19 sickness absence **93**	C-19 self isolating **60**
C-19 shielding **TBC**	

PPE ESTIMATED STOCK DURATION (DAYS)

Fluid resistant face masks **33 (Green)**	FFP3 face masks **9 (Amber)**
Gloves **5 (Amber)**	Gowns **11 (Amber)**

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Essential Measures – Executive Summary

NHS
West Hertfordshire Hospitals
NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Remains within as expected range	SHMI 99.1 HSMR 103.0	**Complaints response times** Above target (80%) and higher than previous month	92.3% YTD 68.0%	**All staff appraisal** Unchanged from previous month Below target (90%)	Suspended
Infection Control – clostrioides Difficile (hospital & healthcare) 1 Cat1 case this month	6 (Cat1: 1 Cat 2:5) YTD 11	**Inpatient Friends & Family Test** Positive scores mainly compliant but variable, ED just below target (95%)	Suspended	**Mandatory training** Consistently achieved (target 90%) and stable	Suspended
Serious incidents & Never Events (NE) Variable – 1 SI in reporting period	SI 1 YTD 7 NE 0 YTD 1	**Mixed sex accommodation** None in reporting period but usually low number when breaches occur	Suspended	**Turnover at 12 months** Worse than target (13%) and similar To previous month	13.6% YTD 14.0%
Patient safety incidents which are harmful Lower than previous month	7.2% YTD 8.5%	**Outpatient DNA rates** Below target (8%) but higher than previous month	6.5% YTD 5.8%	**Income & Expenditure** Breakeven position for July	£0.00m YTD £0.00m
Combined Caesarean Section Standard (28%) not achieved Higher than previous month	35.3% YTD 33.6%	**ED waiting times** Lower than previous month Target (95%)	85.9% YTD 84.5%	**Capital Spend** £0.71m Capital spend in July against a target of £2m	(£0.71)m YTD (£4.19)m
VTE assessments Above target (95%) and similar to previous month	96.1% YTD 95.8%	**RTT waiting times** Lower than the target (92%) Increase in 52 week waits	51.0% YTD 56.9% 484 YTD 974	**CIP Efficiency**	Suspended
Stroke Indicators Admission to Stroke Unit within 4 hrs – target (90%) not achieved 90% admission spent in the Stroke Unit – target (80%) not achieved	4 hr 26.1% YTD 34.8% Adm 83.3% YTD 69.1%	**Cancer waiting times** 2ww achieved consistently 62 day below target (85%) and worse than previous month	2ww 98.5% YTD 98.1% 62 day 82.0% YTD 78.5%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 0 Elec 1881 vs 4336.94 Non-Elec 3732 vs 5089.99
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**	

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West Hertfordshire Hospitals NHS Trust

COVID19 – SNAPSHOT - Indicator Summary

Domain	Theme	Trend Month on Month	Jun-20	Jul-20	Aug-20
COVID 19 Snapshot	**Inpatients**				
	C-19 positive	Worsening	32	19	25
	C-19 suspected	Worsening	10	12	16
	C-19 result awaited	Worsening	62	63	128
	C-19 negative	Improving	364	415	480
	ITU C-19 positive	Stable	2	2	2
	ITU C-19 negative	Stable	6	10	10
	Staff Testing				
	C-19 positive	Stable	1	0	0
	C-19 negative	Improving	3	1	31
	Antibody test postive		73	6	1
	Antibody test negative		149	13	2
	Patient Testing				
	Non-elective C-19 positive	Stable	0	0	0
	Non-elective C-19 negative	Improving	3	72	30
	Elective C-19 positive	Stable	2	0	0
	Elective C-19 negative		38	1	0
	Staff Absence				
	C-19 sickness absence	Improving	171	163	93
	C-19 self isolating	Improving	129	133	60
	C-19 shielding		N/A	N/A	N/A
	Nosocomial Infections				
	Hospital definite	Stable	0	0	0
	Hospital probable	Stable	1	0	0
	Hospital indeterminate	Stable	0	0	0
	Community	Stable	1	0	0
	Estimated duration of PPE stock (days)				
	Fluid resistant face masks	Improving	14	34	33
	FFP3 face masks	Worsening	8	13	9
	Gloves	Worsening	13	11	5
	Aprons	Worsening	15	21	11
	Gowns	Improving	N/A	9	11

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	May-20	Jun-20	Jul-20	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)	26	100	Performance stable and better than target	99.7	99.0	99.1			Feb-20	National	100	Feb-20
		HSMR - Total (Rolling three months)	26	100	Performance deteriorated and worse than target	97.4	101.0	103.0			Mar-20	National	100	Mar-20
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	27	n/a		2	0	1	6		Jul-20	National	n/a	
		Clostridioides Difficile - Healthcare associated (Cat 2)	27	n/a		0	0	5	5		Jul-20	National	n/a	
		Clostridioides Difficile - Hospital and Healthcare associated Total	27	3	Performance stable but worse than target	2	0	6	11	12	Jul-20	National	n/a	
		Hand Hygiene Compliance	28	95%	Performance stable and better than target	95.0%	98.0%	97.4%	97.5%	95%	Jul-20	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	32	4.1%	Performance stable and better than target	3.9%	4.0%	3.3%	3.7%	4.1%	Feb-20	National	4.1%	Feb-20
		30 Day Emergency Readmissions - Emerg *	32	13.2%	Performance stable and better than target	15.1%	14.9%	12.7%	13.8%	13.2%	Feb-20	National	13.2%	Feb-20
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	33	28.0%	Performance stable but worse than target	34.1%	32.8%	35.3%	33.6%	28.0%	Jul-20	Local	28.0%	2017/18
		Caesarean Section rate - Emergency*	33	15.0%	Performance stable but worse than target	18.4%	16.7%	15.6%	16.3%	15.0%	Jul-20	Local	16.0%	2017/18
		Caesarean Section rate - Elective*	33	11.0%	Performance stable but worse than target	15.7%	16.1%	19.7%	17.3%	11.0%	Jul-20	Local	12.0%	2017/18
		Patient Safety												
		% nursing hours (shift fill rate)	34	95.0%	Performance stable and better than target	suspended				95.0%	Jul-20	National	n/a	
		Serious incidents - number*	35	0	Performance stable but worse than target	2	1	1	7	0	Jul-20	National	n/a	
		Serious incidents - % that are harmful*	35	0.0%	Performance stable but worse than target	100.0%	0.0%	100.0%	42.9%	0%	Jul-20	National	n/a	
		% of patients safety incidents which are harmful*	35	0.0%	Performance stable but worse than target	8.4%	8.4%	7.2%	8.5%	0%	Jul-20	National	n/a	
		Never events	35	0	Performance stable and better than target	0	0	0	1	0	Jul-20	National	n/a	
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	-	95.0%	Performance improved but worse than target	Suspended				95.0%	Jul-20	National	93.7%	Mar-20
		Safety Thermometer % New Harm Free Care (acquired within Trust)	-	95.0%	Performance improved but worse than target					95.0%	Jul-20	National	97.8%	Mar-20
		Category 4 pressure ulcers - New (Hospital acquired)	37	0	Performance stable and better than target	0	0	0	0	0	Jul-20	Local	n/a	
		Category 3 pressure ulcers - New (Hospital acquired)	37	0	Performance stable and better than target	0	0	0	1	0	Jul-20	Local	n/a	
		VTE risk assessment*	40	95.0%	Performance stable and better than target	95.8%	96.7%	96.1%	95.8%	95.0%	Jul-20	National	95.3%	Q3 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	41	90.0%	Performance deteriorated and worse than target	26.4%	28.3%	26.1%	34.8%	90.0%	Jul-20	National	54.0%	Mar-20
		Stroke patients spending 90% of their time on stroke unit	41	80.0%	Performance stable and better than target	54.8%	54.1%	83.3%	69.1%	80.0%	Jul-20	National	82.7%	Mar-20

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

NHS
West Hertfordshire Hospitals

Domain		Theme	Page	Target	Trend	May-20	Jun-20	Jul-20	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	192	254	268	1035	0	Jul-20	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	6	53	89	175	0	Jul-20	National	n/a	
		% Patients admitted through A&E - 0 day LOS		n/a		27.1%	31.6%	27.4%	27.3%		Jul-20	National	n/a	
		Patient Flow: In hospital flow												
		Discharges between 8am and 12pm (main adult wards excl AAU)		33.0%	Performance stable but worse than target	12.9%	14.1%	15.1%	13.7%	33.0%	Jul-20	National	n/a	
		Mixed sex accommodation breaches	43	0	Performance stable and better than target	suspended				0	Jul-20	National	59 Trusts breaching	Feb-20
		LOS > 21 days	44	65	Performance stable and better than target	61	53	52	52	65	Jul-20	National	n/a	
		Delayed Tranfers of Care (DToC) beddays used in month	44	n/a		Suspended				n/a	Jul-20	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	44	n/a						n/a	Jul-20	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	-	95%	Performance improved but worse than target	suspended				95%	Jul-20	National	85.0%	Feb-20
		Inpatient Scores FFT % positive	-	95%	Performance improved but worse than target					95%	Jul-20	National	95.9%	Feb-20
		Daycase FFT % positive	-	95%	Performance improved but worse than target					95%	Jul-20	National	n/a	
		Maternity FFT % positive	-	95%	Performance improved but worse than target					95%	Jul-20	National	96.9%	Feb-20
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	47	80%	Performance stable and better than target	38.9%	82.4%	92.3%	68.0%	80%	Jul-20	National	n/a	
		Reactivated complaints	47	0	Performance improved and better than target	1	2	0	3	0	Jul-20	National	n/a	
		Patient Experience: End of life care												
		New indicators to be included in Q4												
	Responsive	**Access to Services**												
		ED 4hr waits (Type 1, 2 & 3)	42	95.0%	Performance stable but worse than target	83.9%	87.1%	85.9%	84.5%	95.0%	Jul-20	National	92.1%	Jul-20
		Referral to Treatment - Incomplete*	49	92.0%	Performance improved but worse than target	56.5%	47.7%	51.0%	56.9%	92.0%	Jul-20	National	52.0%	Jun-20
		Referral to Treatment - 52 week waits - Incompletes	49	0	Performance deteriorated and worse than target	135	302	484	974	0	Jul-20	National	50536 (all Trusts)	Jun-20
		Diagnostic (DM01) <6 weeks		99.0%	Performance stable but worse than target	39.6%	64.8%	73.3%	52.4%	99.0%	Jul-20	National	52.2%	Jun-20
		Cancer												
		Cancer - Two week wait *	50	93.0%	Performance improved and better than target	98.9%	97.7%	98.5%	98.1%	93.0%	Jul-20	National	92.0%	Q1 20/21
		Cancer - Breast Symptomatic two week wait *	50	93.0%	Performance stable and better than target	87.9%	87.2%	98.1%	94.1%	93.0%	Jul-20	National	89.5%	Q1 20/21
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	50	75.0%	Performance stable and better than target	85.3%	82.2%	82.4%	81.0%	72.5%	Jul-20	National	n/a	
		Cancer - 31 day *	51	96.0%	Performance stable and better than target	92.1%	97.3%	97.0%	96.3%	96.0%	Jul-20	National	94.7%	Q1 20/21
		Cancer - 31 day subsequent drug *	51	98.0%	Performance improved and better than target	100.0%	100.0%	100.0%	100.0%	98.0%	Jul-20	National	98.9%	Q1 20/21
		Cancer - 31 day subsequent surgery *	51	94.0%	Performance stable and better than target	87.5%	100.0%	94.4%	94.4%	94.0%	Jul-20	National	88.6%	Q1 20/21
		Cancer - 31 day subsequent radiology *	51	94.0%		-	-	-	-	94.0%	Jul-20	National	95.5%	Q1 20/21
		Cancer - 62 day *	52	85.0%	Performance stable but worse than target	76.7%	87.4%	82.0%	78.5%	85.0%	Jul-20	National	73.3%	Q1 20/21
		Cancer - 62 day screening *	52	90.0%	Performance deteriorated and worse than target	64.3%	100.0%	0.0%	61.7%	90.0%	Jul-20	National	62.0%	Q1 20/21
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	53	5.0%	Performance stable but worse than target	26.2%	16.3%	16.2%	24.0%	5.0%	Jul-20	Local	n/a	
		DNA rate	53	8.0%	Performance stable and better than target	5.5%	6.2%	6.5%	5.8%	8.0%	Jul-20	National	n/a	

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West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Theme	Page	Target	Trend	May-20	Jun-20	Jul-20	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)	54	13.0%	Performance improved but worse than target	14.2%	13.8%	13.6%	14.0%	13.0%	Jul-20	National	15.0% (Beds and Herts orgs)	Q1 19/20
		% staff leaving within first year (excluding medics and fixed term contracts)	54	n/a		16.7%	15.7%	15.7%	16.3%	n/a	Jul-20	National	n/a	
		Vacancy rate	54	10.0%	Performance deteriorated but better than target	9.6%	9.1%	9.1%	9.4%	10.0%	Jul-20	National	11.1% (local survey)	Q1 19/20
		Sickness rate	54	3.5%	Performance stable but worse than target	6.3%	4.1%	4.0%	6.5%	3.5%	Jul-20	National	3.7% (EoE orgs)	Q1 19/20
		Developing Staff												
		Appraisal rate (Total)	55	90.0%	Performance stable but worse than target	87.0%	87.0%	87.0%	87.0%	90.0%	Jul-20	National	n/a	
		Mandatory Training	55	90.0%	Performance stable and better than target	93.9%	93.9%	93.9%	93.9%	90.0%	Jul-20	Local	91.0% (local survey)	Q1 19/20
		Essential Training	55	90.0%	Performance stable and better than target	90.8%	90.8%	90.8%	90.8%	90.0%	Jul-20	Local	n/a	
		Finance overview												
		Financial Risk Rating	14-24	3	Performance improved but worse than target	0.00	0.00	0.00			Jul-20	Local	n/a	
		Income & Expenditure Actual	14-24	£790	Performance stable but worse than target	£0	£0	£0	£0	-£1,551	Jul-20	Local	n/a	
		Income & Expenditure forecast	14-24	£0	Performance improved and better than target	£0	£0	£0	£0	£0	Jul-20	Local	n/a	
		Cash balance at the end of the month	14-24	£4,036	Performance improved and better than target	£51,142	£48,307	£49,140	£49,140	£4,036	Jul-20	Local	n/a	
		Capital expenditure	14-24	-£2,008	Performance stable but worse than target	-£125	-£852	-£710	-£4,187	-£8,025	Jul-20	Local	n/a	
		CIP delivery against plan	14-24	£1,153	Performance improved but worse than target	suspended				£4,610	Jul-20	Local	n/a	
		% Bank Pay**	14-24	12.0%	Performance stable and better than target	8.9%	10.0%	10.8%	10.1%	12.0%	Jul-20	Local	n/a	
		% Agency Pay**	14-24	4.7%	Performance stable but worse than target	2.8%	2.6%	4.9%	3.6%	4.7%	Jul-20	Local	7.3% (local survey)	Q1 19/20
		Activity (chargeable)												
		GP referrals		8,027	Performance stable and better than target	2,500	3,856	5,074	12,889	32,108	Jul-20	National	n/a	
		A&E attendances		15,594	Performance stable and better than target	8,645	9,876	11,559	36,633	54,830	Jul-20	National	n/a	
		Elective spells (overnight)		515	Performance improved but worse than target	141	190	253	721	1,880	Jul-20	National	n/a	
		Elective daycase		3,822	Performance stable but worse than target	435	1,081	1,628	3,535	13,959	Jul-20	National	n/a	
		Total elective spells		4,337	Performance stable but worse than target	576	1,271	1,881	4,256	15,839	Jul-20	National	n/a	
		Non-elective spells		5,090	Performance stable and better than target	3,031	3,394	3,732	12,837	20,032	Jul-20	National	n/a	
		Births		333	Performance stable but worse than target	362	356	389	1,462	1,310	Jul-20	National	n/a	
		Outpatient attendances		22,458	Performance stable but worse than target	7,434	9,452	11,357	35,268	82,019	Jul-20	National	n/a	

* No official cash target
** Straight line target

Activity RAG ratings are shown in the context of the minimum income contract where the primary objective is to match capacity to demand. Therefore, non-elective activity above plan/expectations would be rated red. Births are classified as non-elective activity and so activity below plan is rated green.
Elective spell underperformance against expectations is rated red in the context of waiting list management.

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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Safe Care & Improving Outcomes

Chief Medical Officer

Covid admissions appear to have levelled off, and thus we are still having to ring-fence 3 wards which is having an impact on patient flow, and ED performance. With the launch of rapid in-house testing for all patients imminent, we hope that length of stay and patient flow will improve, and ED performance should improve. Smart is to be relaunched shortly, using a virtual platform to improve cover, and will be renamed V-SMART!

As soon as school holidays end, I hope to be co-ordinating, with executive colleagues, a more focused and intensive consultation regarding our redevelopment, and the EPR projects, with divisions committing significant resource to this vital piece of work.

Chief Nurse

New IPC guidance has been issued and supersedes the June 20 Covid-19 guidance. It outlines the 3 pathways: High risk: Confirmed or suspected COVID-19, No change in additional IPC measures or PPE. **Medium risk:** No contacts or COVID-19 symptoms, No change in additional IPC measures or PPE. **Low risk:** No contacts or COVID-19 symptoms, Negative swab test, Self-isolated prior to admission for planned care following the NICE guidance, Standard IPC measures alone.

Other key messages are that social distancing at 2 metres continues in healthcare settings and the wearing of masks for staff, patients and visitors in all clinical and non-clinical settings.

Tissue viability: currently patients in high risk areas do not have access to medical photography due to limited resources, therefore they do not have the same access to care as patients in low risk areas. The aim of the iPad photography project on isolation is to have 100% of cat 3 and above pressure ulcers photographed within 24 hour of admission. This will ensure early TVN referral and treatment plan.

Another Quality improvement project in scoping phase: AAUL1 with ED to improve skin assessment recording – using the camera to photograph skin damage on admission.

The new ward scorecard has been reviewed with a focus on QI, to give an overview of how the themes from process and safety alerts are being taken forward. The model will be used in the quality improvement forum, performance reviews and the quality committee IPR.

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NHS
West Hertfordshire Hospitals
NHS Trust

Key messages for the Board

Caring & Responsive Services

Chief Nurse

The new infection and prevention control national guidance published in August continues to support limited visiting to essential visitors. As a result we have reviewed the **family liaison line** service to support across all pathways i.e. high to low risk. A business case has been developed and will go to the trust management committee in September.

We have successfully had our inaugural Coproduction Board with 23 members in virtual attendance in which we strive to deliver our aims:

- To create opportunities for cultural shift towards partnership working
- To provide different options to structure and model patient involvement in WHHT
- To provide guidance and support on how to do involvement well and evaluate its impact
- To jointly develop a structure/model that helps realise ambitions within the trust objectives.

We have reviewed the **national end of life care survey** (NACEL) and have agreed key areas of focus for the updated strategy and to develop and use in the Trust Board integrated performance report (IPR)

Gill Balen, chair of the patient panel steps down in October and will be succeeded by Frances Kipping.

Chief Operating Officer

The Trust is now seeing an upward trend in daily ED attendances reaching pre-COVID and winter levels on some days. The Trust has plateaued in relation to the total number of COVID inpatients.

COVID testing on admission has continued with the in-house testing solution eagerly awaited for go live to enable more timely movement of patients from our asymptomatic 'awaiting swab results' beds to the appropriate specialty beds elsewhere within the hospital.

Due to internal patient flow pressures an internal 'Business Continuity' incident was declared at 0657 hrs on Tuesday 18th August, good recovery with increased patient discharges was achieved over a 48 hour period with the incident being stood down at 0803 hrs on Thursday 20th August.

The Emergency Assessment unit opened on Tuesday 18th August, based on the ground floor of Shrodells and open 24/7 this unit provides more space for the assessment of both acute medical and surgical patients.

Interviews took place to appoint a new Head of Emergency Planning and Resilience – a successful external appointment was made with start date tbc. Interviews also took place for the Deputy COO/Divisional Manager for Emergency Medicine . I am pleased to confirm that Stephanie Johnson was successfully appointed to this role and formally takes up this position with effect from 1st September 2020.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief People Officer

- Workforce indicators – We continue to do well in a number of our key workforce indicators with our vacancy rate standing at 9.1% against a target rate of 10%. Turnover stands at 13.6% the lowest rate recorded since October 2013. Turnover for Band 5 Nursing and Midwifery staff is 15.1% (16% last month) The Trust's absence rate stands at 4.0% against a target of 3.5%. Naturally these absence figures have been effected by COVID and whilst they are still high by traditional standards, they are considerably reduced from their high of nearly 20% at the height of the pandemic. The recording of mandatory training and appraisals is due to restart in September.
- Employee risk assessment compliance levels stand at 88%. Further work is being undertaken to look at how we manage employees risk rated as 'moderate risk' to allow them to continue within COVID areas.
- A 'Thank you' letter went out to all staff employees from our CEO to thank them for their efforts during the pandemic and also to provide them with health and well being information.
- In response to COVID19 staff survey feedback the Trust launched it's 'Live for Five' new communications forum which provides direct communication session from our CEO. Plans are also in place to launch a new staff communication phone app in September.
- The Trust has been reviewing its people strategy to ensure that it is cognisant with the new NHS People Plan. It is pleasing to note that broadly speaking our internal plan aligns well with the proposals set out in the national plan.
- The Trust is due to commence on a new programme of leadership development focused principally around the concept of compassionate leadership. This programme is being developed with ICS system partners and roll out is due to begin in September.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief Finance Officer

We continue to progress the financial year managing finances under a temporary system, designed to minimise the risk that any NHS organisation limits its response to the COVID-19 pandemic, due to money constraints. Revenue flows from Commissioners continue to be guaranteed regardless of patient numbers. The Trust continues to follow internal processes to ensure all costs incurred in relation to the pandemic are captured. These processes follow national guidance to ensure full reimbursement of the additional costs. This applies both to revenue and capital expenditure.

In line with the temporary system, the Trust reports that accrued income matches the £35.3m of expenditure incurred in the month. Within the £35.3m, the COVID-19 pandemic created an extra £2.3m of revenue costs. Additional income is beginning to flow to cover these costs. Before the pandemic, the trust had budgeted for income to exceed expenditure by £0.8m. in July. This is linked to seasonal factors and the number of working days allowing for additional income generation within a business as usual scenario. The 'full reimbursement' meant that the Trust was £0.8m worse than the plan that was set at the start of the financial year. Year to date, the Trust is £1.6m better than plan at the end of July.

As the operational restarts gather momentum, The Trust continues to see an upward trajectory in the level of patients treated. The financial performance against plan can be summarised as.

- Elective admissions were 40% of the original plan in month, compared to an average of 20% for previous months.
- Outpatient attendances were 65% of the original plan in month, compared to a 52% YTD average.
- A&E attendances 78% of plan compared to a 62% average YTD Trend.

The Trust spent £0.71m on buildings and equipment assets in July. Cash flow is healthy, at this stage supporting the trust's efforts to pay suppliers as quickly as possible.

As the trust looks to re-start normal service provision, the forecast begins to take into account additional costs associated with enhanced protection needed for patients and staff, and the revised productivity profiles based on the organisations phase two of Restart. Based on the existing funding regime and current cost profiles, it is anticipated that in addition to the existing Covid-19 top up, the Trust could require additional funding to meet recently notified trajectories for activity improvement. This requirement is recognised by regulators.

After including recently notified allocations (eg to support the start of a new multi-storey car park) the Trust is looking to spend potentially twice as much in capital expenditure when compared to 2019/20. Some of this spend is dedicated to the wider hospital redevelopment programme.

Communication from the centre signals the end of the current reimbursement structure at the of Q2 (September). The Trust forecast is being updated to contextualise the requirements of the phase 3 restarts, internal operational targets and the subsequent impact on our finances.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Corporate - ICT

Chief Information Officer

July saw some significant technology projects completed in the month including:

- Transition of the entire estate off of the old N3 Wide Area Network onto the HSC Network
- Successful upgrade of our Patient Administration Service (from v4.6 to v8)
- Expanding Attend Anywhere virtual clinic capacity to all specialties across the Trust
- Implementing Fast Access Machines in the Emergency Department
- Significant progress made on the Trust's Accelerated EPR programme

However July also saw a significant pressure on Business As Usual IT service delivery with deterioration in some service metrics for the second consecutive month.

There were seven priority 1 incidents (up from four in June) in the month with four of the incidents being related to the interface between Sunquest ICE (Integrated Clinical environment) and Winpath limbs. Winpath is the pathology department system which sends results to ICE so they can be viewed. Unfortunately Winpath is still on a 2003 server and old hardware. It was not updated with all the other servers last year as at the time we were expecting the Pathology centralisation programme to have required a complete system upgrade. We have engaged a Data base administration expert from Atos to try and increase resilience prior to the centralisation. The other three priority 1 incidents were as follows:

- 6th July – Infoflex Database locked
- 13th July – External N3 network failure
- 14th July – Failure of Infoflex terminal server

There were 20 P2 incidents in July, up from seventeen in June

There has also been deterioration in service desk customer satisfaction in the month. As the hospital gets busier, we are seeing an increase in service desk contacts. We are working hard with Atos and the team to balance the programme and improvement activities with Business as Usual service delivery.

The longer term strategic projects (Local Area Network, Windows 10, EPR preparation, Digital Strategy for the new hospital) all continued according to plan.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Income and Expenditure July 2020

			In Month (£000's)				YTD			
Trust Definition	**Expense Type**	**Annual Budget**	**Budget**	**Actual**	**Variance**		**Budget**	**Actual**	**Variance**	
Income	Divisional Income	80,923	6,744	7,801	1,058	Bii	26,974	29,607	2,633	Fii
	NHS Revenue	336,416	29,314	27,504	(1,810)	Bi	111,850	109,155	(2,695)	Fi
	Income Unallocated CIPs									
Income Total		**417,340**	**36,057**	**35,305**	**(752)**	**B**	**138,825**	**138,762**	**(63)**	**F**
Pay	Medical Pay	(81,314)	(6,738)	(6,720)	18		(27,251)	(26,684)	566	
	Non-Clinical Pay	(63,199)	(4,895)	(4,372)	523		(19,440)	(16,811)	2,629	
	Nursing Pay	(79,663)	(6,641)	(6,425)	216		(26,556)	(25,555)	1,001	
	Other Clinical Pay	(29,679)	(2,482)	(2,611)	(129)		(9,894)	(10,316)	(423)	
	Scientific, Technical & Profes	(27,317)	(2,290)	(2,301)	(11)		(9,106)	(9,256)	(150)	
	Pay Unallocated CIPs	9,386	481		(481)		1,203		(1,203)	
Pay Total		**(271,786)**	**(22,564)**	**(22,430)**	**135**	**C**	**(91,043)**	**(88,622)**	**2,421**	**G**
Non Pay	Clin Supp Serv	(31,253)	(2,841)	(2,068)	773		(10,376)	(8,653)	1,723	
	Drugs	(21,424)	(1,947)	(1,717)	230		(7,113)	(6,520)	593	
	OTHER (NON CLIN)	(82,590)	(6,857)	(7,729)	(872)		(27,126)	(29,499)	(2,372)	
	Non Pay Unallocated CIPS	6,257	321		(321)		802		(802)	
Non Pay Total		**(129,009)**	**(11,324)**	**(11,514)**	**(190)**	**D**	**(43,813)**	**(44,673)**	**(859)**	**H**
Recharges	Recharges		()				()			
Recharges Total			**()**				**()**			
Financing Charges	Depreciation	(10,948)	(912)	(900)	13		(3,646)	(3,617)	29	
	Trust Debt Redemption	(5,570)	(464)	(464)			(1,864)	(1,857)	7	
	Unwinding Discount	(27)	(2)	2	4		(9)	6	15	
Financing Charges Total		**(16,545)**	**(1,379)**	**(1,362)**	**17**	**E**	**(5,519)**	**(5,467)**	**52**	**I**
Total			**790**		**(790)**	**A**	**(1,551)**		**1,551**	**J**

A – The continuation of the interim arrangements set out by NHSE/I mean the Trust delivered an actual breakeven position for the month of July.
The performance to plan was worse by £790k. The planning process for the first 4 months of 20-21 has been suspended and the plan shown represents the pre-covid business as usual plan. This could be subject to change if the Trust choses to amend its annual plan when existing planning restrictions are lifted.

B- The overall income position saw an underperformance in month of £752k.
Bii – With the interim reimbursement arrangements in place, key points to note within divisional income include reduced MRET, PSF and car parking income within the month. This was mitigated by the national top up payment and claims for additional covid related costs which are captured on slide 11.
Bi- NHS Revenue generated a total of £27,504k in month. This represented temporary block arrangements with all CCGs, regardless of activity performance. This guarantee of income saw an underperformance against the business as usual plan. This is where block arrangements did not cover our original expectations of the activity to be performed in July. The underperformance was £1,810k. Operationally, all points of delivery saw significant underperformances in month as a result of the Covid-19 situation. However, Actual activity levels have continue to increase month on month since May.

C – The overall pay bill for the month was £22,430k which was £135k underspent. Within the pay position, an additional £826k was spent in relation to covid-19 and is offset by income. Reduced activity levels in month contributed to the underspend.

D – The non pay position reported an overspend of £190k. This includes an additional £1,465k spent in relation to covid-19 . This also has been offset by income. Reduced activity levels in month contributed to the underlying underspend.

E – Financing charges broke even in month with a small over performance of £17k.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Finance overview dashboard

Financial Overview 31 July 2020

Month 4 Income & Expenditure

£m	Plan	Actual	Var
Surplus / (Deficit)	0.8	0.0	(0.8)

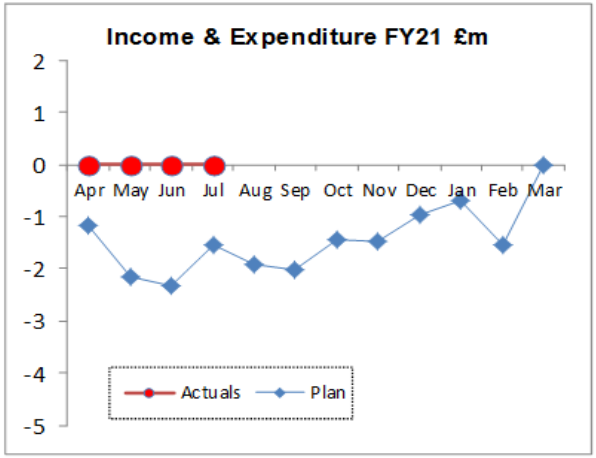
£m	YTD M4 20/21		
Surplus / (Deficit)	(1.6)	0.0	1.6

Statutory / Regulatory Duties

Breakeven	The trust achieved break even year to date and has a break even plan for FY21.	G
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 31/7/20 equated to 49 days' spend.	G
BPPC	Month 4 performance - 86.3% on number, 87.8% on value (95% target)	A

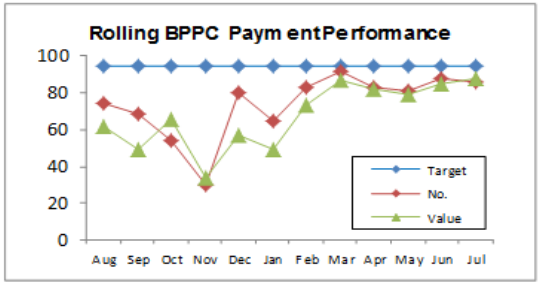
Financial Risk Rating	FY21	2

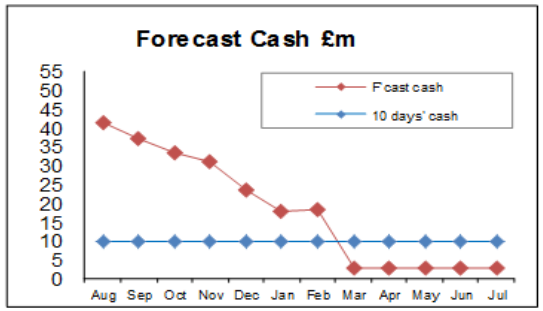
Risk rating on a scale of 1 to 4, with 1 being best and 4 being worst.

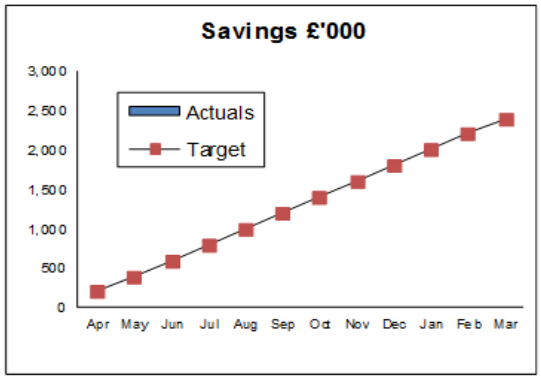


YTD Variance by Division £m

Medicine	(7.9)
Unscheduled Care	(5.1)
Surgery	(12.2)
Women's	(2.9)
Clinical Support	(3.2)
Estates & Facilities	(0.3)
Corporate	(0.0)
Other	33.2
Total	**1.6**







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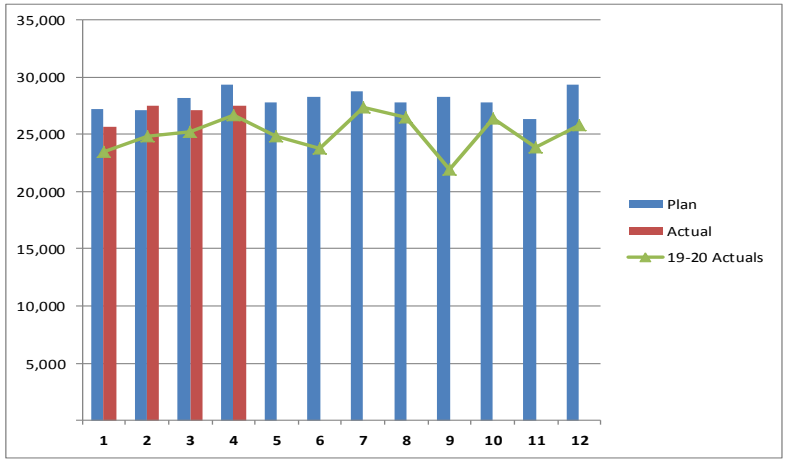
West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Income - July 2020

NHS Revenue: Performance by Month (£s)

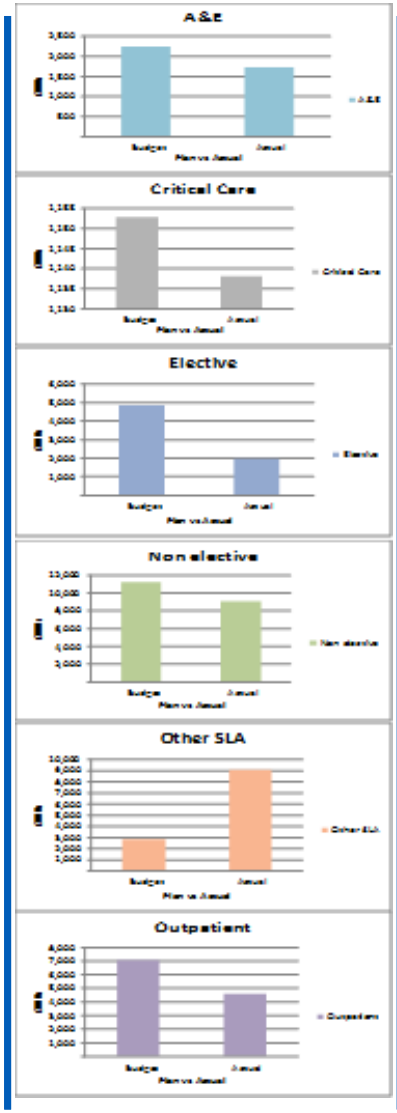


In line with national guidelines, NHS revenue continues to be set at a block amount of £27.5m for the month of July. This resulted in an underperformance against the business as usual plan.

All points of delivery showed underperformances as a result of the Covid-19 outbreak:

Despite increases in activity from previous months, A&E continues to underperform against plan by £0.5m
In July, the number of covid patients requiring critical care facilities continued to reduce. This is behind the breakeven performance against plan, in month.
The cessation of all routine Elective cases continues to drive a monthly underperformance of £2.9m. This is predominately within the Surgery division.
For Non Elective the in month position showed under performance of £2.15m.
Despite an increase in virtual interactions, the overall fall in Outpatient attendances meant performance was £2.5m away from plan.

The adverse variances above were offset by other SLA income being favorable to plan by £6.2m. This reflects the interim block reimbursement arrangements.



In Month Performance (£s)

Expense Type	POD	Annual Budget	In Month (£000s) Budget	Actual	Variance
NHS Revenue	A&E	26,486	2,244	1,728	(516)
	Critical Care	13,664	1,153	1,138	(15)
	Elective	93,207	4,837	1,977	(2,859)
	Non elective	132,004	11,213	9,063	(2,150)
	Other SLA	30,315	2,800	9,038	6,238
	Outpatient	78,724	7,047	4,560	(2,487)
	NHS Rev/Unallocated CIPs				
NHS Revenue Total	Total	338,418	29,314	27,504	(1,810)

In Month Performance (spells)

Expense Type	POD	Annual Budget	In Month (Activity) Budget	Actual	Variance
NHS Revenue	A&E	166,824	16,668	12,208	-3,460
	Critical Care	14,572	1,228	1,127	-101
	Elective	47,706	4,227	1,865	-2,362
	Non elective	64,255	5,485	4,112	-1,353
	Other SLA	3,774,705	342,155	269,377	-72,778
	Outpatient	478,834	42,514	25,472	-17,042
NHS Revenue Total	Total	4,566,920	413,578	315,922	-498,186

Divisional Income

Divisional income delivered a £1,058k surplus in month. Reduced MRET, PSF and car parking income was mitigated by the national covid top up payment. In addition to this the Trust submitted £2.3m worth of claims for additional covid related expenditure. This is included within the position.

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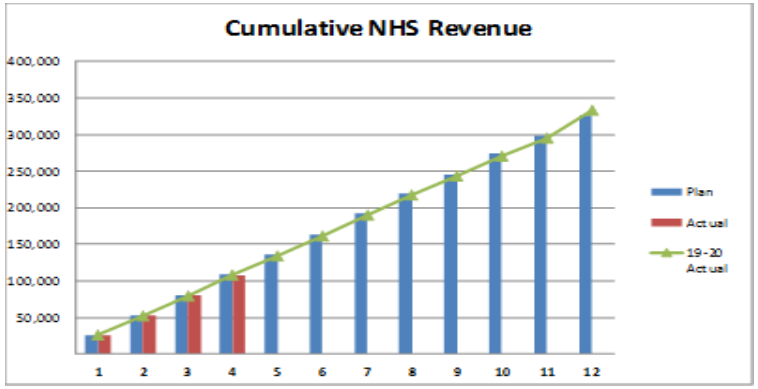
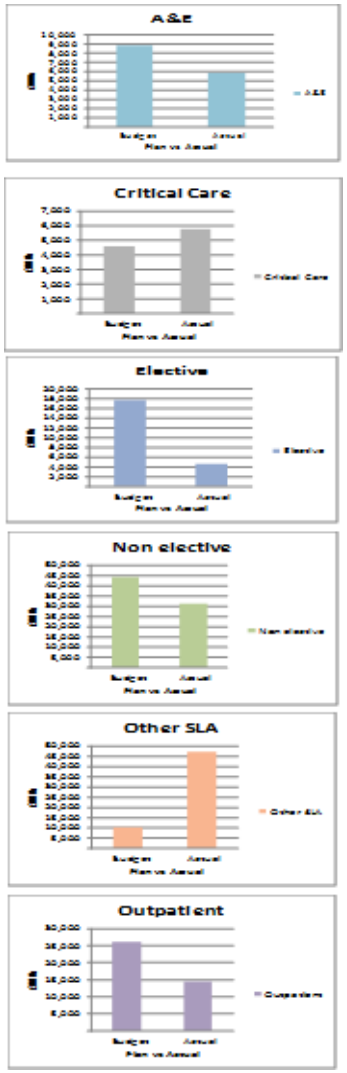
Workforce & Finance : Year To Date (YTD)– Trust Income

NHS Revenue: Performance by Month (£s)



Month 4 YTD shows Income under performance of £2.7m. £109m has been generated against plan of £112m.
A&E has a YTD under performance of £3m which is linked to a price and volume variance.
Critical care is £1.21m better than plan and has seen an average occupancy rate of 80%. The increase is linked to the Covid-19 pandemic.
Elective performance is £13.1m away from the YTD plan. This is mostly driven by underperformances across the Surgery division linked to a reduction in the volume of procedures performed and a reducing complexity of procedures.
Non Elective activity has a deficit against plan of £12.8m. This is predominately centred around the Emergency division and is linked to a reduction in emergencies throughout the pandemic.
YTD Outpatient performance shows £11.7m under performance.
Other SLA income is £36.7m above plan. This is driven by a central adjustment to take into account the impact of current interim reimbursement structure.



YTD Performance (£s)

POD	YTD (£000's) Budget	Actual	Variance
A&E	8,850	5,856	(2,994)
Critical Care	4,563	5,770	1,207
Elective	17,666	4,615	(13,050)
Non elective	44,129	31,317	(12,812)
Other SLA	10,472	47,138	36,665
Outpatient	26,171	14,460	(11,711)
NHS Rev Unallocated CIPs			
Total	**111,850**	**109,155**	**(2,695)**

YTD Performance (spells)

POD	YTD (Activity) Budget	Actual	Variance
A&E	62,449	39,137	-23,312
Critical Care	4,873	5,511	638
Elective	15,839	4,372	-11,467
Non elective	21,512	14,276	-7,236
Other SLA			
Outpatient	159,353	76,557	-82,796
Total	**264,025**	**139,853**	**-124,172**

Divisional Income

The YTD divisional income position is now better than plan by £2.6m. This is driven by claims for Covid -19 revenue reimbursement from the centre.
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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Pay July 2020

Trust Pay Performance

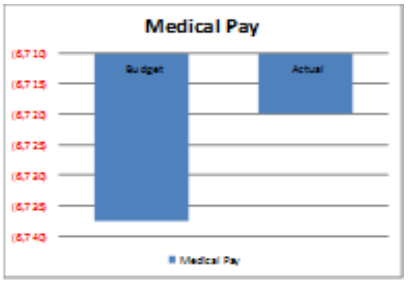
Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	WTE Budget	Actual	Variance
Medical Pay	(81,314)	(6,738)	(6,720)	18	711.37	788.47	-77
Non-Clinical Pay	(63,199)	(4,895)	(4,372)	523	1,270.89	1,218.51	52
Nursing Pay	(79,663)	(6,641)	(6,425)	216	1,629.40	1,557.21	72
Other Clinical Pay	(29,679)	(2,482)	(2,611)	(129)	1,020.82	1,058.41	-38
Scientific, Technical & Profes	(27,317)	(2,290)	(2,301)	(11)	511.40	512.83	-1
Pay Unidentified CIPs	9,386	481		(481)	0.00	0.00	0
Total	**(271,786)**	**(22,564)**	**(22,430)**	**135**	**5,143.88**	**5,135.43**	**8**

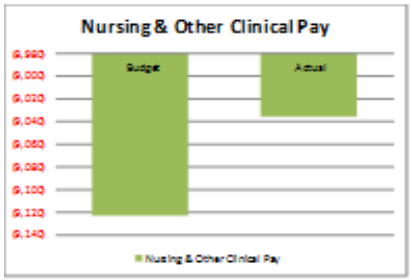
The Trust reported an in month underspend of £135k. This is linked to reduced activity levels performed in month. There was also £826km worth of cost captured in relation to Covid-19.

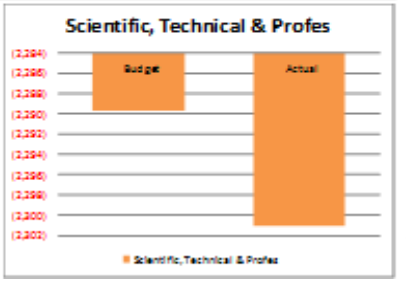
Key areas to note include;

Medical pay was £18k underspent, this is linked to operational changes in dealing with the covid-19 outbreak.
Non Clinical Pay- was underspent by £523k. This represents unspent growth reserves across divisions.
Nursing and other clinical pay showed a combined underspend against plan of £87k. This was driven by a lower bank and agency spend in month due to unfilled shifts.
Agency premium to cover scientific and professional vacancies across clinical support, theatres and cardiology generates the £11k overspend in month.
Expected pay efficiencies in month were not achieved and this caused a £481k adverse movement against plan.

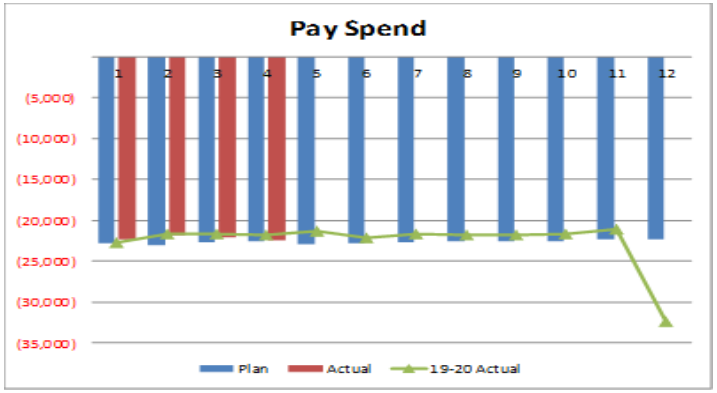
Additional work is ongoing to understand any future cost implications of implemented hospital zoning versus existing funded establishment.







Workforce & Finance: Trust Pay July 2020



The year to date reported position shows an underspend of £2.4m.

Key year to date themes to note are:

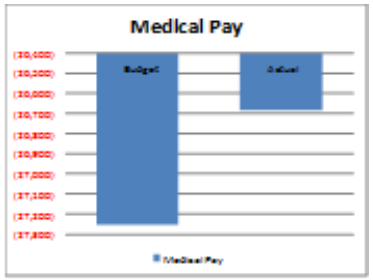
1.Medical pay – is showing an underspend of £0.56m. This reflects operational changes made during the covid-19 pandemic.

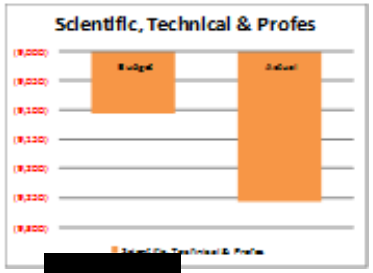
2.Nursing and other clinical pay has a combined underspend of £0.57m YTD. This is driven by a lower bank and agency fill rate and operational changes made to deal with Covid-19 (zonal deployment).
3.Scientific & therapeutic agency premium to cover vacancies across clinical support, theatres and cardiology are causing £0.15m YTD overspend.

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

5.Unachieved CIPs due to the temporary suspension of the efficiency programme account from a £1.2m overspend.

6.Total Pay costs which have been spent in relation to the Covid-19 pandemic total £2.9m.





YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(81,314)	(27,251)	(26,684)	566
Non-Clinical Pay	(63,199)	(19,440)	(16,811)	2,629
Nursing Pay	(79,663)	(26,556)	(25,555)	1,001
Other Clinical Pay	(29,679)	(9,894)	(10,316)	(423)
Scientific, Technical & Profes	(27,317)	(9,106)	(9,256)	(150)
Pay Unallocated CIPs	9,386	1,203		(1,203)
	(271,786)	**(91,043)**	**(88,622)**	**2,421**

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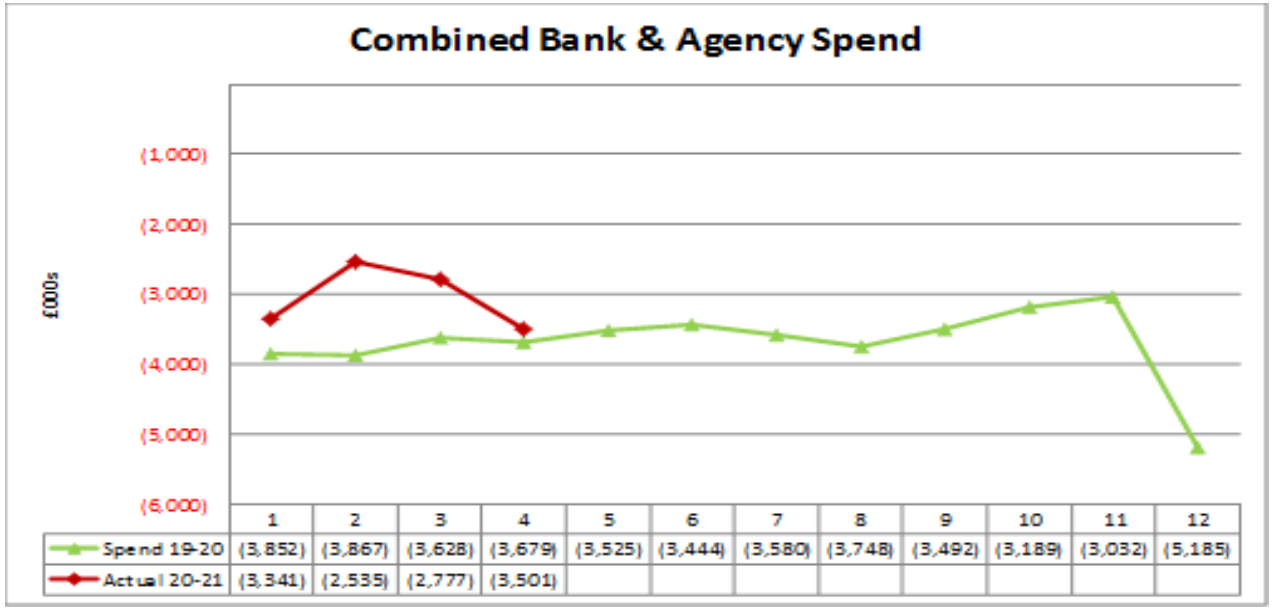
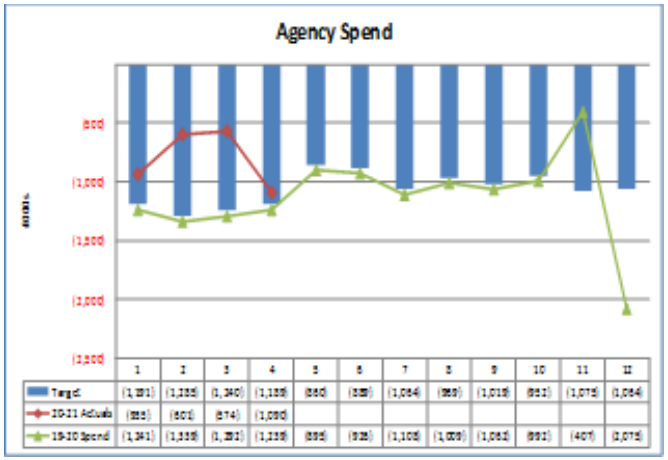
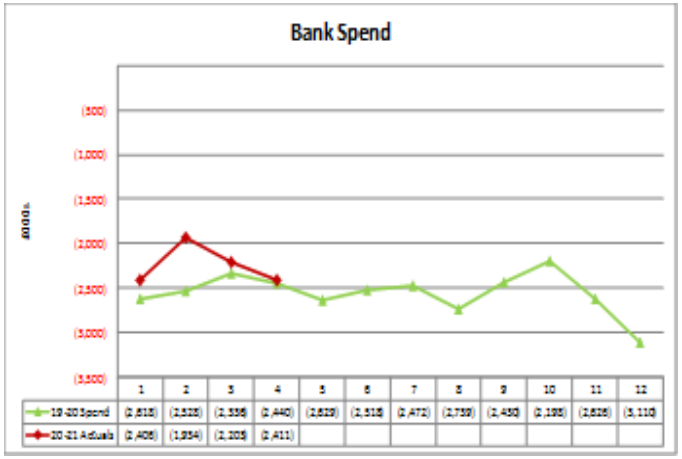
Workforce & Finance: Bank & Agency Spend July 2020







Agency

The Trust has set an internal target of £12.8m for 20-21.

This is £0.2m lower than the internal target set last year.

Agency expenditure in the month totaled £1.1m. This represents an increase on previous months and reflects unfilled agency shifts and operational changes within the Trust.

Of the £1.1m in-month spend, £0.28m was spent in relation to covid.

Bank

Bank spend for July was £2.4m. This is broadly in line with the patterns of spend seen in previous months.

Of the £2.4m spend, £0.35m was spent in relation to covid.

When comparing to the same month last year, the Trust has spent £0.18m less on temporary staffing.

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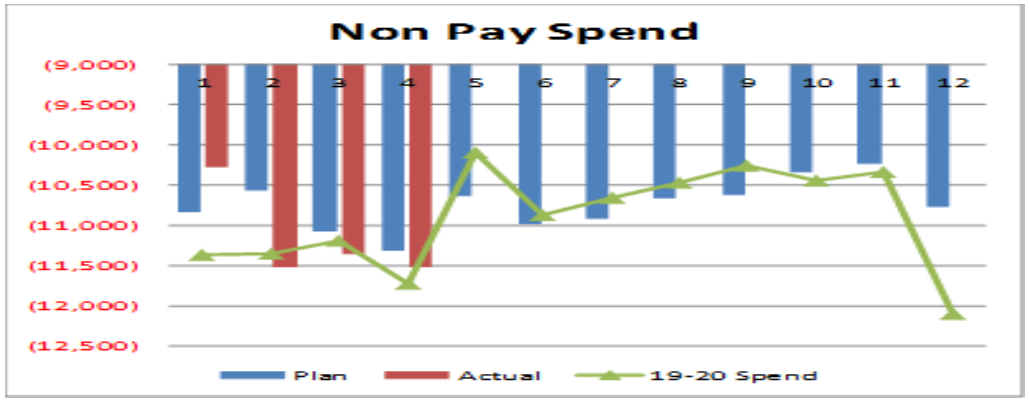
West Hertfordshire Hospitals NHS Trust

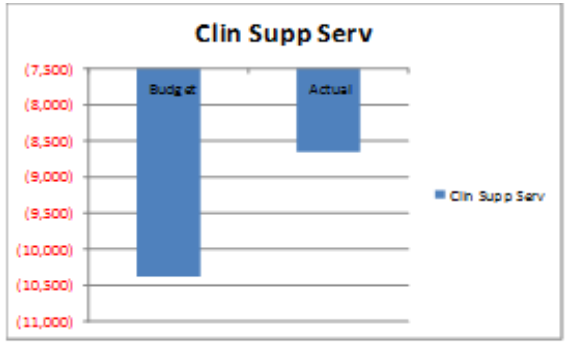
Workforce & Finance: Non Pay July 2020

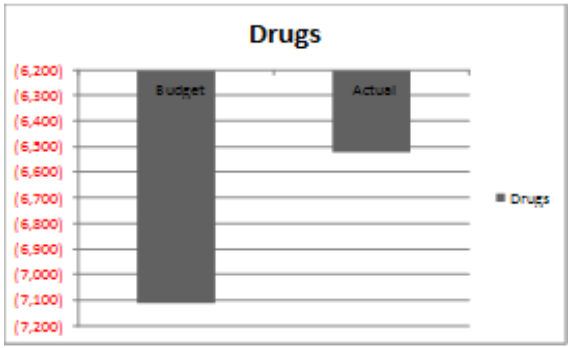
Non Pay Performance

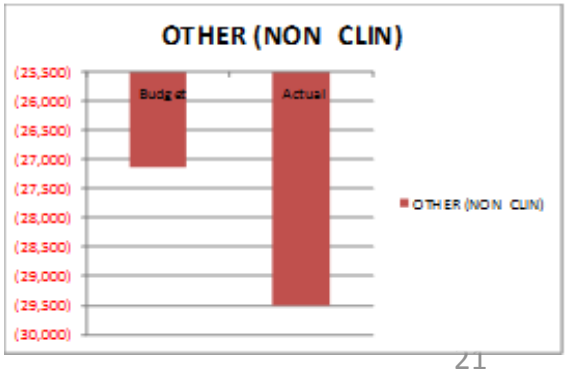
Expense Type	Annual Budget	In Month (£000's) Budget	In Month (£000's) Actual	In Month (£000's) Variance	YTD Budget	YTD Actual	YTD Variance
Clin Supp Serv	(31,253)	(2,841)	(2,068)	773	(10,376)	(8,653)	1,723
Drugs	(21,424)	(1,947)	(1,717)	230	(7,113)	(6,520)	593
OTHER (NON CLIN)	(82,590)	(6,857)	(7,729)	(872)	(27,126)	(29,499)	(2,372)
Non Pay Unallocated CIPS	6,257	321		(321)	802		(802)
Total	(129,009)	(11,324)	(11,514)	(190)	(43,813)	(44,673)	(859)



YTD Performance







The in month non pay position reported an overspend of £0.19m. Actual Spend was £11.51m against a budget of £11.32m.

The main drivers of the position include:

Clinical supplies were £0.77m underspent in month. This was driven by lower activity numbers - fewer elective cases in month resulted in underspends against high cost devices and consumables.
Drugs were underspent by £0.23m. This reflects the volume and complexity of patients seen in month.
Other non clinical supplies were overspent by £0.87m. The majority of this relates to covid related infrastructure costs.
The position includes a total spend of £1.47m in relation to covid-19 in month.

YTD the position is £0.86m overspent. This includes total YTD covid non pay costs of £6.3m.

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Workforce & Finance: Covid-19 Cost Capture July 2020

Principles

Two main financial control principles are used to ensure relevant Covid-19 costs are charged:

All expenditure to the central code must be signed off by a Chief officer.
Divisional expenditure is collated through finance managers within each division, and then assessed for relevance, backup etc before being submitted for Chief approval.

Month 4

In month 4 the following costs have been captured:

£826k pay
£1,465k non-pay

This has been offset with £2,291k worth of central income.

Major equipment purchases will be largely non-recurrent, while staff costs will be ongoing and increasing as the number of patients peaks.

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Pay	Medical Pay	323	799
	Non-Clinical Pay	200	644
	Nursing Pay	111	716
	Other Clinical Pay	41	261
	Scientific, Technical & Profes	152	519
Pay Total		**826**	**2,940**

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Non Pay	Cleaning supplies & materials	177	230
	Computer expenditure	1	54
	Consultancy	15	142
	Drugs	-38	336
	Estates expenditure	390	955
	Furniture & office equipment	1	1
	Healthcare from other NHS Bod	20	20
	Laboratory expenses	171	885
	Medical & Surgical Equipment	-17	1123
	Other non-pay	641	2133
	Printing & stationery	1	22
	Provisions	72	256
	Staff Uniforms	29	166
	Travel & subsistence	2	2
Non Pay Total		**1,465**	**6,324**
Grand Total		**2,292**	**9,264**

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Workforce & Finance: Efficiency Programme

WHHT - FY21 CIP Efficiency Covid 19 impact

FY21 Efficiency Strategy Themes
Covid 19 impact (as of 14.05.20)

Division	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	Total £000
A&C Establishment Review (WTE Reduction)	4	8	12	15	19	23	27	31	35	38	42	46	**300**
A&C Establishment Review (Skill Mix)	1	3	4	5	6	8	9	10	12	13	14	15	**100**
Medical Establishment Review (WTE Reduction)	13	26	38	51	64	77	90	103	115	128	141	154	**1,000**
Medical Establishment Review (Skill Mix)	3	6	10	13	16	19	22	26	29	32	35	38	**250**
Nursing Establishment Review (WTE Reduction)	13	26	38	51	64	77	90	103	115	128	141	154	**1,000**
Nursing Establishment Review (Skill Mix)	6	13	19	26	32	38	45	51	58	64	71	77	**500**
Senior Manager Establishment Review (WTE Reduction)	3	6	10	13	16	19	22	26	29	32	35	38	**250**
Senior Manager Establishment Review (Skill Mix)	1	3	4	5	6	8	9	10	12	13	14	15	**100**
Non-Pay Procurement initiatives	26	51	77	103	128	154	179	205	231	256	282	308	**2,000**
Non-Pay Divisional Targets	60	119	179	238	298	357	417	476	536	595	655	714	**4,644**
Outpatients - Service Development	26	51	77	103	128	154	179	205	231	256	282	308	**2,000**
Contracts & Commercial opportunities	19	38	58	77	96	115	135	154	173	192	212	231	**1,500**
Non-SLA Income opportunities	26	51	77	103	128	154	179	205	231	256	282	308	**2,000**
Total	**201**	**401**	**602**	**802**	**1,003**	**1,203**	**1,404**	**1,605**	**1,805**	**2,006**	**2,206**	**2,407**	**15,644**
			Covid 19 April - July impact	**2,006**									

FY21 CIP Efficiency Divisional Target
Covid 19 impact (as of 14.05.20)

Division	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	Total £000
Clinical Support	18	35	53	70	88	105	123	140	158	175	193	210	**1,367**
Corporate	24	48	72	97	121	145	169	193	217	241	266	290	**1,883**
Medicine	43	86	130	173	216	259	303	346	389	432	476	519	**3,372**
Surgery & Anaesthetics	53	106	159	212	265	318	371	424	477	530	583	637	**4,137**
Emergency Medicine	21	43	64	86	107	128	150	171	192	214	235	257	**1,667**
Womens & Childrens	22	44	66	88	110	131	153	175	197	219	241	263	**1,709**
Environment	19	39	58	77	97	116	135	155	174	193	213	232	**1,508**
Total	**201**	**401**	**602**	**802**	**1,003**	**1,203**	**1,404**	**1,605**	**1,805**	**2,006**	**2,206**	**2,407**	**15,644**
			Covid 19 April - July impact	**2,006**									

At the time of writing NHSI guidance is that the first 4 months of the Trust's FY21 efficiency program have been suspended, it is anticipated that NHSI guidance around impacts beyond July will be provided imminently.

WHHT FY21 April to July impact is £2m

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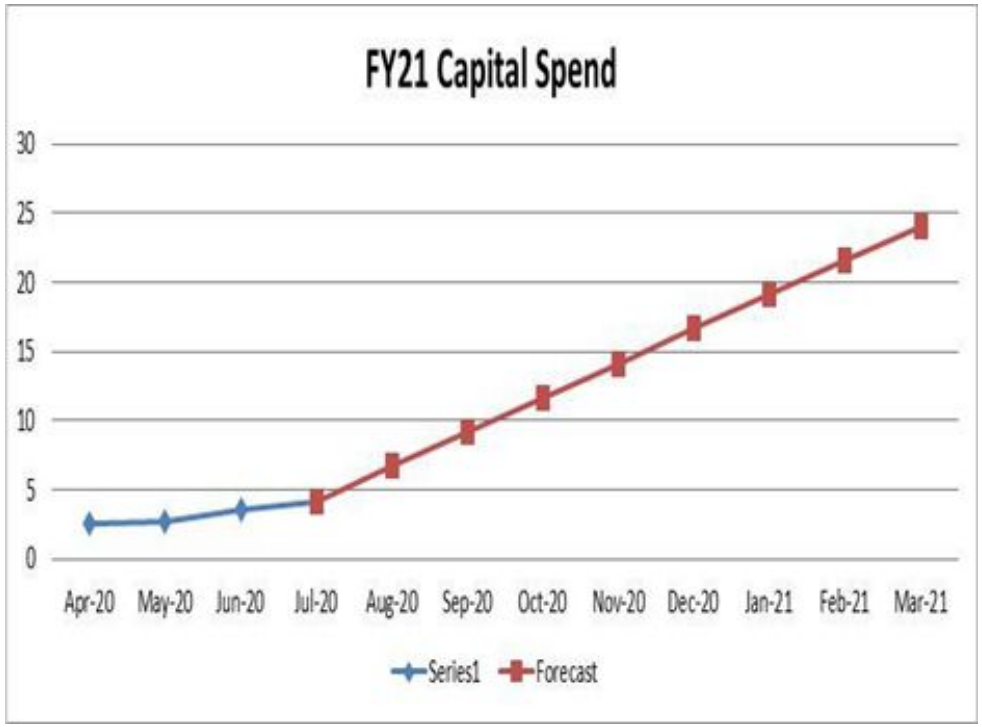
Workforce & Finance: Capital Expenditure July 2020



YTD Capital spend by Scheme

Month	Scheme	Spend (£m)
1	**Your Care Your Future**	**0.3**
1	**LED Lighting**	**0.2**
1	**Medical Equipment**	**0.6**
1	**Backlog maintenance**	**0.1**
1	Covid-19 related projects	1.3
	Month 1 Total Spend	**2.5**
2	Your Care Your Future	0.06
2	Covid-19 related projects	-0.49
2	Fire Safety	0.31
2	Backlog maintenance	0.25
	Month 2 Total Spend	**0.13**
3	Your Care Your Future	0.08
3	Medical Assessment Unit	0.31
3	Endoscopy Equipment	0.29
3	Replacement of Pharmacy Robot	0.06
3	Theatre Project	0.08
3	WAN Infrastructure- IT	0.03
	Month 3 Total Spend	**0.85**
4	Covid-19 related projects	0.02
4	Medical Assessment Unit	0.18
4	Multi Storey Car Park (MSCP)	0.03
4	Fire Safety	0.41
4	Estates projects	0.07
	Month 4 Total Spend	**0.71**
	YTD Spend	**3.48**

West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

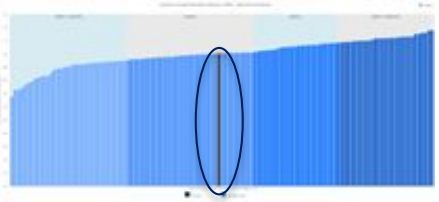
In this reporting period:
The latest available (March 2019 to February 2020) Summary Hospital Mortality Indicator (SHMI) was 99.1 and within the 'as expected' range (band 2). For the 12 month period (April 2019 to March 2020), the Trust's overall HSMR of 100.7 was within the 'as expected' range. The COVID diagnostic code will not be part of the HSMR primary diagnostic bundle and has a separate SMR code and as such effects on mortality indicators are currently predicted to be minimal although will be observed closely.

Quantitative aspects of Mortality :
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. This process is consistent and has not highlighted any lapses of care to date in those outlying groups. Current outlying groups include secondary malignancies but as the SMR has recently shown a downward trajectory, this will be kept under close observation.

Qualitative aspects of Mortality:
Monthly specialty/departmental Mortality Review meetings have restarted as well as the process for Structured Judgement Review (SJR) both of which had been suspended. The level tier 2 work for judgements of potential avoidability of death has resumed.

Performance stable
Better than target/threshold

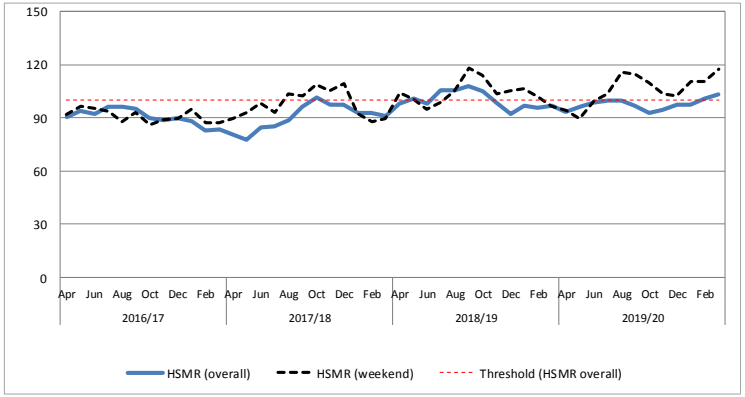
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



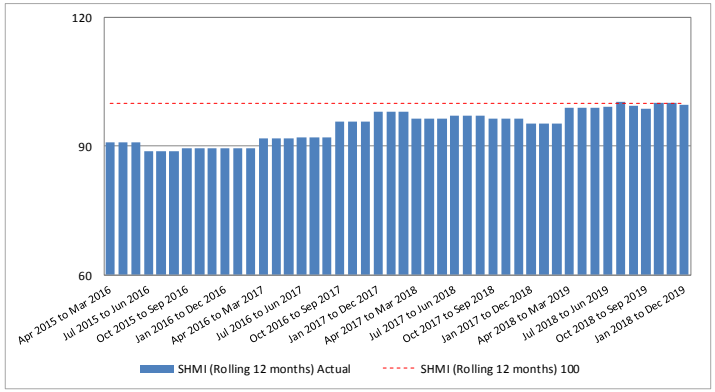
Period: Jan 2020

WHHT 1.01 **Sector: 1.01**

HSMR – rolling 3 months



SHMI – rolling 12 months



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	1a / 1b / 2a / 3a / 4a

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

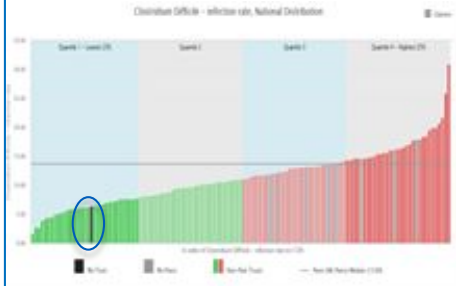
In this reporting period:
Clostrioides difficile Infection (CDI) objectives for 2020/21 are based on a new criteria for apportioning of cases; this system commenced on 1 April 2019: Hospital onset healthcare associated – cases detected 2 days or more after admission (CAT1). Community onset healthcare 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 continues in 20/21. The continuation of work around the CDI action plan has included visits to clinical areas to support patient reviews and raise awareness regarding learning from CDI. This includes PPE compliance and embedding the basics of IPC. In July 2020 6 cases of C diff infection were attributed to the Trust (x1 cat 1 and x5 cat 2) . Total number of Trust apportioned cases April to July is 11 cases (cat 1 x6 and cat 2 x5). RCA's have been commenced in all of these cases, no themes or data suggests any connection with these cases . The IPC team are working with divisions to ensure standards of IPC practice and management of cases continues to be of a high standard.

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 June 2020. With over a year since the last post 48 hour (trust) cases .

Outbreaks/ Covid19: The IPC team supports the management of the Covid19 Pandemic through daily clinical visits and reviews, PPE training in clinical areas. Advice and support regarding management of Covid19 in both clinical and non clinical areas. Work is undertaken in the analysis of positive Covid19 test results , for managing any Hospital Acquired cases (in line with NHSE definitions) , all patients are now tested on admission and screening on day 5 -7 of their admission. During July no outbreaks were identified and a closure of both June outbreaks was undertaken
Hand hygiene (HH): Hand hygiene compliance for the month of July is above the 95% target across the trust. HH training on ward visits is routine, staff now reminded of importance of washing to the elbow in clinical areas. IPC undertakes daily clinical visits to observe and provide support to ensure compliance with hand decontamination and PPE compliance.
Water Management, Ventilation and Decontamination: The Trust has groups in place to monitor all of these areas. Water Safety Group meetings have been undertaken and ventilation/decontamination discussed as part of the covid governance structure.

Performance stable
Better than target/threshold

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

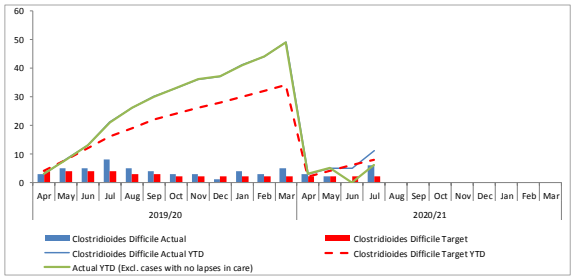


Period: to March 2019

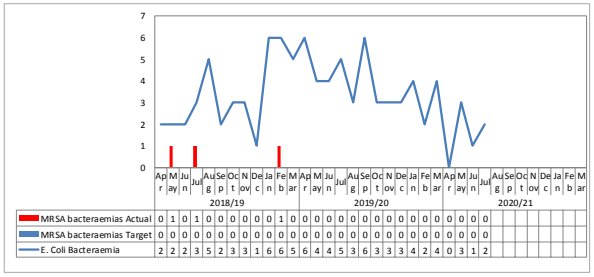
WHHT 6.42 Peer 13.68
National 11.11

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

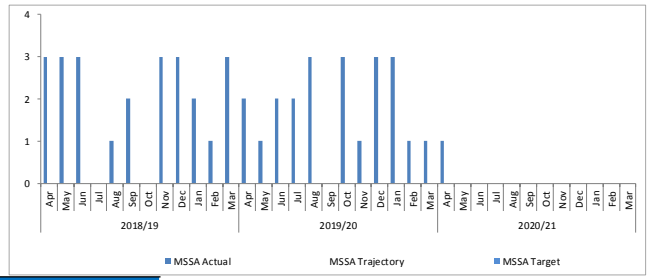
Clostrioides Difficile Infection (CDI)



MRSA



MSSA



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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

In this reporting period:
E. Coli bacteraemia (E colib):
There was 2 post-48hr cases and 29 pre-48 hour cases (non-trust) reported in July 2020. There is no externally set target for the trust but the national target is to deliver a 25% reduction by 2021 and 50% by 2024; this is reflected in the quality indicator which is monitored by the CCG. Thematic data is gathered for post-48 hour cases and reviewed alongside microbiology review of the pre-48 hour cases. Work around this is to be recommenced as part the recovery plan.

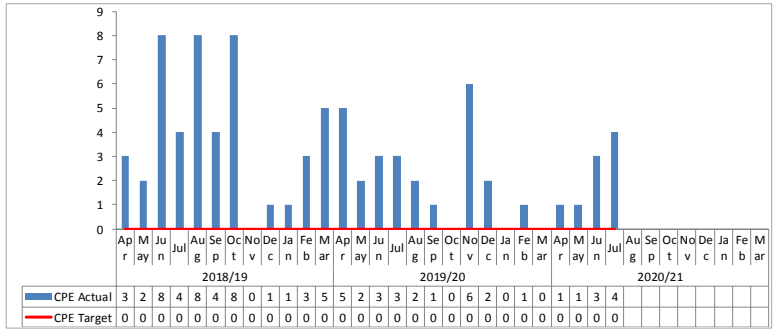
Methicillin-sensitive Staphylococcus aureus (MSSAb):
There was 0 post-48 hour case and 6 pre-48 hour cases of MSSAb in July 2020. Each case is usually reviewed by a microbiologist using an RCA tool to identify and share learning and is to be picked up as part of the Covid19 work. No MRSAb has been recorded (post 48hr) for over a year.

Carbapenemase-producing Enterobacteriaceae (CPE):
The trust routine management and compliance process for CPE continues, including screening, enhanced cleaning and isolation. This is being focussed on by the IPCT as the trust recovers from the Covid19.

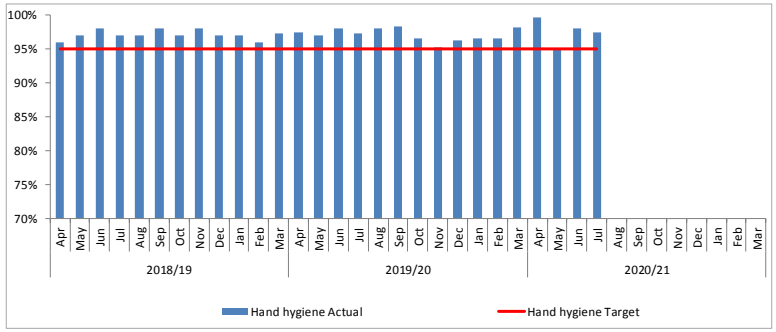
IPC Progress Update: The IPC Code of Practice (CoP) audits have been reviewed to incorporate Covid19 IPC guidance & the BAF. Divisions and wards have recommenced their CoPs audits in their departments, and IPC Team are supporting. During June work on the use of PPE continues for Covid19, . The IPCT have been providing practical support to clinical areas . There is continued monitoring of water quality, ventilation, decontamination, antimicrobial stewardship and cleaning across the trust. Also ongoing discussion from IPC with Facilities, Estates, Mitie and the clinical team to ensure we work together to continue to maintain a high standard of cleanliness of the environment which is fundamental in the prevention of Nosocomial infections in Covid.

Next steps: The work of the IPCT is to support the Divisions in all aspects of IPC supporting the prevention of health care associated infections including COVID in all areas. There is continued focus on cleaning, hand decontamination and PPE compliance to ensure safety of our staff and patients, particularly focusing on Covid19 and other key HCAIs such as CDI, CPE and Gram Negative infections.

Carbapenemase-producing Enterobacteriaceae (CPE)



Hand hygiene compliance



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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Safe care & Improving Outcomes: COVID-19 (Slide 1 of 3)

Learning from COVID-19

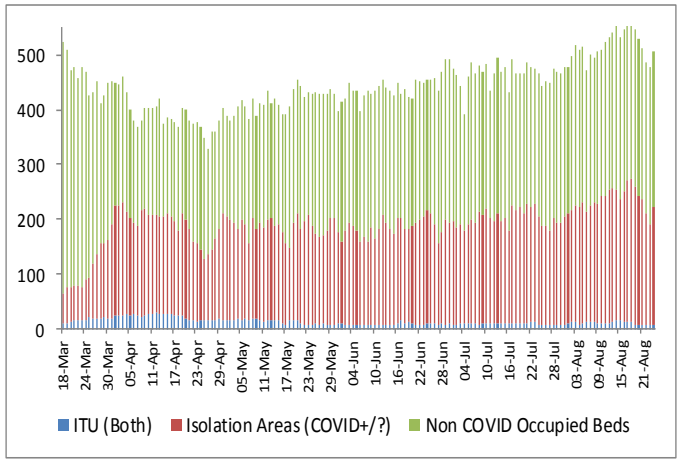
Work around the management of cases throughout the trust has included working alongside clinical areas to ensure that both admission and 7 day screening of inpatients is in place, and to ensure the correct management and placement of patients. Following the NICE guidance issued in July 2020 for elective admission a robust process of screening 72 hours prior to procedure is now in place. This has included making SACH a "green" site and ensuring that all measures are undertaken to re start service in a safe and systematic way. Continued support with the use of PPE and IPC practice continues across the trust.

A COVID RCA tool has been developed to support the review of Hospital-Onset Probable & Definite Heatlhcare-Associated cases. The learning identified through the RCA process will be shared across the divisions and along with audit data/feedback the data will be analysed for any areas requiring improvement.

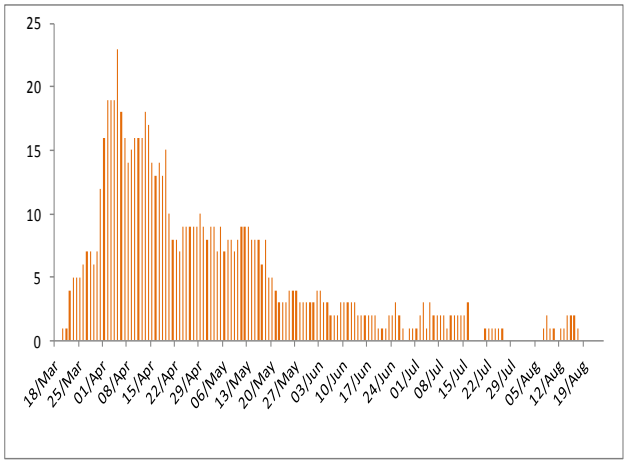
C19 Isolation Wards (including ITU) - discharge status

%	Discharged	Died
18-31 Mar	77%	23%
Apr	66%	34%
May	87%	13%
Jun	95%	5%
Jul	95%	5%

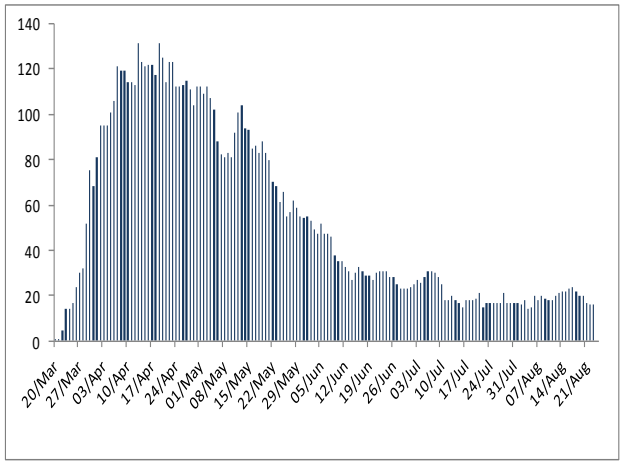
Occupied beds all areas at 0800



COVID-19+ve patients in ITU at 0800



COVID-19+ve patients in other beds at 0800



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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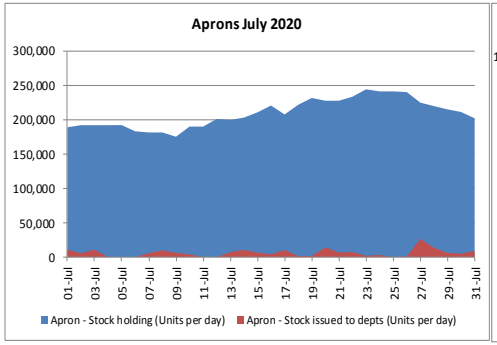
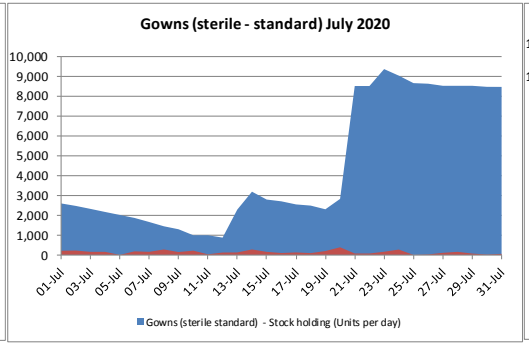
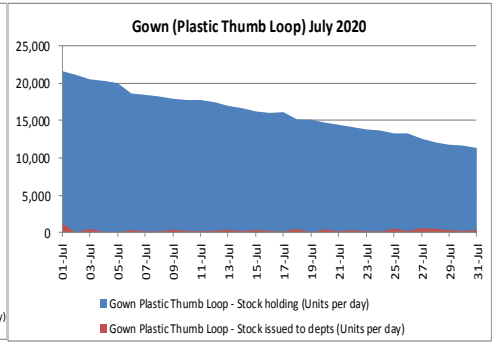
Safe care & Improving Outcomes: COVID-19 (Slide 2 of 3)

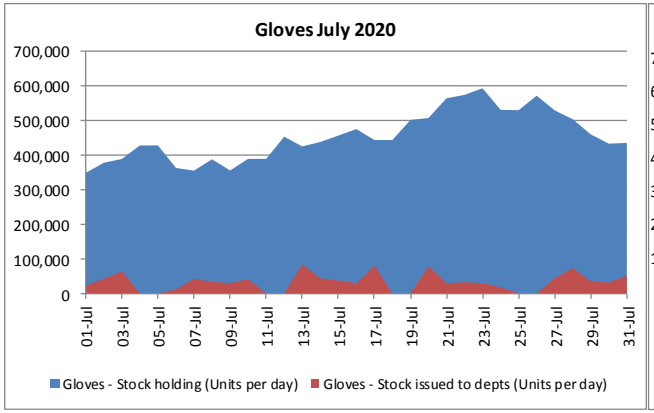
PPE

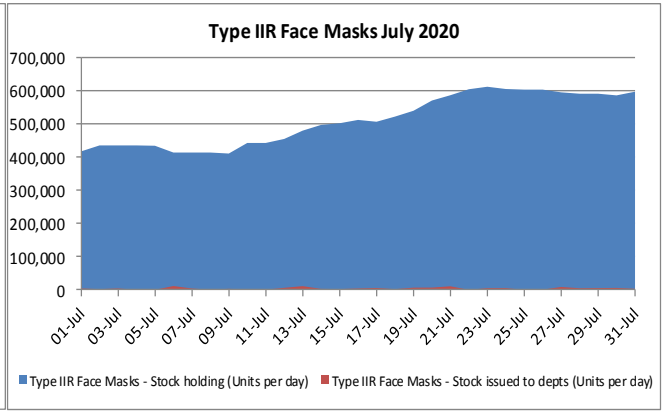
- Central DHSC control of supply and delivery of items from the National Pandemic stock continues.
- The graphs below show at a summary level usage (red block) has remained below stock level although during May stock levels for gowns were under pressure.
- The main current concern remains that National Pandemic stock levels are low on certain (preferred) types of FFP3 masks. This has lead to repeated fit tests on different products that are now being supplied..
- Risks around quality of goods supplied is managed by local examination undertaken by the NHS Herts Procurement clinical product specialist.
- Stock levels for different PPE items are reported to Chief Officers and the IMT every day. This allows Chief Officers to escalate further action at Regional level or seek mutual aid from other organisations.
- PPE use forecasts are being collated and compared to anticipated supply to support the re-start of normal activity.

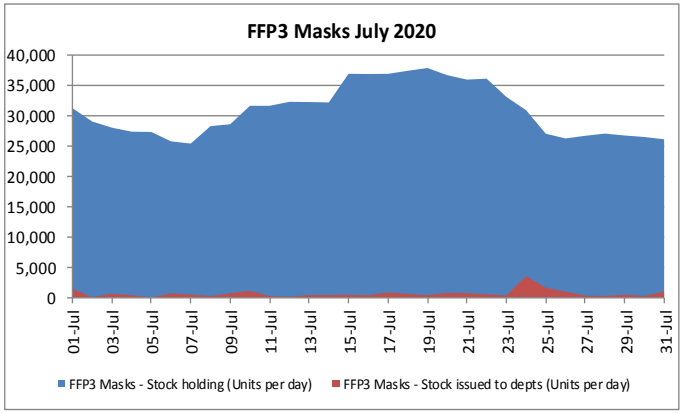












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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Safe care & Improving Outcomes: COVID-19 (Slide 3 of 3)

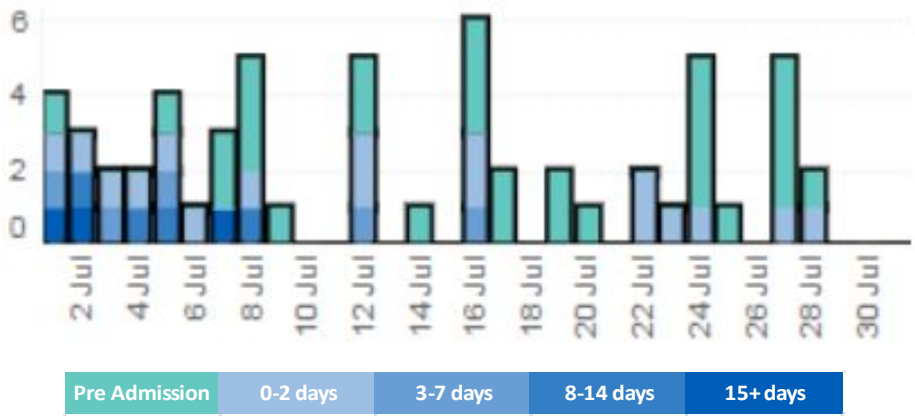
Nosocomial infection cases

COVID19 positive in-patient cases are routinely reviewed by Respiratory & Microbiology team. Cases reviewed prior to national Nosocomial infection definitions did not identify cause for concern.

On the 19th May 2020 four defined categories for COVID Nosocomial Infection was confirmed nationally. The 4 categories of Nosocomial Infection are based on date of patients sample in relation to their date of admission. The 4 categories are 0-2 days (Hospital-onset community Healthcare-Associated), 3-7 days (Hospital-onset indeterminate Heatlhcare-Associated), 8-14 days (Hospital onset probable Healthcare-Associated) and 15+ days (Hospital-onset definite Healthcare Associated). Emergency management and IPCT is working with Information Team to collate and capture this data for reporting to PHE.

A COVID19 RCA has been developed locally to support the clinical review of all Hospital-Onset Probable & Definite Heatlhcare-Associated cases. The RCA process will be supported by the divisions, and learning identified will be shared across the organisation.

Nosocomial infection cases



Staff testing – Drive-through data covers the period 1st July to 31st July

Drive-through testing					
Days from initial contact to drive-through test*			Days from swab taken to result received*		
No of Days	Tests	%	No of Days	Results	%
0	543	21.1%	0	7	1.5%
1	427	16.6%	1	123	25.8%
2	180	7.0%	2	245	51.4%
3	295	11.5%	3	45	9.4%
4	467	18.1%	4	10	2.1%
5	258	10.0%	5	3	0.6%
6	74	2.9%	6	4	0.8%
7	68	2.6%	8	2	0.4%
8+	264	10.2%	9+	38	8.0%

Drive-through - All Results Received	Positive	Negative	Invalid Test	Total Results	% Positive
Staff – All (WHHT + Bank/Agency/Mitie)	6	354	4	364	1.6%
Total (Staff + Household + Other)	9	438	4	451	2.0%

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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Safe care & Improving Outcomes: Emergency Readmissions

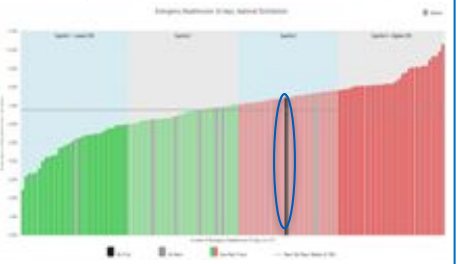
In this reporting period:
The readmission rate, benchmarked against the most up to date national position (Feb 2020) was below the national average overall, and below for readmissions following an elective and emergency (original) admission.

There has been a decrease in emergency readmissions to 12.7%, which is 0.5% lower than the national average of 13.2%.

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

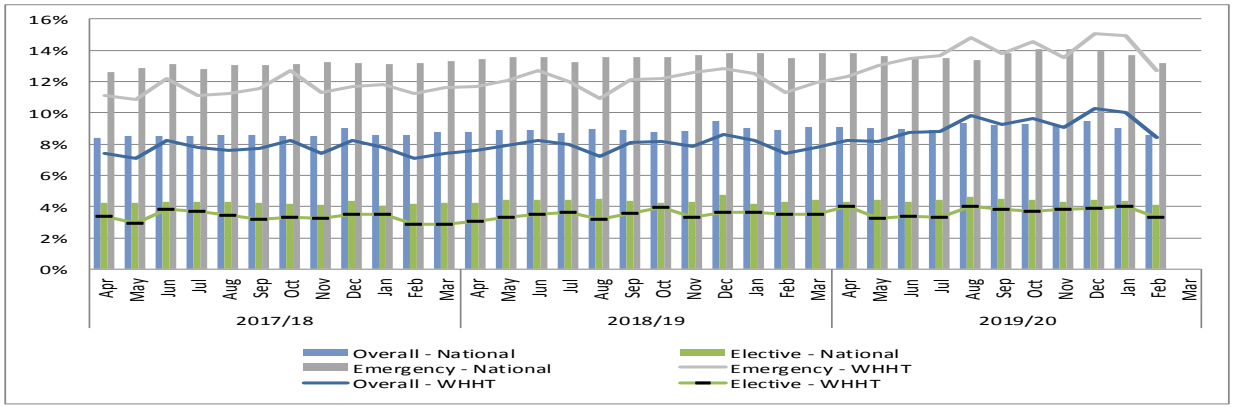


Period: Q4 2019/20

WHHT 7.46% Peer 6.76%
National 7.09%

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

Emergency Readmissions



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	2a / 2b / 2c / 3a / 4c

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Safe care & Improving Outcomes: Caesarean Section rates

C-section rate
The elective and emergency combined rate is 35.3% (15.6% Emergency, 19.7% Elective) .

Women's choices for mode of birth are facilitated as per the NICE guidance.

C-sections have been reviewed daily by the incoming teams on call and the data will be presented at the next Governance meeting and learnings embedded.

The central foetal monitoring system has enabled the on call teams to monitor women more closely especially in isolated patients. The foetal monitoring team has been actively supporting staff to monitor babies.

Training in Instrumental delivery and foetal monitoring are now being offered via virtual platforms. Operative delivery is increasingly consultant led/ supervised . The next course of instrumental deliveries is scheduled for September.

Performance stable
Better than target/threshold

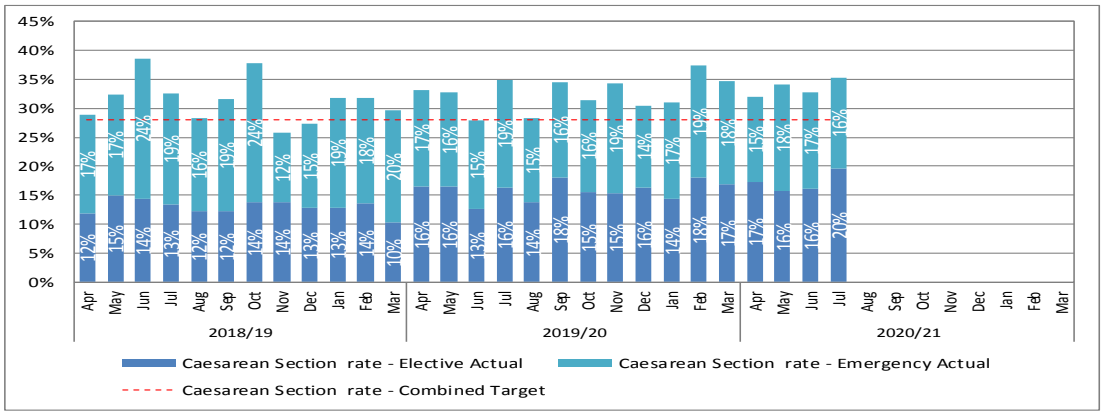
Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate

Period: March 2020

WHHT 18.40% Peer: 16.83%
National: 16.63%

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

Caesarean section rates



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	2a / 2c / 3a / 4c

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Submission suspended

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Safe care & Improving Outcomes: Workforce and CHPPD

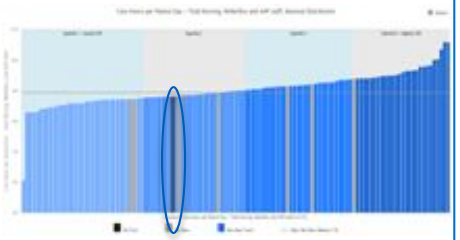
In this reporting period:
On the 8 June staffing templates reverted to pre-COVID establishment templates. Staffing is reviewed as part of the operational site meeting and at the workforce safe staffing hub at 0830 and 1430, where senior nursing staff support, guide and amalgamate workforce resources using patient dependency and acuity recorded on safe care and professional judgement. During July the fill rate was 107.2%; (101.3% registered and 102% unregistered). Zone A – Granger: overall staffing was100% to cover four wards (Red, Bluebell, Winyard and Winter). During this period bed occupancy for isolation was significantly reduced due to low numbers of COVID positive/COVID suspected patients. ITU overall fill rate was 120.4%.

Overall 84% shifts were RAG rated green, down 4.5% from last month. 16% were rated amber, an increase of 4.5% from last month and no red shifts were reported. Ward leaders' supervisory time was 74.6%, down 3.1% from last month and focused on promoting patient safety, developing and supporting junior staff and managing the ward, 25.4% lost represents annual leave and redeployment to clinical areas supporting safe staffing. Bank and agency total demand hours has increased this month. A total of 59,450 demand hours were requested (7,265 more than last month) of which 78.7% were bank and 7.6% agency. Any request for additional shifts within hours must be authorized by HoNs and out of hours by the senior nurse, in discussion with the on call manager. At the July workforce meeting chaired by the Deputy Chief Nurse, KPIs indicated good management of e-rostering. Since March, ie during COVID the realignment of medicine beds has resulted in there being no designated dementia unit. There has been a significant decease in enhanced care usage to 5611.09 hours, and a decease of 2,340.25 from last month. CHPPD rate overall was 9.7 a decrease of .04%.

Current band 5 nursing vacancy is 6% and the turnover is currently at 13.6%, meeting the original target set by NHSEI. Overseas recruitment paused during COVID but HR this will recommence next month. WHHT has 20 overseas nurses working on the temporary register. The Trust is actively working to recruit its students currently working as Aspirant Nurses and Midwives.

Performance stable
Better than target/threshold

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

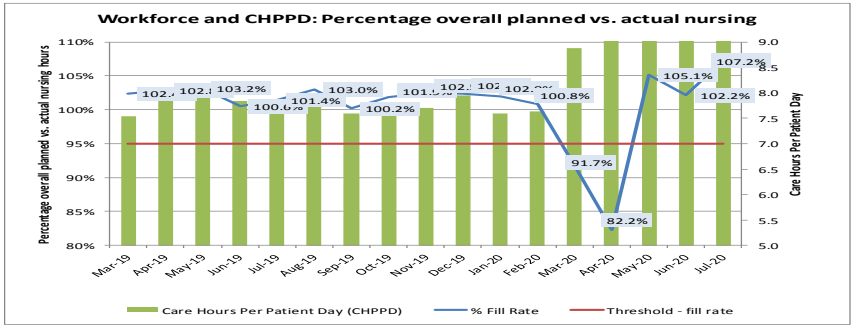


Period: February 2020

WHHT: 7.6 **Peer: 7.9**
National: 8.0

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

Factors/ Themes:
- Increase usage Enhanced care, business case to go to TMC in August.
- COVID staffing is on the risk register (risk 4273) and following review at RRG on 11 June the risk score was de-escalated to 12
- In addition to the 5 daily operational meetings, two workforce safe staffing hub meetings have been established to review staffing based on demand and acuity. These are chaired by the Deputy Chief Nurse and HoNs.
- Staff are supported out of hours (incl BH and weekends) by band 7 bleep holders and by a Senior Nurse. In addition, overnight the senior night sister role has been put in place. Following review in July the role has now been extended until March 2021
- To support recruitment and retention of our students in July an incentive package has been offered .
- 20 July NMC announced opening of the OSCE test centres – 10 of our OSCE nurses have now been given dates to undertake, and the others are waiting on dates from the centres.
- Green brooks contracted to cover UTC at WGH from 1st July
- Simpson ward closed 9th July



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1b / 4c / 7a / 7b / 8c

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Safe Care & Improving Outcomes: Patient Safety

In this reporting period – July 2020:

Never events
There were no Never Events reported in July 2020.

Serious Incidents
One (1) serious incident was declared in July 2020. At the end of July 2020 the Trust had 8 ongoing SIs; Of these , 6 were within date and 1 was overdue ; there was also an additional 1 investigation being undertaken by HSIB.

Following the trajectory for submission of SI's, whereby seven investigation reports were submitted in June 2020, the attention was focused on actions arising from closed SI's which are monitored via the SIRG (Serious Incident review group). There has been increased communication between the patient safety team and the CCG to ensure reconciliation of increased actions arising from the recently closed SIs.

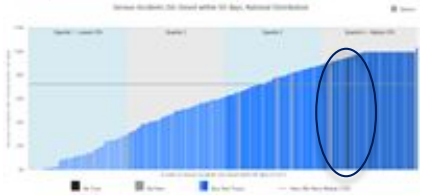
% of patient safety incidents which are harmful
14% (12) of incidents reported in July 2020 were recorded as having caused moderate or higher level of harm to patients, compared with 7.5% (9) in June 2020. This demonstrates a relative increase in incidents rated as moderate or higher in comparison with June data.

There was one incident reported in July 2020 with a harm level of Severe;

1. A Patient was admitted via A&E after presenting with severe abdominal pain. The Patient had emergency surgery about 10 hours after his presentation to A&E and had a severe metabolic acidosis at the time of surgery which had progressively worsened since his initial presentation to A&E. A CT scan suggested a bowel perforation but surgery didn't confirm this finding. The patient continued to deteriorate on ICU and died with multi organ failure due to sepsis. The incident was reviewed via the SJR process and presented to the SI panel for discussion, which resulted in a divisional RCA investigation being commenced.

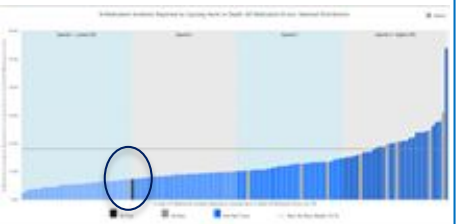
Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



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

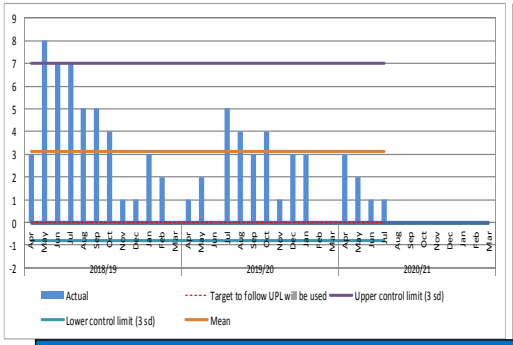
Benchmarking: MODEL HOSPITAL
% medication incidents reported as causing harm or death/all medication errors



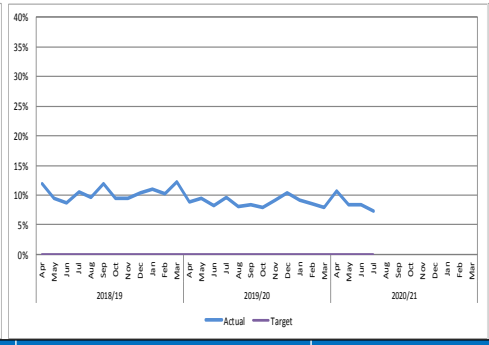
Period: 31/09/2019
WHHT 7.5% **Peer: 18.1%**
National: 10.2%

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

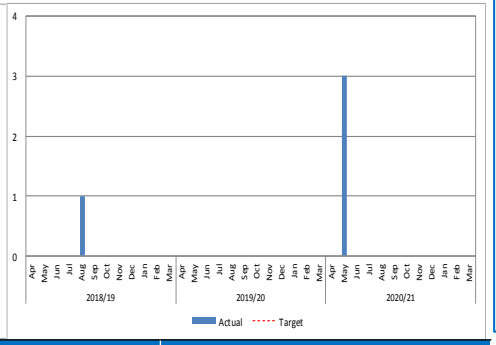
Serious Incidents



Safety incidents (% harmful)



Medication incidents causing serious harm



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1a / 1b / 2a / 3a / 4a / 4b / 4c

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Safe Care & Improving Outcomes: Falls & Falls with harm

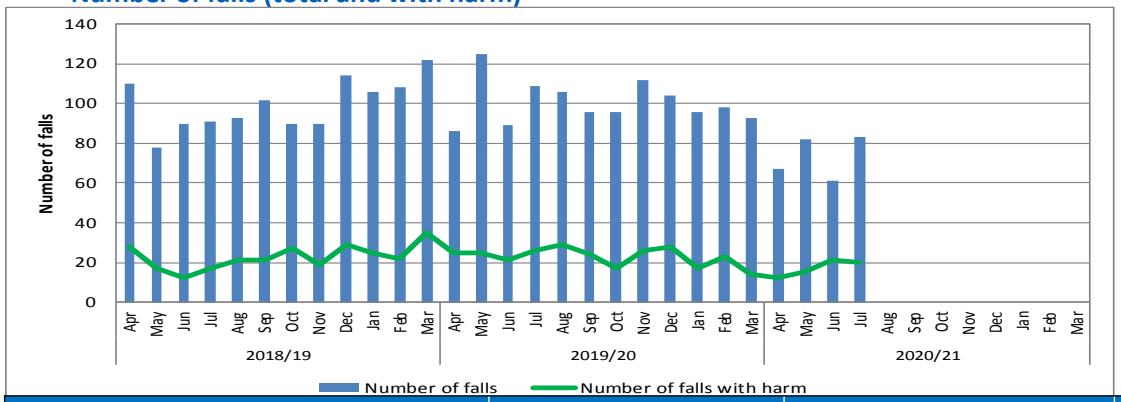
In July there 100 inpatient falls in total. 23 falls with low harm. 1 fall with moderate harm and 1 fall with severe harm. For falls with harm analysis shows that 19 (%) were not witnessed, 6 (%) falls were witnessed,13 incidents occurred during the day shift and 12 during the night shift, 12 (%) incidents with harm involved patients with cognitive impairment. Of these 6 patients reported as having dementia. Most falls 13 (%) occurred around the bed area.
Falls with harm remain low in comparison to the number of falls reported locally and nationally.

Of the 86 falls reported in July , there were 10 recurrent fallers accounted for 25 (%) incidents (this is an significant improvement when compared with previous months).
In July, clinical areas reported higher number of falls; Cleves – 9, Sarratt – 9, AAU Level 3 Blue/Yellow – 8, AAU L1 Blue – 7.

Actions:

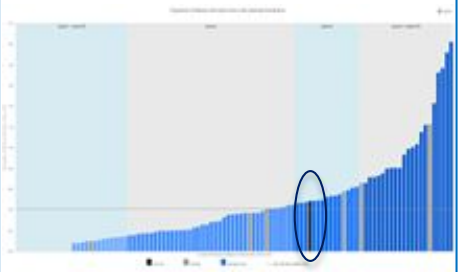
- Ongoing falls awareness, prevention and management sessions on clinical staff development days
- Increase focus on falls assessments and management in areas reporting higher number of falls using safety huddles
- Continue to support work streams using QI methodology aimed at reducing falls and improving patient safety;
  - Test change for wrist bands to identify high risk fallers on Croxley ward is ongoing
  - BP management – aimed at reducing drug induced hypotension in elderly patients at risk of falls
  - Swarming in Tudor Ward to help reduce falls
- Consider scaling up ward based training and support clinical staff in identifying and planning care for patient at risk of falls

Number of falls (total and with harm)



Performance stable
Better than target/threshold

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



Period: December 2019

WHHT 0.5% **Peer: 0.4%**
National: 0.4%

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

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1b / 2a / 3a / 4c

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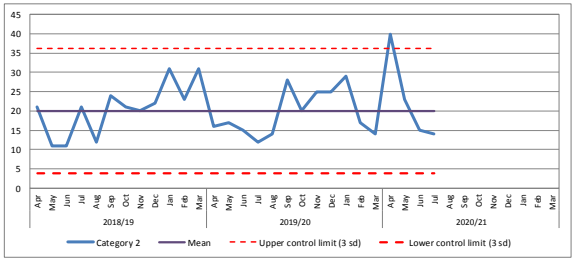
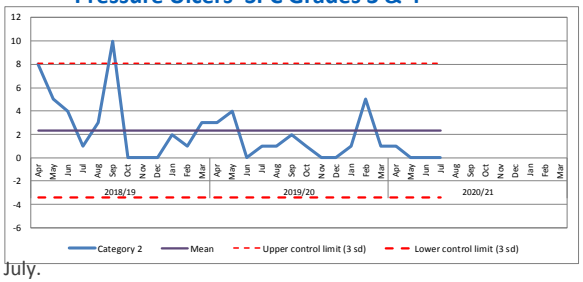
Safe Care & Improving Outcomes: Pressure ulcers (HAPUs)

Reportable HAPU (July 2020)			
Categories	**HAPU**	**Medical Device Related Pressure Ulcer**	**Total HAPU**
Category 2	9	5	14
Category 3	0	0	0
Category 4	0	0	0
Unstageable (possibly category 3 or 4)	0	0	0
Total reportable (affecting 12 patients)	9	5	**14**
Non-Reportable HAPU			
Category 1	3	1	4
Suspected deep tissue injury (SDTI)	4	0	4
Total non- reportable (affecting 5 patients)	7	1	8

Pressure Ulcers SPC Grade 2

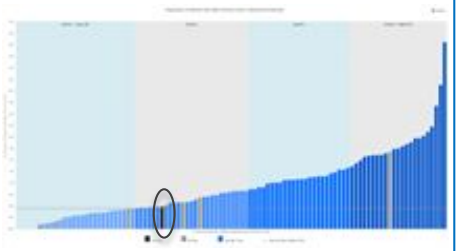


Pressure Ulcers SPC Grades 3 & 4



Stable

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

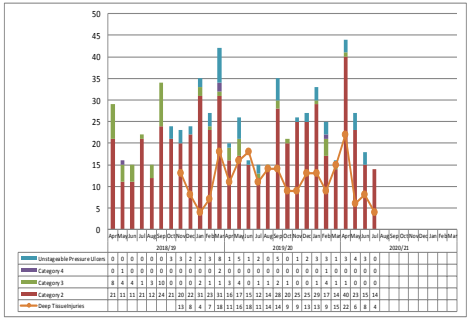


Period: December 2019

WHHT 0.5% **Peer 0.4%**
National 0.8%

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

The SPC demonstrates that the number of HAPU is within normal variation for the month of July.
This report highlighted a significant drop in the overall numbers of HAPUs, due to training focusing on accurate categorisation. implemented from June 2020 report.
Category 2 PUs are down by almost 50%. A number of Category 2 pressure ulcers have been incorrectly validated as a moisture lesions. The drop in category 2 HAPU due to accurate categorisation has led to an increase in the number of moisture lesions. The increase in moisure lesions may be due to the hot weather. The TVN team are working with the continence nurses to focus on the prevention and management of moisture lesions.
There was a decrease in the numbers of medical device related pressure ulcers = 5 reportable compared to 10 in June
Widespread differentiation in location of pressure damage and anatomical location does not evidence specific causation, apart from the need for increased effective repositioning and the need for the use of preventative dressings in a timely manner.



Actions:
1.Continue to raise awareness during the safety huddles regarding the precautionary and preventative approaches , as recommended in the Pressure Ulcer Prevention and Management Policy for patients using medical devices .
2.Continued re-enforcing of the importance of effective repositioning to be highlighted in all clinical areas
3. Weekly ward based 30 minute," bite size" Tissue Viability training sessions to be continued and extended throughout the Trust, focusing on prevention ,accurate categorization and timely implementation of appropriate care plans.
4. Training updates to be arranged for all levels of nursing staff ,who validate pressure ulcers for the clinical areas.
5. Review and re-introduce updated version s of the Tissue Viability Resource Folders on all clinical areas.
6. Liaising with the continence CNS about a training programme on management moisure lesions.

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse	Quality Committee	1b / 2a / 2c / 3a

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Ward Scorecard – Combined Safety and Process Alert Summary

1,3,6 months summary of Process and Safety Alerts Combined

One Month

Emergency Medicine	**25**
AAU Y1	10
A&E	4
AAU G1	4
AAU P1	4
AAU B1	3
UCC	0
MIU	0
Medicine	**63**
Heronsgate & Gade	12
Winter	10
Oxhey	10
Sarratt	6
Winyard	5
AAU B/Y 3	5
Cassio	4
Aldenham	2
Tudor	2
Stroke	2
Red	2
Bluebell	1
CCU/ P/G 3	1
Croxley	1
Simpson	0
Frailty	0
Surgery	**25**
Cleves	6
Letchmore	5
Elizabeth	4
Ridge	3
Flaunden	3
Langley	2
ICU	2
DLM	0
Grand Total	**113**

Three Months

Emergency Medicine	**111**
AAU Y1	31
AAU P1	24
AAU B1	23
AAU G1	19
A&E	12
UCC	2
MIU	0
Medicine	**240**
Heronsgate & Gade	26
Winter	25
AAU B/Y 3	24
Winyard	20
Sarratt	19
Tudor	18
Stroke	17
Croxley	15
Bluebell	14
Red	13
Oxhey	12
Cassio	11
Simpson	10
CCU/ P/G 3	9
Aldenham	7
Frailty	0
Surgery	**95**
Cleves	18
Letchmore	16
Ridge	16
Langley	13
ICU	12
Flaunden	12
Elizabeth	8
DLM	0
Grand Total	**446**

Six Months

Emergency Medicine	**203**
AAU Y1	52
AAU P1	45
AAU G1	42
AAU B1	34
A&E	21
UCC	7
MIU	2
Medicine	**489**
Heronsgate & Gade	51
Tudor	50
AAU B/Y 3	46
Winyard	35
Aldenham	35
Bluebell	33
Stroke	32
Sarratt	32
Croxley	31
Simpson	28
Winter	26
Red	26
Oxhey	21
Cassio	20
CCU/ P/G 3	19
Frailty	4
Surgery	**212**
Cleves	38
Letchmore	37
Ridge	35
Flaunden	32
ICU	27
Langley	19
Elizabeth	17
DLM	7
Grand Total	**904**

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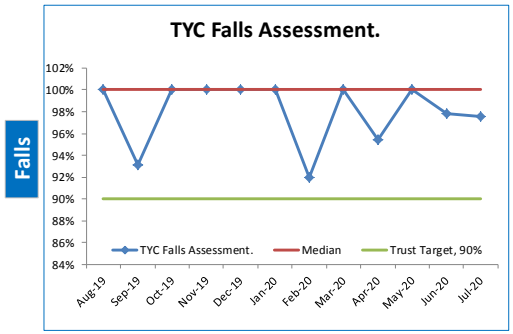
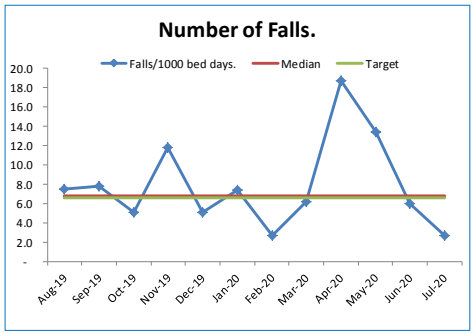
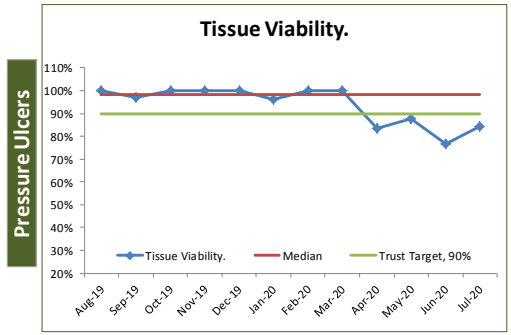
Ward Scorecard – Harm Free Care Improvement Work (overview)

Focus Area: AAU Y1







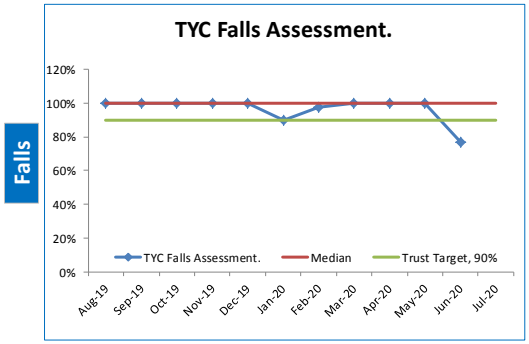
No of HAPU (Cat 2, 3, & 4)

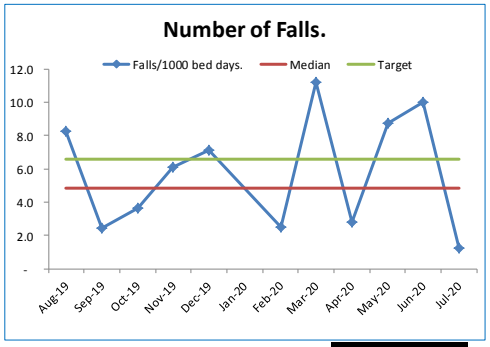
Aug-19	0
Sep-19	1
Oct-19	0
Nov-19	1
Dec-19	0
Jan-20	1
Feb-20	1
Mar-20	1
Apr-20	1
May-20	1
Jun-20	1
Jul-20	1

The national average for falls with harm is 6.6 falls per 1000 bed days. AAUL1Y has had above average falls in April and May 2020. There has been an improvement in performance since June 2020. There is a focus on improving risk assessments, which may lead to a reduction in falls. The falls prevention CNS will be supporting the ward with further training.

Tissue viability assessment performance has declined. This is in line with other areas across the Trust during the covid period. Accurate skin assessment prevents community acquired skin damage being categorised as HAPUs. The Quality Improvement team are scoping a QI project with the clinical team to improve the accuracy of skin assessment on admission to AAUL1.

Focus Area: Croxley





Croxley ward assessment data demonstrates an overall good compliance with falls risk assessment. However, the number of falls per 1000 bed days has been above the national average on 3 occasions in the last 6 months.

A Quality Improvement project began on Croxley in June 2020. The first test of change focused on identifying the number of patients at high risk of falls. The data demonstrates improvement in assessment. The second test of change to improve the bundle of care given to patients at high risk of falls is due to commence. The data on 'days between falls' reflects that an improvement in this area is required.

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Safe care & Improving Outcomes: VTE risk assessment

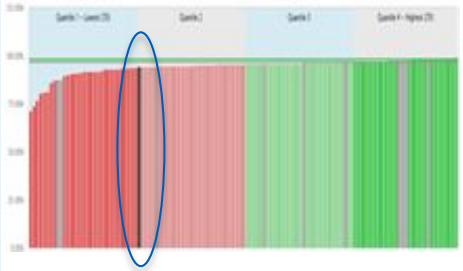
In this reporting period:
The target was achieved this month.

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

Next steps:
- Regular reporting is being provided to all wards where VTE risk assessments are below threshold
- 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

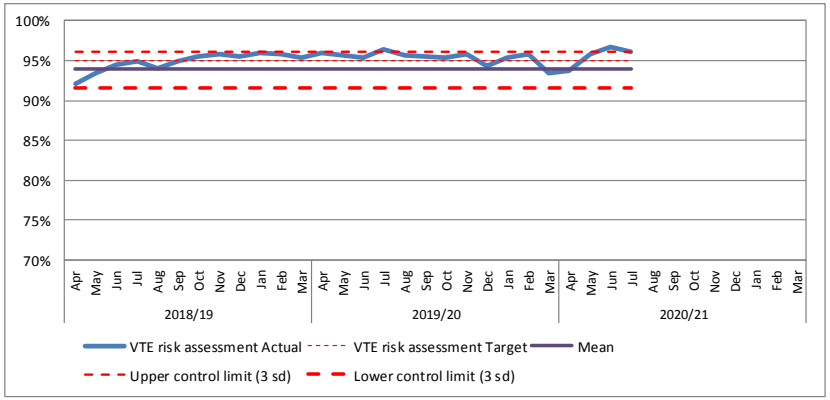


Period: Q3 2019/20

WHHT 94.38% Peer: 94.43%
National 95.99%

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

VTE risk assessment



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	1a / 1b / 2a / 2c / 4c

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Safe Care & Improving Outcomes: Stroke

In this reporting period:

Admission to Stroke Unit within 4 hours – 26.7%

Admission to the unit within 4 hours is not always possible, some patients do not present with standard symptoms and diagnosis is therefore later in the pathway and at times of increased demand capacity constraints affect "right bed" availability. There is also a delay as a result of COVID screening and patients awaiting swab results. Patients have to go to a holding ward and await results, although stroke patients are on a fast track this can take up to 5 hours to come through. Positive COVID stroke patients will not be admitted to the stroke ward. However patients continue to receive Stroke specialist care and input while they await transfer to the Stroke unit.

90% stay on Stroke Unit (target 80%)

78.3 % achieved 90% stay on the Stroke ward, although below target it is an improvement from the two previous months performance. One factor is patients being moved due to the COVID segregation of patients. As mentioned previously, patients have to go to a holding area to await swab results or to a positive ward so cannot spend as much time as previously on the stroke ward.

Thrombolised within an hour – (SSNAP target 55%)

25% achieved: 4 patients were thrombolysed and only 1 completed within 1 hour. A review was undertaken on the remaining three patients; 2 missed the hour window by 5 minutes and 7 minutes respectively the other patient required a specific a perfusion which scan which takes longer.

SSNAP data is reviewed quarterly.

These figures will change as more patients get discharged as the pathways cannot be updated until the patient is discharged

Performance stable
Better than target/threshold

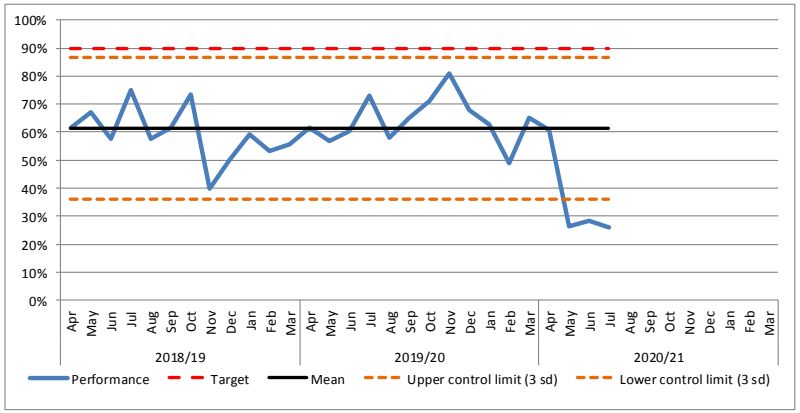
Benchmarking: SSNAP

Period: October to March 2020

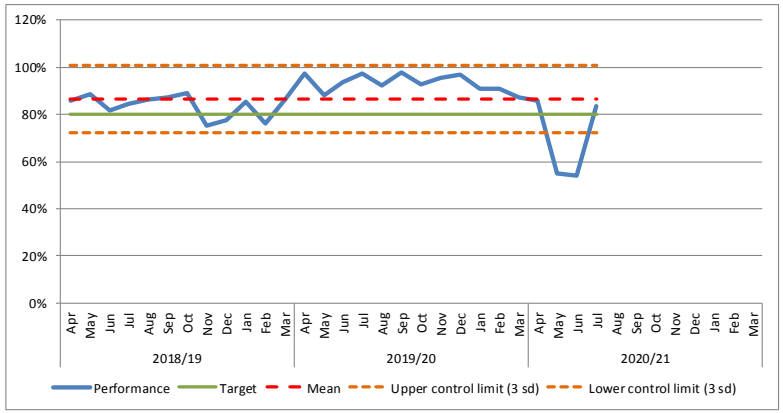
Admission within 4 hours: 54.0%

90% admission on Stroke Unit: 82.7%

Stroke: Admission within 4 hours



Stroke: 90% of admission on Stroke Unit



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	Chief Medical Officer	Quality Committee	1a / 1b / 2a / 2b / 2c / 3a / 4a / 4c

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Caring & Responsive Services: Emergency Department

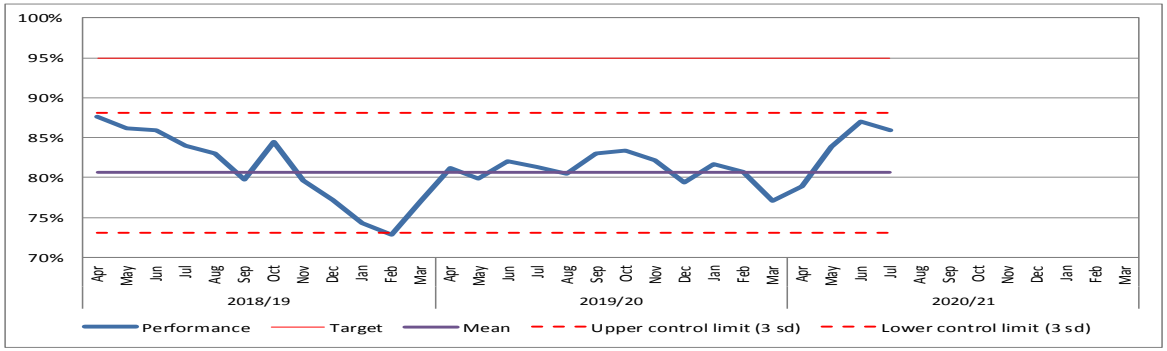
In this reporting period:
At 85.9%, overall performance was slightly worse than the previous month (87.1%). Compliance with the 95% standard was maintained at HH UTC (99.9%). Type 1 attendances were markedly down on the previous month by 22.8% due to the introduction of the UTC at WGH. Performance at the UTC was 99.3%. Processes for COVID pathways hinder established pathways mainly due to capacity constraints in ED and staff are challenged with working in isolation environments in PPE. Hemel UTC attendances were up again in July by 16.6% on the previous month. MIU remains closed. Total Trust attendances including attendances at the UTC were up 17.5% from the previous month.

In July the number of ambulance patients waiting over 30 minutes remained the same as June and the number of patients waiting over 60 minutes to offload rose form 52 in June to 76 in July. The average handover time in July started at 20 and rose to 27 in the 3rd week of July. Conveyances are up 0.6% from the previous year in comparison to 10% decrease across the region.

There are multiple reasons for offload delays including the process for offloads for the COVID protocol which changed at the beginning of March meaning that ambulances needed to offload those patients with COVID symptoms into majors 2 creating 2 streams of patients. A loss of cubicles in STARR for the non-COVID pathway meant loss of offload capacity. Loss of cubicle capacity, an increase in attendances, interrupted bed flow due to swab result delays and changes to AAU and assessment areas impacted on flow within ED. The introduction of the UTC has also meant an increase in the number of walk in patients that are being seen in the STARR area.

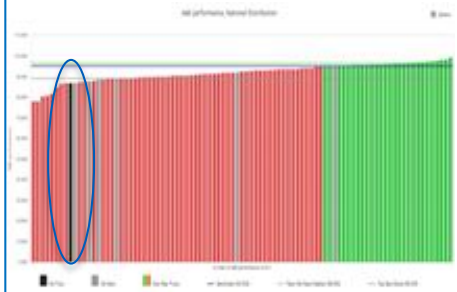
Next Steps:
- The regular check in meetings between the service team and Executive colleagues are to be restarted.
- The monthly programme board meetings oversee the ambulance work stream with a joint action plan between EEAST and the Trust restarted in May.
- A recruitment plan for medical staffing is in place; The middle grade rota is to be rewritten to accommodate 16 MGs from August 2020. Consultant recruitment has not been as successful but we are working with HR on a recruitment and retention package.
- SMART has been limited due to the new COVID pathway but hope to start Virtual SMART in September.
- We aim to improve the UTC flow through to ED with a plan for the fracture clinic space and have reinstated the stroke telemetry bay in resus releasing capacity in STARR.

A&E: Attendances within 4 hours



Performance deteriorated
Worse than target/threshold

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



Period: June 2020

WHHT: 87.06% Peer: 88.93%
National: 95.0%

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

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee	1a / 1b / / 2b / 2c / 4a / 4c / 12b / 12c / 12d

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Caring & Responsive Services: Mixed sex accommodation breaches

Last reported position February 2020:
The submission has been suspended since March

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

Next steps:
The monitoring and management of patients requiring step down from ITU is reviewed daily as part of the regular operational management meetings. Privacy and dignity is maintained at all times. Full length curtains are used and patients are offered the use of the toilet/shower if they are able.

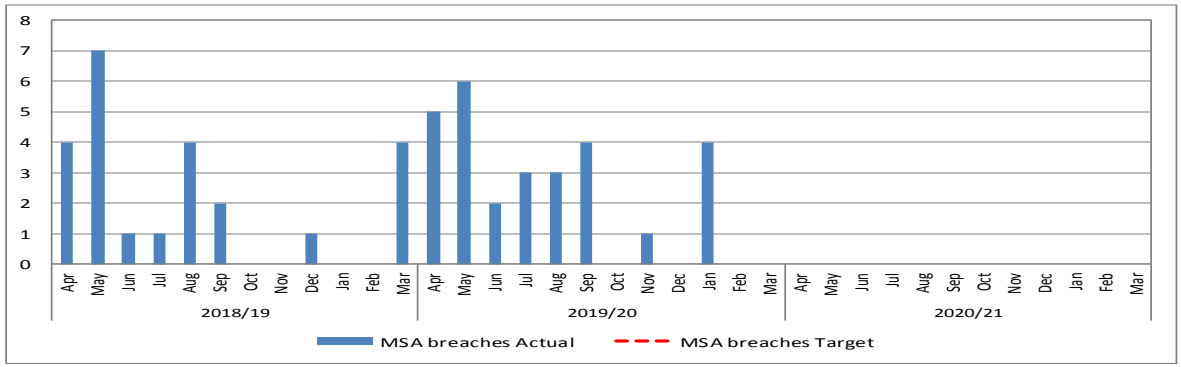
Performance stable
Better than target/threshold

Benchmarking:

Not currently available

Submission suspended

Mixed sex accommodation breaches



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Effective	Chief Nurse	Quality Committee	4a / 4c / 12b / 12c

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Caring & Responsive Services: Delayed Transfers of Care

In this reporting period:

The average number of discharges have risen from 12.5 per day to 13.6, but as a percentage of the daily declared Medically Optimised (MO) list, performance has deteriorated significantly. In June the average percentage of MO patients being discharged was 36%.

Current processes still operate without the deployment of Assessment and Discharge Notification and the inherent delay that this builds in (72 hours).

The current challenges for the team are:

- Delays with swabbing; which has indirectly contributed to some patients being discharged incorrectly without a reportable discharge swab result available
- Ward MDT's not routinely setting EDD's
- Limited capacity of domiciliary, residential and nursing home care providers. SCAH whom are commissioned to provide care at short notice through DH2A are running at capacity.

High demand for swabbing patients returning home with home care continued, as well as for patients moving on to IMC facilities and both residential and nursing homes. Due to the volume of new service users referred for new POC's, there are now delays with POC requests equivalent to TDS and higher. There are also delays in allocation of DTA beds as the majority of commissioned beds have been filled; HVCCG are now routinely turning to higher-cost care providers in order to commission beds.

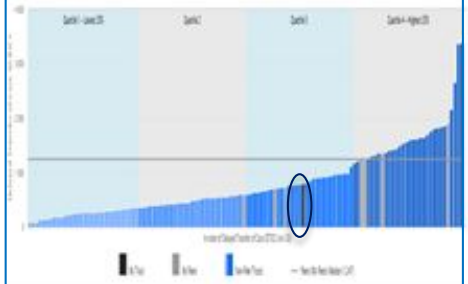
Accurate EDD's remains an issue although through the Care Home PTL a return to best practice is emerging. Patient Flow Manager is working with Informatics to provide the wards with a clear platform for daily submission of EDD and 'reasons to reside'. This is important as the suspension of national data submissions could be lifted.

The Herts Valley COVID Discharge Cell is currently working up cross system plans to develop this model longer term to support patients home safely and provide assurance around pace and flow for the wide system.

Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL

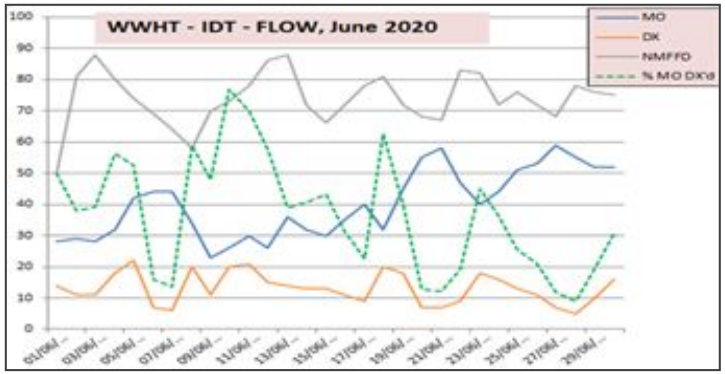
Total number of bed days lost due to patients not being transferred to a more appropriate care setting

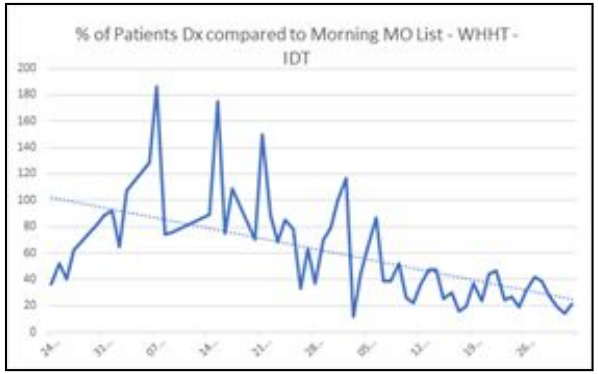


Period: December 2019

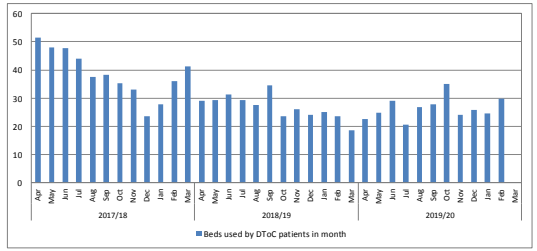
WHHT: 799 Peer: 1247
National: 610
(Peers = Nightingale Group – acute multi-site trusts)

Submission suspended





Delayed Transfers of Care



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Effective	Chief Operating Officer	Finance & Performance Committee	1b / 2b / 2c / 4a / 4c / 11a

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Family Liaison Line and Visitors Helpline

Family Liaison Line (FLL)

12 members of staff cover the FLL, 7 days a week between 8am and 8pm.

Staff call relatives of patients categorised green and amber in Isolation wards (when requested) at least once a day and provide an update. (Calls made by ITU and palliative care are not included in this data). The service was piloted on 30 March and started on 31March 2020. It was paused between 1-2 April for further training.

2040 relatives have been contacted at least once from 1 July – 31 July 2020

I-Reporter is utilised to ensure enquiries are logged and managed. There is a reduction in the number of wards that have covid 19 patients and this is demonstrated in the graph

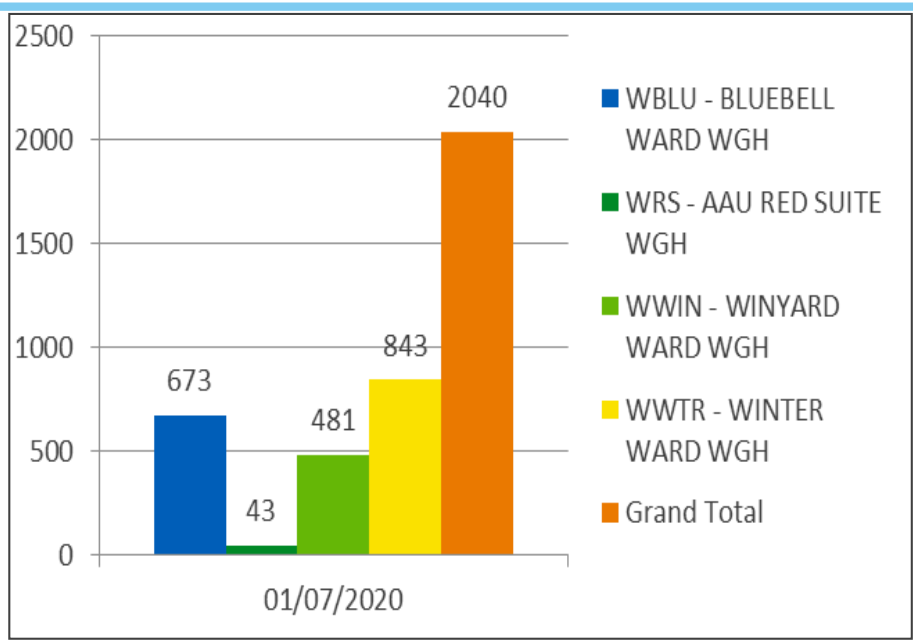
Staffing for the FLL

Following redeployment of staff back to their own clinical areas the FLL has a reduced staff level. A business case request has been submitted for additional staff to help run the line. NHSP have been provided with a request for additional staff, however they will need training on iReporter and Patient Centre to enable the capture of data.

Feedback from relatives

Daughter expressed that she hopes the Trust realised how good these calls are. Daughter said it stops you worrying and helps put your mind at rest. It's amazing and really valuable service, especially during Covid.

NOK was happy about the daily updates and she added her husband is well looked after by the staff



Visiting Helpline (VHL)

The visitors helpline has been a service running since April 2020, however was reduced in June due to a lower number of calls received. The line transferred to the PALS department to enable the PALS team to signpost or help with any concerns that were raised. The data is only available until 13 July as PALS use the datix system.

80 calls were received from 1 July – 13 July 2020

Themes of enquiries includes update requests around patients' medical status and difficulty in contacting wards (non covid) for any information or request to speak with staff.

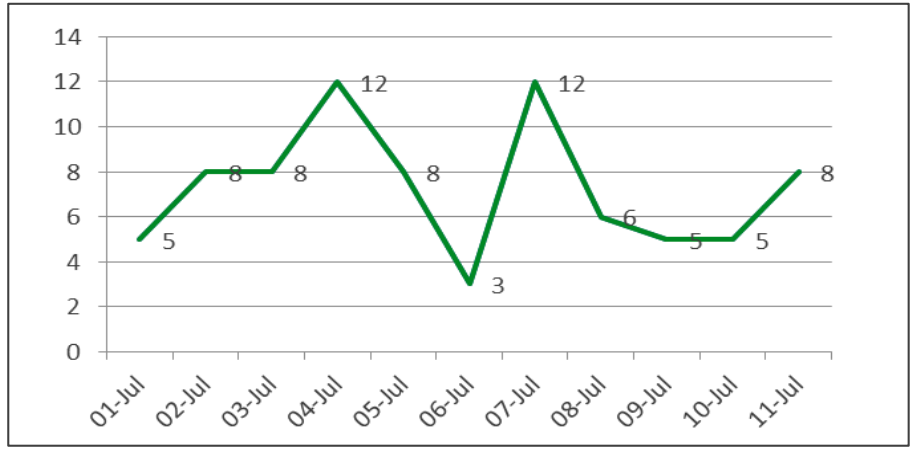
Messages to loved one 1 July -31 July 2020

158 have now been forwarded to patients. The emails are being copied onto template and delivered via volunteer hub to wards , who ensure patient receives the message.

POSITIVIE COMMENTS

'I'm so happy that we could send these messages and that they have been received'

'The way I can leave a message is so good'



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Family Liaison Line – Intensive Care Unit

Family Liaison Line (FLL) (ITU)

Currently 2 members of ITU staff (nurses) cover the FLL, for ITU, 7 days a week between 8am and 8pm.

The staff link directly with ITU for updates. They call relatives of patients giving detailed updates at least once but often twice a day (Calls made by palliative care or ITU medical staff are not included in this data). The service was piloted on 30 March and continues.

Calls made from 1 July – 31 July

935 calls were made which was, on average 3.3 calls per day

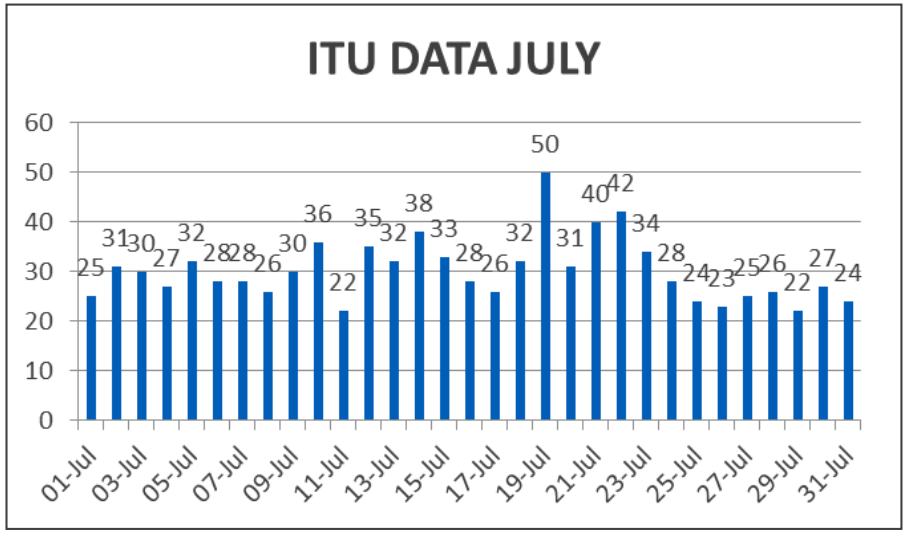
The staff from ITU will be returning to their own department in August.

POSITIVE COMMENTS

Mum expressed how helpful these calls have been in updating family and really made a difference.

Appreciated the call as lovely and was so thankful for the information

Appreciated the call as 'marvellous'. Thank you very much indeed.



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Caring & Responsive Services: Complaints

In this reporting period:
The Trust's monthly target of 80% was achieved - 92% in July.
30 new complaints were received as follows:

- 33% (10) relate to Surgery, Anaesthetics and Cancer (SAC)
- 27% (8) Medicine
- 13% (4) Women's & Children's (WACs)
- 10% (3) Emergency Medicine
- 10% (3) Corporate
- 7% (2) CSS

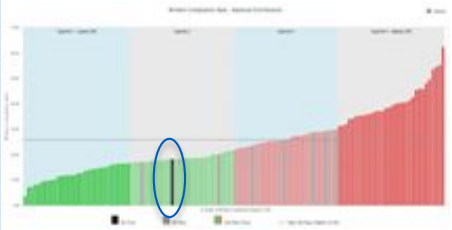
At month end there were a total of 46 live complaints (50 at end of previous month).
33 complaints were closed in the month. No complaints were re-opened in July 2020

Improvement plan:
Complaints have again risen and are now in line with the complaint level seen last year. Surgery have 9 open complaints, none of which are overdue and performance has now increased to 100% on time responses since June 2020. Emergency Medicine had 1 overdue complaint out of 8 open complaints, which will reach 6 months by Mid August. The Complaints team continue to work with EM seeking to improve response performance, which is lower than the other Divisions. Emergency Medicine have weekly meetings with the complaints advisor to discuss complaints performance and responses.

Factors/Themes:
Trust wide, common themes remain all aspects of clinical care (incl. clinical care and treatment) 52% (16); attitude of staff and communication at 26% (8), appointments 7% (2) . Patient Property 7% (2) and 7% (2) other. No specific themes or trends have been identified although communication remains a consistent factor throughout all complaints received.

Performance improved
Better than target/threshold

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

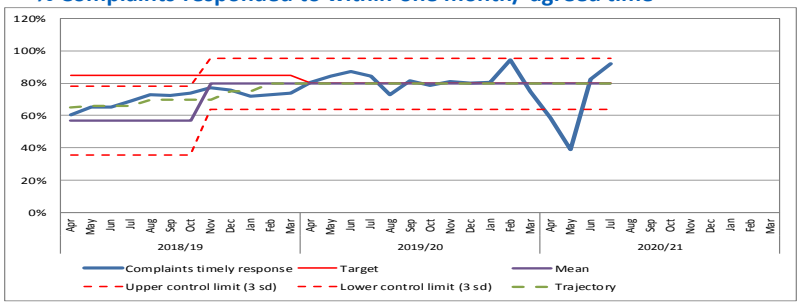


Period: December 2019

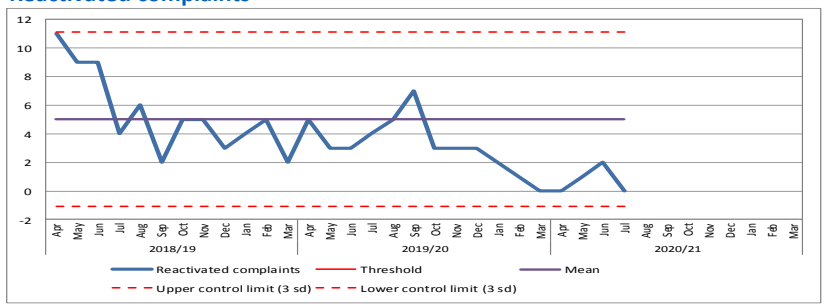
WHHT 18.36 Peer 25.90
National 21.95

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

% Complaints responded to within one month/ agreed time



Reactivated complaints



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee	1b / 2a / 2c / 3a / 4a / 4b / 4c / 10e / 10f / 11a / 12c

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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 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 July 2020 86 referrals were made to the Trust Specialist Palliative Care Team.. Of the patients with capacity to make decisions about PPD, 98% had an identified PPD.

Patients who died at WGH where their identified preferred place of death (PPD) was not achieved
There were 3 patients in July 2020 who died in a setting that was not their preferred place of death (PPD). For the 2 patients wishing to be at home ,1 patient unexpectedly deteriorated, and the other patient's physical symptoms did not permit their transfer home, In one case there was no hospice bed available.

Patients on an Individualised Plan of Care for the Dying Person (IPCD) & Treatment Escalation Plans (TEP)
Of the 16 patients whose deaths were reviewed in July, there were 7 patients who did not have an IPCD; 2 patients were excluded from this part of the audit. Therefore of the remaining 7 patients not on the IPCD it was deemed that it would have been appropriate to use in 4 of these cases. Learning from the audit will be fed back to ward areas to support the identification of patients appropriate for an IPCD.

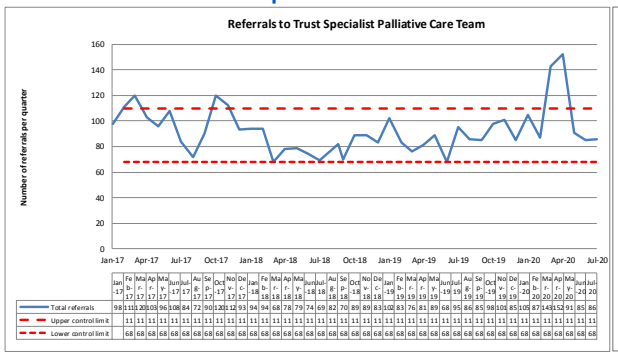
Treatment Escalation Plans (TEP)
Treatment Escalation Plans ensure that every patient's care is reviewed, individualised and their levels of care are considered, in line with the Trust's guidelines.
Of the 16 patients whose notes were reviewed, who died in July 2020, 16 patients had a TEP in place; 11 of those patients had had their TEP reviewed as needed and they were appropriate. It is encouraging to note that all patients reviewed had a TEP completed on initial assessment.

Stable

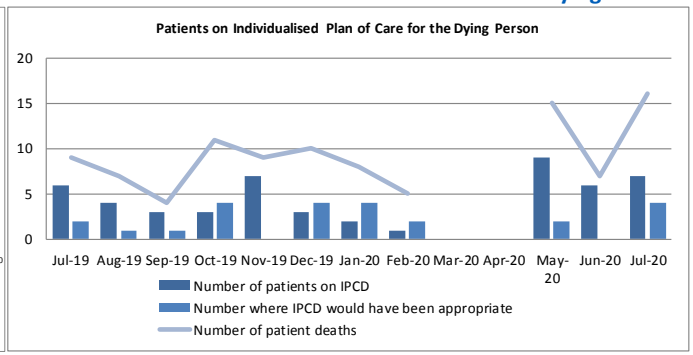
Benchmarking:

Not currently available

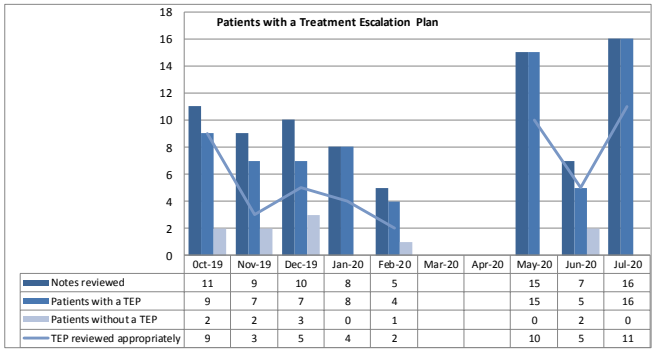
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Notes reviewed	11	9	10	8	5			15	7	16
Patients with a TEP	9	7	7	8	4			15	5	16
Patients without a TEP	2	2	3	0	1			0	2	0
TEP reviewed appropriately	9	3	5	4	2			10	5	11

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Caring	Chief Nurse	Quality Committee	2a / 2b / 2c / 3a / 4c / 11a

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Caring & Responsive Services: RTT Open pathways

In this reporting period:
Although waits for elective care continue to increase, at 51%, performance has improved since last month (47.7%) as a result of an increase in pathways under 18 weeks, largely due to growth in new referrals. The backlog of patients waiting more than 18 weeks continues to grow at a faster rate than patients can currently be treated, however. The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was worse than the national position (18.8 vs 17.6 weeks) and the 92nd percentile wait time was worse also (40.5 vs 37.4 weeks). Service re-starts are ongoing although the level of activity planned is reduced in order to meet stringent IPC and social distancing requirements. At the end of the month there were 484 patients whose waiting time exceeded 52 weeks wait.

Next steps:
In addition to the cancer and urgent procedures previously being outsourced, some non urgent activity is now being undertaken via the national independent sector provider contract, and options for the services unable to outsource within this contract are being explored.

Diagnostics
The recovery of diagnostic performance continues, this month 73.3% were under 6 weeks (previous month 64.7%). Endoscopy is a significant concern although the service is looking at a range of options to increase capacity and activity in both the short and medium to long term.

Performance improved
Worse than target/threshold

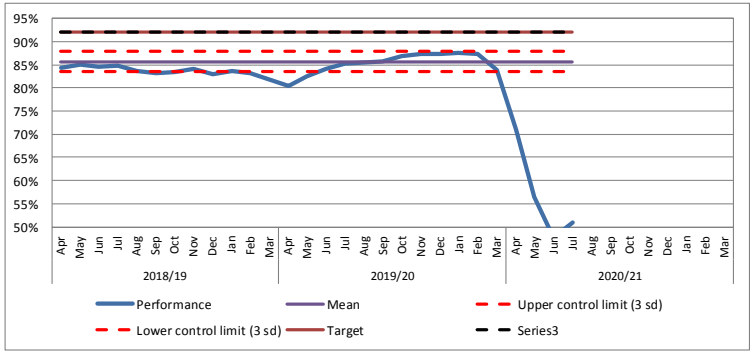
Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

Period: May 2020

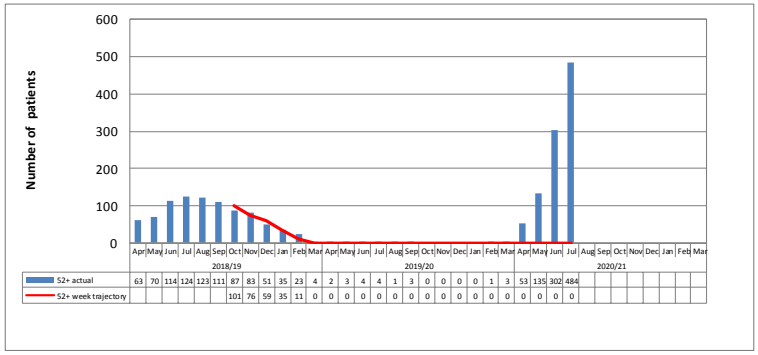
WHHT: 56.51% Peer: 61.52%
National: 61.50%

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

RTT - % within 18 weeks



Number of 52 week waits



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

2 week waits

The provisional position for July is compliant at 98.5% with 1478 referrals of which 22 were seen beyond 14 days. Of the 22, 6 urology, 5 for both skin and UGI and then other services had 1 breach each

The referral numbers have steadily increased since a significant drop in April and approx. 380 fewer than July 2019.

The Trust are monitoring the referral numbers and the numbers of patients diagnosed with cancer. Currently the Trust's conversion rate is lower than usual at 4.2% in July compared with a baseline figure of 6.9%.

2 week wait breast symptomatic

The provisional position for July is compliant at 98.1%. This is an improvement on last month on account of the switch back to usual 2ww eligibility criteria rather than the COVID regional guidance that rejected patients under 25 yrs and also deferred some patients by 3 months.

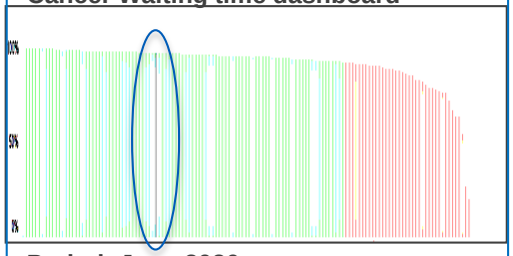
There were 162 referrals and 3 patients were seen beyond 14 days.

28 day Faster Diagnosis Standard

The provisional position is: 2ww - 80.5% Screening –88.9%% Breast Symptomatic – 98.6%

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

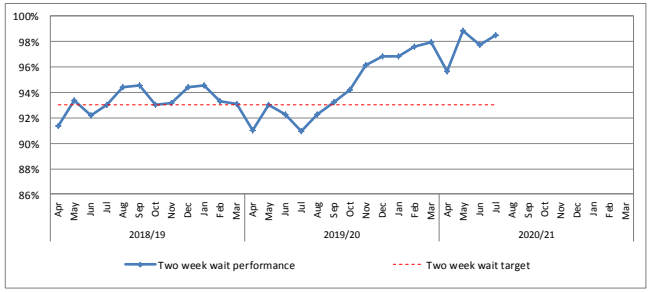


Period: June 2020

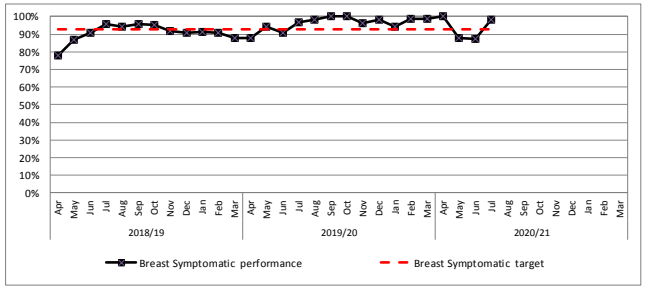
WHHT: 97.7% Peer: 92.0%
National: 92.5%

(Peers = East of England region)

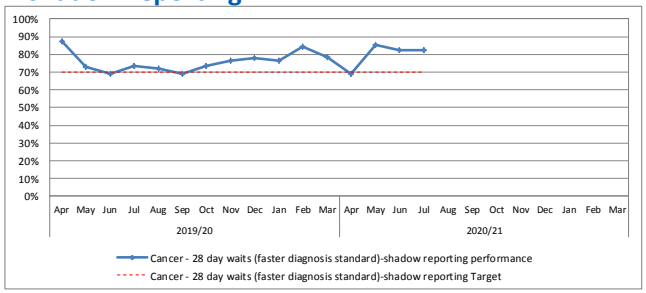
Two week waits: % within target time



Breast symptomatic patients: % within target time



Cancer - 28 day waits (faster diagnosis standard)-shadow reporting



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Quality Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services: Cancer 31 day

In this reporting period:

31 day referral to first definitive treatment
The position for July is provisionally compliant at 97.1% with 136 pathways with 4 breaches (2 x uro and 2 x LGI).

31 day subsequent surgery
The provisional position for July is provisionally compliant at 94.4%, with 18 pathways with 1 breast breach

31 day subsequent Drug
The position for July is provisionally compliant with 100% . There were 17 pathways

31 day subsequent palliative and other
The provisional position for July is compliant at 100 % with 15 pathways

Next steps:
Review the influence of covid on cancer pathways as part of the Trust's recovery plans

Performance improved
Better than target/threshold

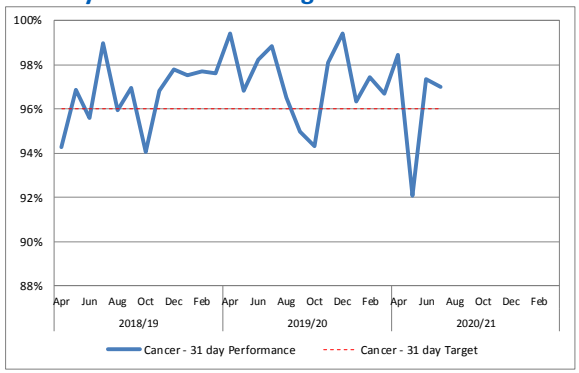
Benchmarking: NHSI Analytics Hub

Period: June 2020
31 day first:

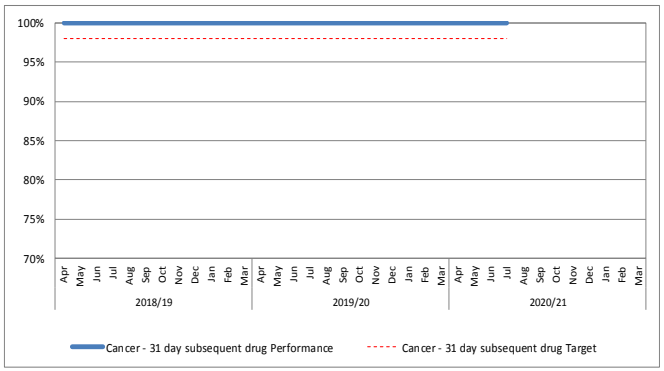
WHHT: 97.3% **Region: 92.3%**
National: 93.7%

31 day surgery:
WHHT: 100.0% **Region: 83.2%**
National: 86.8%

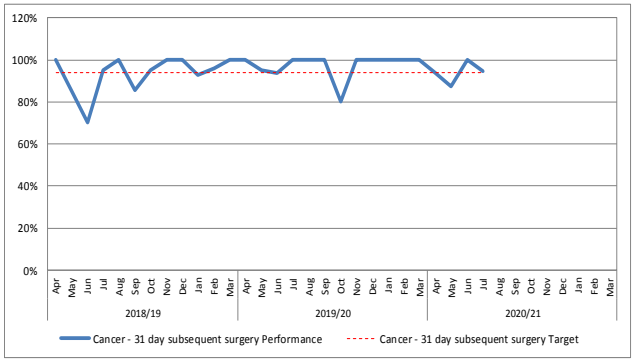
31 day first: % within target time



31 day subsequent drug: % within target time



31 day subsequent surgery: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services : Responsive	Chief Operating Officer	Quality Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services: Cancer 62 day urgent GP referral

62 day referral to first definitive treatment – The provisional position for July is non-compliant at 82% Provisionally there are 75 treatments (94 patients) with 13.5 breaches (21 patients). This include 10 x urology, 2 x H&N, 1 x Lung, 6 x LGI, 1 x UGI and 1 x haem breach.

The number of people that the Trust treated on a 62 day pathway is progressing towards pre-covid levels.

A provisional review of the breaches indicate the trend of longer pathways on account of longer waits for OPA appointments or diagnostics. The cancer pathways progress, but there are longer than usual gaps between each step. This is compounded in situations when patients require interventions which are not in the usual pathways, for example a referral for a second opinion to a tertiary centre. The Trust is also beginning to see patients who are being treated following long waits for colonoscopies and gastroscopies. These breaches have not all been validated and it is possible that more treatments will be added before submission on the 2 September 2020

62 day screening referral to first definitive treatment – Performance is provisionally non- compliant at 0 % with 5 pathways, none of which are in target.

62 day consultant upgrade The provisional July position is 90.5% with 10.5 pathways with 1 breach (2 patients: 1 lung and 1 x H&N).

104 day breaches Open pathways: In July's submission of open pathways over 104 days, there were 101 open pathways which is significantly higher than usual. Of the 101 open pathways, 73 were LGI. (73 x LGI, 9 x urology, 5 x H&N, 3 x haem, 1 x brain, 1 x breast, 1 x gynae, 2 x lung and 6 x UGI). There were some complex pathways and pathways delayed by patients being reluctant to attend, but most were delayed on account of Covid changes.

Closed – Provisionally the Trust has closed 17 pathways over 104 days (including consultant upgrades and screening)

Performance improved
Better than target/threshold

Benchmarking: MODEL HOSPITAL
62 day wait from urgent GP referral

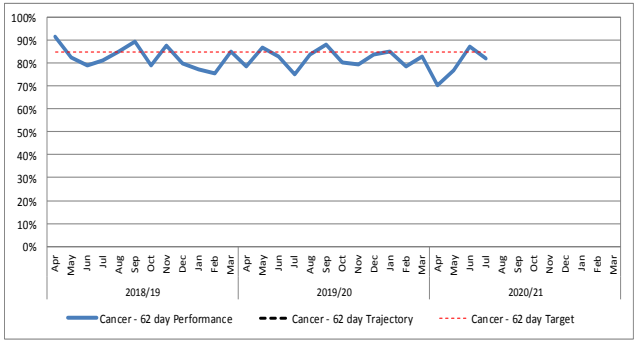
Period: May 2020
WHHT: 74.07% Peer: 70.85%
National: 70.73%

Peers = Nightingale Group – acute multi-site trusts

Benchmarking: NHS Analytics Hub
Period: June 2020
WHHT: 87.0% Peer: 73.42%
National: 75.2%

Peers = East of England Region

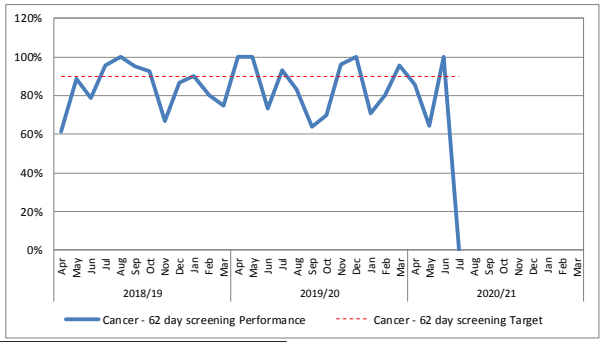
62 day GP: % within target time



62 day GP: Tumour Site

Tumour type	July
Breast	100
Gynaecological	100
Haematological	60
Head and Neck	0
Lower Gastrointestinal	52.2
Lung	75
Skin	100
Upper Gastrointestinal	100
Urological	42.9
Testicular	100
Sarcoma	0
Total	81.6

62 day screening: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Caring	Chief Operating Officer	Finance & Performance Committee	2c / 4b / 4c / 12c

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Caring & Responsive Services: Outpatients

In this reporting period:

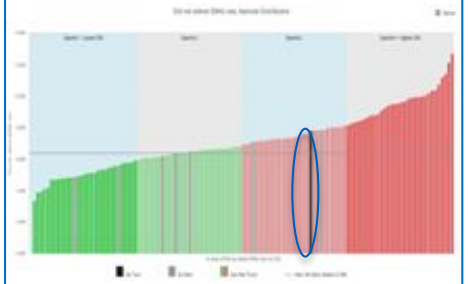
We currently have set 52 services to a referral assessment service in ERS, 315 direct bookable and 21 advice and guidance.
The reinstatement and clinic template revision process is performing within agreed parameters of a 7-10 day turn around.
New drafts of patient appointment letters have been sent to the supplier for final signoff and work to switch back on all OPD communications to be agreed .

New Programme Manager for Medical Records is now in situ and has drafted PID for review and will continue with engagement across the Trust.

Electronic Clinic outcome form pilot went well, next steps are to expand to all of Urology , Cardiology and Dermatology.
The car park waiting room is to be expanded to support face to face services once the required resource is agreed.
We are working with the Royal Free on OPD current state reviews in support of the digital plan.

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Did not attend rate



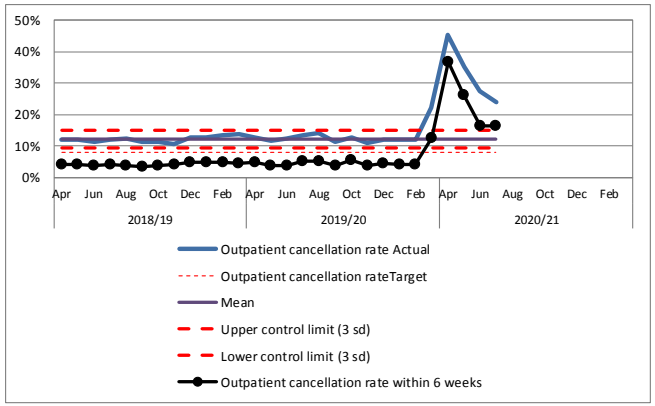
Period: Q4 2019/20

WHHT 7.80% **Peer: 6.38%**
National: 6.91%

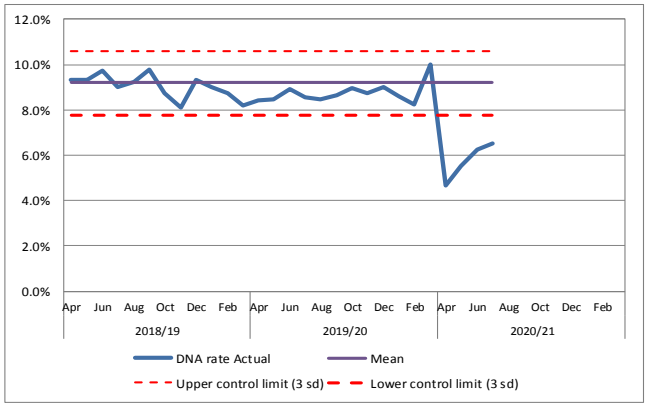
(Peers = Nightingale Group – acute multi-site trusts

Total cancellations: 25.2%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
12.3%	4.3%	10.2%	9.6%

Outpatient cancellation rate



DNA rate



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Caring & Responsive Services: Responsive	Chief Operating Officer	Finance & Performance Committee	3a / 4b / 4c / 10e / 10g / 11a

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Workforce & Finance: Recruitment & Retention

In this reporting period:

- Contracted wte staff in post is 4,661 (4,659) wte last month (+2wte), and + 158wte over 12 months. NB – some of this recent increase is due to COVID staffing arrangements such as employing aspirant student nurses.
- Vacancies (the difference between the ledger establishment and contracted wte on ESR) is 468 wte or 9.1% of the establishment (9.1% last month). The target rate is 10%. NB – the establishment wte for a small number of medical rotational posts has been removed, as the staff are employed outside the Trust and costs are re-charged. A year ago, Trust vacancy rates were over 11%.
- Sickness – the July rate is 4.0% against a target of 3.5%. The 12 monthly sickness rate averages 4.7%. The figure was 4.3% last month, and over 11% for April, the highest rate recorded over the last 10 years.

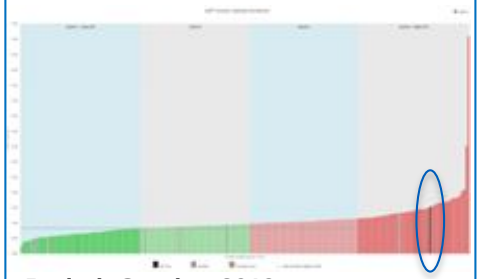
Labour Turnover and Number of staff leaving within first year

- Labour Turnover –This is 13.6% (last month 13.8%). The target is 13%. This is the lowest rate recorded since October 2013. All TUPE related leavers have been excluded from the calculations, as have staff who were on fixed term contracts or have re-commenced working for the Trust. The voluntary rate (excluding retirements / dismissals etc) is 11.0%. The rolling 3 monthly turnover rate is around 7%, which suggests that are less short term pressures for staff leaving.
- Turnover for staff who leave within their first year of is now approx.16% (21% in Aug 2019). The target rate is 15%.
- Turnover for Band 5 Nursing and Midwifery staff is 15.1% (16% last month). The target is 16%, which means that we continue to achieve this target, and is a significant reduction from May 2017 when rates were approx. 30%.This is particularly helpful when recruitment from overseas is disrupted.

Next steps:
At the start of the year, overseas nurse new joiners rose from 5 to 10 for February and 15 for March and April. The COVID situation has meant a reduction in overseas recruits, with 9 in March and 1 out of the 15 planned for April. Since then, all overseas joiners have largely been on hold, although 20 existing transitional nurses who have not yet taken their OSCE exam have been invited to join the temporary register and work as band 4's during the pandemic. In addition 6 nurses have arrived from India and more have been recruited. Final year student nurses have also been employed on fixed term contracts as aspirant nurses , including midwives and children's nurses. Initiatives are being made to employ permanently as many as possible of these staff.

Performance stable
Worse than target/threshold

Model Hospital benchmarking:
Proportion of staff leaving each month

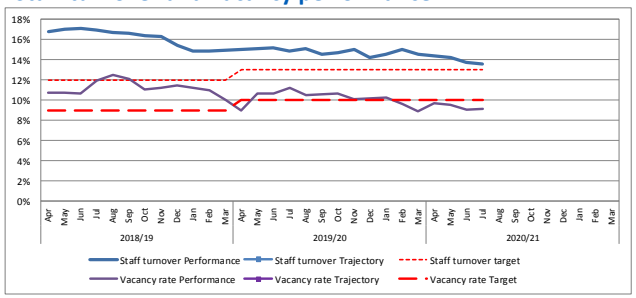


Period: October 2019

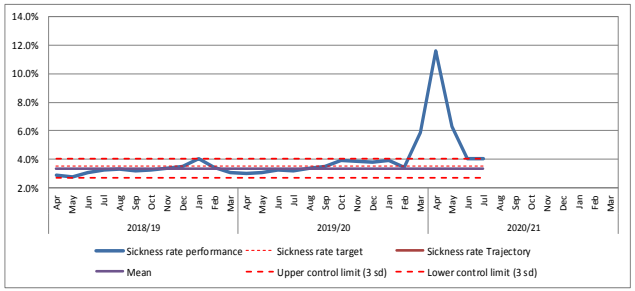
WHHT: 1.54% Peer: 0.83%
National: 0.98%

Peers = Nightingale Group – acute multi-site trusts)

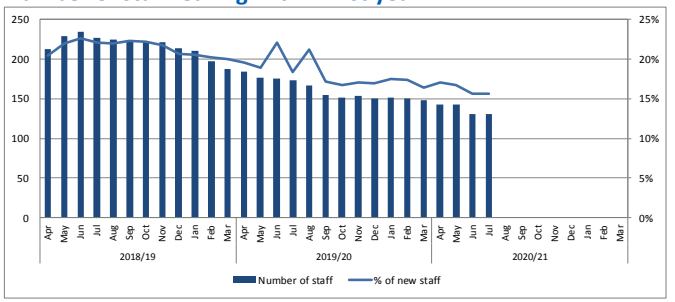
Staff turnover and vacancy performance



Sickness absence performance



Number of staff leaving within first year



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Workforce & Finance: Well Led	Chief People Officer	People, Education & Research Committee	3a / 6a / 6b / 7a / 7b / 12c

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Workforce & Finance: Developing Staff

Submission suspended

In this reporting period:

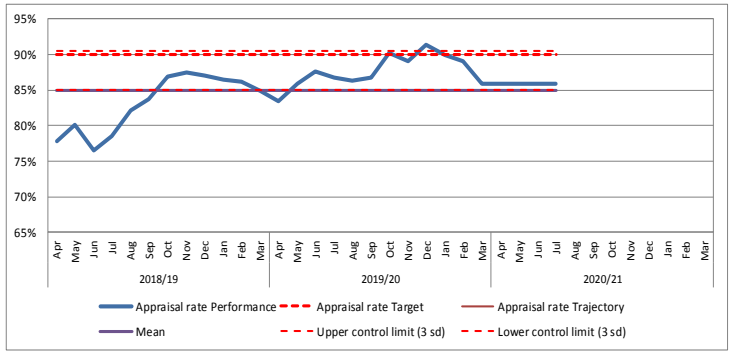
Appraisals

- Current compliance is at 87% (target 90%) for March. In view of the outbreak, for compliance purposes the rate will be kept at 87% until reviewed, based on future circumstances. This figure includes medical staff. The figure is slightly below the target, as COVID19 pressures are impacting on the compliance rate. Medical appraisal rates are 97%, non medical rates are 85%. HRBP's are now working with managers over the next few months in order to ensure as many staff as possible have up to date appraisals, with a view to recommencing reporting in November.
- The Trust will need to implement the national 2018 NHS pay award which agreed to end automatic incremental pay progression for all staff. Instead, this has been replaced with a requirement for staff to be up-to-date with any statutory or mandatory training (providing that this has been made available to them), not have a live formal disciplinary / capability sanction on their record, and have completed appraisals in line with the organisation's appraisal process and standards. The implementation of this agreement is gradual, and there will be increasing numbers of our staff required to undertake this process from April onwards . However, given the current exceptional circumstances that we find ourselves in, it has been decided NOT to implement this agreement at the current time. Instead, we will continue to implement incremental progression automatically to at least September after which implementation will be reviewed. For local benchmarking for appraisals, within Herts Beds and Essex Trusts, the Trust ranks equal 4/13 local Trusts (Q4, 19/20)

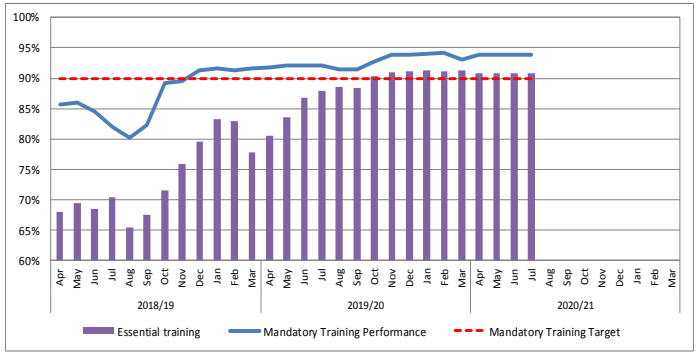
Mandatory / Essential training

- The all Trust mandatory training rate remains above target at 94%. Compliance in the low 90's has now been consistently maintained since November of 2018. For local benchmarking, the Trust also ranks equal 2/13 local Trusts (Q3 9/20).
- Essential training compliance is now also at 91% or above since October 2019.

Appraisal performance



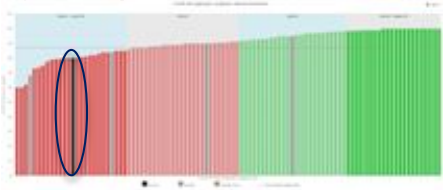
Essential training and mandatory training performance



Performance improved
Better than target/threshold

Benchmarking: Model Hospital

Trust staff with appraisal completed by the required date

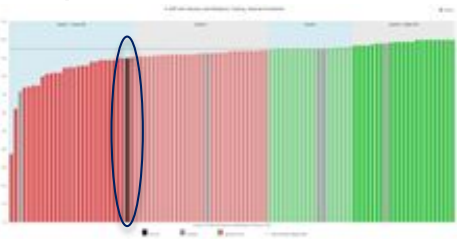


Period: 2018/19
WHHT: 80% **Peer: 87%**
National: 91%

Performance stable
Better than target/threshold

Benchmarking: Model Hospital

Statutory & Mandatory training compliance rate



Period: 2018/19
WHHT 90% **Region 95%**
National 94%
Peers = Nightingale Group – acute multi-site trusts)

DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Workforce & Finance: Well Led	Chief People Officer	People, Education & Research Committee	3a / 5c / 6a / 6b / 8b / 8c

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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 are being monitored, including 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. The turnover of band 5 nurses is currently at 15.1% vs 12.1% overall for all registered midwives/nurses. This represents another decrease from last month and means that the Trust has now achieved its target of under 16%. It is a significant reduction from nearly 30% turnover recorded in May 2017. For Band 5 nurse vacancy rates, these are currently approx. 10%, an increase from rates of 3.2% 5 – 6 months ago, and due to the difficulties in recruiting from overseas . This in turn is a significant decrease from 123wte or 17.2% in March 2018 and 32% in 2015. Nurse vacancy rates for Band 6 and 7 staff have also reduced over the last few months. NB – the Band 5 Nurse vacancy wte figure includes 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 20/21 and beyond to maintain the vacancy rate at under 5% or as close to this as possible. Final year student nurses have been recruited on fixed term contracts as aspirant nurses.

When measured at March month end, combined appraisals rates at March were slightly below the compliant target of 90%, due to the impact of the COVID pandemic. As set out previously the rates have been held at this rate over the COVID period. The overall rate for medical staff (97%) excludes training posts. Mandatory training compliance is 94%, and is now consistently above the 90% target. The monthly Trust sickness rate is 4.0% against a 3.5% target much reduced from the 11.3% at the height of the pandemic. Staff who are off sick as a result of COVID related absence will not enter half pay should they exhaust their sickness pay entitlement over this period. The average 12 month sickness figure reported to NHSI is 4.7%. The 12 month turnover rate is 13.6%, and the lowest since 2013. The Trust is ranked 9 / 12 nearby NHS organisations.

Staff survey - Response rate : Trust response rate 42% (against average of 43% for acute Trusts and 46% nationally) ; Engagement score : Overall WHHT staff engagement score 2019 - 7.02 (2018 – 7.02).

The current agency pay bill percentage is 4.9%. This is a significant reduction compared to any historic comparisons, and is expected to change as services transition to BAU. The 19/20 year expenditure was £13.6m, or 5.2% of the paybill. Without the influence of COVID, the target of £13m or 5% would have been achieved.

Workforce Indictors - Progress Table

Progress against target - July 2020

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	10.4%	10.2%	9.7%	9.1%	10.0%	-0.9%	↘	-9%
Band 5 Nurse Vacancy	11.3%	1.0%	5.9%	10.6%	9.0%	1.6%	↗	18%
Headline Turnover	14.0%	14.9%	14.4%	13.6%	13.0%	0.6%	↘	5%
Band 5 Nurse Turnover	16.3%	15.5%	16.1%	15.1%	16.0%	-0.9%	↘	-6%
Total Sickness	4.8%	3.2%	5.9%	4.0%	3.5%	0.5%	↘	14%
Non-Medical Appraisal	78%	87.0%	87.0%	87.0%	90.0%	-3.0%	→	3%
Medical Appraisal		99.0%	97.0%	97.0%	90.0%	7.0%	→	-8%
Core Skills Framework	89%	92.0%	94.0%	94.0%	90.0%	4.0%	→	-4%
Agency as a % of Paybill	7.3%	5.7%	4.9%	4.9%	4.7%	0.2%	→	4%
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

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		✓	✓	✗	✓
		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 between 8am and 12pm (main adult wards excl AAU)	WHHT	COO		✓	✗	✗	✓
		Mixed sex accommodation breaches	WHHT	COO		✓	✗	✗	✓
		LOS > 21 days	WHHT	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 Q4	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		✓	✗	✗	✓
		Diagnostic (DM01) <6 weeks	WHHT	COO		✓	✗	✗	✓
		Cancer							
		Cancer - Two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - Breast Symptomatic two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent drug *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent surgery *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent radiology *	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		✓	✗	✗	✓

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	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		✓	✗	✗	✓

Trust Board
3 September 2020

Title of the paper	**Midwifery workforce planning bi-annual report 2020**
Agenda Item	10/82
Presenter	**Tracey Carter Chief Nurse and Director of Infection Prevention & Control**
Author(s)	**Colette Mannion, Director of Midwifery & Gynaecology Nursing** **Benedicta Agbagwara-Osuji, Deputy Head of Midwifery & Gynaecology**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: *x*
Executive Summary	This paper has been fully discussed at the Quality Committee where we discussed our recent successful bid to develop maternity support workers to further support the skill mix and continuity of carer. We also outlined the recent maternity survey to show a sustained improvement in women's experience of the service underpinning the importance of the workforce. The paper outlines the implications of the Birthrate Plus® report on West Hertfordshire Hospitals NHS Trust (WHHT) Maternity Services staffing as part of the bi-annual review of midwifery staffing. Appendix 1 provides full details of the Birthrate Plus® report. Bi-annual reporting to the Trust Board demonstrates that the Trust has an effective system of midwifery workforce planning to the required standard to comply with the CNST incentive scheme (Maternity Incentive Scheme –Year 3). The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus® which was endorsed by the RCM Council in 1999, and in the Audit Commission Report; First Class Delivery (1997). There is no other research-based methodology for workforce planning in maternity services. Better Births (2016), the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. WHHT achieved 5% women booked on a Continuity of Carer (CoC) in financial year 2019/20 against a target of 35% set nationally. The expectation is that Trusts will fund BR+ recommendations as the baseline for achieving Continuity of Carer. The model suggested is comprised of teams of 8 midwives caring for 36 women each per annum across the maternity pathway. This will require change management and staff engagement to promote new ways of working. The COVID-19 pandemic has highlighted particular issues for women from a BAME background with research showing that 55% of the pregnant women admitted to hospital came from a BAME background, even though they only

	make up a quarter of the births in England and Wales. Further analysis of the research indicates that Asian women are four times more likely than white women to be admitted to hospital with COVID-19 during pregnancy, while Black women are eight times more likely. The NHS Long Term plan commits to ensuring that by 2024, three-quarters of pregnant BAME women will receive care from the same midwife before, during and after they give birth. This is proven to help reduce pre-term births, hospital admissions, and the need for intervention during labour and to improve women's over experience of care. The recommendation from BR+ is a birth to midwife ratio of 1:22 and so there is the need for an additional 10.18 WTE midwives and 10.62 WTE support roles to be added to the establishment. This is an increased birth to midwife from 1:26 in 2016 and reflects the increase in casemix acuity on Delivery Suite and across the maternity pathway. In 2019/20 the Trust agreed a total midwifery establishment of 182.10 WTE midwives to deliver 4,217 births which was a reduction in births on the previous year. Consequently in April 2019, 5.83WTE midwifery posts were allocated to the Cost Improvement Programme as a non-recurrent reduction. A funded establishment of 189.62 WTE is required to maintain 1:26 for the agreed 4,400 births forecasted in 2020/21. To bridge the gap of 7.5WTE midwives, the Trust has agreed to add back the non-recurrent CIP posts and furthermore the LMNS have funded 3 midwifery posts, this is reviewed annually. This will ensure a funded establishment to achieve a 1:26 midwife to birth ratio. With a view to achieving a 1:22 ratio, a management of change proposal will be undertaken to re-profile band 4 posts on the postnatal ward to band 5 midwife posts. The maternity services are working with the East of England Maternity network to upskill band 2 HCA roles to band 3 Maternity Support workers which will allow a total of 10% skill mix. An action plan is included (Appendix 3) to address the deficits in staffing levels identified and details progress to demonstrate an increase in staffing levels and mitigation to cover any shortfalls. A Quality Impact Assessment has been undertaken to ensure that measures are in place to assure patient safety. In collaboration with the Director of Midwifery I am satisfied professionally that the skill mix and establishment provides the right workforce safeguards.

Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** **Best care** ***Objectives 1-4***	**Aim 2** **Great team** ***Objectives 5-8***	**Aim 3** **Best value** ***Objective 9***	**Aim 4** **Great place** ***Objective 10-12***
	x			x

Links to well-led key lines of enquiry	
	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐Are there clear and effective processes for managing risks, issues and

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<table>
<tr><td></td><td>performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Management Committee</td><td>29th July 2020</td></tr><tr><td>People, Education and Research Committee</td><td>27th August 2020.</td></tr></table></td></tr>
<tr><td>Action required</td><td>This section should explain exactly what action the Board/Committee is being asked to take.

The Board is asked to receive this report for information and assurance that the midwifery staffing meets the Maternity Safety Standards.</td></tr>
</table>

Agenda Item: 10/82

Trust Board meeting – 3 September 2020

Title of paper **Midwifery workforce planning bi-annual report**

Presented by: Colette Mannion, Director of Midwifery and Gynaecology Nursing

1. Purpose

1.1 This paper is being bought to the meeting to enable discussion on the implications of Birthrate Plus® report undertaken in 2018 on West Hertfordshire Hospitals NHS Trust (WHHT) Maternity Services staffing as part of the bi-annual review of midwifery staffing. It also serves as a baseline workforce analysis to inform the workforce requirement for the implementation of Better Births (2016) through the maternity transformation programme. Finally, it demonstrates that the Trust has an effective system of midwifery workforce planning to the required standard to comply with CNST incentive scheme (maternity safety strategy). An action plan is included to address the deficits in staffing levels identified and progress against the action plan to demonstrate an increase in staffing levels and mitigation to cover any shortfalls.

2. Background

2.1 The requirement to ensure midwifery and support staffing levels are safe and sufficient to meet the needs of women, babies and families is clearly an imperative. The Francis enquiry (2013) and subsequent government response 'Hard Truths' (2014) have emphasised the need to get staffing levels right, with seminal papers from Keogh (2013) and Berwick (2013) clearly linking staffing levels to patient safety, outcome and experience. Inadequate staffing has been a recurring theme in organisations where patient care has been found to be substandard.

2.2 Subsequently, the Kirkup Report (2015) and NMC enquiry into Maternity Services in Guernsey (2015) have specifically identified the importance of ensuring adequate numbers of competent skilled midwifery and support staff. Trust Board ownership is very clear with guidance setting out explicit expectations in terms of Board responsibility for maternity services staffing, advocating a twice yearly public Board level discussion to ratify and agree midwifery staffing levels.

2.3 Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Better Births (2016), the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the Review.

2.4 In response to the national maternity transformation programme, NHS England and NHS Improvement- East of England established a Regional Maternity Programme Board (RMPB) to provide oversight, assurance, and support, to ensure there is specific focus on a number of maternity related programmes aimed at improving quality across the region. As a result, in January of 2017, Hertfordshire and West Essex CCGs, and local NHS Maternity providers

came together to establish a Local Maternity System Partnership Board (LMSPB) to lead and implement the local maternity transformation programme.

2.5 The board is based on the geographical footprint of the Herts and West Essex Sustainability and Transformation Partnership (STP) and forms part of the local Sustainability and Transformation Plan (implementing the NHS Five Year Forward View, which has since been superseded by the NHS Long Term Plan).The Hertfordshire and West Essex Local Maternity and Neonatal System (LMNS) is served by three NHS maternity providers which include, Princess Alexandra Hospital in Harlow, West Hertfordshire NHS Trust and East & North Hertfordshire NHS Trust.

2.6 In December 2019 NHS Resolution (NHSR) launched a third year of its incentive scheme to the Clinical Negligence Scheme for Trusts (CNST). The Maternity Safety Strategy set out the Department of Health's ambition to reward Trusts who have taken action to improve maternity safety. The scheme incentivises ten maternity safety actions of which standard 5 require the Trust to demonstrate an effective system of midwifery workforce planning to the required standard.

2.7 A full maternity workforce review was undertaken across the LMNS to reflect the new maternity service delivery model. The aim of the review was to evaluate the appropriateness of the midwifery establishment currently and in terms of future workforce planning. The current traditional workforce arrangement may not be fit for purpose to deliver the national agenda. Therefore, Birthrate Plus (BR+) was commissioned to undertake a midwifery workforce review by the Local Maternity System in 2018. Trusts are required to review their midwifery establishments bi-annually against BR+ recommendations. The current view nationally is that maternity services should be compliant with these recommendations as a prerequisite to implementing continuity of carer. The model consists of a caseload of 36 births per 1 WTE midwife per annum with all aspects of maternity care provided by a team of 8 midwives, based geographically.

2.8 The COVID-19 pandemic has highlighted particular issues for women from a BAME background with research showing that 55% of the pregnant women admitted to hospital came from a BAME background, even though they only make up a quarter of the births in England and Wales. Further analysis of the research indicates that Asian women are four times more likely than white women to be admitted to hospital with COVID-19 during pregnancy, while Black women are eight times more likely. NHSE have issued guidance for maternity services to ensure a framework to identify, assess and implement individualised care plans for BAME women who are at increased risk of poor maternal and neonatal outcomes. The Trust should ensure accurate data is collected for every woman's ethnicity, risk factors such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes. The NHS Long Term plan commits to ensuring that by 2024, three-quarters of pregnant BAME women will receive care from the same midwife before, during and after they give birth. This is proven to help reduce pre-term births, hospital admissions, and the need for intervention during labour and to improve women's over experience of care.

3. Analysis/Discussion

3.1 The most effective and safe way to provide maternity care is to ensure sustainable and productive staffing of maternity services. The NQB's model recommends that NHS providers must ensure that care is delivered by the right staff, with the right skills, in the right place at the right time (National Quality Board (NQB), 2016).

3.2 The RCOG document Safer Childbirth: Minimum standards for the organisation and delivery of care in labour recommends a minimum midwife to birth ratio of 1:28. NICE Safe midwifery staffing for maternity settings guidance (2015) provides specific recommendations for staffing within maternity services. This includes guidance on how to calculate the ratio by excluding managerial and supervisory time, and details of the indicators Trusts can use to determine whether midwifery levels are safe.

3.3 Birthrate Plus (BR+) is a framework for workforce planning and strategic decision making for midwifery staffing and has been used in maternity units since 1988. The maternity department has reviewed it's staffing in light of both of these documents and Maternity incentive scheme – year three (NHS Resolution, 2019) which requires the Trust can demonstrate an effective system of midwifery workforce planning to the required standard:

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done
b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service
c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)
d) A bi-annual report that covers staffing/safety issues is submitted to the Board

This report will provide the following:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- Details of planned versus actual midwifery staffing levels.
- An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.
- The midwife: birth ratio.
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls.
- Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising. The guidance states that it is for the Trust to define what red flags they monitor.

3.4 The birth outturn for 2019/2020 was 4359, better than 4217 forecasted but followed the continued reduction trend seen since 2016. This is a (3.6% reduction), a variance of 166 births from 2018/2019 birth outturn of 4525 (Table 1). The forecast number of births for 2020/21 has been estimated at 4400 based on 2019/20 actuals however, there is a risk that births will continue to decline giving continuing risks of income underperformance**.**

Maternity Bookings And Deliveries Analysis													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/2019 Bookings	483	431	512	465	432	446	513	469	426	471	434	443	5525
2019/2020 Bookings	454	427	421	453	410	443	468	429	436	531	438	428	5338
Bookings Variance	29	4	91	12	22	3	45	40	-10	-60	-4	15	187

Births	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/2019 Births	382	395	375	411	370	402	398	384	377	387	311	333	4525
2019/2020 Births	358	335	372	399	342	398	381	359	353	381	350	331	4359
Variance to 2019/2020 Births	24	60	3	12	28	4	17	25	24	6	-39	2	166

3.5 National maternity planning deliverables 2020/21

The LMNS is tasked with achieving the following outcomes through the maternity transformation programme set by NHSI/NHSE:

- Continue against trajectory to deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025.
- Deliver full implementation of the Saving Babies' Lives Care Bundle (v2) by 31st March 2021.
- Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2021, more than 51% of women are booked on to a continuity of carer pathway. All reasonable endeavours must be undertaken to ensure that continuity of carer is provided to groups that experience the poorest outcomes, outcomes, such as women from ethnic minorities and the most deprived socio-economic groups. Continuity of carer should be delivered alongside ensuring high quality care maternity for all women.
- Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.
- Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings.

3.6 WHHT achieved 5% women booked on Continuity of Carer (CoC) in 2019/20 against a target of 35% set nationally. WHHT have established one midwifery team within current funding who are booking out of area women who are assessed as low risk for antenatal, labour and postnatal care as per the Better Births model. The LMS achieved 9% as a whole in 2019/20. Financial forecasts completed in 2018 across the LMS suggested that additional funding of £1.5m was required to enable achievement of 20% and £3.5m to achieve 51% by March 2021 and 75% CoC for women from BAME and vulnerable groups by 2024 (NHS LTP).

3.7 The Director of Midwifery and Gynaecology is developing a management of change proposal to engage the midwifery workforce with the necessary changes in practice to deliver Continuity of Carer. This will set out the model of care, as described above, and how midwives will be required to work in teams across hospital and community services to ensure continuity of care and realise the benefits to maternal and child health. A reconfiguration of band 4 posts will be proposed so that these can be profiled to Band 5 midwifery roles in addition to upskilling band 2 HCA roles to band 3 Midwifery Assistants. This will facilitate a skill mix review so that 15-20% of postnatal care can be provided by the band 3 roles. A 10% skill mix can be applied across the total clinical midwifery establishment (20 midwives posts based on an establishment of 200 WTE clinical midwives). This will enable the service to bridge the gap between the current funded establishment 1:26 and BR+ recommendation of 1:22.

4. Birth Rate Plus

The Birth rate Plus (BR+) review was conducted between September – November 2018 using the BR+ scoring system and validated by the Birthrate Plus Team to ensure data quality was 100% (Appendix 1). The recommendation to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 21% for annual, sick & study leave allowance and 12.50% for travel in community.

4.1 The casemix is unique to each individual maternity unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making.

WWHT 2018	Cat I	Cat II	Cat III	Cat IV	Cat V
D/S Casemix	0.3%	6.7%	15.8%	35.2%	42.0%
Generic Casemix	5.2%	22.3%	12.3%	27.5%	32.7%

4.2 The analysis of the casemix shows that on Delivery Suite 77.2% of women are in the highest acuity dependency categories (4 & 5), an increase of 7.2% from 2016. The generic (all areas) casemix increased from 57.5% (2016) to 60%. This is likely to be the impact of Saving Babies Lives v1 (2016) care bundle which proactively supports intervention e.g. Induction of labour for reduced fetal movements at term which increases the potential for Caesarean Section. Also the MatNeo maternal and neonatal improvement programme has focussed on the early identification of gestational diabetes and type 2 diabetes which is a high risk maternity pathway with increased surveillance antenatally and intrapartum (during labour). Nationally mothers are having babies at an older age, sometimes through fertility treatment and this places these mothers in a high risk category.

4.3 The recommendation from BR+ in 2018 was a birth to midwife ratio of 1:22, with a recommendation that an additional 10.18 WTE midwives and 10.62 WTE support roles to be added to the establishment. This was an increased staffing requirement from 1:26 in 2016 taking into account the increase in case mix acuity on Delivery Suite. However, WHHT midwife to birth ratio remained at 1:26 during the 2019/20 period.

4.4 The total clinical and non-clinical recommended by BR+ is 222.83 WTE, of this total, 20.44WTE (10%) can be suitably qualified support staff replacing midwifery hours in postnatal care only and therefore requires 202.39 WTE midwives providing clinical care and management roles. This assumes 18.21 WTE (9%) management/supervisory/governance roles to manage the maternity services, however there are currently 16.20 WTE (8.%).

4.5 The forecast number of births for 2020/21 has been estimated at 4400, based on this, the overall clinical establishment which will maintain the current 1:26 ratio for 4400 births at West Herts is summarised as follows:

4.6 In 2019/20 the Trust agreed a midwifery establishment of 182.10 WTE midwives to deliver 4,217 births which was a reduction in the births on the previous year. Therefore from April 2019 5.83WTE midwifery posts were allocated to the Cost Improvement Programme as a non-recurrent reduction.

The following establishment is required to maintain 1:26 for the agreed 4,400 births forecasted 2020/21:

Clinical Midwives required for 1:26	169.20 WTE
Supernumerary Delivery Suite co-ordinators	5.22 WTE
Non-clinical midwifery roles	15.20 WTE
Total	**189.62 WTE**

4.7 To bridge the gap of 7.5WTE midwives, the Trust has agreed to add back the non-recurrent CIP posts and furthermore the LMNS have funded 3 midwifery posts, this is reviewed annually. This will ensure a funded establishment to achieve 1:26 midwife to birth ratio, however further work will be undertaken within the service to achieve 1:22 as a starting point for rolling out the Continuity of Carer teams.

4.8 The total clinical and non-clinical recommended by BR+ is 222.83 WTE, of this total, 20.44WTE (10%) can be suitably qualified support staff replacing midwifery hours in postnatal care only and therefore requires 202.39 WTE midwives providing clinical care and

management roles. This assumes 18.21 WTE (9%) management/supervisory/governance roles to manage the maternity services, however there are currently 16.20 WTE (8.%).

5. Midwifery workforce analysis

5.1 The table below highlight key workforce metrics relating to midwifery staff for April –June 2020:

- Vacancy rate average 10%
- Sickness average 4%
- Long term sickness average 2%
- Short term sickness average 2%
- Turnover average14.7%

Workforce metrics – midwifery staff April – June 2020

	Apr-20	May-20	Jun-20
WTE in post	165.1	166.8	162.3
Sickness %	4%	4%	4.60%
Sickness wte	6.604	6.672	7.4658
Short term sick %	2.40%	1.60%	2.40%
Short term sick wte	3.9624	2.6688	3.8952
Long term sick %	1.60%	2.40%	2.10%
Long term sick wte	2.6416	4.0032	3.4083
Maternity leave wte	3.2	3.6	3.5
Maternity leave %	1.80%	2.20%	2.20%
vacancy rate wte	16.7	15	24.8
Vacancy rate %	9.20%	8.20%	13.30%
Turnover	14.20%	13.80%	16.10%

Midwifery Establishment	181.1	181.1	187.2

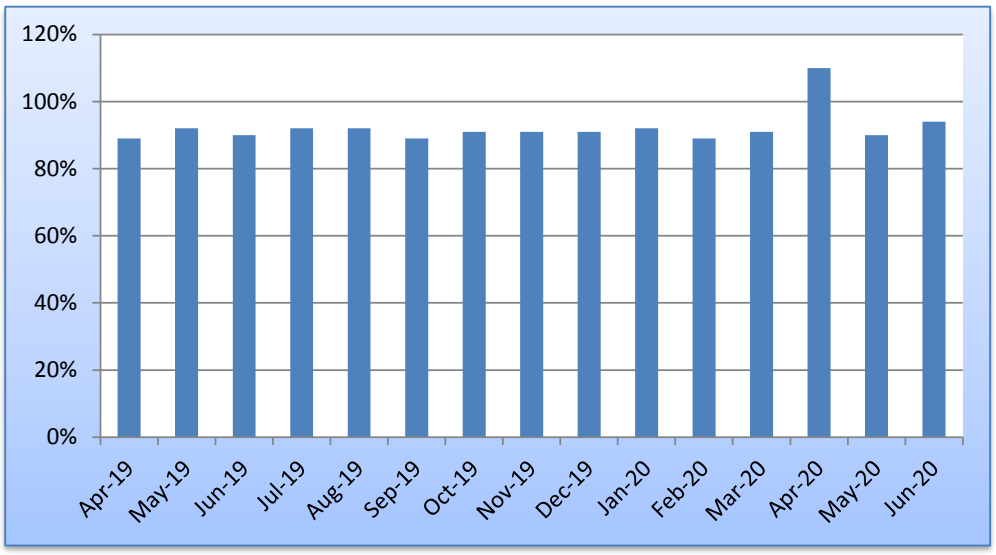
10

5.2 Planned versus actual midwifery hours

The national target fill rate is 95% and this information is submitted monthly to the Department of Health via UNIFY for all inpatients wards, including maternity. Following the Francis Report (2013) all NHS Trusts must publish their registered and unregistered planned and actual hours on their website to promote transparency and public awareness. The table below shows the % planned hours versus actual hours achieved for midwifery staff monthly trend April 2019-June 2020. Appendix 2 shows the full details April-June 2020.

As referenced above, the Matrons have oversight of the operational management of the maternity services in conjunction with the Deputy Head of Midwifery and Director of Midwifery. The daily maternity bleep holder is responsible for assessing patient flow, bed capacity, staffing, skill mix and acuity and dependency of women in order to deploy the workforce effectively and safely. There is a clear escalation process within maternity and to the Trust operational team to ensure that staff and clinical and operation issues are escalated and mitigated.

Planned versus actual April 2019 – June 2020



5.3 Supernumerary status of the Delivery Suite Coordinator

The role of the Delivery Suite Coordinator is pivotal in the safe running of this key area within a maternity service. The role includes, operational responsibilities, responding to emergencies, clinical leadership and support, and liaison with other clinical areas in the organisation. Currently the funded establishment for Delivery Suite is 10.44 WTE to ensure that there are two band 7 midwives on shift 24/7. The Delivery Suite Coordinator is supernumerary and this is highlighted on the Health Roster and does not hold a clinical caseload. The supernumerary role is counted within the BR+ Midwifery Ratio, so an additional 5.22 WTE was funded following workforce financial review 2019. This has been ring-fenced to comply with CNST standards.

10

Compliance with 100% supernumerary Delivery Suite Co-ordinator status

Month	Percentage of shifts Delivery Suite co-ordinator is Supernumerary	Number and Reason
April 2020	100% (30/30 shifts)	
May 2020	97% (29/31shifts)	On two occasions co midwife on the day shifts cared for women with No FM's
June 2020	98% (29/30)	One occasion in June, midwife on the day shifts cared for women with No FM's

The table above shows compliance with 100% supernumerary Delivery Suite Co-ordinator status for April –June 2020 and demonstrates that this standard was not met 100% of the time. This issue will be addressed in the attached action plan.

5.4 One to one care in labour

The table below shows the performance against the 1:1 care in labour target and in Q1, 2020/21 the 100% target was not achieved which resulted in 3 women not receiving 1:1 care in labour within this period.

One to one care in labour April –June 2020

West Herts Maternity Dashboard April - June 2020							
Indicator	**Data Source**	**Rationale for inclusion**	**Goal**	**Red Flag**	**April**	**May**	**June**
1:1 Care in labour	CMiS (All mothers by Inf DOB)	To monitor service provision	100%	<95%	99.7%	99.7%	99.7%

5.5 Midwifery red flag events

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
- Other midwifery red flags may be agreed locally.

5.6 Maternity services use the Birthrate Plus® (BR+) which is a tool for midwives to assess their “real time” workload in the Delivery Suite arising from the numbers of women needing care, and their condition on admission and during the processes of labour and delivery.

The maternity managers also use Safer Staffing which is a Trust wide system to monitor clinical staffing levels which gives high level oversight of staffing throughout the clinical areas. This allows the midwifery managers to mitigate shortfalls and escalate at Trust level and to instigate the maternity escalation policy to mitigate risk to patient safety and experience.

From April 2019 the NICE red flag events relating to midwifery staffing have been added to the Datix risk system to capture specific events that will facilitate regular reporting and triangulation.

Midwifery red flags are reviewed daily at the safety review meeting and will be presented at maternity governance meetings to ensure that themes and trends are identified and are triangulated with patient experience and clinical outcomes. There were six red flags associated with staffing and unit acuity reported in Quarter 1 2020/21

Red flag events April – June 2020

Month	No of Events	Description	Mitigation
10/04/2020	2	Delay in transfer from Katherine ward to Delivery Suite due to high acuity and staff shortage. No one to one care during labour for the patient	Escalation policy followed
May 2020	1	Not able to provide continuous one-to-one care in labour	Escalation policy followed
June 2020	3	Not able to provide continuous one-to-one care in labour Two episodes of delay in Prostin review by Obstetric Registrar due to acuity on Delivery suite	Escalation policy followed

5.7 Conclusion

WHHT maternity services have a high acuity and dependency score of women using their services, with 88.3% (78.90% in 2016) in the moderate to high categories (BR Plus). In order to mitigate the clinical risk profile of this population the Trust has been recommended to have a 1:22 midwife to birth ratio (BR Plus 2018).

The recommendation from BR+ is a birth to midwife ratio is 1:22 and there is the need for 10.18 WTE midwives and 10.62 WTE support roles to be added to the current establishment. An additional 5.22 WTE was funded in 2019 which has been ring-fenced to allow Delivery suite coordinator supernumerary status which complies with the CNST standard. The Trust has funded the additional midwives required to deliver 4,400 in 2020/21 with 1:26 ratio.

An action plan has been developed to address the staffing short falls arising from the deviation from BR Plus recommendations and detail actions taken to mitigate shortfalls. A Quality Impact Assessment is also available in Diligent Resources. There is a workforce reconfiguration work stream in place which will develop a band 3 cohort of maternity support workers which will allow a 10% skill mix. Other roles are being reviewed also to ensure that they are flexible and achieving the maximum skill mix and efficiency.

6. Risks

6.1 Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

6.2 Ensuring the recommended Birthrate Plus midwife to birth ratio will facilitate implementation of Continuity of Carer which delivers high quality, clinically effective midwifery care. The NHS Long Term plan commits to ensuring that by 2024, three-quarters of pregnant BAME women will receive care from the same midwife before, during and after they give birth. This is proven to help reduce pre-term births, hospital admissions, and the need for intervention during labour and to improve women's over experience of care.

7. Recommendation

7.1 The Board is asked to receive this report for information and assurance that the midwifery staffing meets the Maternity Safety Standards.

Name of Director - Tracey Carter
Title - Chief Nurse and Director of Infection Prevention & Control

Date 24th August 2020

Appendix 1

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

The West Hertfordshire Hospital, NHS Trust

FINAL REPORT – May 2019

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Of course birth outcomes are not influenced by staff numbers alone. Nevertheless a recognised and well-used tool like BR+ is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition BR+ caters for the various models of providing care, such as traditional, community based teams and caseload working. It is sensitive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Any maternity unit and service must be able to assess its staffing needs using a tried and tested system of workforce planning. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs, and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff have been applied.

Factors affecting Maternity Services for inclusion within the Birthrate Plus Study

The Governance agenda, which includes evidence based guidelines, on-going monitoring and audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus other key health policies. Birthrate Plus allows for inclusion of the requisite resources to undertake such activities.

Wards provide care to 'normal' uncomplicated postnatal women needing basic midwifery care, which is often over-shadowed by other women who are more complex cases. This results in insufficient time being spent with such women who may require considerable assistance with breast feeding and general care of their baby.

The encouragement of early transfer home does mean that the level of midwifery input during their hospital stay is considerable, in order to ensure that the mothers are prepared for coping at home. It is a known fact that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives, midwifery support roles and GPs. Women and babies are often being seen more in a clinic environment with less contacts at home. However reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have significant impact on community resources in two ways. Some women receive ante and postnatal care from their "home" maternity service, but give birth in another. Because these count as extra to the workload related to that recorded in relation to the annual births of a unit they have been termed as "imported" cross border" cases. West Herts provides intrapartum care to 440 women and some degree of immediate postnatal to women from another maternity service, but "export" their community care. Adjustments to midwifery establishments have been made to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss so the total number of postnatal women is less than antenatal. West Herts similar to most maternity services book approximately 400 women and then have no further contact with the midwife.

SUMMARY: RESULTS/FINDINGS

West Herts & Local Community

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 21% for annual, sick & study leave allowance and 12.50% for travel in community. *A detailed summary is included on page 8.*

The overall clinical establishment for total of 4575 births at West Herts is summarised as follows:

[a] Hospital Services
139.87 wte

[b] Community Services
64.56 wte

TOTAL CLINICAL WTE
204.43 wte

[c] Additional non-clinical midwifery 9%
18.40 wte

Discussion of Findings

9. The main factor in the results is the casemix based on 3 months' data from Sept – Nov 2018 collected using the BR+ scoring system and validated by the Birthrate Plus Team to ensure data quality was 100%.

10. Within the methodology are national standards which include the minimum standard of 1 midwife to 1 woman for care in the labour, delivery and an additional % m/w increase is applied to Categories III (20%); IV (30% & V (40%). Community antenatal care is based on NICE guidance, as is postnatal care with allocation of average midwife hours for the women to cover their standards a/n & p/n assessments, Parent Education, socio-economic issues and all clinical needs.

11. The annual births are based on 4575 as below:

    a. 3519 in Delivery Suite and Obstetric Theatres

    b. 903 in the Birth Centre

    c. 153 at Home or BBAs in community

12. The casemix is unique to each individual unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making (*see appendix 1 for Birthrate scoresheet)*.

13. The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Suite and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.

West Hertfordshire

	Cat I	**Cat II**	**Cat III**	**Cat IV**	**Cat V**
D/S Casemix	0.3%	6.7%	15.8%	35.2%	42.0%
Generic Casemix	5.2%	22.3%	12.3%	27.5%	32.7%

6 The Generic Casemix indicates that 27.5% of births are in the lower categories I & II with 72.5% in the moderate to high categories, of which 60.2% are in IV & V. Key contributory factors include obesity, Postpartum Haemorrhage, Massive Obstetric Haemorrhage, Prelabour Rupture of membranes (requiring augmentation and IV antibiotics) method of delivery and vulnerability with specific reference to mental health issues. Of the 55 maternity units in England who have undertaken a BR+ assessment from 2015 to 2017, the average % of women in Categories IV & V is 56% ranging from 41 to 69%. West Herts at 60.2% is above the average, indicating that a higher % of the population require more clinical input.

7 Category V at 32.7% includes emergency CS, and women with obstetric/medical problems, such as increased diabetes, obesity related problems, mental health and high incidence of complex safeguarding issues

8 The women in Category IV at 27.5% are those having an elective CS or epidural for pain relief with a normal birth. Women with low birth weight/preterm babies; high-risk inductions of labour and PPH fall into this group.

9 Category III women (12.3%) have moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries as well as normal births with continuous fetal monitoring fall into this group.

10 The D/S Casemix will predominantly be those women in categories III to V thus impacting on the workload for this service and also for postnatal care on the ward. Thus, this Casemix was used to calculate the staffing for Delivery Suite and the postnatal ward.

11 The assessment of midwives for the Birth Centre activity is based on a 'package of care' that includes intra-partum care with 2 midwives for the birth, postnatal care until transfer home and examination of the new-born. Time for Parent Education is factored in within all clinical hours allocated. There are a number of women, who commence labour in the Birth Centre but are transferred to Delivery Suite prior to or at delivery due to maternal or fetal complications. The care given to the women is included in the Birth Centre staffing whilst the actual birth and post-delivery care is within the D/S establishment.

12 Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. Category A2 women (n=260) are high risk-antenatal cases that would usually be 'admitted' to a ward for on-going care following a stay on delivery suite having one to one midwifery care.

13 Some additional non-birth activity is caring for women who have a fetal loss prior to 24 weeks gestation (n = 16). On average, there are 25 escorted transfers from West Herts to another obstetric unit usually for neonatal reasons.

14 All maternity units have significant antenatal activity that is both planned and unplanned cases and often the latter equate to the actual number of women delivering in the service. Maternity units deal with this activity in a variety of ways, such as via DAU, the antenatal ward and through a dedicated Triage/Assessment area. The staffing for the annual episodes of 7,770 is based on having a 24/7 Triage that sees women with labour queries and many more presenting reasons as well as planned antenatal cases, so acts like a day unit.

15 The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital and used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters. Many babies require additional observation and monitoring in postnatal wards (n=150). There were 65 PN re-admissions which create additional workload and this is factored into the staffing requirements.

16 Midwives now carry out more of the NIPE checks on the postnatal ward which was previously performed by the paediatric team requiring additional resources from the Midwifery team.

17 The inpatient antenatal annual episodes of (n=1684) exclude elective cases, namely Inductions and Elective Caesarean Sections. It is not feasible to produce comparative data for antenatal admissions in similar sized units as practices depend on bed capacity, geography, clinical decision-making, clinical risk factors and availability of outpatient services.

18 The majority of Inductions of labour take place on the ward with some outpatient inductions, high-risk women are induced on the labour ward. The annual total of 1507 will be fewer women as some may receive more than one dose of prostin/propess. As with many maternity units there has been a significant increase in the number of women requiring induction of labour as part of the 'Each Baby Counts' safety agenda.

19 Outpatient Clinic services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service and will heavily depend on the obstetric specialities provided, complexity of women, etc.

20 The community cases are based on those women birthing in West Herts and having all ante & postnatal community care locally plus any women, who may birth in neighbouring units, but belong to the local CCG area. The total number of community cases is 6389, excluding home births, whilst 440 women are transferred to neighbouring Trusts for their community care, there are an additional 1882 women who receive ante and postnatal care having birthed in neighbouring hospitals and another 450 who receive post-natal care only.

21 There are approximately 400 women who will see a midwife in early pregnancy as per NICE Antenatal Guidelines and the 'Early Contact' recommendation, but do not progress further with their pregnancy. An average 2 hours of midwifery time is allocated to these women.

22 A skill mix adjustment of 90/10% can be applied to the clinical total of 204.43 wte and local community where an average of 10% of the total clinical wte can be competent and qualified support staff usually being Bands 3 & 4 [See Appendix 2]. This equates to 20.44 wte support staff split between postnatal care in hospital and community.

23 The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs.

24 The total clinical establishment of 204.43wte does not include the following roles:

- Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
- Clinical Governance role
- Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
- Additional hours for antenatal screening over & above the time provided in actual clinics
- Coordination for such work as Safeguarding Children
- The research & training aspect of the Consultant Midwife

25 The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 18.40 wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties.

26 **The Total Clinical & Non-Clinical wte is 222.83wte. Of this total, 20.44wte can be suitably qualified support staff replacing midwifery hours in postnatal care only and 202.39wte midwives proving clinical care and management roles.**

Comparison of Birthrate Plus® staffing totals with Current Funded Establishment based on above dataset

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles and skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff can be applied.

The table below outlines the comparison of Birthrate Plus® results with current funded establishments based on above data and results;

Comparison of Maternity Staffing

BR+ Total Clinical & Non-Clinical wte	222.83 wte	The total wte bands 3 - 8 for hospital & community services and including all non-clinical roles
Comparative Current Funded establishment	198.83 wte	The total wte bands 3 - 8 for hospital & community services and including all non-clinical roles
Variance	**-24.00 wte**	**Variance between BR+ Total wte & Current Funded wte – Bands 3 – 8 covering the skill mix for p/n care**

SUMMARY of DATA & REQUIRED WTE for

West Hertfordshire NHS Trust

First draft 22/03/2019
Data collected Sept to Nov 2018

Total births in service **4575**

CASEMIX (2018)

	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	0.3	6.7	15.8	35.2	42.0
%Generic Casemix	5.2	22.3	12.3	27.5	32.7

		Annual No.	Required WTE	
Consultant Led Unit				
Delivery Suite Births		*3519*	46.26	**46.26**
Other DS Activity		*Annual No.*		
	Category A1	*502*		**5.28**
	Category A2	*260*		
	Category R	*26*	4.99	
	Escorted Transfers OUT	*25*		
	Non-viables	*16*		
	Inductions	*167*	0.30	
Triage		*7770*	10.84	**10.84**
Birth Centre		*Annual No.*		
Births only		*903*	10.46	**17.67**
Transfers to DS		*389*	3.98	
Ward Attenders/Cat X		*765*	0.70	
PN Care of women & Parent Education		*822*	2.53	
Victoria Ward	Antenatal admissions	*1684*	8.48	**11.17**
	Inductions	*1507*	2.69	
Catherine Ward	Postnatal women	*3600*	36.70	**38.26**
	Postnatal Re-admissions	*30*	0.16	
	Extra Care Babies	*150*	0.78	
	NIPE		0.62	
OUTPATIENT SERVICES				
Antenatal Clinics	Midwife & Obstetric Clinics		2.36	**6.96**
	Specialist Midwife Clinics		2.00	
	Fetal Medicine		2.61	
Day Unit			3.42	**3.42**
		Annual No.		
COMMUNITY SERVICES	Home Births	*153*	4.31	**64.56**
	Community Cases	*6389*	59.73	
	Community Bookings ONLY	*400*	0.52	
CLINICAL MIDWIFERY WTE REQUIRED				**204.43**
	Additional non-clinical midwifery wte @ 9%		18.40	

10

Using ratios of births/cases to midwife wte for projecting staffing establishments

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will take into account an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (8/10%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 107 cases to 1 wte is the correct ratio to apply. To use the 1:22 ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

Example; A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 29 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

Midwife Ratios based on above data and results

The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

Ratios:

Home births	35 births to 1 wte
Delivery Suite births (all hospital care)	29 births to 1 wte
Birth Centre Births	51 births to 1 wte
Ante & Postnatal Community care only *Community imports only receive postnatal care so affects ratio*	107 cases to 1 wte

- Overall ratio for **all** births 22 births to 1 wte

Note: The overall ratio for West Herts of 22 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte, but they are not directly comparable for the above local factors. The latter ratios are based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

Appendix 1 Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I Score = 6

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:

The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II Score = 7 – 9

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III Score = 10 – 13

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV Score = 14 –18

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V Score = 19 *or more*

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.

Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

MATERNITY SUPPORT WORKERS/CARE ASSISTANTS Appendix 2

Due to changes in skill mix with the increasing use of support staff with a formal qualification in maternity services, there is a need to distinguish between those that can replace midwife hours, and other staff that support the midwife in care of women and their babies. Maternity Support Workers (MSW) refers to those support workers with a formal qualification such as Level 3 NVQ or Nursery Nurse, and who can replace midwife hours. The Maternity Care Assistant (MCA) is used to denote the more basic grade of support worker who supports the midwife. In all clinical areas the use of Care Assistants greatly aids the provision of maternity care, by releasing midwifery staff to be client, rather than ward centered.

Skill Mix Rationale

It is important to distinguish between the situations where support staff assist the midwife and where he/she replaces the midwife.

Birthrate Plus® (1996) makes it clear the ward and clinic staffing levels for midwives are based upon the premise that they are supported by MCA and clerical staff and these staff needs are assessed on a shift by shift basis.

The decision about the percentage of midwife time, which might be replaced, by MSW time must be that of the local service managers.

Antenatal care: As this calls for midwife skills so it is not recommended to replace the midwives with an MSW, but units should ensure that midwives are well supported by clerical and MCA staff.

Intrapartum care: Birthrate Plus® does not recommend any replacement of midwife time by MSW time. To do so would undermine the basic quality standard of one to one care throughout labour plus the increased % of midwife time required for high needs categories.

Postnatal care in Hospital: Many services now suggest 20 - 25% of midwife time can be replaced by MSW input. Once a local decision has been made, the calculations of wte staff for each ward can readily be adjusted.

Postnatal Care in Community: Many services now suggest that 25% of midwife time can be replaced by MSW time. This would allow for full assessment and planning of care by the midwife, with a minimum of three visits and additional visits being undertaken by the MSW working under the direction of the midwife in charge of each woman's care.

Based on adjustments made by other maternity units, an average of 10% of the clinical total wte can be competent and qualified support staff usually being Bands 3 & 4.

The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs. Some services are moving towards an 85/15% split with more MSWs working in community and increasing support staff on the p/n ward to work with transitional care babies.

Note: In addition, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies, but are in addition to the calculated clinical establishments. To assess the requirement of Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision. For example, 2 per shift on D/S at all times inclusive of the leave allowance.

Appendix 2 Planned versus actual midwifery staffing levels April – June 2020

Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff				
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Planned Overall	Actual Overall	Fill rate Overall

April 2020

ABC	0.00	0.00	46.00	34.50	0.00	0.00	0.00	0.00	0.00	0.00	46.00	46.00	0.00	0.00	0.00	0.00	92	80.5	87.5%
Delivery Suite	3210.83	3171.33	609.50	690.00	0.00	0.00	0.00	0.00	2889.00	2699.50	552.00	679.50	0.00	0.00	0.00	0.00	7261.33	7240.33	99.7%
Katherine	1064.92	1359.17	955.33	1065.58	0.00	96.00	0.00	0.00	691.00	1048.50	920.00	1196.00	0.00	0.00	0.00	23.00	3631.25	4788.25	131.9%
Victoria	691.00	577.25	11.50	242.83	0.00	0.00	0.00	0.00	690.50	587.50	92.00	230.00	0.00	0.00	0.00	0.00	1485	1637.58	110.3%
Overall	**4966.75**	**5107.75**	**1622.33**	**2032.91**	**0**	**96**	**0**	**0**	**4270.5**	**4335.5**	**1610**	**2151.5**	**0**	**0**	**0**	**23**	**12469.58**	**13746.66**	**110.2%**

May 2020

ABC	1,161.25	1,397.17	1312.50	857.75	0.00	148.50	0.00	103.50	713.00	1048.5	1069.50	1035.00	0.00	11.50	0.00	103.50	4256.25	4705.42	110.6%
Delivery Suite	711.75	709.33	253.00	299.00	0.00	0.00	0.00	0.00	713.00	713.00	253.00	276.00	0.00	0.00	0.00	0.00	1930.75	1997.33	103.4%
Katherine	1,502.50	1,502.00	138.00	138.00	0.00	0.00	0.00	0.00	1,437.50	1,437.50	115.00	115.00	0.00	0.00	0.00	0.00	3193	3192.5	100.0%
Victoria	1426	816.5	598.00	339.50	0.00	0.00	0.00	0.00	1421.5	823.5	598.00	218.50	0.00	0.00	0.00	0.00	4043.5	2198	54.4%
Overall	**4801.5**	**4425**	**2301.5**	**1634.25**	**0**	**148.5**	**0**	**103.5**	**4285**	**4022.5**	**2035.5**	**1644.5**	**0**	**11.5**	**0**	**103.5**	**13423.5**	**12093.25**	**90.1%**

June 2020

ABC	1,034.50	965.00	345.00	253.00	0.00	0.00	0.00	0.00	1,012.50	944.5	345.00	287.50	0.00	0.00	0.00	0.00	2737	2450	89.5%
Delivery Suite	2,892.50	2,810.92	690.00	598.00	0.00	0.00	0.00	11.50	2,381.00	2,410.00	690.00	655.50	0.00	0.00	0.00	11.50	6653.5	6497.42	97.7%
Katherine	1,312.50	1,311.83	1381.42	794.17	0.00	138.25	0.00	92.00	943.50	1,024.00	1299.50	1000.50	0.00	0.00	0.00	115.00	4936.92	4475.75	90.7%
Victoria	691.5	692.17	345.00	230.50	0.00	0.00	0.00	46.00	690.5	690.5	346.00	311.50	0.00	0.00	0.00	11.50	2073	1982.17	95.6%
Overall	**5931**	**5779.92**	**2761.42**	**1875.67**	**0**	**138.25**	**0**	**149.5**	**5027.5**	**5069**	**2680.5**	**2255**	**0**	**0**	**0**	**138**	**16400.42**	**15405.34**	**93.9%**

Appendix 3 **Action plan to address shortfall in staffing in response to Birth Rate Plus recommendations (2018)**

	Issue	Action	Responsible	By when	RAG status /evidence
1	Midwife to birth ratio recommended 1:22 so there is a shortage of 10.18 WTE midwives and 10.62 WTE band 3 &4	- Change management process to reprofile band 4 posts to band 5 midwives (5WTE)	Director of Midwifery & Gynaecology	1/10/2020	
3	Need to ensure that known risks are documented and mitigated	- Maternity risk register to be updated to demonstrate that potential risk associated with short fall in current midwifery establishment and BR+ recommendation	Director of Midwifery & Gynaecology	3/6/2020	
4	Maternity support workers are not skilled sufficiently to include in the birth to midwife ratio at 10% as recommended by BR+	- Undertake workforce re - configuration to upskill band 2 HCA to band 3 Maternity Support worker in line Trust development programme	Lead Midwife for Education	30/10/2020	

Trust Board
3 September 2020

Title of the paper	Safeguarding Annual Report – May 2019 – April 2020
Agenda Item	11/82
Presenter	Michelle Mulvaney, Lead Nurse Safeguarding
Author(s)	Michelle Mulvaney, Lead Nurse Safeguarding Dawn Bailey, Named Nurse Safeguarding Adults Keiley Perry, Named Midwife Safeguarding Bonnie Sparkes, Clinical Nurse Specialist Safeguarding Adults Orla Burke, Clinical Nurse Specialist Safeguarding Children
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: √
Executive Summary	The Safeguarding annual report has been presented and discussed at the Quality committee and is an account of the safeguarding activity across the Trust for the period from May 2019 – April 2020. The key indicators show that the Trust is protecting children, young people, unborn babies and adults at risk with referral rates that are appropriate and proportionate for a secondary provider organisation. **Children** Of the 2061 referrals made to Children's Services - 1631 referrals were regarding concerns about a child's welfare and 430 referrals were to share information about vulnerable children. • 258 referrals made to Children's Services for children under 18 attending with self-harm or overdose. • 234 referrals were done for children attending with other mental health issues or significant behavioural issues that require a multiagency approach • 31 child protection medicals performed by paediatricians for physical abuse • 882 referrals made regarding parental attendances that cause concern for the child's welfare **Adults** • 403 referrals made to Adult Care Services for safeguarding concerns about adults • 10 referrals for Human Trafficking and Modern slavery that were reported to Operation Tropic/Operation Mantis • 19 information sharing requests for adults at risk from out of area local authorities and Hertfordshire constabulary • Trust have applied for 804 Deprivation of Liberty Safeguards for admitted patients **Maternity** • 202 referrals made to Children's Services for safeguarding concerns about unborn babies • 1055 referrals to the Lavender Team for pregnant women with mental health issues

	The report demonstrates the Trusts commitment to safeguarding both within the organisation and working externally with our partner agencies. Innovative practice within the safeguarding team over the reporting period has been recognised at a national level with the team being finalists in 4 national awards going on to win 2 of these. This has led to significant recognition across the national safeguarding network with the clinical nurse specialist presenting at a number of national conferences representing the Trust. During this period the Herts Valley Clinical Commissioning Group undertook an adult assurance visit which was very positive with areas of good practice identified. The section 11 audit visit for children's safeguarding was cancelled due to coronavirus but has been rescheduled for later in the year. During this period, staff have continued to deal with emerging national safeguarding issues such as trafficking, exploitation and significant domestic abuse. The report shows a significant increase in safeguarding referrals for children particularly around mental health and those living with domestic abuse. There has been an increase in referrals for safeguarding concerns for unborn babies. The number of applications for DoLS has also increased. In the reporting period there have been 3 domestic homicide reviews involving the Trust and no serious adult reviews. The Trust is currently involved in 2 serious case reviews of children with care received in maternity and paediatrics. The compliance for all levels of safeguarding training has remained above 90%. MCA/DoLS training has also remained over 90%. Targeted work has been carried out for medics where there has been lower compliance. Prevent (WRAP) training compliance has met the NHS England expected target of 85% (following a review of the training needs analysis and the addition of a significant number of clinical staff requiring training – 2363 additional staff). This brings us in line with the national average of staff trained in provider organisations across England. Safeguarding supervision compliance figures for paediatrics and neonates has remained high – over 90% for both medical and nursing staff. All relevant safeguarding policies are up to date and have been reviewed in line with national guidance where necessary. The safeguarding training and audit strategies have been fully updated and approved. During the reporting period there has been an increased emphasis on improving care for patients with learning disability. A new learning disability partnership group was launched with work streams producing pathways for end of life care and for patients requiring sedation. Safeguarding has remained a key focus during the coronavirus pandemic. The team ensured that all legislative changes and national guidance have been reviewed and relevant changes put in place. The Team have ensured there was an enhanced focus on learning disability patients during the pandemic. Safeguarding has remained high on the agenda particularly focusing on victims of domestic abuse and the effects of lockdown on vulnerable children. A surge in safeguarding cases is highly likely as lockdown unlocks – additional support has been put in place within the team to meet this increased need.

	Currently there is a significant emphasis on the national safeguarding agenda with increased focus on training demands and emerging themes. Locally, we continue to see a significant rise in safeguarding referrals year on year and an increase in training demands. There is an emerging risk that the current capacity within the safeguarding team will be unable to meet the evolving demands of the service. A business case has been written and submitted that proposes an increase in the safeguarding nursing capacity to meet the evolving demands.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care – *Objectives 1-4*: √ **Aim 2** Great team – *Objectives 5-8*: √ **Aim 3** Best value – *Objective 9*: **Aim 4** Great place – *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 Safeguarding Trust Panel – 18th June 2020 Quality and Safety Group – 16th July 2020 Quality Committee – 27th August 2020
Action required	The Trust Board is asked to receive the report for information and assurance that the Trust is compliant with its duties under the Children Act (2004), Mental Capacity Act (2005) and Care Act (2014).

11

Agenda Item: 11/82

Trust Board – 3 September 2020

Safeguarding Annual Report for May 2019 – April 2020

Presented by: Michelle Mulvaney Lead Nurse Safeguarding

1. Introduction

Safeguarding is a fundamental component of all care provided within WHHT. The Trust acknowledges that safeguarding children and adults is everyone's responsibility and we all have a duty to protect our patients from abuse and harm.

This report will provide information about safeguarding activity across the Trust for the year May 2019 to April 2020. The report will provide evidence and assurance that WHHT is effective in safeguarding children and adults that are at risk and meeting our statutory responsibilities.

The Safeguarding team works across the Trust and externally with our partner agencies and is led by the Lead Nurse for Safeguarding. The team is supported by the divisions within the Trust through membership of the Safeguarding Panel, which is chaired by the Chief Nurse who is Executive Lead for safeguarding.

2. Background

Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice. There is a requirement of WHHT to safeguard and promote the welfare of patients as set out in legislation including Section 11 of the Children Act (2004), Mental Capacity Act (2005), Working Together (2018), The Care Act (2014), Modern Slavery Act (2015) and the Serious Crime Act (2015).

The Trust are registered and monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG). The Care Quality Commission has 2 regulations in their framework relevant to safeguarding that need to be met by registered providers. These are regulation 12: Safe Care and Treatment and regulation 13: Safeguarding service users from abuse and improper treatment

The context of safeguarding continues to change in line with societal risks both locally and nationally, large scale inquiries and legislative reforms. Fundamentally, it remains the responsibility of every NHS-funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the well-being of those children and adults is at the heart of what we do.

The Safeguarding Accountability and Assurance Framework (NHSE/NHSI 2019) states that every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their

statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together within new demographic footprints to seek common solutions to the changing context of safeguarding and developing structural landscape needed to deliver the NHS Long Term Plan (2019).

All health providers are required to have effective policies and procedures to safeguard vulnerable individuals and to assure themselves, regulators and their commissioners that these are compliant and fit for purpose. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse a Named Midwife and a Named lead for MCA/DoLS.

3. Safeguarding Work Plan

An annual safeguarding work plan is produced by the team to enable compliance with regulatory requirements, support continuous development and to direct safeguarding strategic and operational activity. The format allows for a monthly review of all objectives that are RAG rated so progress across the year is clearly visible. Actions from audits and external reviews and inspections are added to the plan and progress against these actions is reviewed monthly. The work plan is overseen, monitored and reviewed by the Safeguarding Panel.

Key Achievement - Annual work plan completed with 95% of actions achieved and those outstanding transferred to 2020 – 2021 work plan.

3.1 Newsletter

The safeguarding newsletter is produced by the safeguarding team bi-annually with contributions from partners, such as Adult Care Services, Acute Health Liaison team and the IDVAs. The newsletter is distributed to all Trust staff electronically, with some hard copies available in clinical areas. The newsletter contains information about the safeguarding team with photographs and contact numbers as well as articles about safeguarding issues and current concerns**.**

4. Overview of progress made relating to national Safeguarding policy / legislation 2019 – 2020

4.1 Safeguarding Children, Young People and Adults at risk – Safeguarding Accountability and Assurance Framework (SAAF) (NHSE/NHSI 2019)

The SAAF was updated in August 2019 to strengthen the NHS commitment to promoting the safety, protection and welfare of children, young people and adults. The purpose of the document is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations. The framework sets out how relationships between health and other systems work at both strategic and operational levels to safeguard children and adults and sets out the legal framework for safeguarding as it relates to NHS organisations in order to support them to discharge their statutory requirements to safeguard adults and children.

WHHT review

A review and gap analyses was carried out against the new SAAF and a paper presented to Safeguarding panel in October 2019. The Trust was compliant with the framework with processes and policies in place that are in line with safeguarding legislation. These are regularly reviewed against national guidance and updated accordingly.

4.2 Amendment to the Mental Capacity Act / Liberty Protection Safeguards (LPS)

The Deprivation of Liberty Safeguards (DoLS) was introduced in the Mental Capacity Act 2007. DoLS provide a framework for approving the deprivation of liberty for people who lack the mental capacity to consent to necessary treatment in a hospital or care home.
The Cheshire West, Supreme Court judgement in 2014 significantly widened the definition of deprivation of liberty. This resulted in more people being considered to have their liberty deprived. This resulted in a ten-fold increase in the number of deprivation of liberty application and the process became unfit for purpose.

In March 2017, the Law Commission published a report and Draft Bill recommending an overhaul of the DoLS process. It recommends that DoLS are repealed as a matter of urgency, and replaced by a new scheme called the Liberty Protection Safeguards. The new safeguards are intended to streamline the process for assessing whether a deprivation of liberty is necessary, and obtaining the required authorisation.

The new Liberty Protection Safeguards (LPS) are due to come into force in October 2020 via the Mental Capacity (Amendment) Act 2019. Although it is anticipated this may be delayed due to the Coronavirus pandemic.

The main changes will include;

- legislation will create Responsible Bodies to authorise an incapacitated person's deprivation of liberty. The identity of the Responsible Body will depend entirely upon the arrangements for the person's care.
- under LPS, deprivation of liberty will have to be authorised in advance by the Responsible Body and will also apply to 16-and 17-year olds alongside adults.
- enhanced rights to advocacy and periodic checks on the care or treatment arrangements for those most in need
- greater prominence given to issues of the person's human rights, and of whether a deprivation of their liberty is necessary and proportionate, at the stage at which arrangements are being devised
- extending protections to all care settings such as supported living and domestic settings –therefore removing the need for costly and impractical applications to the Court of Protection
- cutting unnecessary duplication by taking into account previous assessments, enabling authorisations to cover more than one setting and allowing renewals for those with long-term conditions
- a simplified version of the best interest's assessment which emphasises that, in all cases, arrangements must be necessary and proportionate before they can be authorised.

Progress within WHHT

The Safeguarding Team have attended updates and training around the proposed changes nationally and locally. We have also contributed to professional networks across the East of England to consider the impact of changes within health. Further progress will be made following the publication of the code of practice.

5. Safeguarding response during COVID-19 (March/April 2020)

The Covid-19 pandemic has involved a significant change in service prioritisation and focus of care across the NHS. However safeguarding has remained a key priority within this period and there have been a number of adaptations to frameworks and legislations. Key areas of work during this time include

- Safeguarding Team remotely joined weekly national and local networks to discuss safeguarding issues arising from Covid-19 and to share good practice
- Updates around changes to safeguarding frameworks and legislation, particularly the Coronavirus Act (2020) reviewed and shared with appropriate staff
- Safeguarding Panel held in April – focus on Covid-19 and impact on safeguarding
- Safeguarding handbook for use during the pandemic produced and shared with clinical staff and available on intranet
- Weekly dip dive audits were also carried of both Covid-19 and non Covid-19 patients who had care and support needs
- Provided safeguarding induction training to return to practice nurses and third year students
- Developed separate Level 3 eLearning packages for safeguarding children and adults to provide an alternative training option while face to face training is postponed

5.1 Learning Disabilities

During the initial phase the Acute Health Liaison Team (AHLT) were not on site but working remotely to support LD patients. During this time

- Safeguarding Nurses did daily ward rounds visiting all admitted LD patients, liaising with staff and AHLT and supporting with reasonable adjustments, completing MCA assessments etc.
- Supported staff to give out daily updates to families and carers whilst visiting was limited.
- Electronic devices were used to support patients undergoing clinical procedures. Families and carers were able to access Face Time to reassure the patients who were experiencing anxiety.
- Easy read material and COVID-19 passports have been made accessible electronically to support patients and staff during this period.
- Reviewed and audited every patient with a Learning Disability that tested positive for COVID-19 and had a DNACPR in place.
- Participated in discussions around the use of the frailty score and in reference to health equality when reviewing processes in ethical decision making.
- National specialist guidance on managing LD patients during COVID-19 was reviewed and summarised and shared with staff. Particular information was given to clinical areas on reasonable adjustments, diagnostic overshadowing and expression of pain.
- Developed visiting guidance for parents/carers of LD patents in line with national guidance

Following the return of the AHLT on site, there continues to be close working relationships between the two teams with daily contact and co-location.

5.2 Mental Health

There were some potential changes identified to the mental health legislation and Coronavirus Act that would be enacted in the event that the NHS became overwhelmed with COVID-19 positive patients. These changes were summarised within the online safeguarding resource handbook and reviewed in conjunction with the Mental Health Liaison Team (MHLT).

Hertfordshire Partnership Foundation Trust (HPFT) shared resources that staff would be able to utilise if the changes were instigated. Face to face supervision was given to key clinical staff in relation to these potential changes and there was weekly phone contact with the MHLT to discuss any potential and planned changes and complex cases within the Trust.

5.3 Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

There were no changes to the use of the Mental Capacity Act within COVID-19. The safeguarding team worked clinically with staff to ensure MCA was used as part of the admission process and considered in patients with COVID-19. NHS Professional staff were supported and given face to face power training sessions to ensure MCA was considered and documented appropriately. Weekly dip dives were undertaken and presented to the safeguarding panel to provide assurance that the organisational standard in relation to MCA and DoLS continued.

The Coronavirus Bill introduced potential adaptations to the DoLS documentation. These were not adopted by the Trust as not felt necessary. Staff continued to use the existing documentation appropriately and effectively. This was reinforced as part of the online resources and guidance within the safeguarding handbook during the pandemic. Mental Capacity Webinars were available and attended. These were organised by NHS England to share guidance and best practise throughout other organisations.

5.4 Domestic Abuse

There has been an increasing national focus on domestic abuse during the pandemic due to the risks of lockdown for victims and the significant increase in contacts to helplines and internet sites. Work has included

- Ensured that domestic abuse awareness continued to be a priority. The team developed a selection of materials including posters and banners which were displayed in the emergency care and maternity departments.
- Used E update to raise the individual profile for the IDVAS to encourage staff to make referrals.
- Information and resources in a variety of languages were shared with the pastoral care team and with the supervision counsellors in the staff sanctuary based at WFC.
- Contributed to a weekly update call with the Hertfordshire Domestic Abuse Partnership and were able to collect information on any changes to services, local and national support and campaigns and guidance for acute trusts. This ensured that the information shared within the organisation was current and in line with the national guidance.
- Continued to contribute to MARAC meetings, providing relevant information and actions via MODUS remotely

5.5 Children and Young People

Work has included

- Close working with CAMHS Crisis Mental Health Team who provided on call 24/7 support for children and young people who attended ED and to ensure swift safe discharges
- Continued to run safeguarding children supervision remotely and socially distanced.
- Remote attendance at discharge planning meetings and initial and review child protection meetings
- Worked with CCG and ENHT to develop a pathway agreed with Children Services about the management of well children who are brought to ED by ambulance with a sick parent/carer and there are no alternative childcare arrangements

6. Safeguarding Leadership and Accountability

The Chief Nurse of WHHT is the Executive Lead with responsibility for safeguarding within the Trust. This responsibility aligns to governance, systems and maintaining organisational focus on safeguarding.

The Safeguarding Panel is chaired by the Chief Nurse and meets bi monthly. The panel oversees all safeguarding work across the Trust. The panel is attended by the safeguarding team, Divisional Head Nurses/Midwifery, local authority learning disability team and members of the designated

teams within the CCG. The panel reports safeguarding activity and provides assurance to the Quality and Safety Group within the Trust.

The Lead Nurse for Safeguarding manages the integrated team and also holds the position of Named Nurse for Safeguarding Children. There has been continuity with the Named Nurse for safeguarding adults and the two named Consultants during the reporting period. The adult nurse, children nurses and safeguarding midwife are co-located with the IDVAs attached to the Trust. The Acute Health Liaison team also use the office as a base. Co-location of the team enables good communication, a much more integrated approach to safeguarding promoting the 'think family' approach and managing safeguarding issues across all ages. During the reporting period, there has been long term sick within the team and a vacancy but the team are now fully staffed.

The Named Midwife is managed by the Head of Midwifery and leads the Lavender Team. This is an established team that cares for pregnant women with complex social and psychological needs.

The Lead Nurse has submitted a business case to support increased staffing within the team. Safeguarding activity across the Trust continues to increase with additional demands for increased training, multi-agency and partnership working. Additional staff would allow the team to meet the current increasing demand and also ensure the team is able to meet the demands in the future

The Named Professionals have a key role in promoting good professional practice within the Trust providing advice and expertise for fellow professionals and undertake duties to safeguard children and adults in line with guidance and legislation (Working Together 2018 and the Care Act 2014).

The job descriptions and personal specifications for the Named professionals for children are complete and are aligned to the Intercollegiate Document (2019).

A safeguarding operational group runs monthly and is chaired by the Lead Nurse for safeguarding and attended by all team members and the Deputy Chief Nurse. The group manages operational issues and reports to the Safeguarding Panel.

7. Inspections and Reviews

7.1 CQC inspection

A CQC inspection was carried out in early 2020 with a number of core services inspected as well as the well-led component. At the time of writing the report from the inspection has not been released.

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7.2 Arrangements to safeguard children under Section 11 of the Children Act 2014

The Section 11 inspection by the CCG was due to be carried out in March 2020. Due to Covid-19 the visit was cancelled. The action plan for the recommendations from the section 11 inspection in January 2019 was submitted – all actions were completed except for an audit that was due to be carried out by the CCG looking at staff knowledge about CSE and the Brook Traffic Light Tool. The CCG were unable to carry out this audit due to their capacity issues. To provide some assurance, we completed a case audit involving CSE which demonstrated good understanding by staff.

Despite the inspection being cancelled a presentation was submitted demonstrating the progress made across children's safeguarding during the reporting period. The inspection is due to be completed later in the year.

7.3 Adult Assurance visit

The annual CCG assurance visit took place in January 2020. It was acknowledged that the self-assessment submission was excellent and included a significant amount of key achievements. These included:

- The Trust has now achieved the 85% target for Prevent Healthwrap training which reflects a high proportion of all staff.
- Safeguarding is embedded throughout the Trust with particular attention to the incorporation of maternity into both children and adult safeguarding.
- The partnership operational work on modern slavery.
- National recognition of the work the Trust has done in respect of adult safeguarding including a Parliamentary award and the Adult Safeguarding Nurse of the Year.
- The Trust is now in a position to influence adult safeguarding across the HSAB partnership.

The key findings from the review were as follows:

- The Trust currently has no serious incidents or complaints relating to adult safeguarding.
- The Trust has re-launched the Learning Disability Sub group, creating an aspiration pneumonia pathway as part of this work.
- There is a process in place for flagging patients with learning disabilities.
- The proposed implementation of the Liberty Protection Safeguards is on the Trust's risk register.
- There are established transition processes in place for 16 and 17 year olds with complex health needs.
- The Adult Safeguarding Consultant regularly meets with Consultants to challenge their practice regarding adult safeguarding and keep them updated. Also leads Grand Rounds several times a year.
- TEACH training compliance for reasonable adjustment is at 94%.
- Following the Stanley SAR the Trust have implemented a follow up call to those patients who are adults at risk having attended ED and been discharged.
- There has been an audit of the Chaperone policy and new initiatives implemented to support adults at risk.
- Opportunistic teaching sessions in clinical areas on caring for people with learning disabilities.
- A member of the Safeguarding Team attends all serious incident panels.
- There are integrated working practices with the Mental Health Team based in the Trust.
- The Trust has developed and implemented a tissue viability passport for safeguarding to support face to face teaching. This is to ensure staff are able to recognise the correlation between the development of pressure ulcers and omission in care.

Recommendations made to further the continuous improvement of adult safeguarding included:

- To ensure the Adult Safeguarding Consultant will continue to support medical colleagues in the training and the application of MCA and DoLS. As part of this the Consultant will escalate any areas of concern and identify the impact on practice.
  Progress: Medical training compliance is monitored via the safeguarding panel. The Named consultant continues to provide face to face training for colleagues

- The Trust will provide a report to the HSAB on the initiatives and good practice that have been implemented to support people with learning disabilities.
  Progress: Presentation submitted to HSAB waiting date for it to be placed on agenda

- The Safeguarding Team will continue to support the application of DNACPR and MCA in practice, with a specific focus on patients with learning disabilities and having difficult conversations escalating any areas of concern via the Safeguarding Panel.
  Progress: DNACPR in association with LD audit to be presented to panel in August 2020. Finding will also be shared with the End of Life panel.

- The Trust will incorporate any appropriate learning from the recently published SAR and the other acute trust regarding caring for people with learning disabilities.
  Progress: The safeguarding team work closely with AHLT to review all patients with a Learning disability and their care. The safeguarding will arrange MDT meetings to discuss complex care planning/discharge. The Learning from SARs is discussed at Champions day and is due to be discussed at the LD partnership meeting.

- The Trust to incorporate safeguarding supervision into the existing supervision policy and provide supervision to those staff being trained at level 3.
  Progress: Safeguarding adult supervision will be added to the existing supervision policy. This is on the safeguarding work plan and is due for completion in July. All Safeguarding champions receive supervision and record it in their passports.

- The Trust to continue to roll out level 3 training.
  Progress: Level 3 face to face training commenced twice per month. There is a plan for this to become mandatory from April 2020

- The Trust to provide the CCG with the level 3 training package.
  Progress: Training package shared with the CCG.

These recommendations have been added to the safeguarding work plan to enable progress to be monitored.

Key Achievement – Excellent self-assessment submission with significant key achievements noted by the Clinical Commissioning Group

8. Safeguarding Children

8.1 Safeguarding Children activity

Safeguarding children work can be divided into 3 areas within the Trust:

- Acute paediatrics including emergency care, inpatient care, day patients and out patients. This would also include children seen in Urgent Care and Minor Injuries and in other departments within the Trust. This includes 16 and 17yr olds who may be seen across the Trust.
- Maternity services including inpatient services and community midwives.
- Adult services - where concerns are raised about an adult's attendance and the impact of that presentation on a dependent child. The majority of this activity takes place within the Trusts unscheduled care settings but is applicable to all adult areas of the hospital.

8.2 Service developments within safeguarding children

Developments to improve safeguarding children practices across the trust over the reporting period include –

Safeguarding Children Passport

- Passports have been redesigned and fully updated in line with the Intercollegiate Document (2018). Distributed to Doctors and Nurses working in paediatrics and neonates to record individual safeguarding training and supervision.

Electronic Database

- New electronic database developed to record all safeguarding children activity, referrals and outcomes and patient information. Aids communication and information sharing within the team and improves data collection about safeguarding activity.

Makaton cards for staff

- Packs of cards with useful Makaton symbols and signs that staff can wear on lanyards developed and used within paediatrics. Packs provide staff with some key signs to use with children who have learning disability and/or communication needs to improve interaction and communication.

Improvements in care and safeguarding for 16 and 17yr olds

- Risky sexual behaviours pathway developed to assist staff in managing young people. Development and trial of ED record card for this age group. Virtual ward of all 16 and 17yr olds across the Trust reviewed daily. Level 3 training delivered to adult nurses working in key areas.

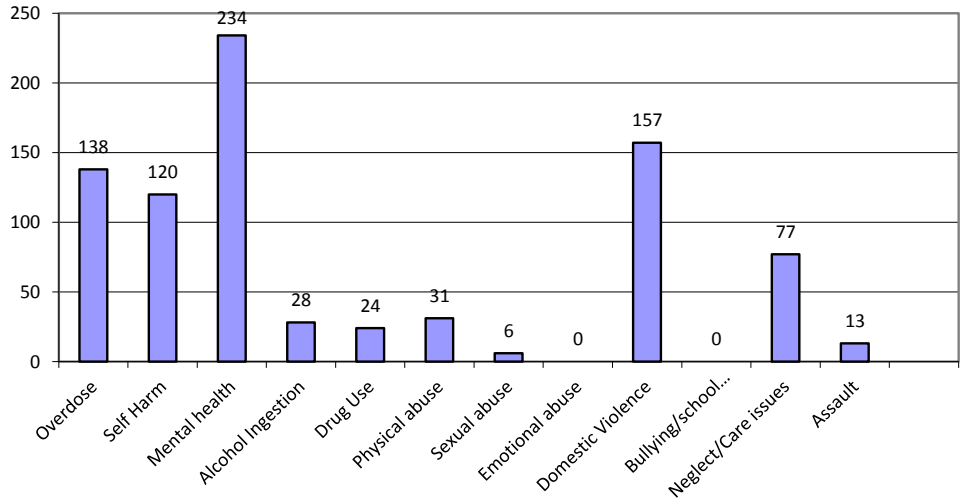
8.3 Referrals to Children Services

Referrals to Children Services made by Trust staff include:

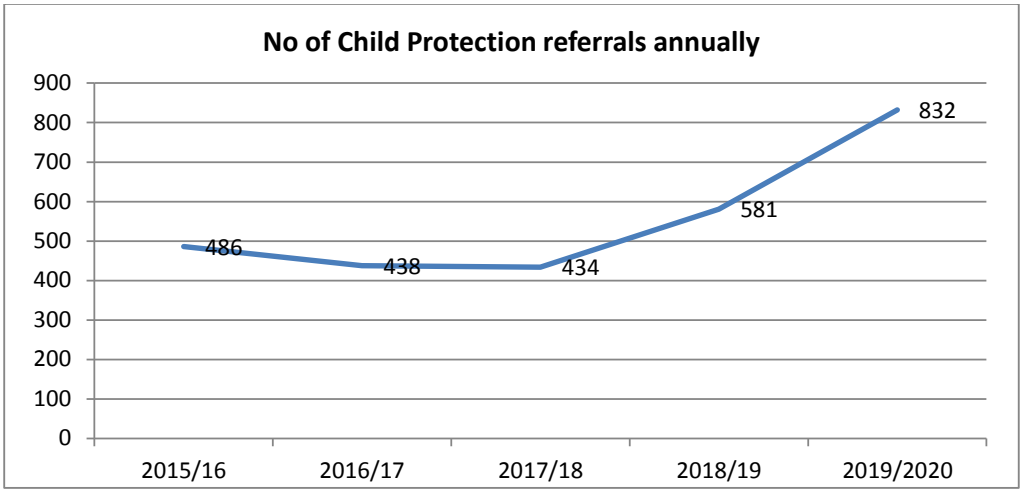
- **Child protection concerns** – these include children attending with for example, possible non-accidental injury, mental health issues or neglect issues. It also includes referrals done regarding attendance of adults who are parents. These referrals are done predominantly by unscheduled care staff and include attendances for domestic abuse, drug and alcohol issues and mental ill health.

- **Information sharing referrals** – these are done for children who attend our services who are known to Children Services e.g. child protection plan in place, looked after children.

Identifying and referring vulnerable children and families is a key role of all Trust staff in all areas of the hospital. There continues to be high numbers of referrals for parental attendances to the Trust due to concerns about the impact of the parental behaviour on the child. The majority of these referrals are made from unscheduled care although referrals are also received from other areas of the hospital such as ITU, AAU and the wards.



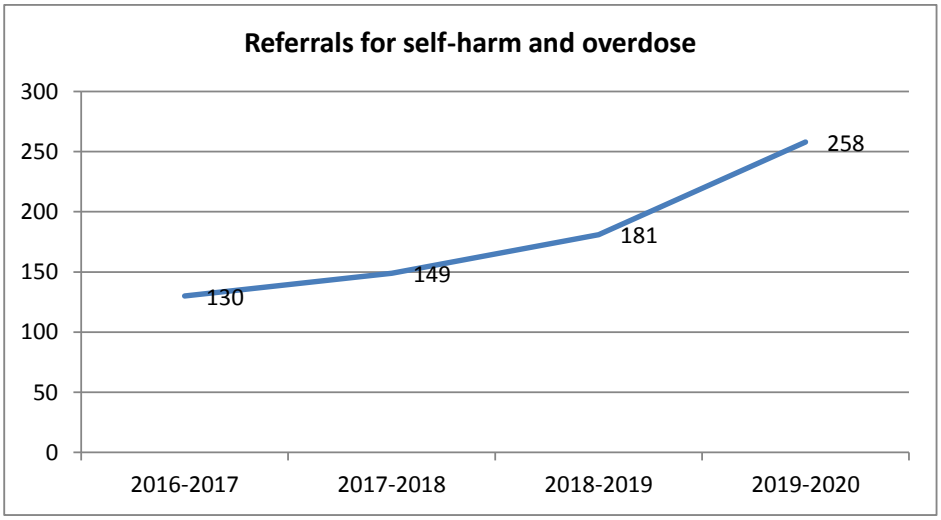
Graph 1 Total Number of Child Protection Referrals made for children under 18yrs made by WHHT staff from May 2019 – April 2020



Graph 2 Number of child protection referrals made regarding children under 18 seen as patients annually.

The above graph shows a significant rise in child protection referrals over the previous reporting years.

Referrals for mental health attendances in young people remain high. Referrals include children attending with anxiety, depression, suicidal thoughts and behavioural issues that may have a mental health component. Many of these children are admitted to Starfish ward and require a multi-agency approach and package of care to discharge them safely home. Figures for young people attending with self-harm and/or overdoses are reported quarterly to the CCG and are continuing to rise.



Graph 3 Number of referrals made regarding children under 18 who have attended with self-harm and overdose annually.

There has been a significant rise in referrals for children who are living in a house with domestic abuse (DA). Over the reporting period there were 157 referrals to children's services regarding DA. There has been a great deal of work around raising awareness of DA by the Trust IDVAs particularly with daily visits to the emergency department. This appears to have led to better recognition by staff and increased referrals for these vulnerable children.

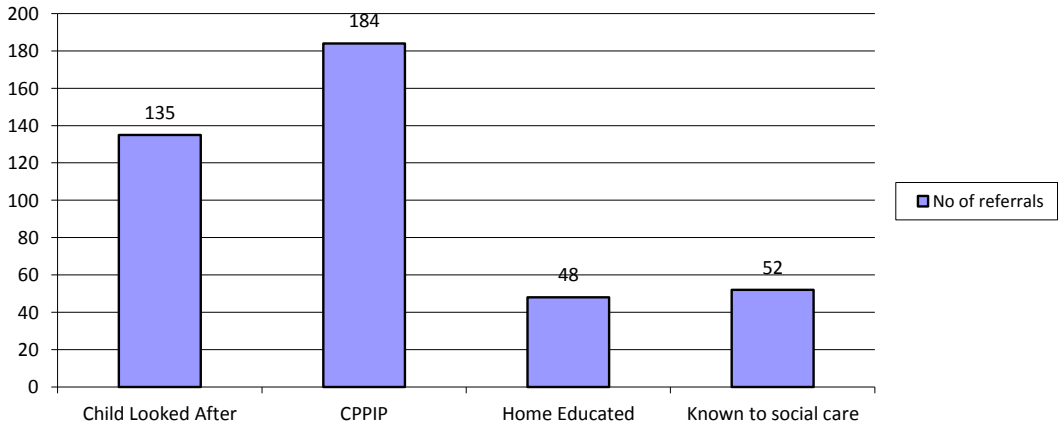
4 referrals have been made for potential child sexual exploitation.

During the reporting period – 31 child protection medicals were carried out by Consultant Paediatrician/ Registrars. The medicals were all done due to concerns about physical abuse

Period	Self-Harm	Trend	OD	Trend	Physical abuse	Trend	Domestic violence	Trend
2019-20	120	↑	138	↑	31	↑	157	↑
2018 - 19	74	↑	107	↑	24	↔	46	↑
2017 - 18	63	↑	86	↑	25	↓	33	↓
2016 - 17	52		78		39		58	

Table 1 Trends of referrals of vulnerable children to Children Services over preceding reporting years

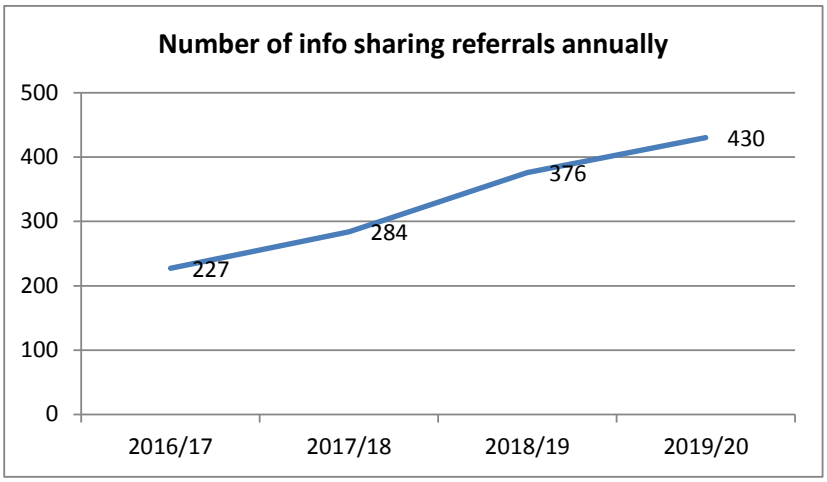
Key Achievement – Significant increase in referrals to CS for children living in a home with domestic abuse – education , awareness raising and working with the IDVAs has led to better staff recognition of these vulnerable children



Graph 4 Total Number of Information Sharing referrals made for children less than 18yrs made by WHHT staff from May 2019 – April 2020

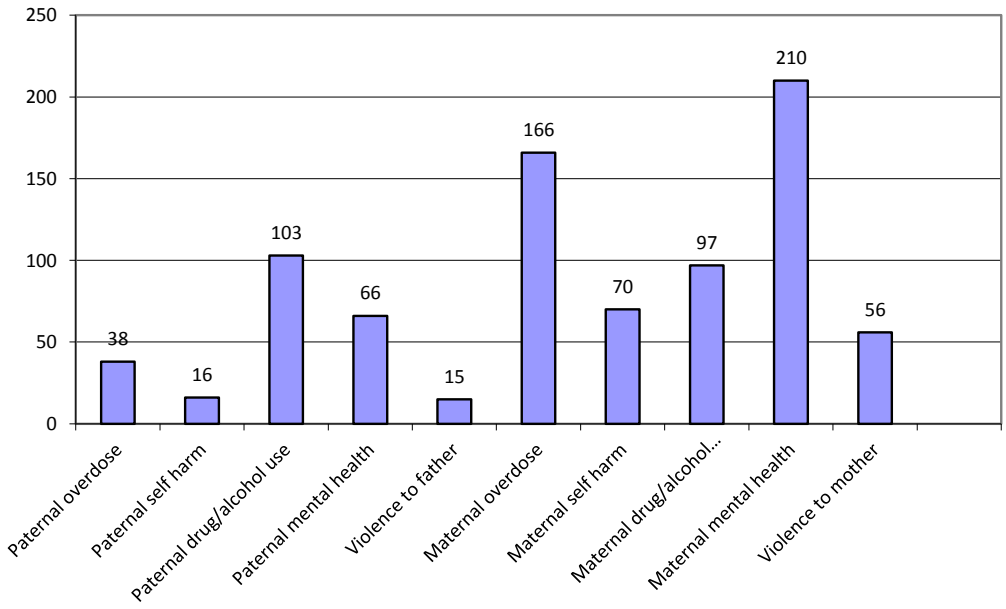
The figures indicate good information sharing with Children Services regarding vulnerable children. One of the reasons for an increased figure is likely due to using CP-IS (child protection information system) within paediatric out patients. This ensures that all vulnerable children attending paediatric outpatient clinics are identified and information shared regarding their attendance or if they are not brought to an appointment. CP-IS is widely used in CED and information sharing referral are completed for children who are looked after children and on CP plans. There is emphasis on recognising home educated children and sharing this information with Children Services. Within Hertfordshire, the numbers of children subject to a child protection plan remains low. In March 2014, 1140 children were subject to plans. In March 2020, 469 children were subject to plans.

Information sharing referrals remain high, with a significant increase in the numbers from last year.



Graph 5 Number of information sharing referrals to Children's Services made annually

Key Achievement – significant increase in information sharing about vulnerable children with Children Services



Graph 6 Total Number of Child Protection Referrals made for adult attendances by WHHT staff from May 2019 – April 2020

Referrals made about adult concerns (when the parent/guardian is the patient) are predominantly done by unscheduled care. The Table 2 looks at trends of referrals over the last 5 years.

The number of referrals for parental attendances has increased in nearly every category. The number of referrals for parental attendances has increased significantly from 175 in 2018/19 to 238 in this reporting period. This is really positive showing that staff are recognising the impact of paternal behaviours on children.

The number of referrals for maternal referrals has also increased significantly from 473 in 2018/19 to 599 in this reporting period. The biggest increase in referrals includes maternal mental health, with increases also in referrals for self-harm and overdose. Referrals for drug and alcohol remain at around the same level as in 2018/19. This has been supported by good links with the

Hertfordshire drug and alcohol services who now regularly attend the safeguarding weekly meeting in the emergency department.

Period	Father overdose	Trend	Father self-harm	Trend	Violence to father	Trend	Father mental health	Trend
2019-20	38		16		15		66	
2018 – 19	35		27		12		54	
2017 – 18	23		10		10		21	
2016 - 17	21		9		9		17	
2015 -16	25		9		16		16	
Period	**Mother overdose**	**Trend**	**Mother self-harm**	**Trend**	**Violence to mother**	**Trend**	**Mother mental health**	**Trend**
2019- 20	166		70		56		210	
2018 – 19	153		47		47		122	
2017 – 18	103		20		41		58	
2016 - 17	98		28		49		58	
2015 -16	96		27		39		86	

Table 2 Trends of referrals to Children's Services over preceding years for adult attendances

The increase in referrals about adult concerns reflects the ongoing work by the safeguarding team about 'think family'. It provides evidence that staff are recognising the effects of adult behaviours and choices on their children and the potential risks.

Key Achievement – significant increase in referrals for concerning adult attendances highlighting an increased awareness of 'think family'.

8.4 Multi agency working

The Trust ensures that inter-agency working is encouraged and supported. There are currently three ward rounds that run across the Trust weekly that look specifically at vulnerable children and safeguarding issues.

- Starfish psychosocial ward round every Friday is a multi-agency meeting attended by hospital staff and occasionally CCATT (CAMHS Crisis Assessment and Treatment Team). During the reporting year, there has been regular attendance by a social worker from the Watford assessment team, Children's Services. This has been valuable for staff for advice and updates on cases and allows staff to discuss if cases reach thresholds for Children Services involvement. The meeting reviews all children who have been admitted to the ward over the preceding week. Staff are also able to bring cases of concern to be discussed. The meeting is chaired by the safeguarding team and remains well attended.

- SCBU psychosocial ward round every Tuesday is a multi-disciplinary meeting attended by SCBU staff and the safeguarding team. Cases on the unit are discussed, with plans and actions clearly defined. A member of the Lavender Team (Midwives for complex needs) attends weekly to share information about safeguarding concerns and expectant high risk woman who are vulnerable are discussed and plans of care.

- CED/ED child protection meeting every Wednesday is a multi-disciplinary meeting that reviews all referrals made to Children Services the proceeding week. The review process ensures that all referrals are dealt with appropriately, with information shared effectively to protect children. During the reporting year, the meeting is attended regularly by the Trust IDVA and also the Spectrum/CGL drugs and alcohol worker based in the Trust. This meeting is attended by ED staff to ensure they have supervision and reflective learning around cases specifically around 16 and 17 year old attendances.

- CAHMS forums **–** safeguarding team have set up a paediatric mental health liaison forum within the reporting period. As highlighted earlier, referrals for young people attending with mental health issues is increasing. These patients often require a joint multi- specialist approach in care management. The meetings are led by the C-CATT Consultant and Nurse Specialist and encourage staff to reflect on case management and discuss ways to improve practice as well and providing support and supervision to staff. All members of staff have found this forum beneficial to their practice and safeguarding passports are used to provide evidence of safeguarding supervisions sessions.

Other areas of multi-agency working include;

- Matron from paediatrics has been a key member of the multi-agency Rapid Response operational group.
- The Named Doctor has been attending a 'Not at school/chronic fatigue' meeting once a term with CAMHS and education – this meeting is currently suspended due to a change in provision provided by the Education Support Medical Absence Team. The named doctor will be encouraging this to continue when all children are back to school.
- Regular attendance at MARAC (multi-agency risk assessment committee) for high risk domestic abuse cases - safeguarding team continue to provide information on cases where appropriate and make professional referrals as required. We continue to share information via Modus and receive information sharing and actions.

Inter-agency involvement in ward rounds leads to better information sharing, reflection, learning and understanding of others roles and helps staff make decisions about thresholds for referral.

The safeguarding team continue to contribute regularly to section 47 strategy telephone conference calls. These calls involve police, Children's Services and health and are for information sharing and to assess a current risk to a child. Further action is then decided. The majority of the telephone strategy's that the Trust contributes to involve unborn babies as part of the HSCB pre-birth protocol.

8.5 Safeguarding work within unscheduled care

The safeguarding nurses continue to support staff working within unscheduled care. The majority of Children Services referrals made by the Trust are from unscheduled care. All referrals are reviewed daily in case of any urgent action or further information sharing needed.

There is also a daily review system in place of notes of adults who have attended with concerning presentations who may have dependent children. Consideration is then made about the risks to any children and a referral made if appropriate. Feedback is given to staff as a learning opportunity regarding 'Think Family' when dealing with such presentations.

The safeguarding nurses visit Hemel Urgent Care Centre and St Albans Minor Injuries Unit regularly to review attendances, referrals and offer support and advice to staff. The team regularly attend clinical governance at HUTC providing training updates on slavery, trafficking, risky sexual behaviours and thin family.

CP-IS (child protection information sharing system) has been in place in unscheduled care for a number of years. It is checked for every child who attends and ensures that we are aware of children who are vulnerable (with protection plans in place or who are looked after) to assist in the assessment process.

System One (community health records) read only access is available to shift leader working in CED. It is invaluable for gathering information when a child with a concern is in CED especially for concerns out of hours. All paediatric consultants, staff across paediatrics, neonates and maternity as well as the safeguarding teal have access to System One.

During the reporting period, the Lead Nurse has worked with Greenbrook Healthcare developing safeguarding pathways for children and adults for the Urgent Treatment Centre opening at Watford ED.

8.6 Safeguarding teenagers and young people

During the reporting period, work to improve safeguarding to teenagers and young people has included -

- **Risky sexual behaviours pathway –** has been developed to assist staff in the recognition and assessment of young people presenting with risky sexual behaviour. The pathway is to be used with the Trust sexual health proforma for young people to ensure potential concerns are identified and referred appropriately. The pathway has been shared within paediatrics and other key areas including AAU and surgery

- **Teenage and young person's special interest group (TYPSI) –** is an established group that is attended by the team. The team is chaired by an ED Consultant and has representation from paediatrics, safeguarding and play specialists. The group aims to support transitional care for young people from paediatrics into adults ensuring safeguarding risks specific to the young person are assessed and managed appropriately. The group encourages supervision and discussion to support staff in this area of care.

- **Casualty cards for 16/17 year olds –** A new casualty card has been developed and introduced during the reporting period to assist staff in recognition of health needs and safeguarding concerns of this group of young people who attend adult ED. A recent audit has shown that the card is a useful aid to staff but some areas require reformatting to improve compliance. Following discussion of the audit with key teams involved – a further development is to produce a card for 13 – 17yr olds.

- **CAHMS forums –** as discussed earlier – to support staff working with young people with mental health issues.

- **Virtual Ward for 16/17yr olds –** daily electronic list of 16 and 17yr old patients, admitted to the Trust and where they are admitted is provided by Informatics. This is shared with

safeguarding and senior paediatric nurses – to ensure oversight and safeguarding review and to provide support to this group of young people while they are admitted.

- **Paediatric nursing support –** staff in adult areas working with 16 and 17yr olds are now able to contact senior paediatric nurses for advice and support. SOP in place to support this work. Close working with safeguarding to ensure all risks considered for these young people.

- **Level 3 children training –** delivered to senior nurses working in adult orientated areas who care for 16 and 17yr olds more frequently – staff trained currently include ITU and surgery – plans to continue with training for AAU level 1 and Cassio are in place.

- **Youth Worker Bid –** working with Youth Connexions and the Local Authority a bid has been produced and submitted to the Police and Crime Commissioner for funding for a Youth Worker post to sit in the safeguarding team to support young people experiencing poor mental health, sexual and criminal exploitation, domestic abuse etc. who area attend the Trust.

8.7 Training

Safeguarding children training is a fundamental part of the Trusts duty to safeguard and promote the welfare of children under Section 11 of the Children's Act (2004) and Working Together 2018. Staff need to be trained and competent to recognise potential indicators of abuse, know what to do about concerns and fulfil their responsibilities in accordance with the Hertfordshire Safeguarding Children Board procedures.

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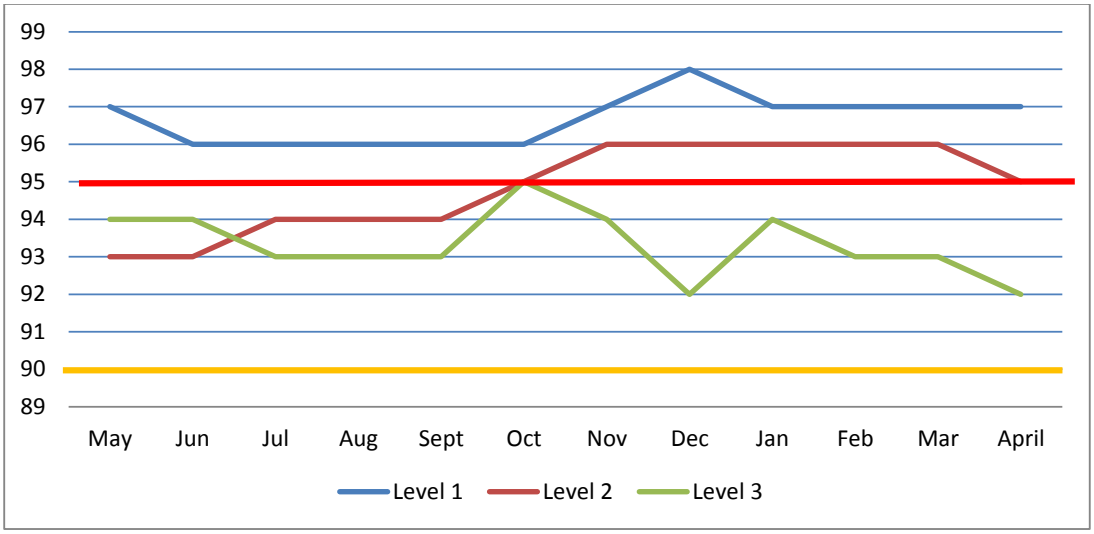
The Intercollegiate Document (2019) identifies a revised safeguarding competency and training framework to guide professionals and the clinical areas they work in. It defines groups of staff; relating more specifically to staff roles as opposed to job titles that require specific levels of training. Within the Trust, Level 1 and Level 2 are available as e learning packages. These are national packages that were adapted to include local information and have been reviewed and revised to ensure that they meet the skills and competencies set out in the new intercollegiate document. Staff must complete a short test to be compliant.

Level 3 training sessions are held once a month. They are organised by the safeguarding team and a programme of sessions is advertised on the Trust Acorn training system where staff can book places. Core Level 3 sessions run for 4 hours and Level 3 updates run for 1 ½ to 2 hours. The Team have put a programme of Level 3 updates together including Child Sexual Exploitation, County Lines, Female Genital Mutilation, Physical Abuse, Domestic Abuse, Sexual Assaults and SARC. Staff that require Level 3 are aware of the expected hours required for training as defined in the Intercollegiate Guidelines (RCPH 2019). Hours of training for this group are monitored via the staff's individual safeguarding passport.

Training compliance rates are reported monthly by the Trust Training Department and these figures are reported to the Safeguarding panel and to the CCG via the safeguarding dashboard and the quality contract.



Graph 7 above shows compliance rates for safeguarding children training for the reporting period. The red line indicates the expected compliance rate for 95% set by the CCG. The Trust compliance set rate is 90% represented by the orange line

During the reporting period

- Level 3 has remained above the Trust target of 90%.
  - Non-compliance list for Level 3 produced monthly and individuals contacted to book sessions.
  - Paediatric and Neonatal Nurses record attendance at training within their Safeguarding Passport – this is reviewed at their yearly appraisal to ensure compliance
  - ITU consultants and senior nurses attended Level 3 training for caring for 16 and 17 year olds in adult settings.
- Safeguarding Children passport has been updated to include the safeguarding core learning outcomes and competencies as set out by the intercollegiate document.
- All 3 levels have been above the Trust target for 12 months of the reporting period, with Level 1 being consistently above the CCG target. Level 2 was above the CCG target for the last 6 of the reporting period
- Grand Round carried out by Named Doctor – case presentations as a Level 3 update
- Level 3 updates around FGM and CSE provided to HHGH and SACH out patients

Multiagency training provided by the Hertfordshire Safeguarding Children Partnership (HSCP) enhances the single agency training provided by the Trust. Staff are encouraged to attend the HSCP training with courses advertised via clinical facilitators. The benefits of multi-agency training within safeguarding children are significant and benefit Trust staff greatly. It is important that the safeguarding team continue to highlight the training and encourage staff attendance.

Key Achievement –

- Overall compliance rates for all levels of training have remained above the Trust target for the last 12 months

8.8 Safeguarding Children Audits

The Safeguarding Audit Strategy has been fully updated within the reporting period and approved at Safeguarding Panel. It provides a programme of audits for 2019 – 2021. The following audits have been carried out during the reporting period:

1. **Dip sample audit carried out for each Safeguarding Panel – bi monthly.**

   A dip sample audit is undertaken using a random set of medical records selected from across paediatrics/neonates/unscheduled care that involved a safeguarding children case. These are reviewed and presented at Safeguarding panel. Areas of good practice or for improvement are fed back to staff in the clinical area.

   Overall, the findings of the audits demonstrate a good standard of safeguarding practice and documentation.

2. **Audit of casualty cards for 16/17 yrs.**

   40 casualty records were audited from a 6 month period from attendances within the accident and emergency departments at Watford General Hospital - cards were randomly selected for the purpose of the audit.

   Outcome: Overall the audit demonstrated some positive staff practice in relation to identifying safeguarding risks in young people. There were some areas of non-compliance in relation to completing the specific risks related to the young person. The findings demonstrate that the casualty card requires review of the layout and format. Following further discussion with wider teams, a 13 – 17yr old card is planned to better meet the needs of this age group.

3. **Audit of the Chaperone Policy**

   20 paediatric records were audited from children attendances in paediatric outpatient clinics, fracture clinic and CED.

   Outcome: The overall findings of the audit in Paediatrics demonstrated a positive focus of the use of chaperones in practice. Areas for improvement include compliance of chaperones for young adults age 14 yrs. The safeguarding team have been supporting through education and promotion of the chaperone policy.

4. **Audit of the standard of electronic referrals to children services**

   75 referrals were audited including 25 child protection referrals from paediatrics, 25 child protection referrals from adult attendances and 25 information sharing referrals.

   Outcome: The standard of information sharing and child protection referrals to Children's services was good, particularly for information sharing referrals. Issues around making CS referrals in adult ED should be recognised. It is often difficult for staff to get all the information necessary that is required on the referral form. Also adult attendances, which could potentially be a concern are identified and reviewed by the safeguarding team to ensure any concerns in regards to risks of harm to children have been raised.

5. **Audit of Record Keeping**

   83 records were audited reviewing the quality of safeguarding record keeping in paediatric and unscheduled care settings across the Trust.

   Outcome: Overall this audit demonstrated an improvement in compliance for safeguarding record keeping. There is still work to be done around think family however the audit demonstrates a significant improvement and demonstrates that staff recognises the importance of safeguarding and the quality of recording of information.

6. **Audit of the VIP policy**

   The audit was carried out to look at staff compliance with the policy to ensure there is no risk to the safety of patient and staff from visitors invited to the hospital. These could include VIPs and celebrities or media representative, along with children's entertainers.

   Outcome: The findings of the audit in both adults and paediatrics demonstrate a positive focus within using the Celebrities, VIPs and media visitors' access policy in practice and adhering to the policies principles effectively within the clinical areas. There continues to be an excellent compliance with the policy

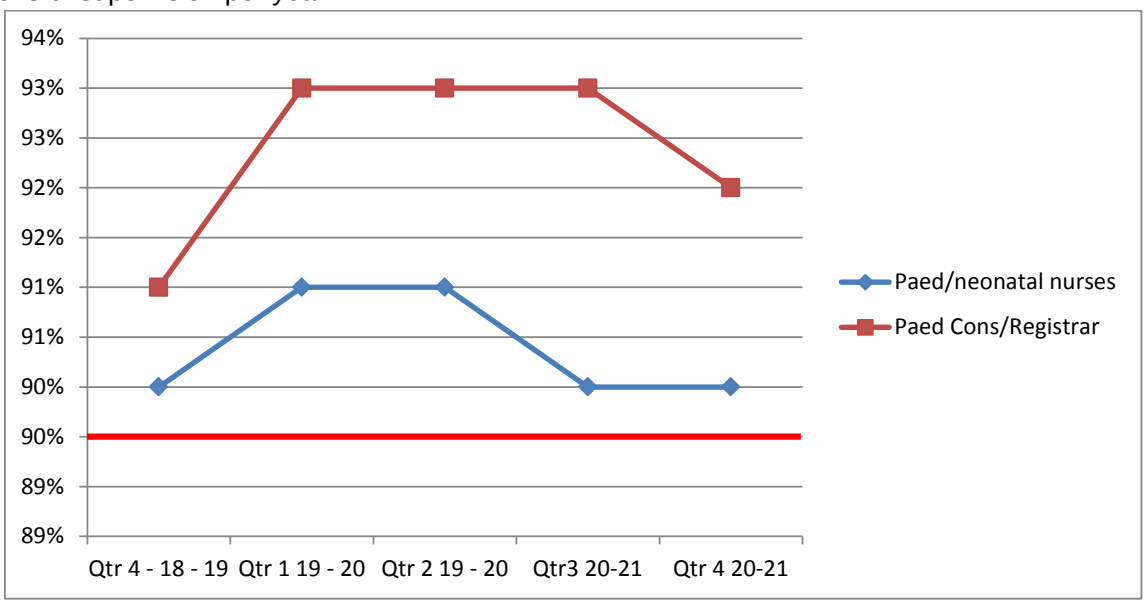
7. **Audit of Child Protection Safeguarding Proforma**

6 Child Protection Medical proforma were audited. The proforma were completed over the last 6 months from attendances within ED.
Outcome: standard and quality of compliance with the child protection medical proforma was good overall. There were some elements within this audit that demonstrated some improvements were required – an issue with existing body maps. These were reviewed by the Named Doctor and updated and are now widely available for staff.

Key Achievement – Audits for safeguarding children procedures and activity show good overall safeguarding practices

8.9 Safeguarding Children Supervision

Safeguarding children supervision is a formal process of professional support and learning which enables practitioners to develop knowledge and competencies and assume responsibility for their own practice in a safe and supportive environment.
WHHT has a safeguarding supervision policy in place with the expectation that paediatric/neonatal nurses (Band 4 and above) and paediatric Consultants and Registrars attend three to four sessions of supervision per year.



Graph 8 shows compliance rates for safeguarding children supervision within paediatrics. The CCG target for compliance is 90% indicated by the red line.

During the reporting period:

- Paediatric and neonatal nurses and doctors have received regular supervision (they must have 3 – 4 sessions per year).
- Supervision has been delivered in a variety of way – group sessions, ad hoc supervision with a member of the safeguarding team, attendance at one of the three psychosocial/supervision ward rounds, attendance at discharge planning meetings and child in need meetings.
- Paediatric and Neonatal Nurses record attendance at supervision within their Safeguarding – this is reviewed at their yearly appraisal to ensure compliance with Policy.
- The safeguarding team keep a database of staff attendance at supervision to review compliance. This is shared with the safeguarding link champions in each area to ensure all staff on duty has an opportunity to attend supervision.

- Quarterly figures show that compliance with supervision remains at 90% for paediatric / neonatal nurses and 92-93%for paediatric Consultants and Registrars. The CCG target is 90%.
- Safeguarding Children's Nurse Specialists attend safeguarding supervision sessions with East and North Herts Hospital safeguarding team proving very successful and has cemented networking relationships across the 2 acute Trusts.
- The Named Nurse has supervision from the Designated Nurse in the CCG.
- The Named Doctor has delivered supervision sessions to staff in relation to case studies in physical abuse and fabricated induced illness, in paediatrics at clinical governance, grand round, peer reviews and sessions provided to GP trainees.
- Additional sessions / De briefs are offered to staff following challenging cases. A debrief led by a staff counsellor was held following a challenging case of significant physical abuse of a toddler
- A Schwartz round was held about a case of physical abuse of a young child

Key Achievements

- Compliance with safeguarding supervision has remained over 90% (CCG target).
- Safeguarding passports remain valued and well used by staff and have been updated to include new intercollegiate safeguarding objectives and competences.

8.10 Paediatric Liaison IT solution

The paediatric liaison IT solution was developed in partnership with Hertfordshire Community Trust (HCT) following the decommissioning of the liaison health visitor service previously provided by HCT. The IT solution allows information to be shared electronically for all children attendances (under 18 years) to unscheduled care with community health care staff.

The system has been developed to flag potential high risk cases such as children attending overnight or children attending under 1 year old. This information then transfers into the individual child's System1 record with alerts sent to the health visitor or school nurse of any flags. HCT have developed a policy for staff around follow up of attendances.

The system is further strengthened by electronic referrals made by unscheduled care staff to health visitors and school nurses regarding children and families who may require additional support such as breast feeding advice or accident prevention. A copy of all Children's Services referrals is also sent electronically to the family health visitor/school nurse.

The system is fully embedded across ED, MIU and HUTC. The model is now being used across Hertfordshire and with neighbouring acute trusts.

Key Achievement

Finalist July 2019 – HSJ Safety Awards Best Healthtech Solution for patient safety – partnership work with Hertfordshire Community Trust for a paediatric liaison IT solution sharing information to improve safeguarding

8.11 Safeguarding Children Policies and Procedures

Safeguarding policies are in place and are accessible to staff via the Trust intranet. Hertfordshire Safeguarding Children's Partnership policy and procedures are also available via links on the staff intranet site. No safeguarding children policies required updating during the reporting period.

8.12 Serious Case Reviews

The Trust has had involvement in two serious case reviews in the reporting period. Two of these cases involved children with physical injuries that had been seen for care within the Trust. The Lead nurse for safeguarding has been a panel member for both of these cases. Both reports have been written and a multi-agency learning event carried out for one review which was attended by Trust staff. Neither report has been published due to ongoing legal issues.

8.13 Serious Incidents

There have been no serious incidents within safeguarding children during the reporting period.

8.14 Partnership Working

The Trust has a responsibility to cooperate with the Local Authority in the operation of the Hertfordshire Safeguarding Children Partnership (HSCP) as a statutory partner. It needs to share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children by ensuring there is appropriate representation at the HSCP Board meetings and sub groups.

Currently, the Trust Safeguarding Team are involved in the following sub groups –

- Chief Nurse / Lead Nurse Safeguarding attends HSCP Board meetings
- Practice, Policy and Procedures Group – attended by Lead Nurse Safeguarding
- Strategic Safeguarding Adolescent Group – attended by CNS Safeguarding Children
- Performance and Development subgroup – attended by CNS Safeguarding Children

The Trust Safeguarding Team have also been involved within the following areas of work

- Task and finish group reviewing data collection of victims of knife crime attending ED

Key Achievement – Continued good representation of Trust safeguarding children team on partnership sub groups and participation in specific work streams

9. Safeguarding Adults

9.1 Service developments within safeguarding Adults

Developments to improve safeguarding adults' practices across the trust over the reporting period include –

Safeguarding Adult Level 3 training and Passport

Training package for level 3 and safeguarding adult's passports have been designed to ensure they are in line with the Intercollegiate Document (2018).These have been provided to safeguarding champions and staff that have attended face to face training. This enables staff to record their safeguarding training and supervision.

Safeguarding referrals

Reviewed the process of raising safeguarding concerns to ensure all referrals meet safeguarding threshold under the Care Act, 2014. This has resulted in fewer but improved quality of referrals to Adult Care Services.

Operation Tropic

Worked with Hertfordshire constabulary on covert operations to provide safe and well checks on individuals who are either being exploited of have been trafficked into working in the sex industry.

Devised a Standard Operation Procedure which is being adapted to use nationally as a best practice model for partnership working.

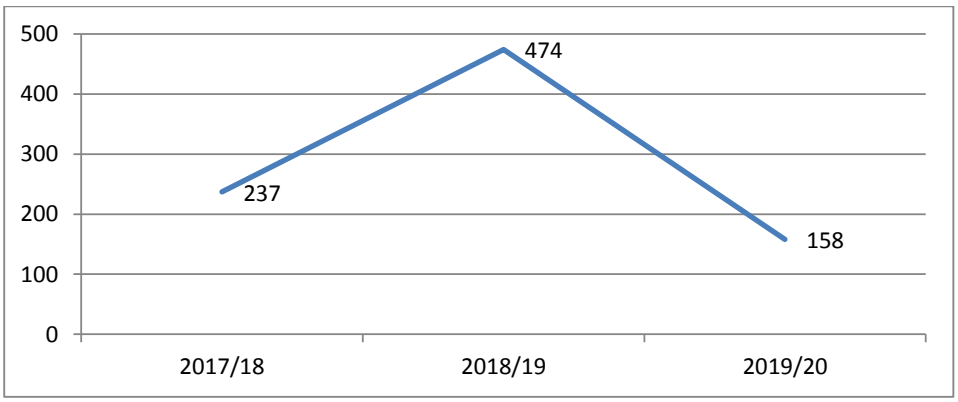
Missing patients
Work has been undertaken in collaboration with Trust security and police to produce a pathway to aid staff when reporting patients missing to establish a clear escalation process and when to reporting to the police.

9.2 Safeguarding Adults activity

The safeguarding team raise safeguarding concerns with the Local Authority: Adult Care Services (ACS). During the reporting period, ACS undertook a service development and established a bespoke safeguarding service. Initially there were concerns about the lack of information within the referrals from the Trust. The safeguarding team worked in partnership with the newly developed team and undertook a significant amount of work to review all the safeguarding referrals to ensure they comply with Section 42 of the Care Act. This has resulted in a decrease in the number of referrals raised to Adult Care Services, however has increased the quality significantly.

The numbers of referrals to adult Care Services has decreased this year:

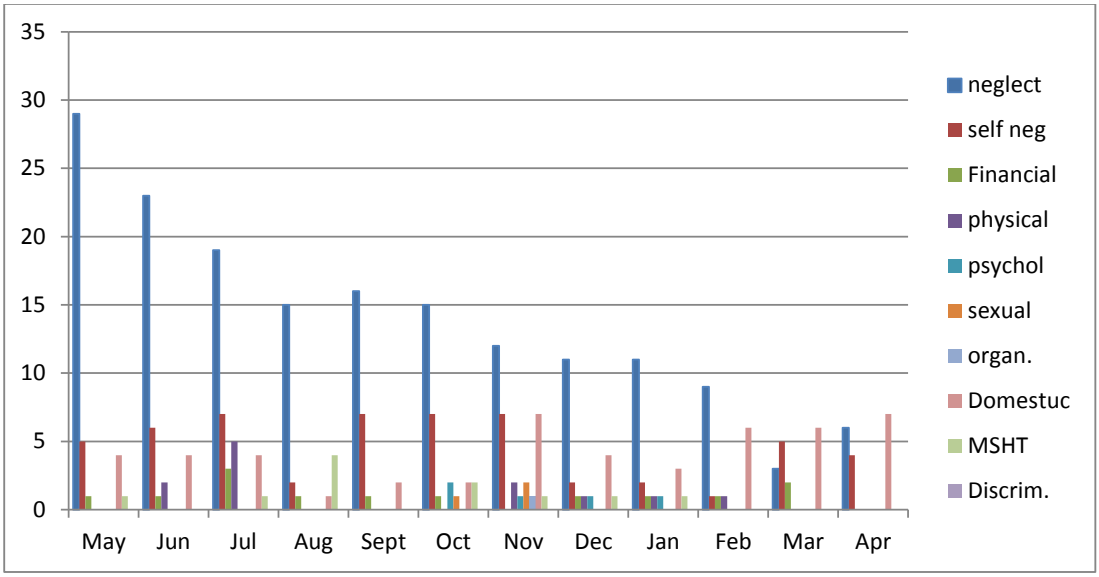
2017/18 - 237
2018/19 - 474
2019/20 – 158



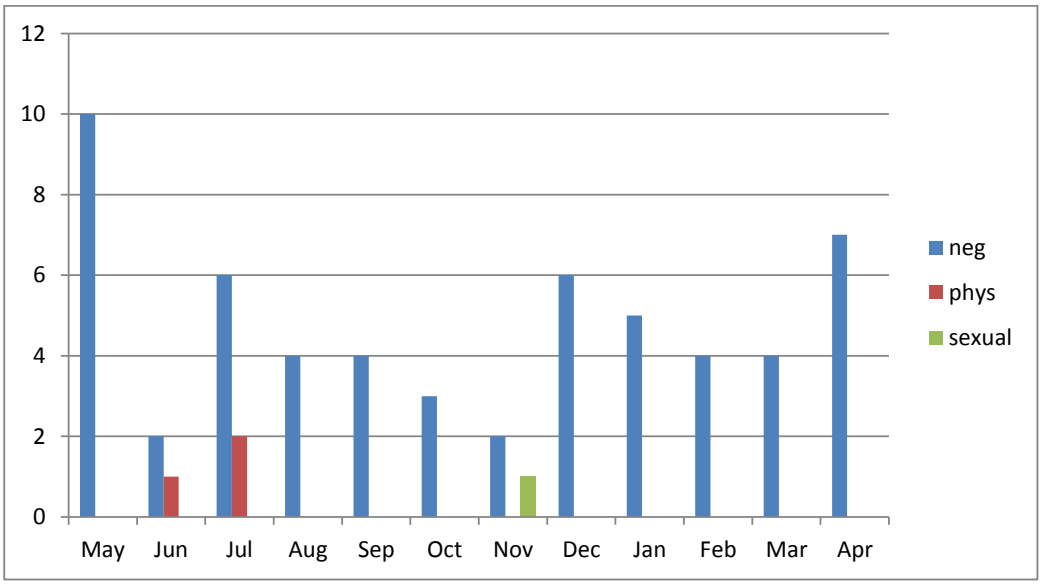
Graph 9 Demonstrates the numbers of safeguarding referrals made to Adult Care Services

The main sources of referrals received by the safeguarding team are made by staff in the Emergency Department and AAU, although referrals are also received from other areas of the hospital. These include;

- Adult protection concerns – these include adults attending with unexplained injuries, neglect/omissions in care, mental health issues and self-neglect.
- They also include referrals for patients who are do not meet the safeguarding criteria according to the Care Act, 2014 but remain at risk as they are no longer coping at home due to a decline in their health or failure in their support mechanisms.



Graph 10 Demonstrates the number of safeguarding referrals the Trust safeguarding team have raised with Adult Care Services.



Graph 11 Demonstrates the number of safeguarding concerns investigated by the Trust according to category

11

The Care Act, 2014 identifies 10 categories of abuse. However for reporting purposes only the categories of abuse that the Trust received concerns have been charted.

Key Achievement – Safeguarding team have increased the scrutiny of safeguarding referrals raised by staff resulting in a decreased number but an increase in quality of referrals to Adult Care Services

9.3 Multiagency working

The Trust ensures that inter-agency working is encouraged and supported. The Trust has a responsibility to cooperate with the Local Authority in the operation of safeguarding adults at risk. The Trust works collaboratively with Hertfordshire Safeguarding Adults Board (HSAB) as statutory partners.

The safeguarding team work with a number of agencies. The Adult team are active members of the HSAB sub groups:

- The Clinical Nurse Specialist is chair for the Public Engagement sub-group
- The Named Nurse Safeguarding Adults is deputy chair for the Domestic Homicide Review Group
- Safeguarding Adult Review panel is attended by the Named Nurse Safeguarding Adults
- Policy and procedure sub group is represented by the Named Consultant for safeguarding adults.

The safeguarding nurses are members of the Operation Tropic steering group and Herts Modern Slavery Partnership Tactical Sub Group. It coordinates a multi-agency anti-slavery partnership in Hertfordshire. The clinical nurse specialist is an active member of the National networking forum at NHS England. This involves attending quarterly meetings and contributing to the National priorities in this threshold of safeguarding.

The Named Nurse for safeguarding adults is an active member of the Hertfordshire LeDeR steering group. This strategic meeting reviews learning and feeds into the Improving Health Outcomes Group (IHOG).

The Named Nurse for safeguarding adults is the co-chair of the Safeguarding Adult Review (SAR) sub group. This ensures that learning identified from deaths involving adults at risk across Hertfordshire is implemented within the trust and thus preventing similar deaths.

The Named Nurse is an active member of the Domestic Homicide Review (DHR) panel. This purpose of the panel is to understand domestic abuse and prevent homicides. Any identified learning is transformed into actions and added to the safeguarding work plan to embed into the Trust.

The Clinical Nurse Specialist is the Chair of the Public Engagement Group (PEG). Within the reporting period there have been Hertfordshire wide campaigns. These have included; World Elder Abuse Awareness day and a week-long safeguarding awareness campaign.

Key Achievement – Continued representation of Trust safeguarding adult team at HSAB sub groups and participation in specific work streams. Continued representation at a national level on modern slavery and human trafficking

9.3.1 Operation Tropic partnership work

During the reporting period the safeguarding team have participated in over 20 covert operations in partnership with Hertfordshire Constabulary and Operation Tropic. These have involved safe and well visits on woman that are suspected to have been trafficked into the country for the purposes of sex work. There has been a number of successful referral into the National Referral Mechanism (NRM) as a result of these operations. To date there have been over 180 women seen and over 15 referrals directly to the NRM.

This format of working in partnership with the police has proved invaluable with the engagement of vulnerable, hard to reach groups and safeguarding. The safeguarding team have gone on to develop safe and well packs in partnership with community organisations to sign post and safeguard potential victims.

A Standard Operating Procedure (SOP) has been developed by the CNS to aid other organisations to adopt this innovative way of working.

This unique way of working resulted in an award at the Houses of Parliament for Health Equality and a nomination for the safeguarding team in the RCNi's innovation category at the 2019 nursing awards.

Key Achievement

Winners of the NHS Parliamentary Award – Health Equalities - July 2019 - partnership work with Operation Tropic supporting potential victims of trafficking in the sex industry

Winner of the Nursing Times – Nurse of the Year Award – Bonita Sparkes CNS Safeguarding Adults – October 2019

9.4 Serious Incidents

There has been 1 serious incident related to safeguarding adults at risk during the reporting period.

Datix number	Ward	Concern	Outcome
DW122406	Ridge	Patient fall resulting in a serious head injury	SI completed awaiting case conference

Table 3 Serious Incidents involving safeguarding adults

9.5 Audits

1. **MCA/DoLS audit**
   20 sets of medical records were audited. These related to patients who required mental capacity assessments.
   Outcome: The standard and quality of Mental Capacity Assessments were reviewed for the purpose of this audit. There were several elements within this re audit that demonstrated improvements in practice. The audit demonstrated that improvement is required in the formal documentation of capacity when applying for DoLS. This will be monitored on a monthly basis using random dip audits.

2. **MCA/DNACPR Audit**
   40 sets of medical records were audited for patients with a DNACPR in place that required a mental capacity assessment.
   Outcome: The audit concluded that there had been an improvement in the compliance of completed documentation for the mental capacity assessments and an improvement in compliance with the guidelines set by the Resuscitation Council, UK (2016), the Mental Capacity Act, 2005 and the Trusts Do Not Attempt Cardio Pulmonary Resuscitation, 2018 and Mental Capacity, 2018 policies. A number of recommendations were made as part of the audit findings. This will be re-audited in six months. Following the audit a check and challenge process by the nursing staff within board rounds has been instigated *to provide further assurance around adequate completion of the documentation.*

3. **Audit of Chaperone policy**
   40 sets of medical records were audited including records of adults attending Watford main Outpatient, Dermatology, Endoscopy, and adults Emergency Department.
   Outcome: The overall findings of the audit in both adults and paediatrics demonstrated a positive focus of the use of chaperones in clinical practice. It established that staff adhere to Trust policy within their working clinical areas. The use of chaperone stamps has improved compliance with record keeping. There is additional work to be undertaken in compliance

with chaperones for young adults and recognising same sex chaperones for male patients. The safeguarding team continue to support this education through face to face training and promotion of the chaperone policy. The audit will be repeated as part of the audit strategy.

4. **Audit of Compliance with missing patient policy**
   For the purpose of the audit 10 sets of notes were audited. Information was obtained following a search using the Trust electronic incident reporting system and cross referencing with the adults at risk register which records patients that had absconded from the trust.
   Outcome: There were positive examples of compliance of missing person's policy within these audit findings. However there was clear evidence that work still needs to be undertaken to promote the check list within the policy and encourage compliance with completing the documentation. A quick link to the missing persons check list was added to the safeguarding internet page to enable easy access for staff. Awareness raising was undertaken with the relevant divisions with support of the modern matrons and practical solutions were implemented with support from the estates department to reduce the risk of patients, who are at risk, being able to leave clinical areas unsupervised.

5. **STOMP audit**
   The aim of the STOMP project is to improve the quality of life of people with a learning disability and autism by reducing the potential harm of inappropriate antipsychotic medicines. The STOMP audit was undertaken by the pharmacy and the safeguarding team.
   Outcome: of this audit demonstrated that a significant number of patients with Learning Disabilities were not on antipsychotics and therefore no medication review was required. This indicates that work undertaken as part of LeDeR recommendations within the community has been effective. This will be fed back to the LeDeR steering group.

6. **Monthly Dip Dive audits**
   Outcome: Five dip dive audits are undertaken on a monthly basis and presented to safeguarding panel to provide assurance. These include:
   - Mental Capacity and DoLS
   - Reasonable adjustments for Learning disability patients
   - Safeguarding documentation
   - MCA/DNACPR compliance
   - Domestic abuse /safeguarding in the Emergency department
   - Weekly COVID assurance dip dive audits

9.6 Safeguarding Champions

During the reporting period the champion's network has been reviewed and relaunched. Currently there are 25 Adult at risk champions for the trust. Work undertaken includes:

- New Terms Of Reference and contracts were devised
- Format of training days reviewed to include supervision
- Guest speakers invited from other agencies such as domestic abuse, SARC
- Champions encouraged to attend external study days as part of HSAB
- Robust Learning Disability awareness training to include diagnostic overshadowing following SAR

Key Achievement –. review of the existing Champions network- relaunched with an effective skill mix and new programme of training

9.7 Safeguarding Adult Reviews

A Safeguarding Adult Review (SAR) is undertaken when an adult in Hertfordshire who has care and support needs dies and HSAB suspects that the death has resulted from abuse or neglect (including suicide) and there is concern that partner agencies could have worked more effectively to protect the adult.

The named nurse is an active panel member of this sub group. During the reporting period, the Trust referred 2 patients to panel for consideration for SAR. One case did not meet the criteria and other is still being considered by the Chair of Hertfordshire Safeguarding Adults Board pending additional information from other organisations involved in the case.

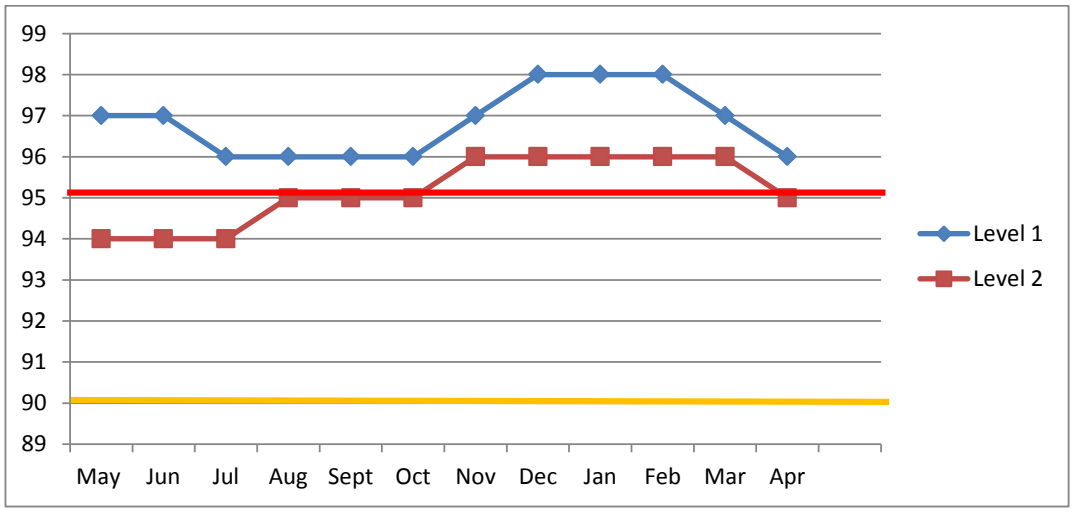
9.8 Safeguarding Adult Training

Safeguarding adults training is a fundamental part of the Trusts duty to safeguard and promote the welfare of adults at risk. This training forms part of the mandatory training framework.

During the reporting period, Level 1 and 2 adult safeguarding training has been delivered via E learning as part of the 3 yearly mandatory clinical and non-clinical days. Level 2 training has also been delivered to all new staff as part of the Trusts mandatory corporate induction programme.

The E learning packages for Levels 1 and 2 have been reviewed to include local information and ensure compliance with the 2018 intercollegiate document for safeguarding adults. These have been uploaded to the ACORN training system and are now available for all Trust staff to complete. Staff must complete a test at the end of the training slides with set criteria of 90% correct answers to be deemed competent.

Training compliance rates are reported monthly and these figures are monitored via the Safeguarding panel.



Graph 12 Demonstrates the % training compliance with safeguarding training. The Trust compliance target is 90% represented by the orange line. The CCG compliance target is represented by the red line

The Intercollegiate document was published by The Royal College of Nursing (RCN) in 2018. It identified a competency and training framework for all staff. It identified five levels of training and outlined recommendations that each staff group will be required to train in order to provide assurance that they are safely caring for patients who are at risk and /or have safeguarding needs within the Trust. As a result the safeguarding team:-

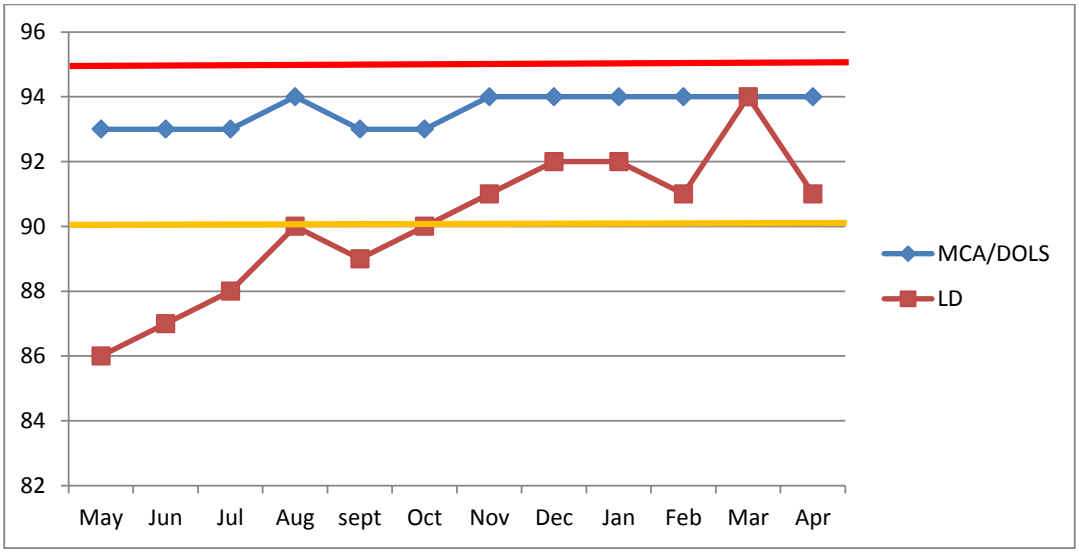
- Agreed a phased approach to training with the CCG

- Completed a Training Needs Analysis identifying all clinical nursing staff at Band 6 and Registrars and Consultants working in unscheduled care and care of the elderly to commence level 3 training
- Developed a safeguarding adults level 3 face to face training package
- Designed a safeguarding passport to enable staff to keep records of any training or supervision they have attended.
- Arranged training days 2/3 times per month and uploaded then to Acorn to enable staff to book on the sessions.

A number of training days were delivered with positive feedback from attendees. Targeting training was activated from January 2020 and will formally become part of Trust mandatory Training from 1 April 2020. Training compliance will then be reviewed by the safeguarding team and presented to the safeguarding panel.

9.8.1 Mental Capacity and Deprivation of Liberty Safeguards training

Compliance training rates with Mental Capacity (MCA)/ Deprivation of Liberties (DoLS) is monitored monthly by the safeguarding team and presented at the Trust Safeguarding panel. The Safeguarding adults' team have arranged a number of additional training sessions to ensure compliance figures remain on an upward trajectory.



Graph 13 Demonstrates the % Mental Capacity and DoLS training and the % training compliance for Learning Disability awareness The Trust expected compliance is represented by the orange line and CCG compliance target is 95% represented by the red line

Key Achievements –

- Overall compliance rates for levels 1 and 2 of training have met the Trust and CCG target for the last 9 months
- Introduced face to face safeguarding level 3 training for key staff with an associated safeguarding adults passport
- Sustained MCA/DoLS training compliance
- Significant improvement of Learning Disability awareness training compliance

9.9 Policies and Procedures

During the reporting period five safeguarding adult policies have been reviewed and approved via the safeguarding panel and policy review group. These include:

- Advance Statements concerning medical treatments

- Care of Adult Patients with Learning Disabilities and Autism Within West Hertfordshire Hospitals Acute Trust
- Safeguarding adults from Abuse
- Mental Capacity
- Deprivation of Liberty Safeguards

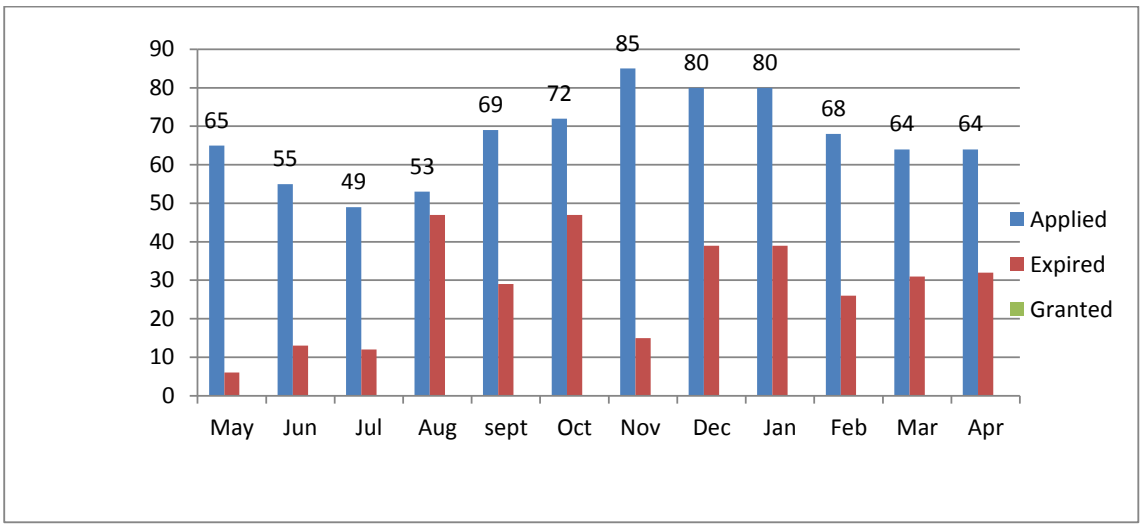
In addition the bruising guidelines were reviewed and approved by the safeguarding panel and the Quality Safety Group.

9.10 Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act, 2005 provides a statutory framework for action and making decisions on behalf of individuals who lack capacity to do so for themselves. The deprivation of liberty of safeguards were introduced to provide a legal framework around the deprivation of liberty to prevent breaches to individuals Human Rights.

Applications by the Trust for DoLS continues to increase annually

- 2017-18 - 477
- 2018-19 – 567
- 2019-20 – 804



Graph 14 demonstrating the numbers of DoLS applications

11

10. Mental Health

The safeguarding team have made mental health a key focus during this reporting period. There have been a number of actions these are:

- Participation at the mental health steering group chaired by the Chief Nurse.
- Patient stories are shared at the Mental Health steering group for discussion and learning.
- The Memorandum of Understanding between HPFT and the Trust has been reviewed and signed off.
- Joint training between the safeguarding team and mental health liaison team (MHLT) for Doctors regarding mental capacity and Mental Health Act
- Terms of reference for Safeguarding Panel have been updated to include oversight of the mental health steering group and associated work.
- Ligature cutters have now been put in all of the resus trolleys in ED, Children's Emergency Department (CED), Minor Injury Unit (MIU) and Urgent Treatment Centre (UTC).

- Mental Health Standard Operating Procedures (SOP) for the management of patients has been developed in regard to police response for violent patients in the acute hospital who are sectioned under the Mental Health Act.

10.1 Management of Mental Health sections

- The Lead Nurse for safeguarding attends the multi-agency meetings with Hertfordshire Partnership Foundation Trust (HPFT)
- The safeguarding team have been working collaboratively with the Emergency division to improve the quality of reporting Mental Health Section 136 via datix. This work is ongoing.
- The process of reporting Mental Health Section 5:2 has been reviewed and work is in progress to develop a robust process to ensure there is a clear pathway for reporting and monitoring of the numbers of patients.

10.2 High Intensity Service User Team meetings (HISUT)

The safeguarding team attend the High Intensity Service User Team to discuss patients with complex needs who a present to the Trust on a regular basis. The meeting is attended by drug and alcohol liaison workers, MHLT, community mental health workers, safeguarding, police and social services. The team discuss and share information. This establishes joint pathways of care in the community. The meetings have been suspended during the covid-19 peak but will be re-established in the recovery phase of the pandemic.

10.3 Missing patients

Work has been undertaken in collaboration to produce a pathway to aid staff when reporting patients missing to establish a clear escalation process when reporting to the police. The finalisation of this pathway has been delayed due to the Covid-19 pandemic. Once approved a programme of training will be arranged for staff.

10.4 Young people and mental health

During the reporting period, work has been undertaken to improve service for children and young people attending with mental ill health

- CAMHS forums set up to improve multi professional working within the Trust.
- The safeguarding children's team attend meetings with community, acute mental health workers and children's services to plan and facilitate safe discharges form the Trust for young people with mental health concerns.
- There has been improved communication with HPFT regarding referrals with children's services.
- The Clinical Nurse Specialist for Crisis assessment and Treatment Team (C-CATT) provides weekly updates on young people with mental health concerns that are admitted to the trust and an overview of actions taken by mental health colleagues. These patients are discussed at psychosocial meeting.
- During the reporting period, there have been some challenging cases involving 16 and 17yr olds who have been admitted with complex mental health issues. The safeguarding team have supported in the management of these young people. It has identified a gap in commissioning of specialist mental health in-reach provision for this age group. This has been raised to the joint Hertfordshire commissioners for mental health services for young people and this is being reviewed.

11. Named Midwife Report

11.1 Maternity Safeguarding Activity

The Lavender Team was launched in April 2016 to provide an enhanced service to mothers and families with complex social needs and mental health concerns. Since the launch the Lavender

Team has seen a marked increase in safeguarding/child protection referrals. This correlates with Government data on local authority social care activity between 31 March 2010 and 2018 where there has been an increase in activity across a range of measures: children in need (+8%), child protection enquiries (+122%), child protection plans (+38%) and looked after children (+17%).
With Lavender Team's notable increase in acuity comparison tables were created for the safeguarding/child protection Lavender referrals for years 2018 and 2019 (Table 1).

	Ja	Fe	Ma	Ap	Ma	Ju	Jul	Au	Se	Oc	No	De	**Total**
SG/Child Protection Referrals 2018	6	14	10	14	13	6	9	10	13	9	10	6	**120**
SG/Child Protection Referrals 2019	20	19	16	10	13	25	27	13	10	17	16	16	**202**

Table 3 Safeguarding/Child Protection Lavender Referrals 2018 and 2019

As seen in Table 1 the increase in safeguarding/child protection referrals to the Lavender Team has risen from 120 in 2018 to 202 in 2019. This is an increase of 68%. Multiple factors have been attributed as potentially contributing to the dramatic rise in demand for the Lavender Team and children's social care services, including:

- Wider societal determinants linked to poverty.
- New and greater risks to children and young people - for example, from County Lines, gang violence, and child sexual exploitation.
- An increased number of unaccompanied children seeking asylum.
- A growth in the overall child population.
- An increase in the number of assessments of children in need which feature risks to child welfare from domestic abuse, parental mental ill-health and parental substance misuse.
- Cuts to early intervention services, leading to greater demand for acute social care.
- Greater awareness and referrals in the wake of high profile cases, such as those involving child sexual exploitation in Rotherham and other areas, and the murders of Peter Connelly (known as "Baby P") and Daniel Pelka.
- More care leavers as a result of the increase in the number of children looked after.

Nationally, between 2008 and 2016 the number of babies separated from their mothers doubled with 42% of removals being newborns < 7 days old. As demonstrated in Table 2 the mean number of unborn babies on a child protection (CP) plan has also risen from 21.3 in 2018 to 29.3 in 2019. This is an increase of 38% reflecting the national increase of +38%.

	Ja	Fe	Ma	Ap	Ma	Ju	Jul	Au	Se	Oc	No	De	**Mean**
2018 Unborns on Child Protection Plan	25		16		9		13		23		30		**21.3**
2019 Unborns on Child Protection Plan	30		26		25		34		24		37		**29.3**

Table 4 Unborns on Child Protection Plan

As stated the increase in safeguarding/child protection Lavender referrals and unborn babies on CP plans is multifaceted. The hard work from the Lavender midwives has directly increased the number of referrals to the Team and Social Care.

To mitigate the mushrooming activity two new experienced safeguarding midwives have been recruited and will commence in June/July 2020. With the additional midwives this will have a positive long term impact on the outcomes for mothers and unborns.

As well as providing benefits directly to the women and babies using maternity services, high levels of expertise offers huge opportunities to enhance the working practices of maternity and affiliated staff. Behind the scenes, safeguarding and mental health proficiency will enable clinicians, enhancing their practice and improving safety.

This model of care will provide:

- Expert, personalised care, centred on the woman, her baby and family, based around their complex needs and decisions, where they have genuine choice, informed by unbiased information.
- Continuity of carer during the antenatal and postnatal period, to ensure safe care based on complex needs, mutual trust and respect in line with the woman's decisions.
- Safer care, with social and health care professionals working together across boundaries ensuring rapid referral, and access to the right care in the right place; leadership for a safety culture across organisations; and investigation, honesty and learning when things go wrong.
- Better postnatal safeguarding and perinatal mental health care, which can have a significant impact on the life chances, wellbeing of the woman, baby and family and overall outcomes reducing health inequalities
- Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

The newly recruited Band 7 Complex Needs Midwives have a senior role within the Lavender Team holding the necessary specialist knowledge and professional leadership to act as safeguarding specialists when representing internal and external meetings on behalf of West Hertfordshire Hospitals NHS Trust. They have the ability to establish good team relationships and collaboration with West Herts colleagues and external agencies. They will have responsibility for their own caseload, support co-ordination of the Lavender Team, liaising with external agencies and collation of data for audits.

11.2 Domestic Abuse and Pregnancy

Domestic abuse occurs across all age groups and life stages. Rather than reducing during pregnancy, expecting a child is a key risk factor for domestic violence beginning or escalating. Research has found that 4.3% of pregnant women due to give birth disclosed domestic violence when asked about it by a midwife at her first hospital visit.

Domestic abuse in pregnancy not only causes distress and trauma for the mother and baby, it increases the risk of the baby having a low birth weight or being born prematurely, which is linked to jaundice, anaemia and respiratory distress in infancy, and diabetes and heart disease later in life. This risk is increased further for women who experience two or more types of domestic abuse during their pregnancy.

The Lavender team continues to support women who disclose domestic abuse using the 'the black dot' system. Coupled with highlighting the importance of 'routine enquiry' at booking, 28 weeks gestation and in the postnatal period at mandatory study days has increased the knowledge and awareness of all maternity personnel.

With the recent Covid-19 pandemic, as predicted, domestic abuse charities and other organisations are reporting an increase in cases:

- General online domestic abuse searches have increased by 352.5%
- Support lines and web chat activity has increased by 53.9% and 70.4% respectively.
- There has been a substantial rise in self-referrals to ChildLine
- An increase of up to 50% in Multi-Agency Risk Assessment Conference (MARAC) domestic abuse referrals.

The Maternity Safeguarding Team works in accordance with the 'Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework', which sets out the roles and responsibilities of all individuals working within the NHS care settings. This includes a duty to support victims to ensure they receive timely care and support from the NHS. It also sets the duties to support perpetrators. It is also important to remember that domestic abuse and domestic violence does not just affect patients and line managers are updated regularly on support facilities available to maternity personnel.

11.3 Mental Health and Pregnancy

The large percentage of referrals to the Lavender team continues to be concerns around mental health; this also appears to be a high indicator of unborn babies on a child protection plan. Early identification therefore, of mental issues, is paramount in assessing risk to mother and child.

The commencement of the specialist mental health midwife has ensured parity between physical and mental health in maternity care, improving midwife knowledge and skills, developing pathways, supporting colleagues and mothers with their families, plays a valuable part in improving outcomes. The mental health midwife has enhanced multidisciplinary working holding a weekly multi-disciplinary triage meeting with the specialist obstetrician and CPN or psychiatrist. At the weekly meeting the week's mental health referrals are discussed and each woman is given a plan to meet their individual needs.

The specialist mental health midwife and Lavender Team work closely with the Community Perinatal Team who supports mothers and their babies for up to a year after birth. The team supports the wider family at an important time by ensuring early intervention; the programme facilitates recovery to promote well-being and attachment between mothers and their babies to raise awareness and to reduce the impact of mental health conditions on the next generation.

The table below shows a 34.2% total increase in perinatal mental health referrals from 2018-2019. This is indicative of better engagement among the multi-disciplinary teams, community and mothers with their babies. There has been an improvement in care delivery, which is tailored to each woman's needs. Women are aware of the service provision and keen to engage for a better outcome.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	66	81	83	53	103	70	68	51	57	50	56	48	**786**
2019	59	68	56	46	56	20	63	55	51	107	54	105	**1055**

Table 5 2018 – 2019 Perinatal Mental Health Referrals

11.4 Teenage pregnancy

The majority of teenage pregnancies are unplanned and around half end in a termination of pregnancy. Research has shown that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty, and have a higher risk of mental health problems than older mothers. Infant mortality rates are 60% higher for babies born to teenage

mothers. As children they have an increased risk of living in poverty and are more likely to have accidents and behavioural problems.

The under-18 conception rate has decreased for ten years running. There are many factors that could explain recent reductions in under-18 conceptions, including programmes to improve access to contraceptives, a shift in aspirations of young women towards education, and the perception of stigma associated with being a teenage mother.

Although the reduction of under -18 pregnancies is reflected in the Lavender Teams bookings the midwives continue to provide support and enhance maternity care. In collaboration with other services the Lavender Midwives identify needs around social exclusion, advice, participate and plan care in partnership with the multi-agency teams.

11.5 Mothers with Learning Difficulties/Disabilities

The 2001 white paper on learning disabilities services indicated that the incidence of learning disabilities is around 5% of the general population. Over the last 25-30 years, adults with learning difficulties have become more likely to develop relationships and form their own families. This is because they are more likely to live in the community (rather than long stay institutions) and because of the increased recognition of their rights to 'an ordinary life' including the right to be parents.

We know from research that once they are expecting or have a child, parents with learning disabilities tend to be reluctant to seek the support they need, for fear of having their child removed. This fear is well grounded as approximately 40% of parents in the English National Survey of Adults with Learning Disabilities were not living with their children.

The classification between a learning disability, difficulty and whether the mother has mental capacity has many connotations on the care offered and decision making during the antenatal, intrapartum and postnatal periods. It was identified there was less knowledge and understanding in recognising the difference between a learning disability or learning difficulty for maternity personnel and therefore collaboration between the Maternity and Trust Safeguarding Teams enhanced skills and confidence in this area.

The support and training from the Adult Safeguarding Nurse has been invaluable in improving awareness and understanding caring for mothers with learning difficulties/disabilities. Guidance and direction around DoLS has also proved to be instrumental in supporting mothers and families and achieving the best outcomes.

11.6 Audits

The Lavender team are involved in regular audits

1. Audit of letters sent to GP advising of referral to Lavender Team and requesting further information.
2. Audit of compliance of the routine enquiry for domestic abuse (monthly).
3. Audit of emotional well-being assessment at booking and mid trimester (Quarterly).
4. Audit of screening for complex social needs (Annual)
5. Audit of compliance to training (Monthly).

Monthly Audit of Routine Enquiry for Domestic Abuse at Booking & Mid Trimester May 2019 - April 2020

	Booking	Mid trimester
Annual average	100%	93

Monthly Audit of Assessment for Mental Well-Being at Booking and Mid_Trimester April 2019 - March 2020

	Booking	Mid trimester
Annual average	100%	97

Monthly Audit of compliance to training April 2019 - March 2020

Annual average	95%

11.7 The Lavender Team – Aims for the future

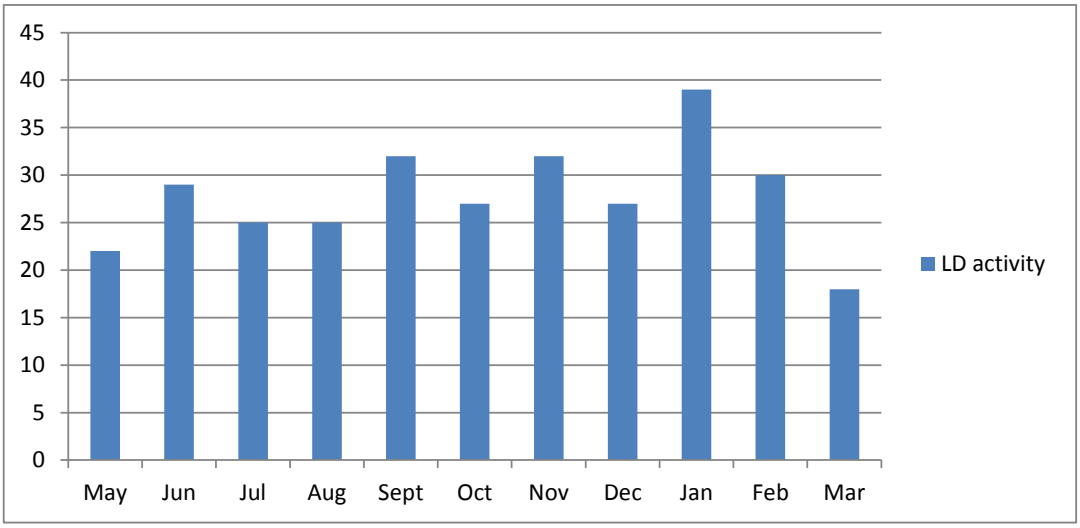
Due to the impact of the Covid-19 pandemic there have recently been many changes in how the Lavender Team midwives practice. Although, providing safe maternity care during this difficult period has been challenging at times, positives have also been noted.

- An increased number of women attending their antenatal appointments. It is believed this is due to every woman receiving a phone call from their midwife prior to their appointment (for Covid-19 screening). This phone call reminds the mother of her appointment as well as facilitating extra, regular communication with the mother.
- The Lavender Midwives have also noted they have more time to spend caring for mothers as less time is spent travelling to and from meetings, which are now attended by virtual or online platforms.
- All the Lavender Midwives have advised there has been improved communication between themselves and West Herts Social Care social workers. They believe this is because the social workers are working from home and therefore easier to contact by telephone.
- With current concerns regarding Covid-19 transmission women must be unaccompanied during their antenatal appointments and whilst they are on the ante/postnatal wards. This increases the opportunity to ask routine enquiry and for the mother to discuss concerns around domestic abuse.

Once the risk of Covid-19 transmission has diminished and services/facilities return to their normal pathways it will give the opportunity to review/audit ‘what went well’ and how the improvements can be sustained.

The specialist safeguarding midwife successfully applied for a 4 month secondment working with the Trust Safeguarding Team to provide support and research associated with Covid-19 and domestic abuse. The increased knowledge and confidence gained by the midwife during this period will be transferrable and benefit the Lavender Team, Maternity services and most importantly mothers/families/new-borns.

12. Learning Disability



Graph 15 - Demonstrates the number of learning disability patient referrals to the Acute Health Liaison team (AHLT)

The safeguarding adult team continue to work in close partnership with the AHLT to increase staff awareness and knowledge to improve patient outcomes for learning disability patients within the Trust. Bespoke face to face sessions have been delivered for both nursing and medical teams in collaboration with the AHLT. Specific sessions were held for junior doctors within this reporting period.

The team have worked collaboratively to plan complex admissions, arrange treatment and investigations which include specialities and plan effective safe discharges.

The appointment of a carers lead within the organisation has ensured that there is improved communication and continuity for carers of individuals with learning disabilities patient. The carers lead attends the learning disabilities Partnership meeting and plans to launch a carer passport to identify carers on the ward and ensure appropriate support.

12.1 The Purple Star Strategy

The Hertfordshire purple star strategy is awarded to clinical areas who have demonstrated outstanding services to people with Learning Disabilities. There are four clinical areas within the Trust that have been accredited with this award. There are another three clinical areas that have expressed an interest and are awaiting assessment.

12.2 The Learning Disabilities Mortality Review (LeDeR)

It has been well documented that there are significant health inequalities faced by people with learning disabilities. Today, people with learning disabilities die, on average; 15-20 years sooner than people in the general population, with some of those deaths identified as preventable had the person received better quality health care**.**

- The recommendations form LeDeR informs the Trust Learning Disability action plan to improve the care and reduce inequalities for patients with a Learning Disability. This is presented at both Trust LD Partnership meeting and Trust safeguarding panel.
- All patients with a Learning Disability who die within the Trust receive a Structured Judgement Review. These are reviewed by the Named Consultant for adult safeguarding prior to submission to LeDeR.
- There have been 24 deaths of patient with a Learning Disability during the reporting period. The three main causes of death in the Trust are pneumonia, aspiration pneumonia and sepsis. This is in line with both the Hertfordshire and the National findings.

- During the Coronavirus pandemic care of patients with learning disabilities remained a priority for the trust. Regional and National information was shared within the trust to support staff.
- Rapid Learning from LeDeR was shared in relation to carers and patients presenting later to hospital than usual resulting in poor patient outcomes in relation to Covid-19.
- Shared information: myth busting and reassurance for parents and patients to encourage presentation to hospital. This was adapted and shared within Hertfordshire.

The Trust has an established mortality review meeting. This is attended by the Named Consultant and Named Nurse for Adult Safeguarding. The initial LeDeR reviews are discussed to disseminate learning amongst medical colleagues.

The Trust has participated in LeDeR by:-

- Ensuring that there are internal systems in place that flag patients with learning disabilities.
- Developing a pathway for reporting the deaths of learning disability patients to the LeDeR programme.
- Developed a pathway to ensure SJRs are completed, reviewed and sent to LeDeR in a timely manner
- Identified four individuals who have completed training to become reviewers as part of this programme.

12.3 Improving care for LD patients

During the reporting period the following work has been undertaken:

- Re-launched the Learning Disability Partnership. This meeting chaired by the Named Nurse for safeguarding adults and is supported by the AHLT. A wide range of multidisciplinary Trust staff are represented.
- Updated the LD action plan to ensure it is aligned with strategic LD work in both Hertfordshire and nationally following recommendations from LeDeR.
- Delivered a Trust wide LD learning forum. This incorporated the findings from the LeDeR annual report. Topics covered included sepsis and identifying the deteriorating LD patient, preventing aspiration pneumonia, having difficult conversations and end of life care planning
- Developed an end of life pathway with the palliative care team to ensure patients with a Learning disability are identified and supported in the last year of their life
- Developed a pathway for LD patients who may require sedation for examinations with the AHLT
- Dip dive audits are undertaken monthly to ensure compliance with reasonable adjustments. These are discussed at safeguarding panel
- Established a link with the newly appointed carers lead and ensure patient/visitor information includes updated guidance on services and signposting
- Updated the safeguarding intranet page to ensure there are links to accessible information
- Contributed to existing hospital pathways on sepsis and aspiration pneumonia, working with specialist teams to ensure pathways consider LD

12.4 Recognition of LD patients

The Trust uses Patient Administration System (PAS) to attach an electronic alert to the record of a patient with a LD. This information is gained from regular updates from the Strategic Liaison nurse. The use of the alert identifies when a patient with LD attends or is admitted. This helps to alert staff that the individual may require additional support or reasonable adjustments. The safeguarding team provide a list of patients who have been admitted to the AHLT team on a daily basis. This enables them to provide support to both staff and the patient.

12.5 Memorandum of understanding

There is a Memorandum of Understanding between the Trust and the Acute Health Liaison Team. This provides a clear outline of roles, responsibilities and expectations. This has been reviewed and updated during the reporting period.

12.6 End of life care

The safeguarding, palliative care and AHLT worked together to produce a pathway for referral of any learning disability patient identified as end of life. This will encourage patients to be referred to the palliative care team regardless of presenting symptoms. The pathway is available to staff via the intranet page. This pathway was reinforced during Covid-19. The pathway has seen effective patient outcomes related to diagnostic overshadowing symptom control and supporting difficult conversations

Key Achievement –

- new approach to engaging staff around LD awareness with a monthly programme of events
- re-established LD Partnership within the Trust
- delivery of a Trust wide LD forum for all staff.

12.7 Makaton

Makaton is a communication system for people with communication difficulties. During LD awareness week, a video was produced. It recorded staff making a pledge to improve care given to learning disability patients using Makaton signs which was uploaded to social media platforms.

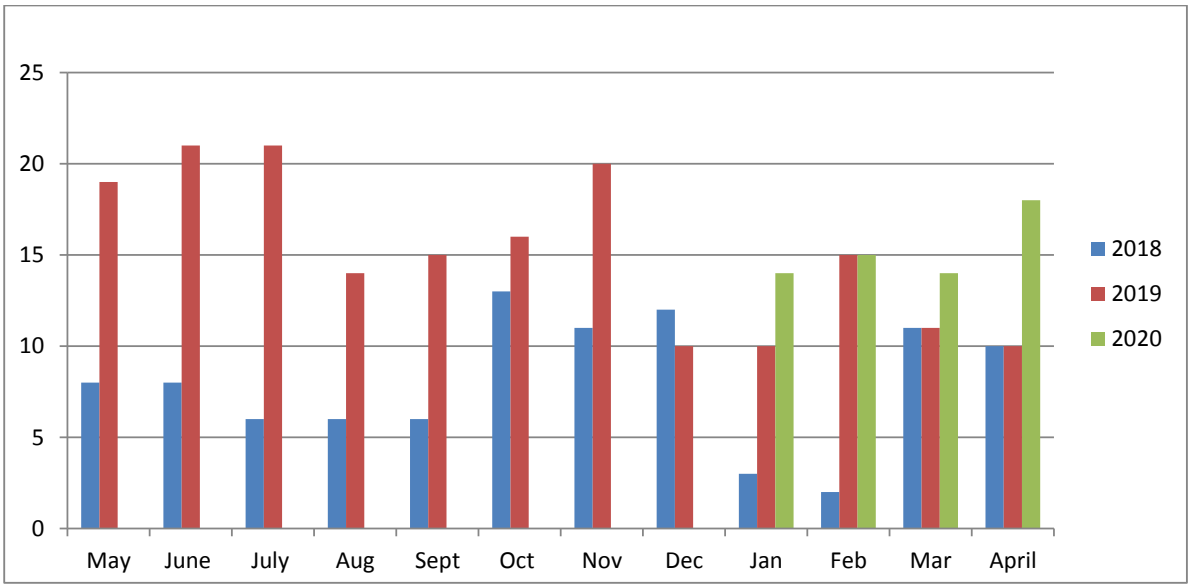
12.8 STOMP (Stop the over use of psychotropic)

People with a learning disability, autism or both are more likely to be prescribed these medicines to manage challenging behaviour rather than their intended use. A national plan invited healthcare providers to audit their own practice to ensure health equality and good health outcomes for patients with learning disabilities.

During the reporting period the Named Nurse for safeguarding worked collaboratively with the pharmacy team to review and audit the use of Psychotropic medication of patients with a learning disability. The findings will be presented at Safeguarding Panel.

13. Domestic Abuse

The Trust currently has 2 part time Independent Domestic Violence Advisors (IDVA) in post. They are employed and managed by Refuge but have an honorary contract with the Trust. They are co-located with the safeguarding team. They accept referrals with the individuals consent to provide support, safety planning and advice to anyone who discloses domestic abuse within the Trust. This includes Trust employees.



Graph 16 Demonstrates the number of referrals to the IDVA service received from Trust staff

The majority of referrals to the IDVA service are generated from Watford ED but include other areas such as maternity, in patient areas, outpatients and HUTC.

Key Achievement – Significant increase in referrals made by Trust staff to the ISVA service – showing good recognition and awareness of domestic abuse.

There has been an increase in the number of referrals made to the IDVA service over the reporting period. This demonstrates good awareness of the service by frontline staff. During the COVID peak, the national profile of domestic abuse was at the forefront of safeguarding discussions. There was an increase of individuals attending ED following the relaxation of “lockdown” rules and thus an increase in referrals. This is thought to be as a result of tensions building and pressured home situations increasing serious harm and incidents of domestic abuse.

The safeguarding team continue to promote domestic abuse awareness across the Trust by

- Providing wipe clean posters displayed in the ED and CED
- Large printed banners at the entrance of the hospital to include the Refuge logo and the National domestic violence helpline
- A resource book for staff containing signposting information for victims , patients and staff
- Online staff communication tools with articles on domestic abuse and the IDVA service within the organisation
- Social media was used , including the safeguarding twitter page, Trust social media and communication team to share information
- Teaching session with ‘COVID on site testing staff’ on how to refer if domestic abuse is disclosed
- Resources provided to the “Sanctuary” for staff

- Collaboration with the chaplaincy service, carers lead and patient experience staff to provide referral information and resources for patients/carers and staff that disclose domestic abuse

13.1 Domestic Homicide Reviews

During the reporting period the safeguarding team have contributed towards 3 Domestic Homicide reviews. The learning from these reviews, once complete will be adapted to ensure they are relevant to the Trust.

13.2 Multi Agency Risk Assessment Conference

Multi-Agency Risk Assessment Conference (MARAC) is a meeting where agencies talk about the risk of future harm to people experiencing domestic abuse and if necessary their children, and draw up an action plan to help manage that risk. The safeguarding team attend monthly meetings to share relevant the information held by the Trust with

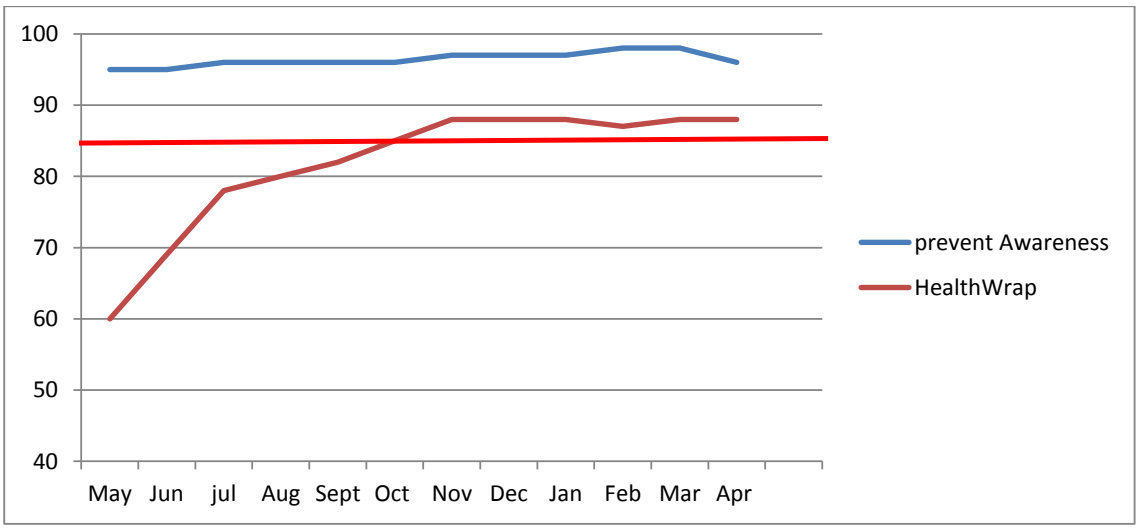
- Watford and Three Rivers
- St Albans and Dacorum
- Hertsmere MARAC.

14. Prevent

Prevent is part of the Governments counter terrorism strategy CONTEST. It aims to stop people being radicalised into illegal activity which may include gang violence, becoming terrorists/ supporting terrorism. The expectation is that providers have 85% compliance with Healthwrap training. The Trust submits training compliance to NHS England via Unify.

The Training Needs Analysis has been reviewed by the safeguarding team to include all registered patient facing staff of Band 5 and above. Medical staff identified will include Registrars (ST1/CT1) including Trust Grades doctors and Consultants. Registered Nursing Associates are also included. These staff are required to complete WRAP by e learning or by pre-arranged face to face sessions. This has bought the Trust identified staff in line with the national average.

The training compliance has remained above the expected 85% for the last six months. Training compliance is monitored via monthly by the safeguarding team and presented to the safeguarding panel.



Graph 17 Demonstrates the % of training compliance for Prevent awareness and Healthwrap. NHS England expected compliance target is 85% represented by the red line.

15. Employment Practice

The Trust has safe recruitment practices with policies in place. The Trust has a DBS policy, which was fully updated and ratified in the reporting period with a review date in 2022.The policy, includes mechanisms to ensure that the required DBS have been received for staff and an audit process in place within the recruitment team.

All volunteers within the Trust also have DBS checks following recommendations from the Lampard report. All volunteers also complete safeguarding training.

The Trust has Allegations of abuse against staff policy and is due for review in August 2020.

During the reporting period, the Trust made no referrals to DBS. One referral was made to the Designated Officer (LADO) in the Local Authority regarding a member of Trust staff. This referral was not taken further by the LADO.

16. Risks

There are 4 risks on the Trust risk register

Risk No	Description	Controls	Score
4209	Failure to complete Learning from deaths of people with a learning disability (LeDeR) investigations in a timely manner	-Additional Reviewers trained -Named Nurse liaises with the regional LeDeR contact to gain oversight of allocated investigations so that progress can be monitored. - The safeguarding lead provides feedback to the safeguarding panel on the current situation of investigations and staff training. -The mortality panel oversee the LD deaths within the Trust	6
3710	Aspects of non-compliance with Do Not Attempt Cardiopulmonary Resuscitation	-DNACPR is mandatory for all staff -Safeguarding team undertake bi-annual audits and present to safeguarding panel - Safeguarding team teach on the new Dr Trust induction -Teaching sessions provided at Divisional Clinical Governance meetings -One to One teaching sessions with named Consultant -Bespoke DNACPR/MCA form developed and distributed across all clinical areas to ensure MCA is considered for appropriate patients. -New form promoted by safeguarding team across clinical areas	13
3713	There is a risk that some patients will be detained	- Laws society consultation has received Royal assent	8

	without any legal framework due to a gap in the statutory framework for DoLS	-Process will change to Liberty Protection Safeguards. - There have been numerous delays due to issues in parliament and COVID-19. - The Named Nurse receives regular updated from 39 Essex street (Legal firm)	
4238	Lack of in-reach mental health service for 16- 17 year old patients with chronic needs on general wards	-An SOP for this cohort of complex patients is being developed -There is some support from C CAT and the mental health liaison team -Raised with the commissioners to review the gap in provision	12

Table 6 Current risks relating to safeguarding

17. Recommendation

The Trust Board is asked to receive the report for information and assurance that the Trust is compliant with its duties under the Children Act (2004), Mental Capacity Act (2005) and Care Act (2014).

Executive Director: Tracey Carter, Chief Nurse & Director of Infection, Prevention Control
Date: August 2020

Appendix 1

Future priorities for the period May 2020 – April 2021

- Continue to deliver Safeguarding Adults Level 3 training across the Trust to identified staff – delivering face to face training sessions and working towards achieving expected compliance
- Increase awareness of Makaton – campaign running throughout 2020.
- Introduction of FGM-IS within unscheduled care settings
- Review and update Safeguarding Children Trust handbook
- Maintain training compliance at 90% for all levels of safeguarding training.
- Ensure Level 3 eLearning options are available for staff to access during suspension of face to face training during coronavirus pandemic.
- Develop programme of Level 3 safeguarding children updates on specialist topics – CSE, Domestic Abuse etc.
- Continue to provide Level 3 safeguarding children training specifically focussed on young people to senior adult nurses in key clinical areas
- Working with senior colleague in CED/ED – develop an emergency record card for teenagers/adolescents (13 – 17yr olds) incorporating HEADSS assessment
- Develop safeguarding patient pathways and good working relationships with the new UTC at Watford hospital
- Increase offer of safeguarding children supervision to staff working in HUTC and MIU and support training at clinical governance settings
- Review current policy and training for physical interventions, clinical holding and rapid tranquilisation for children and young people.
- Continue with developing innovative partnership working around modern day slavery and human trafficking and share work nationally
- Maintain and strengthen Trust representation and work with the HSCB and associated work groups/sub groups.
- Develop a safeguarding adult supervision timetable for Band 7 & 8 staff in adult clinical areas
- Maintain Trust involvement in Serious Case Reviews and ensure any relevant recommendations are implemented and completed
- Maintain Trust involvement in Domestic Homicide and Safeguarding Adult Reviews and ensure that actions from recommendations are implemented
- Continue to develop the adult champions role and incorporate safeguarding children champions
- Targeted work to increase medical training compliance for all levels of safeguarding training especially MCA/DoLS
- Develop a multi-agency clinical group to review learning disability patients who are complex or frequent attenders
- Develop a multi-professional work group to consider an alternative way of working with patients who have significant alcohol dependency and are resistant to treatment.
- Develop chaperone training workshops for staff to develop skills and competencies around the role of the chaperone
- Ensure actions are carried out from Participate in NHS Benchmarking national learning disability audit

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Trust Board Meeting
2019

Title of the paper	Emergency Planning & Business Continuity Report
Agenda Item	12/82
Presenter	*Sally Tucker, Chief Operating Officer*
Author(s)	*James Mason, Head of Emergency Planning & Resilience*
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	The aim of this paper is to provide information and assurance on emergency planning, resilience and business continuity plans development and preparedness across the Trust. The paper relates to the Trust obligations under NHSE Emergency Preparedness, Resilience and Response (EPRR) and the Civil Contingency Act 2004 and the Trusts requirements for Major Incident and the Corporate Business Continuity. Emergency Planning assurance has been reflected in the NHS England Annual Assessment for Emergency Preparedness confirming the Trust's substantially compliant status. The Emergency Planning Department is currently leading the Trust's response to the Coronavirus Disease (COVID19) Testing and exercising the Trust continues to exceed minimum obligations outlined in the NHS England EPRR Framework. The Emergency Planning & Resilience Department has submitted a bid for strategic coordinating group funds to undertake oxygen manifold upgrade works.
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?

12

	☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	<table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td></td><td></td></tr></table>
Action required	• *The Trust Board is asked to receive this report for information and assurance*

Agenda Item: 12/82

Trust Board meeting – August 2020

Emergency Planning & Business Continuity Report

Sally Tucker, Chief Operating Officer

1. Purpose

1.1 The aim of this paper is to provide information and assurance on emergency planning, resilience and business continuity plans development and preparedness across the Trust.

2. Background

2.1 The paper relates to the Trust obligations under NHSE Emergency Preparedness, Resilience and Response (EPRR), the Civil Contingency Act 2004 and the Trust's requirements for Major Incident and the Corporate Business Continuity.

2.2 The Emergency Planning & Resilience department has successfully placed the Trust in a secure position in relation to regulatory scrutiny and meeting our statutory obligation. This level of assurance has been reflected in the NHS England Annual Assessment for Emergency Preparedness confirming the Trust's substantially compliant status for 2019/20.

2.3 There continues to be an absolute need to effectively and promptly communicate, train and test emergency preparedness and continuity processes across the trust to ensure that there is full engagement and knowledgeable response from all staff and key stakeholders.

3. Analysis/Discussion

3.1 The Emergency Planning & Resilience Department has made significant progress in advancing awareness and capabilities of responding to a range of emergencies within the Trust.

3.2 The department has led the response to COVID-19, initial monitoring of the virus commenced in February with a planning group established followed by the command & control structure. The Emergency Planning & Resilience Department delivered the training of enhanced infection control to the critical responding departments.

3.3 The department has represented the Trust at multi-agency working response groups for COVID-19 including the Hertfordshire Strategic Coordinating Group, LRF & Health TCGs, Hertfordshire PPE Cell, Operation Hypnos (mortuary) Cell.

3.4 The Department has engaged with the Ministry of Housing, Communities & Local Government's Resilience & Emergency Division to enhance current mortuary capacity with an additional 385 mortuary spaces across 3 units on the Hemel Hempstead Hospital site. Discussions are ongoing with the Hertfordshire Local Resilience Forum as to the future of

this provision as part of preparedness for a COVID-19 second wave & mass fatality planning for other incident types.

3.5 To support the response to COVID-19 the Emergency Planning & Resilience Department has operated a 24/7 incident coordination centre and out of hours by providing a tactical commander on-call. This has provided and continues to provide technical advice and guidance to services throughout the response phase. At the peak of the pandemic to support the Emergency Planning & Resilience Department further staff were seconded to support:

- Emergency Planning Officer
- Incident Coordination Centre Manager
- Incident Coordination Support Officer

3.6 The department has implemented an e-learning package. The package has been deemed as essential training for all staff on a triennial basis. 91.50% of staff have completed the e-learning package to date. Additionally Joint Emergency Services Interoperability Principles (JESIP) have been launched for on-call managers and directors as required by the Home Office. The Emergency Planning Group reviews training compliance figures on a monthly basis. The table below outlines current compliance by division:

Division	Compliance Percentage
Clinical Support	95.90%
Surgery & Anaesthetics	92.20%
Corporate	92.10%
Emergency Medicine	92.00%
Environment	89.80%
Womens & Children	89.80%
Medicine	88.80%
Total	**91.50%**

3.7 There continues to be a national shortage of powered respiratory protection suits (PRPS), however the Trust's current stock levels still exceed the minimum threshold, NHS England are coordinating delivery of new stock to Trusts over the course of 2020/21.

3.8 The Emergency Planning Department led the Trust's preparedness activity for EU Exit, although the United Kingdom had left the European Union. The Hertfordshire EU Exit TCG will be re-established in September in preparation for the end of the transition period where the Trust will be represented.

3.9 The Accountable Emergency Officer (AEO) and Head of Emergency Planning have undertaken the annual NHS England emergency preparedness, resilience & response assurance process on behalf of the Trust. The assessment by NHS England has indicated that the Trust has a reduction in compliance from fully to substantial. This reduction is as a result of the Trust failing to comply with all elements of the Data Security Protection Toolkit. The Trust is waiting to receive information on the 2020/21annual assurance process.

3.10 The Trust declared a critical incident on Saturday 4 April 2020 as a result of the oxygen demand was exceeding upper limits of the oxygen manifold on the Watford General Hospital site, this resulted in a multi-agency response and the transfer of 7 critical care patients to other organisations to reduce the demand and in a full closure of the hospital for 10 hours. Emergency engineering works were undertaken by British Oxygen Company (BOC) with support from the military following a successful military aid to civilian authorities (MACA) request to bring the Trust to a stable position.

3.11 Following completion of the emergency oxygen works undertaken by BOC the Trust noted that there is still an opportunity to upgrade the manifold vaporisers and control panel further which would allow for additional capacity in the oxygen system and allow for a further surge critical care beds in the event of a requirement to surge in a second COVID19 wave or another incident. The Emergency Planning & Resilience department has submitted a bid for these upgrades to be funded through the Strategic Coordinating Group COVID19 funds. The SCG will consider this bid in particular the benefit of having local Hertfordshire surge critical care but also consider the NHS England/Improvement East of England regional decision that critical care surge beds would be managed at a regional level with pre-identified sites.

3.12 In the peak of the pandemic three phases critical care surge were designed, the Trust mobilised phase one & two surge plans bringing the maximum occupancy at the peak of the pandemic to 32 critical care patients. The business as usual available occupancy is 19 critical care beds.

3.13 Following the resignation of our existing Head of Emergency Planning & Resilience, the Trust has appointed a new Head of Emergency Planning & Resilience, start date is to be confirmed.

4. Risks

4.1 EU Exit may continue to present a risk to the Trust although will be dependent on the deal which is negotiated by the government at the end of the transitional period, this will be reviewed by the Emergency Planning & Resilience department as new information and guidance emerges through the Hertfordshire EU Exit Tactical Coordinating Group.

4.2 The ongoing coronavirus pandemic presents an issue to Trust operations in the event of a second pandemic, the ongoing internal command & coordination structure supported by the regional command & coordination will enable effective management of the incident.

5. Recommendation

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

Sally Tucker
Chief Operating Officer

26 August 2020

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03 September 2020

Title of the paper	**Strategic Priorities Update**
Agenda Item	13/82
Presenter	**Helen Brown, Deputy Chief Executive**
Author(s)	**Esme Walsh, Strategy Delivery Office**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	This paper provides an update to the Trust Board on the progress of the key strategic priorities for 2020-21. The Covid-19 incident paused or delayed the majority of projects but progress is now being made in most areas.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care — *Objectives 1-4* ✓ **Aim 2** Great team — *Objectives 5-8* ✓ **Aim 3** Best value — *Objective 9* ✓ **Aim 4** Great place — *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 Trust Board is asked to note the delivery status of the strategic priority projects.

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Agenda Item: 13/82

Trust Board – 03 September 2020

Strategic Priorities Update

Presented by: Helen Brown, Deputy Chief Executive

1.0 Purpose

1.1 This paper outlines the strategic projects that have been identified as priorities for 2020-21 and provides an update on their development and delivery.

1.2 **Table 1: 2020-2021 Strategic Priorities**

WHHT 2020-21 STRATEGIC PRIORITIES - Reporting to TMC	BEST CARE	BEST VALUE	GREAT TEAM	GREAT PLACE
CLINICAL STRATEGY				
CLINICAL STRATEGY	✓	✓	✓	
REPATRIATING CHEMOTHERAPY	✓		✓	
HEAD & NECK PATHWAY	✓			
INTERVENTIONAL RADIOLOGY	✓			
EMBEDDING SMART AS BAU	✓	✓		
MOUNT VERNON CANCER CENTRE REVIEW	✓			
VASCULAR HUB	✓			
ICS / ICP DEVELOPMENT	✓			
INTEGRATED CARE JOINT QIPP				
TRANSFORMATION PLAN	✓	✓	✓	
UTCs WGH and SACH & HEMEL	✓	✓	✓	
CAPITAL PROGRAMME				
THEATRES	✓	✓	✓	✓
EMERGENCY DEPARTMENT	✓	✓	✓	✓
MAU EXPANSION	✓	✓	✓	✓
LOCAL AREA NETWORK / WINDOWS 10 (ETC.)	✓	✓	✓	✓
OFF SITE BACK OFFICE	✓	✓	✓	✓
HEALTH RECORDS BC	✓	✓	✓	✓
OTHER BACKLOG MAINTENANCE PROJECT				✓
MRI SCANNER (SACH)	✓			✓
CARDIAC CATHETER LAB	✓			✓
FIRE SAFETY SPEND				✓
£1M MISCELLANEOUS MEDICAL EQUIPMENT				✓
CT SCANNER (WGH)	✓			✓
MULTI-STOREY CAR PARK				✓

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2. Clinical Strategy

2.1 There has now been significant engagement with divisional and specialty leads and the shape of the **Clinical Strategy** is starting to emerge. Engagement will continue over the next two months before the final draft of the strategy comes to the Board for approval before Christmas.

2.2 The **Head and Neck (H&N) Pathway** was previously paused due to Covid-19, however work has been happening this month on agreeing internally the aspects of the H&N pathway that require attention. The current service model the WHHT service working with two specialist multi-disciplinary teams (MDTs) at Northwick Park and Luton and Dunstable Hospitals. The cancer team had been considering reviewing this arrangement with a view to potentially working with either one or the other (but not both) MDTs. This would have required approval by the specialised commissioning team and a formal decision making process. Following further discussion the team are proposing to focus on a range of internal and pathway improvements that should improve patient pathways whilst maintaining the current working arrangements. **It is therefore proposed to close this as a formal corporate level change project and manage via the divisional governance processes**

2.3 The **Interventional Radiology** project is currently at the design stage. The internal team have undertaken work and c. £23k funding has been approved for designs and surveys to get to OBC standard.

Once the location and associated plans have been approved, the delivery timetable is likely to be dependent on the relocation of services (CT) from AAU and confirmation of capital funding. The Trust has asked Raise (West Herts Hospitals charity) to run a charitable fundraising campaign to support this project. This will commence once the OBC has been approved.

2.4 Due to the Covid-19 emergency, work on the **Mount Vernon Cancer Centre Review** was paused in March 2020, resulting in slippage to the due diligence and redesign work, and therefore consequently impacting on the date of transfer, which was originally identified as April 2021, and has now been revised to a planned date of 01 April 2022. The revised timeline which includes planned business case and consultation timelines was approved by the Programme Board on 19 August 2021. WHHT clinicians continue to engage in the clinical review process. Preliminary discussions have been held with the redevelopment team to consider potential flexibilities for accommodating elements of the service into our redevelopment plans if this is subsequently agreed as the preferred clinical way forward via the review process. Any changes to the service model or configuration of MVCC services is expected to require formal consultation so all discussions are exploratory only at this stage.

2.5 The amended proposal for a **SMART (Senior Medics Assigning & Re-designing the Take)** virtual consultation solution (for Cardiology & Respiratory) was presented at TMC on 12 August 2020. The pilot will run over a two month period, with an anticipated start date of 07 September 2020. Due to staffing issues, the Respiratory cover will run Monday to Wednesday through the pilot phase.

Key Performance Indicators (KPIs) are being finalised to include a new baseline for comparison. Dedicated areas for virtual consultations have been identified and are being prepared. The

majority of IT requirements have been collated and are to be reviewed. The team continue to look into options around IT equipment security and will request further assistance from IT colleagues in regards to this and equipment delivery.

2.6 The **Vascular Hub** project is currently at the impact assessment/OBC finalising stage, which resumed following pause due to clinical availability issues caused by the Covid-19 pandemic.

The full financial and workforce impact is being assessed; the hub team leading the work at East and North Herts have secured additional resource to support this work.

2.7 Following agreement of the updated plan for the **Integrated Care Partnership** for 2020-21 the supporting working groups have started to meet again following the pause during the Covid-19 period. Four of the six working groups that were due to restart during July have met at least once, and dates for the other two are being arranged. A key focus for the steering groups is to consider the decision making framework that will be needed to support the operation of the ICP to enable us to work together effectively within a clear governance framework.

The Integrated Care System / joint HWE CCGs leadership team has commenced with the appointment into a number of its senior posts, which took effect from 01 August. David Evans, Interim AO for HVCCG has been appointed to the role of Managing Director for Herts Valley CCG.

3. Integrated Care Joint QIPP (part of Transformation Plan)

2.8 **Frailty** outreach recommenced 03 August 2020, to support patients in ED identified through the Clinical frailty Score (Rockwood) as being frail to access options for admission avoidance. The Frailty unit plan to recommence full operation in the previous MAU space following go live of the new emergency assessment unit on 18 August 2020. Work has commenced with CLCH community services and primary care to bring together the frailty hotline with the Rapid Response service into a single clinical offer.

2.9 **Outpatient Transformation –** an active programme of work to reinstate cancelled referrals as a result of Covid-19 is underway, with a clear tracker to support a complete return to pre-Covid activity levels. Active validation is ongoing to establish a clean waiting list, including supporting patients whose symptoms may have changed whilst waiting.

Priority areas for transformation have been jointly agreed between WHHT & HVCCG to include Urology, Dermatology and Rheumatology in this year and Neurology from April 2021, to align with the community service plans.

2.10 **Children's and Young People -** Introductions in place with the new Divisional Director and Manager with the HCT community service to start aligning plans along with commissioning intentions and the locality models.

2.11 **UTC WGH** – all teams continue to work together to embed the service, with on-going reviews of pathways and processes. The first formal contract review meeting is planned for September.

HHGH UTC – the decision has been taken to pause the procurement of service and review in January 2021. Current contract arrangements with HUC have been reviewed and a new agreement is with HUC for comment.

SACH UTC development – MIU remains closed until further notice in the context of Covid- 19 recovery and the need to maintain a fully Covid protected service model at SACH. HVCCG are leading work to develop plans for future service provision for St Albans, in close collaboration with the Trust's clinical team.

3.0 Capital Programme

3.1 The **WGH Theatres Reconfiguration** Full Business Case (FBC) has been approved and the Capital Team will now enter into discussions with the successful contractors to finalise the details of their respective contracts and agree a mobilisation plan in preparation for a start on site. This programme of works is currently expected to start around the end of October with a c. 13 months programme to complete.

3.2 The **Emergency Department Development** project is currently at the detailed design stage in preparation for the FBC, following delay due to clinical and supplier availability issues caused by the Covid-19 pandemic. The supplier for the modular unit is now engaged, as are architects for the internal work and the preferred options have been reviewed with the Exec team. Further work is required to refine the preferred option in the context of the longer term redevelopment of emergency services as part of the Trust's acute redevelopment programme. NHSI&E have been updated on the timeline and proposed scope, together with continued requirement for the allocated Wave 4 funding.

The OBC and £350k investment needed for creation of the FBC has been approved via TMC and been included in the capital plan.

Maintaining a fully functional department during construction is expected to provide the biggest challenge.

3.3 The final phase of the **MAU Expansion Plans (part of Winter Plans)** agreed in 2019-20 is to create further assessment space in the ground floor of the Shrodells unit. The Trust has been awarded £2.5m national urgent and emergency care / winter funding with a requirement that the scheme delivers by 01 January 2021. The environment team are progressing discussions with a modular build provider – delivery by end December 2021 is dependent on the modular provider being able to deliver the new unit by November / December 2020 and will require Trust approval and procurement processes to be expedited.

3.4 The **Local Area Network** (LAN) upgrade is in progress in WGH. The WGH schedule has been fully agreed, and some of the work has been moved to out of hours to minimise operational disruption, this has subsequently moved the completion timeline marginally to the second week of September. Windows 10 roll out is proceeding as planned.

3.5 The business case for the **Off Site Back Office project (Administrative Staff Project)** was approved by Trust Board and it is an essential enabler scheme for the second phase of works to create additional emergency assessment space on the ground floor of the Shrodells Unit.

The original preferred option (commercial lease in Watford town centre) is no longer available to the Trust. The Project Team are resubmitting a paper for approval from TMC, FPC and Trust Board to pursue Unit 11 Thomas Sawyer Way (subject to change in planning permission use and confirmation of capital costs).

The original timeline for delivery was July/August 2020. A revised date will be provided once the revised preferred solution has been confirmed.

3.6 The **Medical Records** Programme Manager commenced their role on 03 August and induction sessions are being held with key project stakeholders.

Creation of a project initiation document has begun with first release due week commencing 24 August for review with the Chief Information Officer. Once the basis of the PID is approved, workstreams for the full business case and procurement can start prior to a full business case being finalised for approval.

3.7 An additional funding request arising from changes to the specification for the project was presented for the **Cardiac Catheter Labs** and approved by CPFG in July 2020, with permission granted to raise purchase orders, prior to an updated paper being presented and approved at August TMC (26 August).

The project team have compiled an estimated timeline with completion by March 2021; a detailed milestone plan is being finalised.

3.8 The Environment Division have agreed the prioritised **Backlog Maintenance Programme** (BLM) works to be undertaken as part of the £2.5m investment included in this year's Capital Programme. A prioritisation process was undertaken as an estimate of the costs and time to complete the list of "High and Significant " BLM works highlighted exceeded that which could be accommodated with the the Capital Programme.

The prioritised list includes works to remedy BLM problems across the full spectrum of services e.g. electrical, mechanical, medical gases, water etc. as well as building fabric repair.

The CFGC have agreed to advance £100k of the £2.5m BLM investment to instigate surveys to facilitate better scope definition for tender documentation.

3.9 This is the fourth consecutive year of significant investment for **Fire Safety Improvements**. As in previous years, a material element of the works will address remedial works in relation to fire door set replacement, fire compartmentation repair and the replacement/extension of emergency lighting (predominantly at SACH and HHH).

Around £1.5m of the £2.5m allocated in this year's Capital Programme will be invested in addressing the works outlined above. The remainder will be used to replace and extend the Trust's aging fire alarms with a standardised compliant system. A significant part of the main distribution network has been successfully replaced at WGH and is being made ready to connect to the exiting local networks. There is still a material amount of work to be undertaken to complete the fire alarm works and a plan is being prepared to ensure that works are sequenced in accordance with the risk assessed priorities.

3.10 The Trust has had to turn down the offer of a static **MRI scanner for SACH** due to the requirement for works to be completed during FY 2020/21. This would require significant capital funding in the enabling works and is not possible to fund or deliver within this year's Capital Programme. The Trust submitted a bid for a modular MRI for the SACH site which has now been confirmed. The Trust will be required to fund enabling works including an upgrade to the HV electricity supply on the site. This represents a pressure to the in-year capital programme.

3.11 Plans are being finalised to install the Wave 2 funded CT Scanner into Level 1 AAU (WGH) by the end of 2020/21.

3.12 DHSC and NHSI&E have approved Public Dividend Capital (PDC) funding in principle for the **Multi-Storey Car Park** (MSCP) enabling works programme. FBC completion has been delayed due to ongoing negotiations with the LABV but the potential impact on the overall timeline can be mitigated. The target date for MSCP completion remains March 2022.

4. Recommendation

The Board is asked to note the update on progress with key strategic projects.

WHHT Board
Thursday 3rd September 2020

Title of the paper	Acute redevelopment Programme Directors update
Agenda Item	13.2/82
Presenter	Helen Brown, Deputy CEO
Author(s)	Duane Passman, Acute Redevelopment Programme Director Laura Wilkes, PMO
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: X
Executive Summary	**Introduction** This Programme Director's update provides a progress summary for the WHHT Acute Redevelopment Programme and was presented to the Great Place Programme Board on 12th August 2020. It gives a dashboard view of progress against the critical path, summarises actions for each of the programme workstreams and outlines the key risks and issues which require escalation. The update is a standing agenda item for the monthly Great Place Programme Board (GPPB) that oversees both the redevelopment and digital transformation programmes. In future the detailed oversight and assurance of the programme with be via the Great Place sub-committee which will meet for the first time in September 2020. Assurance reports will be provided to the Board via the sub-committee in the usual way. **1) Key items of note from 12th August 2020 GPPB are:** • Options Appraisal Investment objectives and Critical Success Factors finalised and process set out for completion of Long-list Appraisal, process remains on track as per programme plan. • Design Brief The first schedule of accommodation, based on light touch activity data was approved at August Great Place Programme Board. Report states that the second schedule of accommodation will be signed off in September 2020, this will now be concluded in October 2020. • Clinical Strategy Paper presented to the Clinical Senate and was well received, formal feedback is awaited • Stakeholder Engagement Stakeholder Reference Group have been engaged on the Longlist Appraisal process as per requirements of the Green Book guidance and further engagement on the proposed shortlist is planned for September 2020 • Procurement The Architect Led Design team have been appointed (BDP), in line with the

programme they will be progressing design work from September 2020.

2) Further recent updates to note:

- New Risk Added – Space Requirements

A new risk has been added to the programme as the initial outputs of the first schedule of accommodation are significantly larger than those detailed at SOC stage. Further work is needed in order to refine the schedule and apply it to the differing estates option and agree the route to affordability.

- Successful end User Engagement

Since producing the original report in July 2020 the risk regarding end user engagement has not materialised. The programme has seen positive engagement (both clinically and operationally) from WHHT through the clinical design process.

Board to note:
Following the inaugural meeting of the Great Place Sub-Committee, to be held on 17th September 2020, future updates will be presented as assurance reports into the Board.

Trust strategic aims

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

Aim 1 Best quality care *Objectives 1-5*	Aim 2 Great place to work *Objectives 6-8*	Aim 3 Improve our finances *Objective 9*	Aim 4 Strategy for the future *Objective 10-12*
X	X	X	X

Links to well-led key lines of enquiry

☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?

Previously considered by

Committee/Group	Date
Programme Steering Group	4th August 2020
Great Place Programme Board	12th August 2020

Action required

The Trust Board is asked to:

- Review the contents of this report and cover sheet, noting areas of

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	progress since the report was drafted.

WHHT Redevelopment

Programme Director's update - Dashboard

Jul-20

NHS West Hertfordshire Hospitals NHS Trust

Programme Summary

RAG STATUS		SOME ISSUES, BEING MANAGED, NEEDS CLOSE MONITORING	KEY	No Change, position remains the same	→	Level of risk/ issue decreased, following activity undertaken	↓	Level of risk/ issue increased, additional work required	↑	

Key achievements in period	Next steps	Lead
1) Options appraisal Progress has been made in undertaking the long list appraisal. This has included final agreement of the Investment Objectives and Critical Success Factors following stakeholder engagement. The programme team have been compiling the evidence base for the appraisal pack, which has included commissioning an independent feasibility report of greenfield site options.	- Panel to undertake long list appraisal on 18th August (including Healthwatch). - TMC approval (subject to stakeholder engagement) 25th August - SRG and PRG engagement in September - GP committee and WHHT Board approval Sep/ Oct	H Brown
2) Design brief Significant end user engagement has taken place this month to further develop the clinical brief. The first schedule of accommodation, based on a light touch refresh of SOC activity data, has been completed, which will be handed over to the design team. The second schedule of accommodation, informed by the OBC activity model and detailed review with operational teams. It is forecast that this will be completed in September, following a group sign off event.	Continue to develop the design brief Finalise the OBC activity model	E Moors
3) Clinical strategy A materials for the clinical senate (5th August) have been produced. The Clinical strategy remains on programme to be agreed at WHHT Board in December 20.	Clinical senate arranged for 5th August	E Moors
4) Stakeholder engagement process developed A Stakeholder Reference Group and Professional Reference Group has been established to support redevelopment planning. Further sessions have taken place this month regarding the digital strategy. In addition, a presentation has been recorded relating to the Green Book business case process, which will go live in early August.	The communications workstream will plan the next stage of engagement for the SRG	L Halfpenny
5) Procurement and resourcing Programme director in post from 20th July. Additional resources have also been added to the Estates and Finance workstreams. Arcadis have been appointed as a cost manager for the scheme through to OBC. The tender for the architect led design team has been undertaken, with negotiations on-going with the preferred supplier. The design team will be appointed later in August.	The programme team will be seeking approval to appoint an Architect led design team at August Programme Board.	P Hennessy

Top risks

Description	Change in month	RAG	Mitigation	Owner
Significant risk that the space requirements captured for the OBC schedule of accommodation will be greater than the requirements captured at SOC stage	↑		Change control processes are to be implemented, against the agreed design principles. Demand management assumptions are being reviewed within OBC activity model.	D Passman
Risk that limited clinical capacity, particularly in the event of a second wave of COVID-19, has an impact on either the timeline for delivery of key outputs (e.g. service packs, 1:200 designs), or the quality of the outputs is compromised.	↓		This risk is being closely monitored, though in July, clinical engagement has been positive. Monthly user groups set up, to develop design brief. The next steps will be to ensure redevelopment is a regular agenda item at relevant existing meetings, and to appoint clinical champions.	E Moors
Risk that assumptions used for light refresh are incorrect, thus requiring significant costly changes and delays to the design process.	→		A light re-fresh of the SOC activity assumptions has been carried out in liaison with the CCG and the clinical workstream. Where concerns have been raised, a risk-based approach was adopted, by 'rounding-up' the requirements. This should allow for opportunities for space reductions once the full activity model is agreed.	D Richards
4) Timescales for delivering enabling schemes (such as pathology & NEQAS) if delayed, risk affecting the timeline for the redevelopment.	→		Regular update on enabling schemes to be provided to Programme Board and mitigation plans reviewed.	D Richards P Hennessy

Work stream status

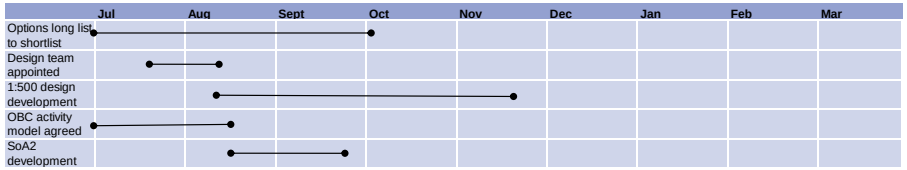
Work stream	RAG	Description
Clinical		Significant engagement has taken place this month to develop clinical brief. The light touch schedule of accommodation has been produced ready to handover to the design team in August. All outputs for the clinical senate have been developed.
Finance, activity & workforce		Following agreement of the light refresh, the F&A workstream have been working to develop the full OBC activity model. This is circa 3 weeks behind schedule though is not forecast to have a critical delay to the programme. Separately, the workstream have been working on the longlist options appraisal process. This has included providing the evidence base to allow PA consulting to undertake the appraisal. The long list appraisal workshop is taking place on 18th August.
Capital & estates		The tender review for the architect led design team is underway. Approval to appoint the design team will be sought at Great Place Programme Board in August. RFL PS are finalising the greenfield site feasibility report, which will include 2 Watford options as a comparator.
Stakeholder engagement & comms		Further SRG and PRG sessions have taken place on the digital strategy. The workstream are planning further sessions, including a Green Book explainer and a session on the clinical strategy.

Top issues

Description	Change in month	RAG	Action	Owner

There is an issue (generally) within the Redevelopment Programme with regard operational capacity within the WHHT Programme team to support the redevelopment	↓		Key roles within the programme are currently being supported by specialist skills (e.g. Healthcare Planners) until resource can be recruited. Additional resource has been added to the programme team this month, including a Programme Director, and other Estates and Finances support.	H Brown
The OBC activity model was programmed to be agreed by the end of July. This is circa 3 weeks behind schedule, which will in turn delay the production of the second schedule of accommodation, and may require user groups to be rescheduled	↑		A resequenced programme has been developed with PA Consulting through to the agreement of the OBC activity model at a sign off workshop on 17th August.	D Richards

Overview of upcoming milestones



Funding draw-down		Comments
Budget FY20/21	£6.522m	
Spent to date	£0.9m	

Trust Board Meeting
03 September 2020

Title of the paper	Corporate Risk Register Report
Agenda Item	14/82
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) to the Trust Board. This report captures the decisions made by the Risk Review Group (RRG) on 11 August 2020. Data for this report was extracted from Datix on 15 August 2020 following updates made at the RRG meeting; a total of 20 open risks were registered on the CRR at that time. The report contains 4 open risks on the CRR arising from the Covid-19 pandemic. All Covid-19 related risks on Datix (on the CRR and Divisional risk registers) are reviewed by the RRG on a monthly basis. These risks are included under a separate report for discussion at this meeting. During the on-going Covid-19 pandemic, this report also contains any risk which is considered outside of the RRG and has received chairs actions. The report was reviewed by Quality Committee on 27 August where the Committee received additional assurance on the strength of the Trust's risk management process
Trust strategic aims	**Aim 1** Best care – *Objectives 1-4* ✓ **Aim 2** Great team – *Objectives 5-8* ✓ **Aim 3** Best value – *Objective 9* ✓ **Aim 4** Great place – *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?

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	☒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	• Risk Review Group on 11 August 2020 • Quality Committee on 27 August 2020
Action required	The Trust Board is asked to review the corporate risk register and endorse the changes to the CRR.

Agenda Item: 14/82

Trust Board Meeting – 03 September 2020

Corporate Risk Register Report

Presented by: Mike van der Watt, Chief Medical Officer

1. Purpose

1.1 The purpose of this report is to provide the Trust Board with an update on the status of the corporate risk register (CRR) including current risk scores, new, escalated, de-escalated, merged and closed risks.

2. Background

2.1 The CRR forms part of the Trust's overall board assurance and integrated risk management arrangements.

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

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

2.4 The CRR contains all risks rated 15 or above from each of the operational/divisional risk registers. The risk register is a 'live' repository of risks recorded on Datix and Risk Owners regularly review and update entries to reflect the current position of the risk.

2.5 Divisions regularly review all their risks rated 12 and under on the risk register and those risks which have been on the register for over two years.

2.6 Risks are closed as appropriate and any outstanding risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to the Quality committee to agree future action.

3. Corporate Risk Register

3.1 This report captures the decisions made by the Risk Review Group (RRG) on 11 August 2020. Data for this report was extracted on 15 August 2020 (following updates made at the RRG); a total of 20 open risks were registered on the CRR at that time.

3.2 A full summary of all corporate risks as presented to the Risk Review Group on 11 August 2020 is provided in Appendix 1.

3.3 The table below presents the movement of risks on the CRR by division, against each month since January 2019.

Table 1 – Movement of risks on the Corporate Risk Register

Division	Risk ref	Jan 2019		Feb 2019		Mar 2019		Apr 2019		May 2019		Jun 2019		Jul 2019		Aug 2019		Sep 2019		Oct 2019		Nov 2019		Dec 2019		Jan 2020		Feb 2020		Mar 2020		April 2020		May 2020		June 2020		Jul 2020		Aug 2020	
Clinical Informatics	3894	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	16	↓	16	→	16	→	16	→	16	→
	3896	16		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	3899	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→
	3897	20	→	20	→	20	→	20	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**12**	↓
	4116	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4197																	20		20	→	16	↓	16		16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
Clinical Support Services	3965	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	2755									16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
Corporate	3828	20	→	20	→	20	→	20	→	15	→	20	→	20	→	15	↓	15	→	15	→	15	→	15	→	15	→	15	→	12	↓	15	↑	15	→	15	→	20	↑	**20**	→
	3120	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→
	4191									15	→			15		15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**15**	→
	4207									16	→							16		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	3949									15	→											15		15	→	15	→	15	→	15	→	15	→	15	→	15	→	**15**	→
	4269																													25		25	→	25	→	25	→	**25**	→
	4292																																	15		15	→	**15**	→
	4280																																			20		**20**	→
	4304																																					**15**	
Emergency Medicine	3995									16	→	15	→	15	→	15		15	→	16	↑	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
Environment	4135							16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	4154									**16**	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	2795									**16**	→	12	↑	20	↑	16	↓	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
Finance	4205																	15		15	→	**15**	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**10**	↓
Medicine	4287																															15		15	→	15	→	**15**	
	4301																																					**12**	↓

Surgery & Cancer	2951																											16		16	→	16	→	16	→	16	→	16	→	**16**	→

Key: Purple = Closed risk   Orange = De-escalated risk   Green = New risk/Escalated risk   Blue = Merged

3.4 **Risk activity**
The following provides an overview of risk activity as discussed at the Risk Review Group on 11 August 2020:

3.4.1 New risks (2)

Two new risks were presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR) but were **not admitted** at this time.

ID	Division	Current Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
4301	Medicine	**20 L5 x C4**	Loss of nutrition Team	The loss of the Nutrition Team – (from May 2020) means that patients on parenteral nutrition (a highly specialised treatment with significant risk) will have no clinical oversight. In addition patients (inpatient and outpatient) will have no clinical review or specialist management. Highly vulnerable patients with learning difficulties and complex eating disorders will have no clinical review. A Nutrition Team, headed by a consultant, is required by NICE and NCEPOD and the lack of a Nutrition Team at an Acute Trust would leave the Trust exposed to complaints; legal challenge; and regulatory concerns by the CQC	The Group discussed the risk and agreed a reduced risk score of 12 due to controls in place to mitigate the risk. The risk will be discussed at the Divisional Governance meeting in respect of the recruitment into the Consultant Lead position. If however, the position remains vacant, the risk may be re-escalated to the CRR at a later date.	**MVdW/TC**

ID	Division	Current Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
4304	Corporate Services	**15 L5 x C3**	End of Life IT Devices/Systems	Running End-of-Life software potentially puts the data infrastructure at considerable risk. The impact from unsecured hardware and software can include: costly data loss; exposure of corporate and personnel data; and network failure Data loss and exposure of corporate and personal data can have a tremendous impact on the business. The General Data Protection Regulations (GDPR) means that the cost in fines for data compromises could be crippling.	The Group discussed the risk and did not approve it for addition to the CRR as the risk had not been through the appropriate governance process. The Group requested that the risk be reviewed and rephrased as the title was misleading and could suggest patient end of life care.	**PB**

3.4.2 Escalated Risks (0)

During this reporting period, there were no escalated risks to consider.

3.4.3 De-escalated risk (1)

One risk was presented to the Group for de-escalation to the Finance Divisional risk register due to reduction in the risk score. After discussion by the Group, it was agreed that this risk should be closed in its entirety.

ID	Division	Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
4205	Finance	15 ↓ 10 **L2 x C5**	Risk of not receiving Financial Recovery Fund as a result of failure to meet base criteria	Current assurances with regard to Trust funding mechanisms mean that this risk is less likely to materialise.	The Group discussed this risk and agreed the risk should be closed in its entirety if the funding mechanism was no longer in place.	**DR**

3.4.4 Closed Risks (1)

One risk was tabled for closure at the RRG and it was agreed it should be closed as it was now mitigated.

ID	Division	Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
4287	Medicine	15 ↓ **L3 x C5**	Inability to provide a safe working environment to maintain patient and staff safety during COVID -19 pandemic	There are clear pathways for the management of patients admitted to the hospital; Risk appropriate PPE is made available; Staff are trained. There are trust-wide rules including the requirement to wear a mask at all times except eating/drinking, social distancing; Use of virtual platforms for meetings etc.	The Group discussed this risk and agreed the risk should be closed as it was now mitigated.	**MVdW**

3.4.5 Reduced risk score (1)

During this reporting period, one risk was considered for reduction in current risk rating but was **not approved**.

ID	Division	Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
4280	Corporate	20 ↓ 15 **L5 x C3**	Workforce Well-Being	This risk was accepted onto the CRR at the last RRG. Following the meeting, a review of the risk consequence score was done and the revised risk score of 15 agreed to reflect the consequence of the risk more appropriately.	The risk was discussed by the Group and the Group did not approve the reduction of the risk score to 15 due to the potential long term impact of the pandemic on the mental well-being of the workforce.	**PDG**

3.4.6 Merged Risk (0)

During this reporting period, there were no merged risks to consider.

3.4.7 Risks receiving Chairs actions (0)

There have been no risks receiving chairs actions since the last RRG meeting on 11 August 2020.

4. Risks arising from the Covid-19 Pandemic

4.1 There are currently 4 open risks on the corporate risk register arising from the Covid-19 pandemic. Risk Leads are required to provide updates on these risks on Datix at least once a month.

4.2 **Emerging Risks**

There were no emerging risks proposed to the RRG for consideration. However, as part of the discussion of the overarching Covid-19 risk on the CRR - Risk ID. 4269 (Risk to service delivery from COVID-19), the Group agreed for an urgent review and reframing of this risk with emphasis on the Trust's recovery plan and a potential 2nd wave.

5. Risks

5.1 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.

6. Recommendation

6.1 The Board is asked to review the CRR and agree the changes made to the CRR during this reporting period.

Mike van der Watt
Chief Medical Officer

August 2020

Appendix 1

Corporate Risk Register – Data extracted from Datix on 15 August 2020 (by Division)

COVID-19 RELATED	ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	PROGRESS NOTE	RATING (CURRENT)	EXECUTIVE LEAD
Clinical Support Services (2)							
No	2755	28/07/2011	Risk of failure of the MRI scanner at HHGH and deterioration in image quality	16	Parts availability ok	16	Sally Tucker
No	3965	11/12/2017	Delays in imaging of patients requiring interventional radiology procedures	16	Team have had further input into plans. Paper went to Trust Management Group in June 2020, OBC to follow.	16	Patrick Hennessy
Clinical Informatics (5)							
No	4116	23/11/2018	Delivery of the Trust's Digital transformation programme	16	The Trust board approved a Strategic Outline Case (SOC) in January 2020 and an Outline Business Case (OBC) in April 2020. Work is currently ongoing to explore an accelerated option.	16	Sean Gilchrist
No	4197	16/08/2019	Missing Patches - ICT Server Estate	16	Patching of the onsite server estate has commenced and is now in month 3 of updating. All servers in Atos world are patched monthly.	16	Sean Gilchrist

No	3894	12/06/2017	ICT Applications reduced availability, poor reliability & performance	20	The ICE upgrade work progresses, with a planned delivery date of October 2020	16	Sean Gilchrist
No	3896	12/06/2017	ICT Data Networks reduced availability, poor reliability & performance	20	Hemel Hempstead and WGC are all completed. Work is currently being undertaken in Watford with a completion date in early September 2020	16	Sean Gilchrist
No	3899	12/06/2017	ICT Trust Bleep System	20	Work ongoing to get the infrastructure ready so that the bleeps can be used. Delivery anticipated for Oct 2020	20	Sean Gilchrist
Corporate Services (8)							
No	3949	24/10/2017	Patient experience and patient safety is compromised due to ongoing challenges with current non-emergency transport provider	15	Risk was discussed at the August RRG. Sally Tucker mentioned that the Trust use of transport had changed during the Covid-19 pandemic. ST agreed to discuss the risk with James Mason outside the meeting and report back to the RRG.	15	Sally Tucker
No	4191	10/07/2019	Risk of a financial liability to Trust following outcome of legal case 'Flowers'	20	Risk reviewed at the August RRG. Outcome of the legal case is still awaited. No change to risk score.	15	Paul Da Gama

Yes	4292	05/06/2020	Inability to have in place mechanisms to monitor the impact of COVID 19 for BAME staff	15	Vitamin D program not going ahead as evidence of link to Covid inconclusive and potentially confusing message for staff; External audit underway to review our policies, processes, strategy and structure; Trust match funding Charity bid for further training and staff to support Connect; Diversity dashboard being developed that will enable Trust to more regularly monitor data throughout the year and therefore respond to trends more pro-actively; and Listening and safe space events to better understand local issues and nuance in BAME staff experience to feed into finalised WRES action plan by October	15	Paul Da Gama
No	4207	12/09/2019	Inadequate post in-patient discharge appointment booking processes	20	Risk discussed at the August RRG. Risk to be brought back to the September RRG following a DIP sample.	16	Sally Tucker
Yes	4280	28/04/2020	Workforce Well-Being	16	Risk reviewed at the August RRG and the Group did not approve the reduction in risk score to 15 and asked for the score to remain at 20 due to the long term impact of the pandemic on the mental well-being of the workforce.	20	Paul Da Gama
No	3120	09/07/2014	Lack of Storage facility for Patient Medical Notes leading to missing, poor condition and delayed location	20	Management of change process due to end 20/03/2020, this is to relocate prep team to Hemel as new area was not cost effective to move into. Notes sanitizing pilot will not be taken forward as documentation not standardized. Failed racking due to be removed week commencing 16/03/2020 and relocated as static in another area to assist with the storage issues in the library at Hemel.	20	Sean Gilchrist

Yes	3828	09/11/2016	Patients may come to harm and have a poor experience due to long waits for elective care	15	No change to assurance or controls. Current risk score remains unchanged and is not expected to reduce until non-urgent care recovery plans are fully implemented.	20	Sally Tucker
Yes	4269	13/03/2020	Risk to service delivery from COVID-19 (Coronavirus)	25	Risk was reviewed at the August RRG. This is the overarching Covid-19 corporate risk. The RRG agreed that the risk will be reviewed and reframed with emphasis on the Trust's recovery plan and a potential 2nd wave.	25	Sally Tucker
Emergency Medicine (1)							
No	3995	06/03/2018	Challenges in Recruitment of Emergency Medicine Medical Workforce	20	No changes to the risk. Meeting held in July with Sally Tucker, Paul de Gamma and Mike van der Watt to discuss consultant recruitment.	16	Mike Van der Watt
Environment (3)							
No	4135	15/02/2019	Lack of A E & CP's across Safety Groups in accordance with HSE and DoH Managing safely guidance and accepted Codes of Practice	20	Statutory Compliance meetings for all specialisms commenced in June 2020	16	Patrick Hennessy
No	4154	08/04/2019	Non-compliance with HTM00 (safe systems of work)	16	Risk reviewed at the August RRG. Last remaining issues closed out; pending review and independent assurance by the Fire Brigade. Risk score to be reviewed at the Fire Safety Group following Fire Brigade review.	16	Patrick Hennessy

No	2795	15/12/2011	Management and control of - Asbestos Containing Materials (ACMs)	20	Permit to work system and contractor induction review - Monitor and review in line with Site Control Officer role. - July 2020 MICAD project Lead in post - asbestos is a priority - Review July 2020 Statutory Compliance meetings commenced June 2020 - Asbestos is part of the Specialist Groups. Will be monitored via this forum, Div Governance and Health and Safety - Review July 2020	16	Patrick Hennessy
Surgery & Cancer (1)							
No	2951	05/12/2013	Insufficient anaesthetic staffing levels impacting on patient care	16	Risk discussed at the August RRG. No change to risk score.	16	Paul Da Gama

DRAFT

Great Place Committee
Terms of Reference

Status:	Committee of the Trust Board
Chair:	Non-Executive Director
Executive Lead:	Deputy Chief Executive
Clerk:	TBC
Frequency of meetings:	Bi-monthly
Quorum:	Two Non-Executive Directors (one of which must chair the committee) and two Executives

Introduction

The Trust has developed four key aims as part of its five year strategy 2020-2025. Aim 4 is "Great Place". The Trust recognises that poor estate and digital infrastructure has a negative impact on the experience of patients and staff. The Great Place aim addresses this twin challenge – renewing and upgrading buildings and IT so that both patients and staff can benefit from modern, fit for purpose care facilities. The Great Place Committee is established under delegated authority from the Trust Board to gain assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and to provide senior level leadership to shape and drive the implementation of these key elements of the Trust's strategy.

1. Constitution

1.1. The Trust Board (the Board) hereby resolves to establish a Committee of the Board to be known as the Great Place Committee. The Committee has no powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Trust Board.

1.2. The committee is authorised by the Board to investigate any activities within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

2. Purpose

2.1. The purpose of the Committee is to gain assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and to provide

senior level leadership to shape and drive the implementation of the Great Place elements of the Trust's strategy.

3. Membership

3.1. The Committee will be appointed by the Board and its membership will consist of:

- Non-Executive Director Chair
- Non-Executive Director Deputy
- Non-Executive Director (nominated reserve)
- Chief Executive Officer
- Deputy Chief Executive Officer
- Chief Information Officer
- Chief Medical Officer
- Chief Nurse and Director of Infection Prevention and Control
- Chief Operating Officer
- Chief People Officer
- Chief Financial Officer
- Associate Medical Director, clinical strategy
-

3.2. The following will attend the Committee on a regular basis

- NHSE/I Director of Strategy and Implementation
- CCG Accountable Officer
- CCG Chair
- Representative of Healthwatch Hertfordshire
- Great Place Programme Director

3.3. Executive Directors will nominate an appropriate deputy if they are unable to attend a meeting. A deputy must be able to make decisions on behalf of the Executive and will be recognised as part of the quorum.

3.4. All Non-Executive Directors have a standing open invitation to attend any meetings of the Committee and to have access to the agenda and papers on request from the Committee Clerk or the Trust Secretary. They will not however count against the quorum.

3.5. Should the quoracy not be met, the meeting will go ahead on the understanding that no key decisions can be made or significant actions taken.

4. Duties and Responsibilities

4.1. To ensure good governance arrangements are in place for the Great Place programme, ensuring that strong, compelling recommendations are made to the Trust Board.

4.2. To ensure that the right structures, leadership and capability are in place to deliver the programmes on time and within budget.

4.3. To review the outline business cases and full business cases prior to making recommendations to the Trust Board

4.4. To review options appraisals, procurement strategies and other relevant proposals prior to making recommendations to the Trust Board

4.5. To monitor the progress of the programmes and achievement of core aims and objectives within agreed timescales, ensuring any potential variances are highlighted in a timely way

4.6. To ensure alignment of key programmes to the Trust strategy, ensuring opportunities for cross-organisational projects are identified and enabled, utilising the Board Assurance Framework and Corporate Risk Register.

4.7. To receive regular reports from the Great Place Programme Board (requires a rename) on the actions being taken to mitigate the principle risks and monitor controls and assurance sources.

4.8. To ensure communication within the Trust and across the health and care system is strong and in line agreed communications objectives across the ICP and ICS.

5. Accountability and Reporting Arrangements

5.1. The Committee will be directly accountable to the Trust Board.

5.2. The Chair of the Committee will prepare an assurance report to the Board detailing items discussed, actions agreed and issues referred to the Board.

5.3. The Committee will escalate to the Board any issues of concern through identified unresolved risks arising from the scope of these terms of reference, that require executive action or that pose significant threats to the operation, resources of reputation of the Trust.

5.4. Members of the Committee should act in the interests of the Trust as a whole and should not confine focus to representing or advocating for their respective department, division or service area. This will ensure the focus of the Committee is maintained on Trust wide governance.

5.5. The Committee will report annually to the Audit Committee who will review the work of the Committee to ensure it is working efficiently and meeting the terms of reference.

6. Review and Monitoring

6.1. The Committee will undertake and evidence an annual self-assessment review of its performance in order to evaluate its effectiveness, the fulfilment of its functions in connection with the terms of reference and achievement duties. This report will be provided to the Audit Committee as part of the Annual Assurance Report.

6.2. Terms of reference will be reviewed annually and approved by the Board.

Ratified by:	Trust Board
Date of ratification:	**x**
Date of review:	**x**

Agenda Item: 16/82

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**03 September 2020**
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 meetings on 24 June and 29 July..

Background

The Committee meets 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 of 24 June

- An update on COVID-19 recovery and it was noted a potential second wave is being planned for
- A COVID-19 risk update was provided by the Chief Medical Officer.
- The Committee reviewed the Infection Prevention and Control BAF and noted the report, evidence and assurance of the gap analysis.
- The Chief Nurse advised that the Trust is keeping with the quality priorities allocated for 2020/21. Publication of the quality account has been delayed until December due to COVID-19.
- The Bi-annual Establishment Review – Adult Inpatient Wards was received for assurance.
- The Committee reviewed options for appraisal dates and agreed for Appraisals to be linked with the incremental start date, but messaging needs to be carefully considered due to the pandemic, therefore agreeing not to stop people's increments for this year. Full change to be made from April 2021.
- A staff wellbeing report was received to provide an overall of current support mechanisms available to staff to support them in the immediate aftermath of COVID19 and also to detail the approach to detail an outline for internal thinking on this issue
- The CFO advised that budgets have been set for the Divisions as per pre-COVID, which has allowed us to measure the effect of COVID.

Topics covered at the meeting of 29 July

- The Deputy CEO gave an update on the COVID Recovery Plan. Divisions will be contacted regarding reinstating all services over the next period, which will set a framework for each specialty. A new group will be set up that will focus on the COVID protected elements of the programme.
- The Committee supported the Theatres Development FBC.
- The Committee supported a case for the pilot on the use of body cameras to commence.
- The conclusion of the bi-annual midwifery report was that the report meets all the criteria for the CNST for the maternity safety standards and also establishes that with an increase in births to 4,440 the Trust has have necessary funding to maintain the 1-26 birth to Midwife ratio.
- The Committee supported the continuation of providing testing services in the short term.
- The Chief People Officer gave an overview of the outcome of the COVID staff survey which had been run over two weeks. It was noted that the experience of our staff being in a major hot spot for Covid is very intense compared to elsewhere in the country. Results should be fed back to the divisions to have honest discussions regarding what we could have done better.
- The Deputy CEO provided a strategy update

Risks to refer to the risk register	None
Items to escalate to the Board	None
Attendance	See next page

Summary of the Trust Management Committee

Held on 24 June 2020

Executive Meeting Room, Watford Hospital

Name	Title	Attendance
Allen Christine	Chief Executive	Y
Members		
Brown Helen (HB)	Deputy Chief Executive	Virtual
Banks Freddie (FB)	Associate Medical Director, Clinical Strategy	Virtual
Barlow Andy (AB)	Divisional Director, Medicine	Apologies
Bannister Paul (PB)	Chief Information Officer	Virtual
Bhatti Mary (MBh)	Divisional Manager, Women and Children's	Virtual
Borkett-Jones Howard (HBJ)	Associate Medical Director for Education	Virtual
Carter Tracey (TC)	Chief Nurse and Director of Infection, Prevention and Control	Virtual
Cato Sarah (SC)	Lead Nurse, Emergency Medicine	Apologies
Da Gama Paul (PdG)	Director of Human Resources	In person
Gaunt David (DG)	Chief Clinical Information Officer	Virtual
Gertler Fran (FG)	Director of Integrated Care	Virtual
Gilchrist Sean (SG)	Director of Digital Transformation	Virtual
Halfpenny Louise (LH)	Director of Communications	Virtual
Hennessy Patrick (PH)	Director of Environment	Apologies
Hoey Rachel (RH)	Director, Emergency Care	Apologies
Johnson Stephanie (SJ)	Divisional Manager, Medicine	Virtual
Keble Martin (MK)	Chief Pharmacist and Divisional Manager, Clinical Support	Virtual
King Paula (PK)	Head of Nursing, Surgery, Anaesthetics and Cancer	Virtual
Mason James (JMa)	Head of Emergency Planning & Resilience	Virtual
McKee Jason (JMc)	Divisional Manager, Surgery, Anaesthetics and Cancer	Virtual
Mannion Collette (CM)	Director of Midwifery	Virtual
Miles-Kemp Natalie (NMK)	Head of Programme Delivery Support	Virtual
Moors Esther (EM)	Acute Redevelopment Programme Director	Virtual
Odlum Elaine (EO)	Divisional Manager, Medicine	Virtual
Clare Parker	Director of Integrated Care Partnership Development	Virtual
Pindai Rodney (RP)	Director of Contracts, Efficiency and Commercial Development	Virtual
Richards Don (DR)	Chief Financial Officer (Chair)	In person
Reece Ashley	Associate Medical Director for Medical Education	Virtual
Shentall Jane (JS)	Director of Performance	Virtual
Thorpe David (DT)	Deputy Chief Nurse	Virtual
Tucker Sally (ST)	Chief Operating Officer	In person
Van Der Watt Mike(MVDW)	Chief Medical Officer	In person
Wellman Angela (AW)	Head of Nursing Medicine and Emergency Medicine	Virtual
Walker Karen (KW)	Head of Nursing, Children's	Virtual
West Simon	Divisional Director, Surgery, Anaesthetics and Cancer (from 1/04/20)	Apologies
While Rod	Trust Secretary	Virtual
Whittle Natalie	Divisional Manager for Clinical Support Services	Virtual
Wood Anna (AWo)	Deputy Medical Director & Associate Medical Director, Clinical Standards & Audit	Virtual
In attendance		
Alderman Julia (JA)	Business Co-ordinator to CEO & Chairman	In person
Liam Cummins	Estates	Virtual

Summary of the Trust Management Committee

Held on 29 July 2020

Executive Meeting Room, Watford Hospital

Name	Title	Attendance
Allen Christine	Chief Executive	In person
Members		
Brown Helen (HB)	Deputy Chief Executive	In person
Ball Adrian (Aba)	Divisional Manager, WACS	Apologies
Banks Freddie (FB)	Associate Medical Director, Clinical Strategy	Apologies
Barlow Andy (AB)	Divisional Director, Medicine	Virtual
Bannister Paul (PB)	Chief Information Officer	In person
Bhatti Mary (MBh)	Divisional Manager, Women and Children's	Apologies
Borkett-Jones Howard (HBJ)	Associate Medical Director for Education	Apologies
Carter Tracey (TC)	Chief Nurse and Director of Infection, Prevention and Control	Virtual
Cato Sarah (SC)	Lead Nurse, Emergency Medicine	Apologies
Da Gama Paul (PdG)	Director of Human Resources	In person
Forson William (FW)	Divisional Director WACs	Virtual
Gaunt David (DG)	Chief Clinical Information Officer	Apologies
Gertler Fran (FG)	Director of Integrated Care	Virtual
Gilchrist Sean (SG)	Director of Digital Transformation	Virtual
Halfpenny Louise (LH)	Director of Communications	Virtual
Hennessy Patrick (PH)	Director of Environment	Virtual
Hoey Rachel (RH)	Director, Emergency Care	Apologies
Johnson Stephanie (SJ)	Divisional Manager, Medicine	Virtual
Keble Martin (MK)	Chief Pharmacist and Divisional Manager, Clinical Support	Apologies
King Paula (PK)	Head of Nursing, Surgery, Anaesthetics and Cancer	Apologies
Mason James (JMa)	Head of Emergency Planning & Resilience	Virtual
McKee Jason (JMc)	Divisional Manager, Surgery, Anaesthetics and Cancer	Virtual
Mannion Collette (CM)	Director of Midwifery	Virtual
Miles-Kemp Natalie (NMK)	Head of Programme Delivery Support	Apologies
Moors Esther (EM)	Acute Redevelopment Programme Director	Virtual
Odlum Elaine (EO)	Divisional Manager, Medicine	Virtual
Clare Parker	Director of Integrated Care Partnership Development	Virtual
Pindai Rodney (RP)	Director of Contracts, Efficiency and Commercial Development	Virtual
Richards Don (DR)	Chief Financial Officer (Chair)	In person
Reece Ashley	Associate Medical Director for Medical Education	Apologies
Shentall Jane (JS)	Director of Performance	Virtual
Thorpe David (DT)	Deputy Chief Nurse	Apologies
Tucker Sally (ST)	Chief Operating Officer	Apologies
Van Der Watt Mike(MVDW)	Chief Medical Officer	In person
Wellman Angela (AW)	Head of Nursing Medicine and Emergency Medicine	Apologies
Walker Karen (KW)	Head of Nursing, Children's	Virtual
West Simon	Divisional Director, Surgery, Anaesthetics and Cancer (from 1/04/20)	Virtual
While Rod	Trust Secretary	Virtual
Whittle Natalie	Divisional Manager for Clinical Support Services	Virtual
Wood Anna (AWo)	Deputy Medical Director & Associate Medical Director, Clinical Standards & Audit	Virtual
In attendance		
Alderman Julia (JA)	Business Co-ordinator to CEO & Chairman (**note taker**)	In person
Tania Marcus		Virtual
Jeremy Livingstone		Virtual

Agenda Item: 20a/81

20

Report to:	The Trust Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	03 September 2020
Recommendation:	For assurance
Chairperson:	Paul Cartwright, Non-Executive Director
Purpose	The report summarises the assurances received by the Audit Committee at the meeting held on 24 July.

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

- The Audit Committee undertook a self-assessment of its performance to measure its effectiveness and reviewed two self-assessment check lists. The first was focused on Committee administration and the second on the operational aspects of the Committee's work. At the meeting it was suggested that narrative be developed to indicate how the Committee might move from "agree" to "strongly agree" on a number of points relating to the Committee's operational responsibilities. After the meeting, the two Non-Executive Directors developed a more detailed narrative and this is described in the accompanying annual report.

- The Committee received a progress report from the new internal audit provider BDO. BDO noted that a full handover had taken place with previous internal audit provider RSM and presented an update on actions taken to address recommendations of audits undertaken during 2019-20. The Committee expressed disappointment that some actions had not been completed due to apparent miscommunication within the Trust.

- The annual report and regular progress report was received from the Local Counter Fraud Specialist and the Committee was assured that good progress had been made in the Trust's self-review submission. It was noted that project alpha had been submitted to the CPS for a charging decision. Two fairly low level referrals had been received in the reporting period.

- The Committee received the annual audit letter from external auditors and this has now been published on the Trust website. http://www.westhertshospitals.nhs.uk/about/external_reports.asp

- As part of the regular system of reviews of Board Committee performance an assurance report was received from the Chief Executive on the activities of the Trust Management Committee (TMC). The Committee observed that TMC was working well with good alignment with the Board programme of business.

- A report was received on salary overpayments and the Committee was disappointed to note that little apparent progress had been made on this issue. It was agreed that a root cause analysis would be undertaken on specific examples of overpayment.

Risks to refer to risk register None

Issues to escalate None

Attendance record

Attendees

Paul Cartwright, Non-Executive Director (Chair)
John Brougham, Non-Executive Director
Don Richards, Chief Financial Officer
Rod While, Trust Secretary
Stephen Dunham, Associate Director Efficiency, Costing and Financial Risk
Onali Mohamedali, Financial Controller
Greg Rubens BDO
Ciaran McLaughlin Grant Thornton
Ade Oyerinde Grant Thornton

In attendance for specific items
Christine Allen, Chief Executive

Board Meeting
3 September 2020

Title of the paper	**Audit Committee Annual Report 2019/20**
Agenda Item	20b/82
Presenter	Paul Cartwright Committee Chair
Author(s)	Rod While Trust Secretary
Purpose	*Please tick the appropriate box ** Refer to guide on second page* *For information and assurance*: *For discussion and assurance*: x *For approval*:
Executive Summary	In line with best practice in other sectors, the Audit Committee is required to prepare an annual report to the Board that sets out how the Committee had discharged its responsibilities and met its terms of reference. The annual report focuses on the activities undertaken by the Audit Committee for the year 01 April 2019 to 31 March 2020 and also includes key activities between April and July 2020. Points of note during the year: • No significant causes for concern were noted by the Committee • A programme of assurance reports from the other Committees continued throughout 2019/20 and the Audit Committee was assured that the Committees were meeting their terms of reference. • The external Auditors issued an unqualified opinion on the financial statements and a qualified value for money opinion • The Head of internal Audit issued his annual opinion as Level 2 opinion for governance and risk management and a level 3 opinion for system of internal controls
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care – *Objectives 1-4*: x **Aim 2** Great team – *Objectives 5-8*: x **Aim 3** Best value – *Objective 9*: x **Aim 4** Great place – *Objective 10-12*: x
Links to well-led key lines of enquiry	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care?

<table>
<tr><td></td><td>☒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?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Audit Committee</td><td>24 July 2020</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for discussion and assurance on the work of the Audit Committee</td></tr>
</table>

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda Item: 21b/82

Board meeting – 03 September 2020

Draft Audit Committee Annual Report 2019-20

Presented by: Audit Committee Chair

1. Introduction

The Audit Committee is a senior independent non-executive Committee of the Board. This report summarises the activities undertaken by the Committee to satisfy its terms of reference for the year 01 April 2019 to 31 March 2020. The report also includes key activities between April and July 2020

2. The role and operation of the Audit Committee

The NHS Code of Conduct and Accountability and the NHS Audit Committee Handbook requires that an Audit Committee is established to provide an independent and objective view to the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes and securing economic, efficiency and effectiveness (value for money).

The establishment and constitution of the Audit Committee is mandated by the Trust's standing orders, which were updated and endorsed by the Board in October 2019.

The Audit Committee is authorised to take decisions on behalf of the Board on matters relevant to the purpose of the Committee (but not reserved to the Board), to obtain outside legal or other independent professional advice, and to secure attendance of outsiders with relevant experience and expertise if they consider this to be necessary.

2.1 Governance, establishment and duties

2.1.1 Membership of the Committee

Members of the Audit Committee are appointed by the Board to ensure that the non-executive directors have sufficient knowledge to identify key risk areas and to challenge both management and the Auditors on critical and sensitive matters. As well as the three non-executive Committee members, there is an open invitation to the remaining non-executives to attend Audit Committee meetings if they wish.

The Chief Financial Officer, Deputy Chief Executive and Deputy Medical Director regularly attended meetings during the year and the Chief Executive attended when the Committee considered the mandated annual documents. Internal Auditors, external Auditors and the local counter fraud specialist also attended meetings. In line with best practice which dictates that there should be a nurse in attendance at meetings, the Chief Nurse was also a regular attendee of the Committee.

The trust secretary provided support to the chair and the wider Committee.

The members of the Committee disclosed their declarations of interest at each meeting. The following were the interests declared as at 01 April 2020, however it should be noted that these may have changed during the reporting year:

Paul Cartwright, non-executive director and chair of Audit Committee

- Member of Council of King's College London
- Member of Charity Committee for West Hertfordshire Hospitals NHS Trust

John Brougham, non-executive director

- Non-Executive Director and Chair of the Audit Committee of Technetix Ltd

Natalie Edwards, associate non-executive director

- None

2.1.2 Meetings and attendance

All meetings were quorate and chaired by a non-executive director. Natalie Edwards was a nominated reserve non-executive director and therefore was only required to attend meetings when the quorum would be compromised. A breakdown of attendance of meetings is presented below:

	Audit Committee members		
Meeting date	Paul Cartwright (chair of Committee)	John Brougham	Natalie Edwards (nominated reserve)
10 May 2019	✓	✓	Not required
23 May 2019 *(extraordinary to approval of annual documents)*	✓	✓	Not required
05 June 2019	✓	✓	Not required
19 July 2019	✓	✓	Not required
18 October 2019	✓	✓	Not required
6 March 2020	✓	Apologies	✓

2.1.3 Terms of reference

The Committee's terms of reference (appendix 1) were reviewed against the revised guidance for Audit Committees issued by the UK Corporate Governance Code and the Financial Reporting Council (FRC) in April 2018 and adopted by the Board on 05 September 2019.

2.1.4 Delivery of the work plan

The work of the Committee was delivered around a structured work plan (appendix 2), aligned with its terms of reference and endorsed by the Board on 05 September 2019. Each meeting agenda included the standing items listed below, with the exception of meetings on 23 May 2019, which focused on the development and approval of the annual documents and 5 June 2019, which focused on the approval of the quality account.

- Chief financial officer's overview
- Internal Audit progress report
- Local counter fraud report
- External audit progress report
- Review of the following:

- Tender waiver register
- Losses and compensation register
- Review of salary overpayments
- Hospitality and gifts register
- Central register of interests
- Trust seal

The Committee reviewed the arrangements in place to manage risk, including the maintenance and monitoring of the board assurance framework (BAF). The Committee received assurance that the risk management strategy and procedure had been reviewed to reflect a revised governance structure and were informed that work had continued throughout the year to improve the board assurance framework (BAF) and, following approval of a refreshed set of strategic objectives, the format of the BAF had been reviewed to ensure that it fully met the needs of the Board. Internal and external Auditors acknowledged that the risk and governance arrangements had improved significantly over the past few years.

On a rolling programme, the non-executive chair and executive lead for each Committee provided assurance to the Audit Committee that the other Committees were operating effectively and were appropriately controlling risk.

The Committee reviewed and the 2018/19 quality account on behalf of the Trust Board prior to publication on 30 June 2019 and prior to formal presentation to the Board in July.

During the year, the Committee continued to systematically monitor and have 'deep dives' into the controls in place around tenders, losses and compensation and salary overpayments. In July 2019, the director of environment was invited to attend the Audit Committee meeting to provide assurance around plans to address long standing issues with tender and waivers. He advised that actions included the development of measured term contracts, which invited services to tender for individual work packages with a schedule of rates for various activities. To provide added assurance a dip testing process would also be undertaken.

The Committee was disappointed that despite additional controls being put in place, no significant improvement had been achieved in performance of salary overpayments and requested an update on actions to remedy this long standing issue in spring 2019.

In addition to the areas covered above, during 2019/20, the Audit Committee also monitored the following areas:

- The Integrated Care System (ICS) governance
- Whistleblowing/freedom to speak up
- The implementation of the Conflicts of Interest Policy
- Valuation of land
- Estates procurement and contract management
- Progress against the well-led action plan
- Clinical audit plan
- Standing financial instructions, standing orders and scheme of delegation
- Annual accounts and annual report, including annual governance statement
- Directors' liability insurance
- Insurance policy compliance

2.1.5 Reporting from the Committee

The chair of the Committee provided an assurance report to the Board following each meeting and escalated areas of concern and underperformance.

3. COVID-19 Pandemic

Following the declaration of a level 4 national incident on 3 March 2020, interim governance arrangements were put in place to maintain reasonable and appropriate processes and effectively streamline activities to prioritise Executive and clinical focus on COVID-19. The Audit Committee requested a desktop review be carried out to ensure that all decisions made by the Trust during the pandemic had been appropriate an in line with the Trust's standing orders. As a result of the review the Committee took assurance that decisions taken during the COVID-19 pandemic for the period 5 March to 28 May were appropriate and in line with the Trust's Standing Orders.

4. Independent assurance

4.1. Internal Audit

RSM acted as the Trust's internal Auditors in 2019/20 and a structured Audit plan was approved by the Audit Committee March 2019. RSM provided progress reports on the delivery of the plan at each meeting and an end of year report. During 2019/20, internal audit issued two reasonable assurance opinions and five partial assurance opinions. In addition, there were three advisory reports.

All internal audits were mapped to an assurance Committee and aligned to an executive lead to ensure full ownership. A full report was received at each meeting on progress towards implementing the recommendations, with particular attention paid to overdue actions, and the Committee was pleased to note that the timeframe for closing recommendations improved during the year in line with increased focus by the trust executive Committee.

For the 12 months ended 31 March 2020, the head of internal audit opinion for
The Trust was
Level 2 opinion for governance and risk management
In general, the organisation has an adequate and effective framework for risk management and governance.
Level 3 opinion for system of internal controls
There are weaknesses in the framework of internal control such that it could be inadequate and ineffective.

In the summer of 2019, the Trust ran a competitive tender for internal audit services and this was won by BDO which became responsible for internal audit from April 2020.

4.2. External Audit

External audit services were provided by Grant Thornton UK LLP (GT) and it completed a full and thorough audit of the Trust's accounts for 2019/20. The Committee reviewed the external auditor findings prior to considering approval of the annual accounts and was assured to note that the auditors would be issuing an unqualified audit opinion on the financial statements and a qualified opinion on value for money.

On behalf of the Board, the Audit Committee approved the signing of the accounts by the chief executive and chief financial officer for submission to NHS Improvement on 25 June 2020.

During the year, the contract with Grant Thornton for external audit services was extended for a further two years.

4.3. Local counter fraud service

Local counter fraud services were provided by RSM. Regular reports were received through the year from the local counter fraud services which provided assurance to the

Committee and provided detail on investigations undertaken to counter fraudulent activities. The Committee received assurance that benchmarking had suggested that that the Trust's counter fraud measures were as effective as other Trusts.

A major activity during the year was "Project Alpha" – this was relating to an allegation that a manager has procured a piece of stolen medical equipment for use at the Trust and has subsequently submitted invoices to the Trust purporting to be from an overseas hospital for loan and purchase fees. The investigation was passed on to the NHS Counter Fraud Authority, though this was then subject to lengthy delays.

In the summer of 2019, the Trust ran a competitive tender for local counter fraud and this was won by the current incumbent provider, RSM.

5. Internal assurance

5.1. Freedom to Speak Up (whistleblowing)

The Freedom to Speak Up (FTSU) arrangements were reviewed by the Committee at its October meeting. The Committee was assured that prior to the issue of new guidance in July 2019, the Trust had been compliant with national requirements, however it was reported that there was still work to do to meet all the requirements of the updated guidance. The Committee agreed that FTSU had been impactful, thoughtful and energetic and sometimes a useful augmentation to the Trust. Concern was raised that the change of guidance could potentially override established employee relations policies and procedures and, although the Committee acknowledged that a number of external organisations expected the Trust to follow the new guidance, the Committee agreed with the Trust's approach of channelling normal day to day complaints and issues through established HR processes rather than through FTSU.

5.2. Audit performance

The Audit Committee undertook a self-assessment of its performance to measure its effectiveness on 10 May 2019. The outcome of the self-assessment revealed that the Committee had met its terms of reference in 2019/20.

A further self-assessment took place in July 2020 when the Committee reviewed two self-assessment check lists. The first was focused on Committee administration and the second on the operational aspects of the Committee's work. At the meeting it was suggested that narrative be developed to indicate how the Committee might move from "agree" to "strongly agree" on a number of points relating to the Committee's operational responsibilities. After the meeting, the two Non-Executive Directors developed a more detailed narrative as shown below in section 6 below.

6. Non-Executive Director Observations

- Frequency of meetings: The Committee believes that it meets the right number of times for regular business; the removal of two meetings two years ago continues to seem appropriate. The informal 'WHHT only' audit meeting introduced five years ago is no longer needed as WHHT report production is now very efficient. The Committee will adopt a 15 minute agenda item at one of the four existing full audit meetings to check that annual regulatory reporting production is going smoothly and cease to have an informal meeting.
- NEDs: The Chair of Finance and Performance Committee should continue to be the 2nd NED. The Chair of Audit should continue not being a member of Finance Committee. The reserve NED from PERC is appropriate.
- Executive Attendance: Following the inclusion two years ago of the Chief Nurse we now have the right attendees from the Trust with senior Nursing, Medical, Finance and new hospital development represented. Good questions are asked and asked well. The Committee would benefit from Operations attendance given that some of

the perennial problems have an operations component. In an executive's absence, appropriate deputies should be sent and no constituency should be uncovered at Audit. The Committee members also agreed that whenever controls are found to have seriously failed, or corrective actions are well overdue, the responsible Executive should be called to the committee to confirm ownership, explain and assure corrective actions.

- External Professional Service Providers: After recent tender process, all are appropriate and internal audit and counter fraud continue to be best provided externally. Clarity of new internal audit reporting is promising. Progress on Counter fraud is welcome. External Audit is working well.
- Overall Approach: Rolling enquiry into the operation of each subcommittee and keeping substantive audit work in those committees (eg main substantive review and follow up of internal audit reports) as far as possible seems right. Some things (the 'hardy perennials' such as tender waivers) could happily fit in Finance or Audit but are probably best left as they are. If they moved to Finance, we could cut an Audit Meeting but at the cost of stretching the time of an already busy Finance Committee and distracting from main purpose.

7. Conclusion

As chair, I can confirm that the Audit Committee has reviewed its business over 2019/20 and appropriate steps have been taken to perform its duties as delegated by the Board. There are no significant issues of concern for the Board in this annual report.

The Committee has contributed to improving internal control within the Trust and can provide the Board with assurance that, by meeting its terms of reference, the Committee has scrutinised the levels of controls in place to ensure the Trust remains compliant with its legislative and statutory duties.

In making this statement, the Committee acknowledges the support provided to it by management, in particular the chief financial officer, the deputy chief executive, the deputy medical director, the trust secretary, and by the internal and external auditors.

During 2020/21, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its effectiveness.

Paul Cartwright
Chair, Audit Committee

July 2020

Appendix 1. Terms of reference 2019/20.
Appendix 2. Work plan 2019/20.