TRUST BOARD MEETING IN PUBLIC
AGENDA

01 October 2020 at 11.30 – 14.00
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
11.30	01/83	**Opening and welcome**	Information	Chair	Verbal
	02/83	**Patient story**	Information	Chief Nurse	Verbal
11.50	03/83	**Apologies for absence**	Information	Chair	Verbal
	04/83	**Declarations of interest**	Information	Chair	Paper
	05/83	**Minutes of previous meeting on 3 September 2020**	Information	Chair	
	06/83	**Board decision log.**	Information	Chair	Paper
	07/83	**Chair's and Chief Executive's report**	Information	Chair / Chief Executive	Paper
12.00	08/83	**Board Assurance Framework**	Information and assurance	Chief Executive	Paper
12.05	09/83	**Activity Recovery Update & Access Standards Performance**	Information and assurance	Chief Operating Officer	Paper
	10/83	**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
12.20	11/83	**Annual Serious Incidents Report**	Information and assurance	Chief Medical Officer	Paper
12.30	12/83	**Quarterly learning from deaths report**	Information and assurance	Chief Medical Officer	Paper
15 Minute Break					
12.55	13/83	**Bi-annual establishment review - adult in-patient wards**	Information and assurance	Chief Nurse	Paper

13.00	14/83	**Strategic Priorities Update:** **14.1 Strategic Priorities Update** **14.2 Strategic objectives delivery update report**	Information and assurance	Deputy Chief Executive	Paper
13.10	15/83	**COVID recovery report**	Information and assurance	Deputy Chief Executive	Paper
13.20	16/83	**Office Relocation of HR & Finance**	Approval	Chief People Officer	Paper
13.35	17/83	**Corporate risk register report**	Approval	Chief Medical Officer	Paper
13.40	18/83	**Assurance report from Trust Management Committee**	Information and assurance	Chief Executive	Paper
	19/83	**Assurance report from People, Education and Research Committee**	Information and assurance	Chair of Committee/Chief People Officer	Verbal
	20/83	**Assurance report from Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
	21/83	**Assurance report from Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	22/83	**Assurance report from Charity Committee**	Information and assurance	Chair of Committee / Deputy CEO	Paper
	23/83	**Assurance report from Great Place Committee**	Information and assurance	Chair of Committee / Deputy CEO	Paper
13.50	24/83	**Any other business previously notified to the chair**	N/A	Chair	Verbal
13.55	25/83	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal
	26/83	**Questions from our patients and members of the public**	N/A	Chair	Verbal
14.00	27/83	**Date of the next board meeting: 5 November** Executive Meeting Room and via Zoom, Watford Hospital	Information	Chair	Verbal

Acronyms and abbreviations

A

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

B

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

C

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

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

D

DBS	Disclosure Barring Service
DCC	Direct Clinical Care
DD	Divisional Director
DGH	District General Hospital
DGM	Divisional General Manager
DM	Divisional Manager
DIPC	Director of Infection Prevention and Control
DHSC	Department of Health and Social Care
DNA	Did Not Attend
DNR	Do Not Resuscitate
DO	Developing our Organisation
DoC	Duty of Candor
DoLS	Deprivation of Liberty Safeguards
DPH	Director of Public Health
DQ	Data Quality
DTA	Decision to admit
DTOC	Delayed Transfers of Care
DQ	Data Quality

E

EA	Executive Assistant
EADU	Emergency Assessment and Discharge Unit
ECG	Echocardiogram
ECIP	Emergency Care Improvement Programme
ED	Emergency Department
ED	Executive Director
EDD	Expected Date of Discharge
EDS	Equality Delivery System
EHR	Electronic Health Record
EHRC	Equality and Human Rights Commission
EIA	Equality Impact Assessment
ENHT	East & North Herts NHS Trust
ENT	ear, nose and throat
EoE	East of England
EoL	End of Life
EPAU	Early Pregnancy Assessment Unit
EPRR	Emergency Preparedness, Resilience and Response
ERAS	Enhanced Recovery Programme after Surgery
ESR	Electronic Staff Record
EWTD	European Working-Time Directive

F

FBC	Full Blood Count
FBC	Full Business Case
FCE	Finished Consultant Episode
FFT	Friends and Family Test
FD	Finance Director
FGM	Female genital mutilation
FOI	Freedom of Information
FRR	Financial Risk Rating
FSA	Food Standards Agency
FT	Foundation Trust
FTE	Full Time Equivalent
FYE	Full Year End

G

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

H

H&S	Health and Safety
HAI	Hospital Acquired Infection
HAPU	Hospital Acquired Pressure Ulcer
HCA	Health Care Assistant
HCAI	Healthcare-Associated Infections
HCC	Hertfordshire County Council
HCT	Hertfordshire Community NHS Trust
HDA	Health Development Agency
HDD	Historical Due Diligence
HDU	High Dependency Unit
HEE	Health Education England
HHH	Hemel Hempstead Hospital
HES	Hospital Episode Statistics
HIA	Health Impact Assessment
HITP	Hertfordshire Integrated Transport Partnership
HON	Head of Nursing
HPA	Health Protection Agency
HPFT	Hertfordshire Partnership NHS Foundation Trust
HR	Human Resources
HRG	Health Related Group
HSC	Health Service Circular; (House of Commons) Health Select Committee
HSC	Health Scrutiny Committee, sub-committee of Overview and Scrutiny Committee, Hertfordshire County Council
HSE	Health and Safety Executive
HSMR	Hospital Standardised Mortality Ratio (Rates)
HSO	Health Service Ombudsman
HTM 00	Health Technical Memorandum
HUC	Herts Urgent Care
HVCCG	Herts Valley Clinical Commissioning Group
HWE STP	Hertfordshire & West Essex Sustainability and Transformation Parternship

I

IBP	Integrated Business Plan
IC	Information Commissioner
ICAS	Independent Complaints Advocacy Service
ICNs	Infection Control Nurses
ICO	Information Commissioners Office
ICS	Integrated Care System
ICT	Information, Communications and Technology
IDT	Integrated Discharge Team
IVF	In Vitro Fertilisation
ICU	Intensive Care Unit
IDVA	Independent domestic violence advisors
IG	Information Governance
IMAS	Interim Management Service
IM&T	Information Management and Technology
IP	Inpatient
IPR	Integrated Performance Report
ISE	Integrated Standards Executive
IST	Intensive Support Team
IT	Information Technology
ITFF	Independent trust financial facility
ITU	Intensive Treatment Unit

J

JSNA	Joint Strategic Needs Assessment

K

KLOE	Key Line of Enquiry
KPI	Key Performance Indicator

L

LAs	Local authorities
LABV	Local Asset Backed Vehicle
LAT	Local Area Team (of NHS England)
LCFS	Local Counter Fraud Service
LD	Learning Disability
L&D	Learning and Development
LDB	Local delivery board
LGBT	Lesbian Gay Bisexual and Transgender
LHCAI	Local Health Care Associated Infections
LHRP	Local Health Resilience Partnerships
LMC	Local Medical Committee
LSMS	Local Security Management Specialist
LSP	Local Service Provider
LTFM	Long Term Financial Model

M

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

N

NBOCAP	National Bowel Cancer Audit Programme
NE	Never Event
NED	Non Executive Director
NHS	National Health Service
NHS CFH	NHS Connecting for Health
NHSE	NHS England
NHSLA	NHS Litigation Authority
NHSTDA	NHS Trust Development Agency
NHSP	NHS Professionals
NHSP	Newborn Hearing Screening Programme
NICE	National Institute for Health and Clinical Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
#NoF	Fractured Neck of Femur
NPSA	National Patient Safety Agency
NSF	National Service Framework
NTDA	NHS Trust Development Agency

O

OBC	Outline Business Case
OD	Organisational Development
OJEU	Official Journal of the European Union
OLM	Oracle Learning Management
OMG	Operational Management Group
ONS	Office for National Statistics
OOH	Out of Hours Service
OP	Outpatient
OSC	(local authority) Overview and Scrutiny Committee
OT	Occupational Therapist/Therapy

P

PA	Programmed Activities
PAC	Public Accounts Committee
PACS	Picture Archiving and Communications System
PALS	Patient Advice and Liaison Service
PAM	Premises Assurance Model
PAS	Patient Administration System
PAS 5748	Publicly Available Specification 5748 - provides a framework for the planning, application and measurement of cleanliness in hospitals
PbR	Payment by Results
PCC	Primary Care Centre
PCT	Primary Care trust
PEG	Patient Experience Group
PFI	Private Finance Initiative
PHO	Public Health Observatory
PID	Project Initiation Document
PLACE	Patient Led Assessment of the Care Environment
PMO	Programme Management Office
PMR	Provider Management Regime
PPI	Proton Pump Inhibitors
PPI	Patient and Public Involvement
PR	Public Relations
PSED	Public Sector Equality Duty
PSQR	Patient Safety, Quality and Risk Committee
PTL	Patient Tracker List

Q

QA	Quality Assurance
Q&A	Questions and Answers
QG	Quality Governance
QGAF	Quality Governance Assurance Framework
QIA	Quality Impact Assessment
QIP	Quality Improvement Plan
QIPP	Quality, Improvement, Prevention and Promotion
QRP	Quality Risk Profile
QSG	Quality and Safety Group

R

R&D	Research and Development
RA	Registration Authority
RAG	Risk and Governance/Red Amber Green
RCA	Root Cause Analysis
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RES	Race Equality Scheme
RFH	Royal Free Hospitals NHS Foundation Trust
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RSRC	Risk Summit Response Committee
RTT	Referral to Treatment
RTTC	Releasing Time to Care

S

SACH	St Albans City Hospital
SCBU	Special Care Baby Unit
SES	Single Equality Scheme
SFI	Standing Financial Instructions
SHMI	Standardised Hospital Mortality Index
SHO	Senior House Officer
SI	Serious Incident
SIC	Statement of Internal Control
SIRG	Serious Incident Review Group
SIRI	Serious Incident Requiring Investigation
SIRO	Serious Incident Risk Officer
SLA	Service Level Agreement
SLR	Service Line Reporting
SLM	Service Line Management
SMG	Strategic Management Group
SMS	Security Management Service
SOC	Strategic Outline Case
SOP	Standard Operating Procedure
SQ	Safety and Quality
SPA	Supporting Professional Activity
SRG	System Resilience Group
STEIS	Strategic Executive Information System
ST & M	Statutory and Mandatory
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Partnership
SUI	Serious Untoward Incident (same as Serious Incident, more commonly used).

T

T&D	Training and Development
TDA	Trust Development Authority (also known as NTDA)
TEC	Trust Executive Committee
TLEC	Trust Leadership Executive Committee
TNA	Training Needs Analysis
T&O	Trauma and Orthopaedic
TOP	Termination of Pregnancy
TOR	Terms of Reference
TPC	Transformation Programme Committee
TSSU	Theatre Sterile Service Unit
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
TVT	Tissue Viability Team

U

UCC	Urgent Care Centre
UTI	Urinary Tract Infection

V

VFM	Value For Money
VSM	Very Senior Manager
VTE	Venous Thromboembolism

W

WACS	Women's and Children's Services
WBC	Watford Borough Council
WFC	Workforce Committee
WGH	Watford General Hospital
WHHT	West Hertfordshire Hospitals NHS Trust
WHO	World Health Organisation
WRVS	Women's Royal Voluntary Service
WTD	Working-time directive
WTE	Whole Time Equivalent (staffing)

Y

YTD	Year to date
YCYF	Your care, your future

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Declarations of board members and attendees interests
01 October 2020

Agenda item: 04/83

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 (ends 6 October 2020) • 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 • Trustee Infection Prevention Society
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

Last updated: June 2020

TRUST BOARD MEETING IN PUBLIC
03 September 2020
Executive Meeting Room, Watford and via Zoom

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)
Dr Mike Van der Watt	Chief Medical Officer	Yes
Non-voting members		
Dr Andy Barlow	Divisional Director, Medicine	Yes
Tania Marcus	Deputy to the 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	No
Dr Simon West	Divisional Director, Surgery, Anaesthetics and Cancer	Yes (virtual)
In attendance		
Dawn Bailey	Named Nurse for Safeguarding Adults	Yes (virtual) – item 02/82
Meg Carter	Hertfordshire Healthwatch	Yes (virtual)
William Forson	Divisional Director, Women's and Children's	Yes (virtual)
James Mason	Head of Emergency Planning & Resilience	Yes (virtual) Item 13/82
Bonita Sparkes	Clinical Nurse specialist safeguarding Adults	Yes (virtual) item 02/82
Rod While	Trust Secretary (notes)	Yes

3 members of the public were in virtual attendance

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/82	**Opening and welcome**		
01.01	The Chairman welcomed the Board and members of the public to the meeting.		
02/82	**Patient story**		
02.01	Bonita Sparkes (BS) introduced the item with the following points. • D was a 44 year old gentleman, he had learning disabilities and had a learning disability and was a high intensity service user. • His past medical history included epilepsy, dystonia and challenging behaviour when distressed • Frequent attender of A&E relating to angioedema. On admission to hospital D was usually accompanied by a carer and staying in hospital would cause a great deal of stress. • Due to the high frequency of attendance at A&E, a meeting was set up involving the care manager, the emergency care matron, the lead nurse for safeguarding and the acute health liaison team (AHLT) to agree a pathway for when D attended and was discharged. The A&E team was willing to make reasonable adjustments and keep a spare epipen. • When medically unwell D would stay in AAU level 1 yellow and became very familiar with the staff. • On 20 March, D presented at A&E and was treated with a large amount of adrenaline. He was discharged on 21 March but re-attended on 22 March after being breathless overnight and was diagnosed with aspiration pneumonia. It was considered that his respiratory distress may be related to coronavirus. • On 23 March AHLT and safeguarding team visited D on the ward. The medical team were actively making reasonable adjustments and he was being closely monitored by nursing staff • On 25 March his condition deteriorated and he was declining all fluids. He became drowsy and less responsive. He had tested positive for COVID- 19 and the medical team advocated an immediate move to an open ward area in the hospital. • His care was discussed with palliative team and moved to AAU L3B. • The team on AAU L3 Blue started D on the end of life pathway. His specific needs were taken into consideration and staff showed great compassion and care. The family was contacted frequently and staff were asked if they could provide religious and spiritual care for the patient. This was provided. The nursing staff spent additional time comforting D and looking for subtle cues related to symptom control. • A syringe driver was set up for management of seizures and his Parkinson medication was changed to patch form on arrival to AAU L3 Blue • D passed away peacefully on 27 March. • An extremely positive message was received the family of D.		
02.02	The Chairman asked what had been learned from the whole experience. In response BS stated that the Trust had provided exceptional care to patients with learning disabilities and staff were very compassionate and caring. It was clear that staff had clearly taken on		

Agenda item	Discussion	Lead	Dead-line
	board messages regarding mental capacity and the importance of reasonable adjustments to care.		
02.03	The Chief Nurse stated that a great deal of progress had been made around learning disabilities and this is shown in the annual safeguarding report		
02.04	The Chairman thanked Bonita and Dawn for their presentation.		
OPENING			
03/82	**Apologies for absence**		
03.01	Apologies were received from Anna Wood and Paul Da Gama.		
04/82	**Declarations of interests,**		
04.01	No changes were reported to the declarations of interest from those circulated prior to the meeting.		
05/82	**Minutes of previous meeting**		
05.01	**Resolution**: The Board approved the minutes of 2 July as a true accurate record		
06/82	**Action log**		
06.01	It was noted that all actions were complete and should be closed.		
07/82	**Chair's and Chief Executive's report**		
07.01	The Chairman noted that there had been an extraordinary Board meeting in August to agree the focus on the new Electronic Patient Record. He also noted that the January Board meeting will be removed from future schedules.		
07.02	The Chief Executive stated that the Trust had been working closely with Herts Valleys CCG to ensure an effective restart of GP referrals. She noted that Duane Passman had joined the Trust as Programme Director for the acute redevelopment programme. The Urgent Treatment Centre had opened in July at the Watford site. Digital visioning workshops had taken place to inform the Trust's digital strategy and its alignment with the acute redevelopment programme.		
08/82	**Board Assurance Framework (BAF)**		
08.01	The Chief Executive introduced the report noting that it was the latest version which had been updated to incorporate the revised Trust aims and objectives. The BAF described how the Trust is managing the risks relating to the achievement of those objectives.		
08.02	It was clarified that the BAF would be reviewed and tested externally within the next 18 months.		
08.03	**Resolution**: The Board approved the Board Assurance Framework		
PERFORMANCE			
09/82	**Performance report on access standards**		
09.01	The Chief Operating Officer introduced the report and informed the Board that good progress had been made in terms of cancer standards. RTT had improved compared with the previous month to 51%. A&E performance fell slightly in July to 85.9% in the context of increasing demand, which had returned to pre-COVID levels. In the first month of the Urgent Treatment Centre, performance was 99.3% with over 3,000 type 3 attendances. There had been an increase in the number of patients waiting for more than 52 weeks, with the figure currently at 484.		
09.02	Ginny Edwards asked what plans were in place to recover improved performance on oral surgery and ENT. The Divisional Director for		

Agenda item	Discussion	Lead	Dead-line
	Surgery noted that oral surgery was a pressure area pre-COVID and discussions were taking place how to increase capacity. ENT had been under pressure as much of this took place at the Watford site where there have been issues with restarting services because of its blue status. It was likely that ENT would recover faster than oral surgery.		
09.03	Ginny Edwards asked how the Trust was assuring itself regarding harm to 52 week waiters. The Chief Medical Officer stated that a consultant led process for the cancer waits had been implemented, which included a Root Cause Analysis. For 52 week waiters, these were reviewed 48 weeks with a review of notes and virtual consultation if required. The Divisional Director for Surgery noted that the Trust had commissioned software which advised the Trust of all patients that needed a harm review.		
09.04	John Brougham noted that extent to which COVID had impacted upon elective and outpatient activity.		
09.05	Helen Davis asked for the reasons for a fall in A&E performance. The Chief Operating Officer stated that this was due to an increase in demand post-COVID and also an increase in ambulance conveyances.		
10/82	**Integrated performance review**		
10.01	The Chief Operating Officer introduced the report and gave the following headlines: • At the current time the Trust was caring for 15 positive COVID patients, one of which was in ITU. There were 13 suspected positives and 121 patients awaiting swab results. • The position regarding COVID patients has plateaued over the past few weeks. • The in-house testing facility was being validated currently. • As demand has increased, the Trust had experienced capacity issues and a business continuity incident had been announced. • The Emergency Assessment Unit opened in August and this allowed patients to be streamed away from ED.		
10.02	The Chief Nurse gave the following updates: • New infection prevention and control guidance had been published and this superseded the guidance published in June. The new guidance highlighted the high, medium and low risk pathways and zoning. • A new ward scorecard had been completed, with a focus on quality improvement. • Caring and responsive: Visiting guidance utilised by the Trust was in line with the new published guidance. • The inaugural co-production board had taken place with 23 members. • The national survey for end of life care had been reviewed and key areas of focus had been agreed. These would be reported in the integrated performance review.		
10.03	The Chief Medical Officer gave the following updates: • The SMART initiative was being redesigned as fewer people were able to work within this. A virtual SMART platform approved by the GMC would be implemented. • Significant clinical inputs were being mobilised regarding the EPR programme and the acute redevelopment programme.		
10.04	The Deputy Chief People Officer gave the following updates: • Workforce indicators were performing well, with vacancy rate at		

Agenda item	Discussion	Lead	Dead-line
	9.1% against a target of 10%. • Six new overseas members of staff had been welcomed and a further five on the 7 September. • Sickness absence was 4% against a target of 3.5%. • Some areas had been refurbished in the admin block to provide support such as counseling. • 89% staff had been risk assessed and this was a good performance. Additional work was taking place with staff of moderate risk, with further engagement sessions planned. • A compassionate leadership model would be launched shortly.		
10.05	The Chief Finance Officer gave the following updates: • Month 4 was the last month of the officially notified temporary financial regime but this was being extended to month 5. • The Trust had continued to spend within its financial budget and is less than originally planned. • Within the month the Trust spent £35.3m and income was received to cover this. Cumulative spend was £139m with £9m being spent on COVID. • Capital expenditure was £3.5m after four months. • The full business case for the development of a new multi storey car park is being progressed.		
10.06	The Chief Information Officer gave the following updates: • In June and July there were some difficult challenges with external telephony and pathology. Good progress had been made in resolving these issues. • A number of significant milestones had been reached, including upgrading the wide area network, PAS was upgraded and Windows 10 has begun to be implemented. Additionally, the local area network programme would shortly be completed. • The EPR programme had formally launched and a full business case would come back to the Board for consideration.		
10.07	The Chairman asked the Chief Financial Officer whether the different trusts had been consistent in spend on COVID. The Chief Financial Officer noted that it was difficult to compare but he considered that the Trust had been quite efficient in that claims were relatively low.		
10.08	Ginny Edwards asked the Chief Medical Officer how decisions made for patients in the SMART programme would be quality assured. The Chief Medical Officer stated that patients would be seen in ED by ED staff, if they required a cardiological or respiratory opinion, there would be on site staff available during the day and online staff available to provide and assessment between 17.00 and 21.00. All patients would then be seen by the relevant team the following day.		
10.09	Paul Cartwright asked what assurance the Trust had that the transfers of care process was as smooth as possible. The Chief Operating Officer noted that the national reporting was changing and the Trust would looking at how this could be presented in a meaningful way. A proven process was in place with care homes but some delays had been introduced because of COVID.		
10.10	Natalie Edwards asked the extent to which staff absence was COVID related and what plans were in place to address this with the move into the winter months. The Deputy Chief People Officer noted that absence hubs were continuing, with regular contact with staff who were off sick.		
10.11	The Chairman noted that the Trust's PPE stocks appeared to be strong		

Agenda item	Discussion	Lead	Dead-line
	but gowns was marked as red. The Chief Operations Officer noted that this applied to the reinforced gowns and was red because of the lead-in time but no specific issues had been encountered so far. However the supply was lower that other items of PPE.		
11/82	**Midwifery workforce establishment**		
11.01	The Chief Nurse introduced the paper stating that the paper had been fully discussed at the People, Education and Research Committee and was based upon the birth rate plus model. When reviewed previously the establishment was 182 WTE, clinical and non-clinical, and this was based on a birth rate of 4,000 in 2019/20. For 2020/21 the proposal is for a 4,400 birth rate and an increase in establishment to 190 to maintain a 1 to 26 birth ratio. The Trust had been successful in a bid for maternity support workers and a number of band 3 and band 4 staff would be developed within the service to achieve a 1 to 22 birth ratio. Within the local maternity system the Trust compared well on the midwife to birth ratio.		
11.02	Ginny Edwards proposed a review at Quality Committee on the relationship between the staffing and the caesarean section rate. The Chief Nurse stated that a caesarean section summit would be taking pace later in the year. Also the maternity support worker role could support post natal care. The Divisional Director, Women's and Children's stated that there were a number of initiatives being put into place and the maternity support workers would free up time for the midwives.		
11.03	Jonathan Rennison asked for the timeframe on achieving the 1 to 22 birth ratio. The Chief Nurse informed the Board that this would take 12-18 months but this would be reviewed in six months' time.		
11.04	Jonathan Rennison asked whether the changes being made support the continuity of carer. The Chief Nurse noted that the Trust is part of a national programme in relation to continuity of carer and the local maternity system had funded three midwives to support this and also the maternity support worker role would support this.		
12/82	**Safeguarding Annual Report**		
12.01	The Chief Nurse informed the Board that the report had been considered in detail by the Quality Committee. There had been year on year increased activity around safeguarding and a business case has been agreed to increase the capacity within the safeguarding team to support this. A major focus over the past few years had been mental health and learning disabilities.		
12.02	Jonathan Rennison asked whether COVID had impacted on workload with the apparent increases in domestic violence. The Chief Nurse informed the Board that the Trust had been able to develop the independent domestic violence advisor supported by the county council. This had made a big impact on the Trust's ability to address the issues.		
13/82	**Annual Assurance Report on Emergency Preparedness Resilience and Response**		
13.01	The paper was introduced by the Head of Emergency Planning & Resilience who informed the Board that the paper was the annual assurance paper relating to compliance with the standards for EPRR. The Trust remains substantially compliant and last year had dropped from fully compliant as a result of the data security protection toolkit. A revised assurance process would be taking place later in the year.		
14/82	**Strategic Priorities Update and Programme Director's Report**		

Agenda item	Discussion	Lead	Dead-line
14.01	The Deputy Chief Executive introduced the item and noted that good progress was being made across a range of strategic priorities against a background of COVID. Additional capital funding had been secured, though this had created a workload challenge. The first stage of the Emergency Assessment Unit expansion had been implemented and £2.5m from the national winter fund has been awarded in the expectation that the unit would be ready to operate on 1 January 2021. She also reminded the Board that capital had also been awarded to improve the Emergency Department and a full business case was being progressed to support this.		
14.02	The Deputy Chief Executive introduced the Programme Directors Report noting that the first Great Place Committee of the Board would take place on 17 September.		
14.03	Helen Davis noted that a new risk had been added around space requirements and asked what the process was to review the schedule of accommodation. The Deputy Chief Executive informed the Board that that a number of key pieces of work were on-going to address this and detailed work was taking place on activity forecasting.		
15/82	**Corporate Risk Register**		
15.01	The Chief Medical Officer introduced the report and informed the Board that this had been discussed at the Risk Review Group on 11 August and Quality Committee on 27 August. At the Risk Review Group two risks were proposed but not accepted, no risks were escalated, two were de-escalated and one proposed reduction was rejected.		
15.02	**Resolution**: The Board approved the Corporate Risk Register		
16/82	**Great Place Committee Terms of Reference**		
16.01	It was note that this new Committee would be meeting on 17 September and the Board was asked to approve the terms of reference.		
16.02	Paul Cartwright asked whether the Committee was responsible for external communications as well as internal. The Deputy Chief Executive noted that tis was specifically communications relating the redevelopment and digital programme and was both internal and external.		
16.03	**Resolution**: The Board approved the Terms of Reverence for the Great Place Committee		
17/82	**Assurance report from the Trust Management Committee**		
17.01	The Board noted the assurance report.		
18/82	**Assurance report from People, Education and Research Committee**		
18.01	The Board noted the assurance report.		
19/82	**Assurance report from Finance and Performance Committee**		
19.01	The Board noted the assurance report.		
20/82	**Assurance report from Quality Committee**		
20.01	The Board noted the assurance report.		
21/82	**Assurance report and Annual Report from Audit Committee**		
21.01	The Board noted the assurance report and the annual report.		
22/82	**Any other business**		
22.01	There was no other business		
23/82	**Questions from Hertfordshire Healthwatch**		
23.01	The were no questions from Healthwatch		

Agenda item	Discussion	Lead	Dead-line
24/82	**Questions from the patients and members of the public**		
24.01	A question from a member of the public asked for the Board's view on the site review as part of the redevelopment programme as there had been no financial consideration of alternative sites to Watford. The Deputy Chief Executive stated that there would be a full discussion by the Board on 1 October and a detailed economic appraisal would take place on shortlisted options as it was not a requirement to carry out an economic appraisal on the long list of options.		
25/82	**Date of the next Board meeting**		
25.01	1 October 2020		

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
01 October 2020

Title of the paper	**Chairman and Chief Executive report**
Agenda Item	**06/83**
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.

7

Agenda Item: 06/83

Trust Board Meeting – 01 October 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 October Board meeting is only open to members of the public via MS Teams.

2. NEWS AND DEVELOPMENTS

Appointments

2.1 We would like to welcome our new Freedom to Speak up Guardian, Joanna Bainbridge. Joanna has worked in HR at the NHS for 20 years. Her position is completely independent from the trust. This continues our focus on openness, transparency and supporting staff to raise concerns. Joanna offers support to any member of staff raising a concern and can assist in escalating any issues where needed, acting as a conduit to ensure any problems are resolved.

Other Trust News

2.2. The Trust's Annual General Meeting (AGM) 2019/20 was held for the first time virtually on 3 September and was attended by 60 people, a significant increase compared with previous years. Attendees heard from each member of the Executive Team on the Trust's far reaching achievements in 2019/20 and also details on how we managed the COVID-19 pandemic at a local level. Videos of the event are available to view at the following location https://www.westhertshospitals.nhs.uk/agm/

2.3. Following the AGM, our formal annual report was published on our website on 21 September and this can be viewed at the following location http://www.westhertshospitals.nhs.uk/annualreport/1920/WHHT_Annual_Report_and_Account_2019-20.pdf

2.4. In August we announced the successful launch of our joint Electronic Patient Record (EPR) programme with our colleagues from the Royal Free London (RFL). This programme gives us access to support from an experienced Royal Free EPR team who have successfully launched the same system at Barnet and Chase Farm hospitals. It also reduces our costs and helps us 'go-live' 14 months earlier than planned. An EPR will bring patient records and clinical applications together and will provide you with all the information you need at your fingertips to make the best decisions for our patients. Safety and accuracy will be improved and other organisations who are involved in our patients' care will (with their permission) be able to access the records too and so patient care will become more joined up. This will revolutionise how we work as we will spend less time looking for information and more time looking after patients. The EPR go-live date is

currently November 2021 but will take a couple of years to bring fully online. We will work closely with the acute redevelopment team and others as we prepare the way for new models of care in line with our acute redevelopment plans.

2.5. In September we announced the relaunch of the Connect BAME network chaired by Marsha Jones, associate chief nurse for quality and assurance, and Tejal Vaghela, CPG programme manager. Our newly formed Connect BAME steering committee aims to support all staff who self-identify as being from a BAME background of which 40% of our staff do. We hope the network will engage more widely with this staff group. Our mission is to improve our approach to diversity, equality and inclusion to help West Herts become a more inclusive team; improve staff experience and wellbeing, and drive forward the best care for our patients in everything that we do.

MP Updates

2.6. Successful meetings were held with Dean Russell, MP for Watford and Daisy Cooper, MP for St. Albans.

Other Meetings

2.7 The Chairman has conducted the following business on behalf of the Trust:

- Attended the Royal Free Partnership Board
- Attended a meeting with the CEO of ATOS
- Progressed the recruitment of a Non-Executive Director
- Visited the new robot in pharmacy
- Visited Shrodells and new services
- Attended Board Committees
- Chaired the ICP Chairs meeting
- Attended a meeting with Watford Football Club

Local System News

2.8. Hertfordshire Partnership NHS Foundation Trust has announced the appointment of Sarah Betteley as the new Chair of HPFT and will take up post on 1 January 2021. The current Chair, Chris Lawrence will be stepping down at the end of this year as his term of office comes to an end.

3. BOARD NEWS

Board Development Meeting

3.1. A Trust Board development meeting was held on 17 September to consider the forward looking Trust strategy.

Board visit programme

3.2. As part of the monthly Board visit programme, the Board visited three areas at Watford hospital in September 2020, namely Paediatric Outpatient admin office, Radiology PMOK Level 2, Medical Equipment Library and the Diabetes Centre. Verbal feedback from the visits was received in the private session of the Board meeting in September 2020 and will be included in a bi-annual engagement Board report.

4. RECOMMENDATION

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

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

Trust Board Meeting
01 October 2020

Title of the paper	Board assurance framework report
Agenda Item	08/83
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

8

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

Agenda Item: 08/83

Trust Board meeting – 01 October 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 Directors.

Christine Allen
Chief Executive

October 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	Actions completed and in place. IPC BAF reporting part of QC workplan and repository in place on PM3. RCA's completed for Covid cases over 7 days. Staff & Pt testing in place and business cases developed and approved. Further monitoring in place and to reivew further actions with new IP&C guidance. 1) Ventilation review 2) Monitor IPC BAF and Covid risks 3) Assessments for Covid protection and soical distancing. To reivew again in **December 20**
			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 establishment reviews Quality Committee reporting and IPR NHSE/I review and level 4 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	Actions completed and ongoing. PPE being reviewed according to new IP&C guidance and updated guidance issued. To continue with current actions and review again in **December 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** **Performance against trajectories**	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	31.12.20	
			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	31.12.20	
			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	Continue to review complaints and PALS to enable themes to be monitorted. Call back service continues to operate with no major themes emergeing but patient issues being resolved at source i.e. medication explanation, OT deliveries, patient discharge follow up. Coproduction Board project initiation documents being completed and reviewed. Future codesign support with CPG and redevelopment. Organisational information being sent to update coproduction board members and their networks. PEG reviewing all CQC Picker surveys to enable corporate focussed support. Review again in **March 21**
			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	Coproduction Board to form working party to support visitation. Review of ITU visiting to enable first visit to be managed. Friends and Family Liaison line business case to be completed this month after further discussion within CAG regarding medical support. Review again in **January 21**
	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.		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	First Great Place Board sub-committee scheduled 17/09/20 Programme Director commenced in post July 2020. A national assurance programme for HIP One schemes is being developed - initial meeting held with DHSC lead. Assurance approach to be further developed for sub-committee review and approval.
			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	In progress. Offers made to all vacancies - notice periods TBC User groups established, first meetings held and forward plan in place.
	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
1 October 2020

Title of the paper	Activity Recovery Update & Access Standards Performance (August 2020 reporting period)
Agenda Item	09/83
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 an update on the activity recovery programme and associated progress, with reference to the phase 3 return, forecast and the targets for elective activity described in the July 2020 phase 3 recovery letter from Sir Simon Stevens. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf A high level summary of the activity completed in August, RAG rated against the phase 3 targets shows the variance in delivery against these targets (the baseline being the corresponding month of the previous year). Nationally and locally commissioned independent sector activity is key to delivery of the activity forecast and achievement of the recovery targets. The second section of the paper provides an update on compliance with national Access standards, factors affecting performance are also included. Performance data is provisional at the time of writing (18/9/2020) 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%	83.1%	↓
Diagnostic waits	99%	62.5%	↓
RTT incomplete pathways < 18 weeks	92%	62.5%	↑
52 week waits	0	669	↓
2 week wait referrals	93%	96.6%	↓
2 week wait breast symptomatic referrals	93%	96.2%	↓
28 day Faster Diagnosis standard (Shadow)	70%	82.1%	↔
31 day first definitive treatment	96%	96.4%	↔
31 day subsequent - surgery	94%	77.8%	↓
31 day subsequent - drug	98%	100.0%	↑
31 day subsequent - palliative	94%	100.0%	↔
62 day referral to first treatment	85%	84.7%	↑
62 day screening referral to first treatment	90%	66.7%	↑

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

	Performance against the A&E 4 hour waiting time standard was lower than the previous month (85.9%) at 83.1% Diagnostics has deteriorated at 62.5%, previously 73.3%. This is largely the result of a growing backlog of DEXA scans. RTT performance has improved further, from 51% to 62.5% this month. However, there has been a further significant increase in 52 week waits, now at 669 (was 484). The two week wait, breast symptomatic, 28 day faster diagnosis and 31 day pathway standards have all been achieved with the exception of the 31 day subsequent surgery standard where 2 breaches have resulted in non-compliance. The standard has not been met for either 62 day first pathways, where there are 10.5 breaches or 62 day screening pathways where there were 1.5 breaches.
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 Trust Management Committee — 23 September 2020 Finance & Performance Committee — 24 September 2020
Action required	The Board is asked to receive this report for information.

9

Trust Board
01 October 2020

Agenda Item: 09/83

Access Standards Performance & Activity Recovery
(August 2020 reporting period)

Presented by: Jane Shentall, Director of Performance

1. Purpose

1.1 The first section of this paper provides details of the progress made in activity recovery, measured against the targets set for activity, measured as a percentage of the corresponding month in the previous year, eg August 2020 activity as a percentage of August 2019 activity.

1.2 A summary of progress against plan and target is included in Appendix 1.

1.3 The second section of the paper provides details of performance against access targets, the relevant factors where standards have not been achieved, and the actions in place to improve waiting times and achieve compliance when non-urgent elective care is reinstated.

1.4 The relevant standards and guidance are included in appendix 2.

9

ACTIVITY RECOVERY

2 Background

2.1 Sir Simon Stephens wrote to the NHS on 31 July 2020 with priorities for the phase 3 recovery as follows:

- Accelerating the return to near normal levels of non-COVID services
- Preparation for winter demand pressures with continuing vigilance in light of further probable COVID spikes
- Doing both of the above, taking in to account lessons learned during the first peak, locking in the beneficial changes and tackling fundamental challenges including support for staff and action on inequalities and prevention.

2.2 This section of the paper will focus on delivery of the plan to return to near normal levels of pre-COVID activity, covering Diagnostics, Outpatients and Elective inpatient/day case spells.

2.3 Delivery against the activity plan and the phase 3 targets will be measured against a baseline of activity delivered in 2019/20.

2.4 An activity recovery tracker has been developed to support the oversight of progress against all elements of elective and emergency activity and this is updated and circulated on a weekly basis and shared with members of the Activity Recovery Planning Group (chaired by the Deputy CEO) and the Operational Delivery Group (chaired by the COO).

2.5 The trust's initial activity plan return for September through to March 2021 has been drafted and submitted for consolidation in to the ICS plan. Since release of the template and

associated guidance on completion, there have been multiple changes to instructions regarding baseline activity (the corresponding months of 2019/20) and plans. These have largely centred around whether independent sector activity should be included/excluded, and Outpatient procedures and where these should be counted. In addition there have been discussions regarding the inclusion of unplanned CT and MRI activity which has now been included. In response to the changing landscape several versions of the return have been produced at very short notice to accommodate these changes.

2.6 A table showing the activity plan, actuals and gap against targets is included in Appendix 1. This also includes a brief update on progress, reasons for shortfall and future plans.

2.7 There has been a reduction in the capacity made available to the trust at Spire Bushey, via the nationally commissioned independent sector contract. Of the 6 theatres at Spire Bushey, 2 are ring fenced for trust activity. This is significantly less than anticipated. In addition, MRI and CT sessions are also going to reduce, to accommodate NHS activity from other sources. There have been a number of local discussions and escalation to the regional NHSEI team, but the situation is unchanged.

2.8 Discussions with other local independent sector providers are underway, with an immediate focus on securing diagnostic (including endoscopy) capacity. This would be locally commissioned and therefore the commercial aspects of any arrangement will be handled by the Finance team.

2.9 Additional support (Attain) has been brought in to support Surgery with the further development and delivery of the divisional recovery plan. Extra analytical support has also been provided with a focus on the recovery forecasts and trajectories and to identify opportunities to increase efficiencies in throughput.

2.10 The summary of activity versus plan/target in Appendix 1 highlights the current shortfalls. The main areas of concern are MRI and Endoscopy where plans to supplement in house capacity through outsourcing are not yet fully established and so a significant shortfall against plan and target remains. The plan for both, that was submitted for inclusion in the ICS return, was drafted prior to the notification from Spire Bushey of a reduction in available capacity. This will be revisited when the commercial discussions with alternative providers have been concluded and the final capacity available is better understood.

2.11 Additional MRI capacity on site (MRI in a box) requires enabling works at SACH to address power supply issues. Capital has been made available to support this but workforce resources will also need to be identified to make optimum use of the potential capacity available.

2.12 Outpatient activity remains significantly lower than the previous year. This could in part be due to changes in referral management which now include Advice & Guidance and Referral Assessment services, both of which contribute to fewer referrals progressing to outpatient appointments. Good progress has been made in the conversion of face to face to virtual appointments however. Divisions are currently reviewing the plans for outpatients at service level to ensure all phasing and template changes etc are progressing as expected.

2.13 Elective inpatient activity is currently being delivered through a reduced number of theatres (4 of 6) at SACH and supplemented by independent sector activity. The Surgical division planned to extend to 6 theatres in the week of 21 September, but this has been delayed by a number of weeks due to an issue with ventilation in one theatre. September's activity is is still expected to increase, but will not be at the level originally anticipated until ventilation works are completed.

ACCESS STANDARDS PERFORMANCE

3 Indicators not achieved in the reporting period

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

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	83.1%	↓
Diagnostic waits	99%	62.5%	↑
RTT incomplete pathways < 18 weeks	92%	62.5%	↑
52 week waits	0	669	↓
31 day subsequent - surgery	94%	77.8%	↓
62 day screening referral to first treatment	90%	66.7%	↑

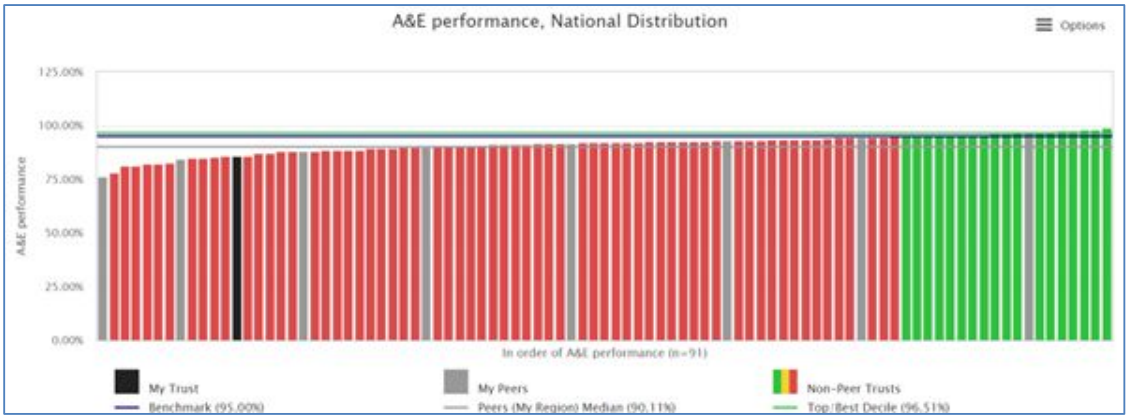
↑ improved non-compliant	↓ deteriorated non-compliant	↔ no change non-compliant	↑ improved compliant	↓ deteriorated compliant	↔ no change compliant

4 A&E 95% target

4.1 83% of attendances at the trust's urgent or emergency care units were compliant with the 4 hour waiting time standard as compared to 85.9% the previous month. Demand continues to recover, with 12311 attendances overall. CED performance was just below the standard at 94.4%. Flow of Majors patients remains challenging with fewer compliant pathways this month at 57.7% (previously 66%). The Minor Injuries Unit at SACH remains closed but UTC at Hemel Hempstead achieved 99.6% compliance.

4.2 Watford UTC performance was 99.4%, similar to July (99.3%) but with an additional 241 (total 3269) type 3 attendances. When this is combined with the WGH type 1 activity performance was 77.1%.

4.3 Model Hospital benchmarking (July 2020 performance at 87.1%) shows the Trust (the black bar) in a marginally better position, albeit still at the lower end of the national range, with a national median of 88.3% and a regional median of 90.1%.



5 Ambulance Handover Delays

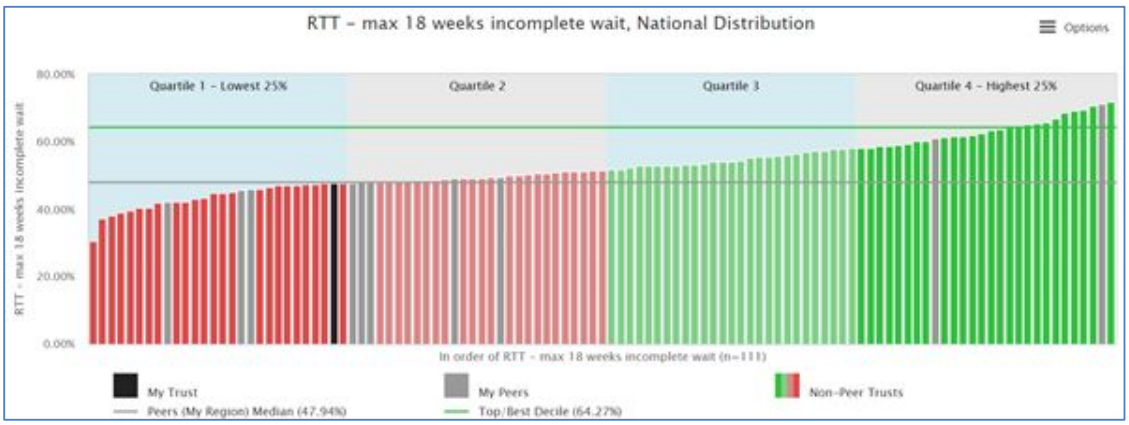
5.1 The number of patients arriving at A&E in an East of England ambulance has grown by almost 4% compared with July (2659). This method of arrival equates to 47.5% of the type one attendances recorded. There were 354 (previously 268) delays between 30 and 60 minutes and 180 (was 89) delays over 60 minutes.

5.2 The ambulance handover improvement programme is working on reducing delays with some key areas of focus. The segregation of pathways (COVID positive/suspected/negative) has resulted in limited opportunities to reduce delays but review of processes and areas like STARR are underway and are expected to support the improvement plan.

6 RTT Incomplete pathways

6.1 Performance continues to improve and this month 62.5% of RTT pathways were less than 18 weeks (July 51%). This is due to the increasing number of referrals and a reduction in the backlog.

6.2 Model Hospital benchmarking (June 2020 performance at 47.7%) shows the Trust (the black bar) in the lowest quartile, but it should be noted that no organisation achieved the standard, the highest performance being lower than the previous month (80%) at 71.7%. The regional median fell to 49.5%, and the national median was 51.4%.



7 52 week waits

7.1 The number of patients waiting more than 52 weeks continues to increase at a fast rate, with 670 pathways waiting a year or more, and the highest number of these long waits remains in Oral Surgery.

Service	Aug-20
ORAL SURGERY	208
ENT	147
OPHTHALMOLOGY	90
UROLOGY	72
TRAUMA & ORTHOPAEDICS	67
GENERAL SURGERY	36
PAIN MANAGEMENT	23
VASCULAR SURGERY	15
ORTHODONTICS	6
COLORECTAL SURGERY	2
GASTROENTEROLOGY	1
UPPER GI SURGERY	1
CLINICAL ONCOLOGY	1
Total	669

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

7.2 It should be noted that the pathway recorded for Clinical Oncology is not an active cancer pathway. The patient has received cancer treatment and remains under active surveillance. However, the clinician indicated that the RTT pathway should remain open and although this has since been discussed and corrected, it had not been agreed until early September. The outcome of the harm review for this patient is awaited.

8 Cancer Waiting Times Performance

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

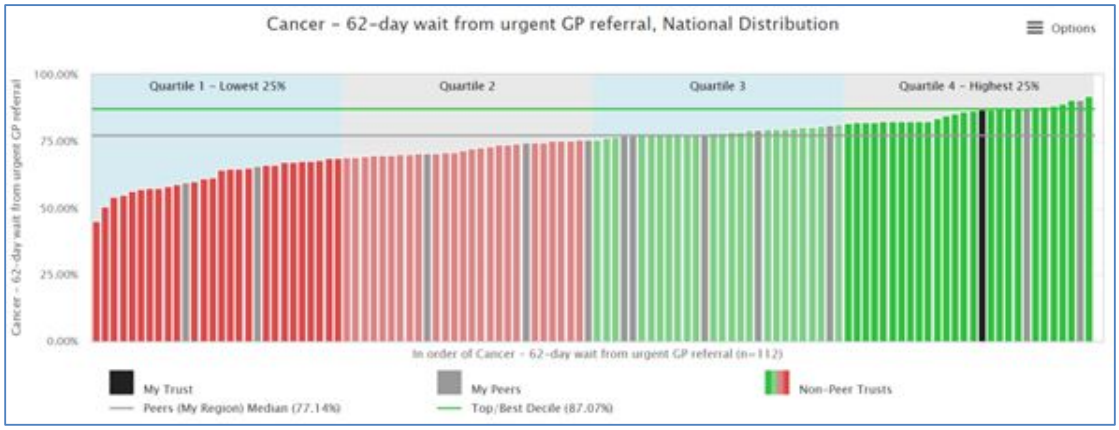
8.2 There were 2 breaches (Breast, Lower GI) of the 31 day subsequent surgery standard, resulting in a failure to achieve the target. It is likely that further activity will be recorded against this standard and performance will change as a result up to the submission deadline (early October).

8.3 Performance against the 62 day referral to first treatment standard is currently just below the 85% target but the reporting period is still open and additional activity will be recorded which could affect performance either way. Validation is also ongoing at the time of reporting but there are 10.5 breaches (4.5 Urology, 3 LGI, 2 Lung, 1 Haematology). The Urology and Lung Cancer Improvement Groups are to be reinstated and will pick up the improvement actions that had been agreed pre COVID.

8.4 There has been a significant improvement in performance against the 62 day screening referral standard, although the target has not been achieved. There were 1.5 breaches (Lower GI and Breast), and patient initiated and referral delays were contributory factors.

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

8.6 Model Hospital benchmarking (June 2020 performance at 86.9%) shows the improving position at WHHT (the black bar). Performance was better than the national median of 75.6%, and the regional median of 77.1%.



9 Diagnostic waiting times performance

9.1 The standard for diagnostic waiting times was not achieved, and current performance at 68.5% is lower than the previous month (73.3%). Most modalities' performance remains below the standard.

Description	<6 wks	>=6 wks	Total	<6 wks(%)
W01: Imaging - Magnetic Resonance Imaging	915	292	1207	75.8
W02: Imaging - Computed Tomography	677	134	811	83.5
W03: Imaging - Non-obstetric ultrasound	1019	213	1232	82.7
W04: Imaging - Barium Enema	13	0	13	100
W05: Imaging - DEXA Scan	306	566	872	35.1
W06: Physiological Measurement - Audiology - Audiology Assessments	217	179	396	54.8
W07: Physiological Measurement - Cardiology - echocardiography	419	177	596	70.3
W08: Physiological Measurement - Cardiology - electrophysiology	0	0	0	
W09: Physiological Measurement - Neurophysiology - peripheral neurophysiology	85	0	85	100
W10: Physiological Measurement - Respiratory physiology - sleep studies	0	0	0	
W11g: Physiological Measurement - Urodynamics - pressures & flows (Gynae)	33	0	33	100
W11s: Physiological Measurement - Urodynamics - pressures & flows (Surgical)	19	2	21	90.5
W12: Endoscopy - Colonoscopy	162	70	232	69.8
W13: Endoscopy - Flexi sigmoidoscopy	95	56	151	62.9
W14: Endoscopy - Cystoscopy	88	58	146	60.3
W15: Endoscopy - Gastroscopy	295	251	546	54
Total	**4343**	**1998**	**6341**	**68.5**

9.2 There is a significant backlog in DEXA scanning which has influenced the overall position. Recovery planning is in progress and a trajectory in development to allow oversight of delivery of activity against the plan.

9.3 Model Hospital benchmarking (June 2020 performance at 64.8%) shows the Trust's (the black bar) improving position, in line with the national median, 64.4% and slightly better than the regional position at 60.8%.

10 Harm Reviews

10.1 Work to filter out the RTT harm reviews prior to March 2020 is ongoing but not yet complete. The reviews tracked in the tables below include pre and post COVID RCAs completed. The totals completed in some services also include an element of double counting as a result of a request to repeat a number of reviews that were incomplete but recorded as completed.

10.2 A weekly random audit sample of harm reviews has been introduced and this has identified that in some cases completion of a review was recorded prior to clinical sign off and so services have been asked to address this.

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

Reporting Month: Aug 20	Tracking		Outcome		
RTT	Reviews in progress	Reviews completed	Number of patients with harm identified	Degree of harm	Notes/Comments
ENT	13	603	0		Service has not yet re-set counting from March
Ophthalmology	4	441	0		Service has not yet re-set counting from March
Oral Surgery	1	688	0		Service has not yet re-set counting from March
Orthodontics	1	11	0		Awaiting consultant sign off
General Surgery	78	47	0		58 awaiting consultant sign off, 20 in progress
Urology	78	65	5	tbc	30 awaiting consultant sign off, 48 in progress
Orthopaedics	152	48	0		
Pain	27	16	2	tbc	

Reporting Month: Aug 20	Tracking		Outcome		
Cancer	Reviews in progress	Reviews completed	Number of patients with harm identified	Degree of harm	Notes/Comments
Urology	31	10	0		
Colorectal	14	11			
Head & Neck	18	0			Tertiary provider RCAs outstanding at NWP, L&D
Upper GI	3	7			
Breast	1	7			
Gynaecology	3	5			Tertiary provider RCAs outstanding at ENHT, L&D
Lung	2	14			
Haematology	6	5			
Dermatology	1	0			
Sarcoma	1	0			Tertiary provider RCA outstanding at RNOH

11 Risks

11.1 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.

11.2 Risks relating to delivery of the activity recovery plan and phase 3 activity targets will be informed by the risks held by the task and finish groups reporting to the Activity Recovery Planning Group and further detail will be provided when these have been agreed.

12 Recommendation

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

Jane Shentall
Director of Performance
20 September 2020

Appendix 1
Elective Recovery – Actual vs Plan vs National Target

Activity type			Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Update / Comment
Diagnostics	CT	Plan		103%	102%	102%	102%	102%	102%	102%	Planned activity is RAG rated against the recovery targets, as is the actual activity delivered. Activity delivered in the corresponding 2019/.20 month is used for the baseline. **MRI** Throughput is constrained by IPC and social distancing requirements. Some activity is undertaken via the nationally commissioned IS contract at Spire Bushey but this is due to reduce in September.Discussions with an alternative ISPto secure some additional locally commissioned activity are progressing. MRI in a box capital has been confirmed but enabling works (HV supply) are required before this can proceed. The unit is un-staffed and resource needs to be identified to maximise this opportunity. **Endoscopy** Ventilation, IPC and social distancing requirements have significantly impacted efficiency. Recent improvements in air changes have facilitated an increase in procedures. Capacity for endoscopy procedures are included the local ISP proposal. Recent bid for capital has been successful for kit and estates works. **Outpatients** Not all services have re-started. Pre-existing templates require alteration to reflect the shift to nonf2f activity where possible. **Elective Inpatient** The phased re-opening of SACH theatres began in August, with a view to all 6 theatres opening from 21/9/20. IPC requirements have resulted in limited cases per session but early feedback has enabled additional activity to be scheduled. IS actiivity has been limited to Colorectal, Breast, Gynaecology, Urology and a very small amount of Orthopaedics. The capacity made available by Spire Bushey is lower than anticipated and where available, alternative IS options are in development.
		Actual	97%								
		Target	90%	90%	100%	100%	100%	100%	100%	100%	
		Gap	7%								
	MRI	Plan		113%	102%	104%	104%	102%	108%	106%	
		Actual	71%								
		Target	90%	90%	100%	100%	100%	100%	100%	100%	
		Gap	19%								
	Endoscopy	Plan		55%	81%	100%	100%	100%	100%	100%	
		Actual	55%								
		Target	90%	90%	100%	100%	100%	100%	100%	100%	
		Gap	35%								
Outpatients	All Outpatients	Plan		75%	90%	90%	90%	90%	90%	90%	
		Actual	74%								
		Target	90%	100%	100%	100%	100%	100%	100%	100%	
		Gap	16%								
Electives	Day Case	Plan		98%	94%	94%	95%	95%	94%	94%	
		Actual	51%								
		Target	70%	80%	90%	90%	90%	90%	90%	90%	
		Gap	19%								
	Inpatient	Plan		79%	89%	89%	89%	89%	89%	89%	
		Actual	76%								
		Target	70%	80%	90%	90%	90%	90%	90%	90%	
		Gap	6%								

Appendix 2

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 – August 2020

Description	Total	Less than 18 Weeks	18 Weeks Plus	% Under 18 Weeks
PAIN MANAGEMENT	597	138	459	23.12%
ORTHODONTICS	40	10	30	25.00%
ORAL SURGERY	980	263	717	26.84%
VASCULAR SURGERY	142	41	101	28.87%
OPHTHALMOLOGY	1580	600	980	37.97%
TRAUMA & ORTHOPAEDICS	1942	790	1152	40.68%
ENT	1498	639	859	42.66%
PAED CARDIOLOGY	35	15	20	42.86%
PAED OPHTHALMOLOGY	183	90	93	49.18%
GERIATRIC MEDICINE	125	62	63	49.60%
OTHER	27	15	12	55.56%
GENERAL SURGERY	1342	786	556	58.57%
HEPATOLOGY	53	32	21	60.38%
PAED UROLOGY	95	63	32	66.32%
GENERAL MEDICINE	12	8	4	66.67%
UROLOGY	1402	941	461	67.12%
GYNAECOLOGY	961	666	295	69.30%
COLORECTAL SURGERY	352	245	107	69.60%
RHEUMATOLOGY	320	247	73	77.19%
CARDIOLOGY	1446	1141	305	78.91%
NEPHROLOGY	17	14	3	82.35%
RESPIRATORY MEDICINE	392	339	53	86.48%
CLINICAL ONCOLOGY	29	26	3	89.66%
ENDOCRINOLOGY	247	222	25	89.88%
UPPER GI SURGERY	185	167	18	90.27%
NEUROLOGY	611	552	59	90.34%
GASTROENTEROLOGY	909	829	80	91.20%
ORTHOTICS	25	23	2	92.00%
CLINICAL HAEMATOLOGY	156	144	12	92.31%
MEDICAL ONCOLOGY	16	15	1	93.75%
PAEDIATRICS	259	243	16	93.82%
DERMATOLOGY	1174	1106	68	94.21%
DIABETIC MEDICINE	79	75	4	94.94%
PAED ENDOCRINOLOGY	22	21	1	95.45%
BREAST SURGERY	168	161	7	95.83%
PAED DERMATOLOGY	51	49	2	96.08%
CRITICAL CARE MEDICINE	3	3	0	100.00%
PAED EPILEPSY	12	12	0	100.00%
PAED GASTROENTEROLOGY	20	20	0	100.00%
PAED CLINICAL HAEMATOLOGY	5	5	0	100.00%
OBSTETRICS	1	1	0	100.00%
GYNAECOLOGICAL ONCOLOGY	24	24	0	100.00%
Total	**17537**	**10843**	**6694**	**61.83%**

Appendix 4
Cancer waiting times performance – update (at 18/9/20)

Standard	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 YTD (latest)
2ww	93.0%	93.2%	94.1%	96.3%	96.8%	97.0%	97.6%	98.0%	95.1%	99.0%	97.7%	98.6%	96.6%	97.5%
2ww 28 day FDS	75.0%	N/A	71.1%	75.2%	76.8%	75.8%	84.7%	77.0%	68.8%	85.6%	82.1%	80.9%	80.6%	80.3%
2ww breast	93.0%	100.0%	100.0%	96.3%	98.4%	94.2%	98.6%	98.5%	100.0%	87.9%	87.9%	98.1%	96.2%	95.5%
31 day 1st	96.0%	95.0%	94.3%	98.0%	99.4%	96.3%	97.2%	97.1%	98.5%	92.1%	97.2%	96.4%	96.4%	96.1%
31 day surgery	94.0%	100.0%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	87.5%	100.0%	94.4%	77.8%	89.9%
31 day drug	98.0%	94.4%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%	100.0%	97.5%
31 day palliative	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day radiotherapy	94.0%	N/A	N/A	N/A	N/A	100.0%	100.0%	N/A	NA	NA	NA	NA	NA	50.0%
62 day	85.0%	88.0%	79.4%	77.9%	82.9%	84.8%	80.1%	83.1%	70.3%	76.9%	86.4%	77.6%	84.7%	80.0%
62 day screening	90%	64.0%	66.7%	92.3%	100.0%	72.0%	80.0%	92.0%	85.7%	64.3%	100.0%	0.0%	66.7%	58.3%

NB:

- Performance is provisional at the time of writing

Trust Board Meeting
1 October 2020

Title of the paper	**Integrated Performance Report** ***(September 2020 reporting period – August 2020 data at 25/9/20)***
Agenda Item	10/83
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** • Fewer COVID-19 positive at 10 (was 19) but slight increase in suspected at 14 (was 12), and no ITU COVID-19 positive patients (slide 3, 28-30) • Results awaited is higher at 111 than in previous months (slide 3, 28-30) • Increase in COVID-19 negative inpatients, now 478 (was 415) (slide 3, 28-30) • COVID-19 negative patients in ITU has increased to 13 (from 10) (slide 3, 28-30) • Staff absence indicators show a significant decrease in COVID-19 sickness (40 from 93), a significant decrease in staff self-isolating at 18 (was 60) (slide 3) • No nosocomial infections were reported (slide 3, 30) • PPE RAG rating indicates that there was a good supply of items, all of which were green in terms of days' supply (slide 3, 29) **Safe Care & Improving Outcomes** • Mortality indicators have risen– SHMI 100.6 (99.1 last period), HSMR 117.5 (103 last month) (slides 4, 25) • There was 1 hospital apportioned clostridium difficile case (previous month 1) with a year to date total of 7 (slides 4, 26) • The overall C-section rate is lower at 29.3% (previously 35.3%) and is just above (worse than) target (28%); the elective rate has reduced to 15.6% (was 19.7%), above the local target (11%), but the emergency rate is lower (better) than target (15%) at 13.7% (was 15.6%). The year to date rate for all C-sections is 32.8% (slides 4, 32). • Reporting for safe care, nursing shift fill, remains suspended as a result of the COVID-19 pandemic (slides 4, 34) • There was one serious incident with patient harm, although patient safety incidents that are harmful is only slightly higher than the previous month (7.2%) at 7.9% and year to date 8.3% (slides 4, 34) • Safety thermometer new harms remains suspended as a result of the COVID-19 pandemic (slide 4, 35) • VTE risk assessment remains better (higher) than target (95%) at 95.3% and year to date the rate is 95.7% (slides 4, 37) • Stroke indicator performance saw 18.5% (previously 26.1%) of patients admitted to the Stroke unit within 4 hours (target 90%, national average 54%), but 84.1% (was 78.9%) of patients spent 90% of their admission on the unit (target 80%, ytd 72.1%, national average 82.7%) (slides 4, 38) **Caring & Responsive Services** • Ambulance turnaround delays increased, with 354 (was 268) between 30 and 60 minutes and 180 (was 89) over 60 minutes (slides 5, 39) • ED 4 hour performance dropped for the second successive month to 83.1% (from 85.9%) with a year to date position of 84.2% (slides 5, 39) • Reporting requirements for delayed transfers of care (DToCs) remain suspended as a result of the covid-19 pandemic (slides 5, 41) • Friends & Family testing has also been paused for COVID-19 • Complaints response times remain better than target (80%) at 80.6% with 5

10

	reactivated complaints received in the month (slides 5, 44) • RTT (incomplete) performance is better at 62.5% (from 51%) (ytd 56.9%). There were 669 x 52 week breaches (previously 484) (slides 5, 46) • Diagnostic waiting times performance has fallen and remains below the standard (99%) at 68.4% (slides 5, 46) • 2 week wait (96.6%) is better (higher) than target (93%), 2 week wait breast symptomatic is compliant with the standard (93%) at 94.8% (slides 5, 47) • 28 day faster diagnosis standard (2ww) performance is compliant at.82.1% (slides 5,47) • 31 day subsequent surgery performance is currently below the standard (94%) at 77.8% (slides 5, 48) • Performance against the 62 day urgent referral to first treatment is currently just below target (85%) at 84.7% (slide 5, 49) • 62 day screening performance has improvement but remains non-compliant at 57.1% (slides 5, 49) • Short notice appointment cancellations remain above (worse than) target, but better than the previous period, at 14.3% (from 16.2%) (slides 5, 50) • Outpatient DNA rates have risen slightly but remain better (lower) than target at 7.6% (previously 6.6%) (slides 5, 50) **Workforce & Finance** • 12 month turnover rate is similar to previous months at 13.3% (previously 13.6%) and is just above target (13%); the vacancy rate is similar to last month, at 9.7% and remains better (lower) than target (10%) (slides 5, 51) • Sickness absence rates have returned to the target level at 3.5% (from 4%) (slides 6, 51) • All staff appraisals rates are temporarily suspended (slides 5, 52) • Mandatory training and Essential training are temporarily suspended (slides 5, 52) • Bank pay is better (lower) than the target (12%) but higher than previously (10.8%) at 11.4% (ytd 10.4%) and agency pay has also returned to better than target (4.7%) at 3.7% (slides 6,17) • 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 £0.34m lower than the business as usual plan. The YTD actual breakeven position is £2.0m 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 £1.0m. The YTD CIP ask of £3.0m has been mitigated by the interim reimbursement arrangements. • A range of activity counts are now included for information (slide 6): 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 – 16/9/2020*
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

10

<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>24 September 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 information, assurance and discussion.</td></tr>
</table>

NHS
West Hertfordshire Hospitals
NHS Trust

Integrated Performance Report

September 2020

Reporting Period: August 2020

Trust Board: 1st October 2020

Performance data updated on: 22nd September 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** 80.6% Target 80%	**Mandatory Training** 93.9% **Appraisal Rates** 87.0% Target 90%
Clostrioides Difficile cases 2 Target 2	**ED 4 hour standard** 83.1% Target 95%	**Agency pay** 4.2% Target 4.7%
VTE assessment 95.3% Target 95%	**RTT 52 week waits** 669 Target 0	**Vacancy rate** 9.7% Target 10%
Inpatient Friends & Family positive scores Suspended Target 95%	**CWT - 62 day referral to first treatment** 84.7% Target 85%	**I&E forecast** (Full year) £0 **I&E actual** (YTD actual & YTD plan) £0 Target -£ 1,925

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

COVID-19 SNAPSHOT – 15th September 2020

BEST CARE

INPATIENTS

C-19 positive **10**	C-19 suspected **14**	ITU C-19 positive **0**
C-19 result awaited **111**	C-19 negative **478**	ITU C-19 negative **13**

PATIENT TESTING

Non-elective C-19 positive **2**	Non-elective C-19 negative **50**
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 **3**
Antibody test positive **1**	Antibody test negative **16**

STAFF ABSENCE

C-19 sickness absence **40**	C-19 self isolating **18**
C-19 shielding **TBC**	

PPE ESTIMATED STOCK DURATION (DAYS)

Fluid resistant face masks **39 (Green)**	FFP3 face masks **17 (Green)**
Gloves **15 (Green)**	Gowns **39 (Green)**

The very best care for every patient, every day

Essential Measures – Executive Summary

NHS
West Hertfordshire Hospitals
NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Higher than previous months but within the "as expected" range	SHMI 100.6 HSMR 117.5	**Complaints response times** Above target (80%) but lower than previous month	80.6% YTD 71.1%	**All staff appraisal** Unchanged from previous month Below target (90%)	Suspended
Infection Control – clostrioides Difficile (hospital & healthcare) 1 Cat1 and 1 Cat2 case this month	2 (Cat1: 1 Cat 2:1) YTD 13	**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 8 NE 0 YTD 1	**Mixed sex accommodation** None in reporting period but usually low number when breaches occur	Suspended	**Turnover at 12 months** Just above (worse than) target (13%) Similar to previous month	13.3% YTD 13.9%
Patient safety incidents which are harmful Higher than previous month	7.9% YTD 8.3%	**Outpatient DNA rates** Below (better than) target (8%) but Higher than previous month	7.6% YTD 6.2%	**Income & Expenditure** Breakeven position for August	£0.00m YTD £0.00m
Combined Caesarean Section Standard (28%) not achieved but better (lower) than previous month	29.3% YTD 32.8%	**ED waiting times** Lower than previous month Target (95%)	83.1% YTD 84.2%	**Capital Spend** £1.40m Capital spend in August against a target of £2m	(£1.40)m YTD (£5.59)m
VTE assessments Better (above) than target (95%) Similar to previous month	95.3% YTD 95.7%	**RTT waiting times** Lower than the target (92%) Increase in 52 week waits	62.5% YTD 58.3% 669 YTD 1643	**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 18.5% YTD 31.3% Adm 84.1% YTD 72.1%	**Cancer waiting times** 2ww achieved consistently 62 day below target (85%) Better than previous month	2ww 96.6% YTD 97.7% 62 day 86.4% YTD 79.1%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 0 Elec 2005 vs 3771.25 Non-Elec 3708 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	Sep-20
COVID 19 Snapshot	**Inpatients**					
	C-19 positive	Improving	32	19	25	10
	C-19 suspected	Improving	10	12	16	14
	C-19 result awaited	Improving	62	63	128	111
	C-19 negative	Stable	364	415	480	478
	ITU C-19 positive	Improving	2	2	2	0
	ITU C-19 negative	Improving	6	10	10	13
	Staff Testing					
	C-19 positive	Stable	1	0	0	0
	C-19 negative	Improving	3	1	31	3
	Antibody test postive	Stable	73	6	1	1
	Antibody test negative		149	13	2	16
	Patient Testing					
	Non-elective C-19 positive	Worsening	0	0	0	2
	Non-elective C-19 negative	Improving	3	72	30	50
	Elective C-19 positive	Stable	2	0	0	0
	Elective C-19 negative	Stable	38	1	0	0
	Staff Absence					
	C-19 sickness absence	Improving	171	163	93	40
	C-19 self isolating	Improving	129	133	60	18
	C-19 shielding		N/A	N/A	N/A	N/A
	Nosocomial Infections					
	Hospital definite	Stable	0	0	0	0
	Hospital probable	Stable	1	0	0	0
	Hospital indeterminate	Stable	0	0	0	0
	Community	Stable	1	0	0	0
	Estimated duration of PPE stock (days)					
	Fluid resistant face masks	Improving	14	34	33	39
	FFP3 face masks	Improving	8	13	9	17
	Gloves	Improving	13	11	5	15
	Aprons		15	21	11	N/A
	Gowns	Improving	N/A	9	11	16

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Jun-20	Jul-20	Aug-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 but worse than target	99.0	99.1	100.6			Mar-20	National	100	Mar-20
		HSMR - Total (Rolling three months)	26	100	Performance deteriorated and worse than target	103.0	109.0	117.5			May-20	National	100	May-20
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	28	n/a		0	1	1	7		Aug-20	National	n/a	
		Clostridioides Difficile - Healthcare associated (Cat 2)	28	n/a		0	5	1	6		Aug-20	National	n/a	
		Clostridioides Difficile - Hospital and Healthcare associated Total	28	3	Performance stable and better than target	0	6	2	13	13	Aug-20	National	n/a	
		Hand Hygiene Compliance	29	95%	Performance stable and better than target	98.0%	97.4%	97.3%	97.5%	95%	Aug-20	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	33	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 *	33	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*	34	28.0%	Performance stable but worse than target	32.8%	35.8%	29.3%	32.8%	28.0%	Aug-20	Local	28.0%	2017/18
		Caesarean Section rate - Emergency*	34	15.0%	Performance stable and better than target	16.7%	15.9%	13.7%	15.8%	15.0%	Aug-20	Local	16.0%	2017/18
		Caesarean Section rate - Elective*	34	11.0%	Performance stable but worse than target	16.1%	19.9%	15.6%	17.0%	11.0%	Aug-20	Local	12.0%	2017/18
		Patient Safety												
		% nursing hours (shift fill rate)	35	95.0%	Performance stable and better than target	suspended		102.7%	99.9%	95.0%	Aug-20	National	n/a	
		Serious incidents - number*	36	0	Performance stable but worse than target	1	1	1	8	0	Aug-20	National	n/a	
		Serious incidents - % that are harmful*	36	0.0%	Performance stable but worse than target	0.0%	100.0%	100.0%	50.0%	0%	Aug-20	National	n/a	
		% of patients safety incidents which are harmful*	36	0.0%	Performance stable but worse than target	8.4%	7.2%	7.9%	8.3%	0%	Aug-20	National	n/a	
		Never events	36	0	Performance stable and better than target	0	0	0	1	0	Aug-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%	Aug-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%	Aug-20	National	97.8%	Mar-20
		Category 4 pressure ulcers - New (Hospital acquired)	38	0	Performance stable and better than target	0	0	0	0	0	Aug-20	Local	n/a	
		Category 3 pressure ulcers - New (Hospital acquired)	38	0	Performance stable and better than target	0	0	0	1	0	Aug-20	Local	n/a	
		VTE risk assessment*	41	95.0%	Performance stable and better than target	96.8%	96.1%	95.3%	95.7%	95.0%	Aug-20	National	95.3%	Q3 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	42	90.0%	Performance deteriorated and worse than target	28.3%	26.1%	18.5%	31.3%	90.0%	Aug-20	National	54.0%	Mar-20
		Stroke patients spending 90% of their time on stroke unit	42	80.0%	Performance stable and better than target	54.1%	78.9%	84.1%	72.1%	80.0%	Aug-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	Jun-20	Jul-20	Aug-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	254	268	354	1389	0	Aug-20	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	53	89	180	355	0	Aug-20	National	n/a	
		% Patients admitted through A&E - 0 day LOS		n/a		31.6%	27.5%	28.3%	27.5%		Aug-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	14.1%	15.2%	16.8%	14.5%	33.0%	Aug-20	National	n/a	
		Mixed sex accommodation breaches	44	0	Performance stable and better than target	suspended				0	Aug-20	National	59 Trusts breaching	Feb-20
		LOS > 21 days	45	65	Performance stable and better than target	53	52	58	58	65	Aug-20	National	n/a	
		Delayed Tranfers of Care (DToC) beddays used in month	45	n/a		Suspended				n/a	Aug-20	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	45	n/a						n/a	Aug-20	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	-	95%	Performance improved but worse than target	suspended				95%	Aug-20	National	85.0%	Feb-20
		Inpatient Scores FFT % positive	-	95%	Performance improved but worse than target					95%	Aug-20	National	95.9%	Feb-20
		Daycase FFT % positive	-	95%	Performance improved but worse than target					95%	Aug-20	National	n/a	
		Maternity FFT % positive	-	95%	Performance improved but worse than target					95%	Aug-20	National	96.9%	Feb-20
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	48	80%	Performance stable and better than target	82.4%	92.3%	80.6%	71.1%	80%	Aug-20	National	n/a	
		Reactivated complaints	48	0	Performance deteriorated and worse than target	2	0	5	8	0	Aug-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)	43	95.0%	Performance stable but worse than target	87.1%	85.9%	83.1%	84.2%	95.0%	Aug-20	National	89.3%	Aug-20
		Referral to Treatment - Incomplete*	50	92.0%	Performance improved but worse than target	47.7%	51.0%	62.5%	58.3%	92.0%	Aug-20	National	46.8%	Jul-20
		Referral to Treatment - 52 week waits - Incompletes	50	0	Performance deteriorated and worse than target	302	484	669	1643	0	Aug-20	National	83203 (all Trusts)	Jul-20
		Diagnostic (DM01) <6 weeks		99.0%	Performance stable but worse than target	64.8%	73.4%	68.4%	56.8%	99.0%	Aug-20	National	60.4%	Jul-20
		Cancer												
		Cancer - Two week wait *	51	93.0%	Performance stable and better than target	97.6%	98.6%	96.6%	97.7%	93.0%	Aug-20	National	92.0%	Q1 20/21
		Cancer - Breast Symptomatic two week wait *	51	93.0%	Performance stable and better than target	87.2%	98.1%	96.2%	94.8%	93.0%	Aug-20	National	89.5%	Q1 20/21
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	51	75.0%	Performance stable and better than target	82.3%	82.7%	82.1%	81.4%	73.0%	Aug-20	National	n/a	
		Cancer - 31 day *	52	96.0%	Performance stable and better than target	97.3%	96.4%	96.3%	96.2%	96.0%	Aug-20	National	94.7%	Q1 20/21
		Cancer - 31 day subsequent drug *	52	98.0%	Performance stable and better than target	92.9%	100.0%	100.0%	99.1%	98.0%	Aug-20	National	98.9%	Q1 20/21
		Cancer - 31 day subsequent surgery *	52	94.0%	Performance deteriorated and worse than target	100.0%	94.4%	77.8%	92.2%	94.0%	Aug-20	National	88.6%	Q1 20/21
		Cancer - 31 day subsequent radiology *	52	94.0%		100.0%	-	-	100.0%	94.0%	Aug-20	National	95.5%	Q1 20/21
		Cancer - 62 day *	53	85.0%	Performance stable but worse than target	86.7%	77.6%	84.7%	79.1%	85.0%	Aug-20	National	73.3%	Q1 20/21
		Cancer - 62 day screening *	53	90.0%	Performance stable but worse than target	100.0%	0.0%	57.1%	58.9%	90.0%	Aug-20	National	62.0%	Q1 20/21
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	54	5.0%	Performance stable but worse than target	16.3%	16.1%	14.3%	22.0%	5.0%	Aug-20	Local	n/a	
		DNA rate	54	8.0%	Performance stable and better than target	6.2%	6.6%	7.6%	6.2%	8.0%	Aug-20	National	n/a	

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West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain		Theme	Page	Target	Trend	Jun-20	Jul-20	Aug-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)	55	13.0%	Performance improved but worse than target	13.8%	13.6%	13.3%	13.9%	13.0%	Aug-20	National	15.0% (Beds and Herts orgs)	Q1 19/20
		% staff leaving within first year (excluding medics and fixed term contracts)	55	n/a		15.7%	15.7%	16.0%	16.2%	n/a	Aug-20	National	n/a	
		Vacancy rate	55	10.0%	Performance stable and better than target	9.1%	9.1%	9.7%	9.4%	10.0%	Aug-20	National	11.1% (local survey)	Q1 19/20
		Sickness rate	55	3.5%	Performance stable and better than target	4.1%	4.0%	3.5%	5.9%	3.5%	Aug-20	National	3.7% (EoE orgs)	Q1 19/20
		Developing Staff												
		Appraisal rate (Total)	56	90.0%	Performance stable but worse than target	87.0%	87.0%	87.0%	87.0%	90.0%	Aug-20	National	n/a	
		Mandatory Training	56	90.0%	Performance stable and better than target	93.9%	93.9%	93.9%	93.9%	90.0%	Aug-20	Local	91.0% (local survey)	Q1 19/20
		Essential Training	56	90.0%	Performance stable and better than target	90.8%	90.8%	90.8%	90.8%	90.0%	Aug-20	Local	n/a	
		Finance overview												
		Financial Risk Rating	14-24	3	Performance improved but worse than target	0.00	0.00	0.00			Aug-20	Local	n/a	
		Income & Expenditure Actual	14-24	-£374	Performance stable and better than target	£0	£0	£0	£0	-£1,925	Aug-20	Local	n/a	
		Income & Expenditure forecast	14-24	£0	Performance improved and better than target	£0	£0	£0	£0	£0	Aug-20	Local	n/a	
		Cash balance at the end of the month	14-24	£2,733	Performance improved and better than target	£48,307	£49,140	£52,789	£52,789	£2,733	Aug-20	Local	n/a	
		Capital expenditure	14-24	-£2,008	Performance stable but worse than target	-£852	-£710	-£1,400	-£5,587	-£10,033	Aug-20	Local	n/a	
		CIP delivery against plan	14-24	£1,153	Performance improved but worse than target	suspended				£5,763	Aug-20	Local	n/a	
		% Bank Pay**	14-24	12.0%	Performance stable and better than target	10.0%	10.8%	11.4%	10.4%	12.0%	Aug-20	Local	n/a	
		% Agency Pay**	14-24	4.7%	Performance stable and better than target	2.6%	4.9%	4.2%	3.7%	4.7%	Aug-20	Local	7.3% (local survey)	Q1 19/20
		Activity (chargeable)												
		GP referrals		8,027	Performance stable and better than target	3,875	5,230	4,883	17,949	40,135	Aug-20	National	n/a	
		A&E attendances		15,594	Performance stable and better than target	9,876	11,559	11,892	48,525	70,425	Aug-20	National	n/a	
		Elective spells (overnight)		448	Performance stable but worse than target	190	253	345	1,066	2,328	Aug-20	National	n/a	
		Elective daycase		3,324	Performance stable but worse than target	1,081	1,628	1,660	5,195	17,283	Aug-20	National	n/a	
		Total elective spells		3,771	Performance stable but worse than target	1,271	1,881	2,005	6,261	19,611	Aug-20	National	n/a	
		Non-elective spells		5,090	Performance stable and better than target	3,394	3,732	3,708	16,545	25,122	Aug-20	National	n/a	
		Births		333	Performance stable but worse than target	356	389	381	1,843	1,643	Aug-20	National	n/a	
		Outpatient attendances		19,528	Performance deteriorated and worse than target	9,452	11,357	9,500	44,768	101,548	Aug-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

Our SMART and V-SMART pilot has restarted successfully, and the pilot is designed to confirm that V-SMART is as safe and effective as our proven SMART programme. Our Clinical Strategy workshops have been launched, which will be fundamental to the redevelopment programme. The trust's Emergency Assessment Unit has opened, and embedded well, with surgeons and physicians working together. We hope to triple capacity shortly, which should then allow orthopaedic and gynaecology to be included in this new way of working. Waiting list reviews, with regards risk stratification is going well, and the trust was invited to shows its methodology and result recently at a regional meeting.

Although the focus has been on restarting services affected by the pandemic, divisions are also being asked to prepare for an increase in hospitalisations, and how they would minimise the effect on elective care, should this happen.

Chief Nurse

We continue to undertake audits of PPE and cleanliness i.e. cleaning of equipment as part of our 'code of practice ' (COP) to ensure we focus on areas requiring support and any learning i.e. the wearing of gloves and getting the basics right.
Our Test Your Care audits also address infection control documentation and screening for other HCAI's.
We continue to monitor Covid training compliance through the divisional performance reviews to ensured all staff clinical and non-clinical are adequately trained and aware of IPC procedures.
As part of winter planning with the limited side room capacity in our estate, we have trialled pop up isolation facilities and the use of plastic curtains/screens to provide further separation of the bed spaces. These will be implemented in our designated isolation area and a further area to support our risk assessment for infection & prevention control practice.

Safe staffing continues to be an area of focus and we are reviewing templates in line with the escalation surge plan. Working closely with HR around recruitment and health and wellbeing, also ensuring a clear plan of communication as we move into winter.

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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Caring & Responsive Services

Chief Nurse

The maternity visiting guidance has been published and we are working across the local Maternity & Neonatal System (LMNS) to review and finalise a system approach. One birth partner at this time is permitted to accompany women during labour in the delivery suite and the initial post-natal phase prior to moving to the post-natal ward.

A review of the patient property policy and process is being undertaken, looking at learning from our first phase of Covid. We are now beginning to see an increase in concerns around patient property from next of kin. This was expected due to the processes in place and the delay due to infection, prevention control in the release of property and its management. We now have a clear process in place should we see a phase 2 of Covid. The complaints, PALs and patient affairs contacts are being captured on our incident management system.

ITU have joined the NHSE/I patient experience leads to use storytelling as a narrative/catalyst to support teams to understand staff and patient experience during the pandemic. A short video will be used nationally as a resource and we will also be supported to take a QI approach to understand experience during Covid.

Chief Operating Officer

The Trust has continued to see an upward trend in ED attendances to pre-COVID levels with a marked increase in ambulance conveyances also.

COVID testing on admission has continued with the in-house testing solution having gone live at the beginning of September, improving the turnaround times for patients enabling them to move out of our 'awaiting swab results' beds in a more timely way.

The Emergency Assessment unit which opened in mid August, is being used to great effect, plans are being finalised for Phase II which would enable a further 20 assessment trolleys, supporting the dispersal of patients from the ED department. Minor works have commenced in the old MAU to enable its provision as the interim Frailty Unit which should open in early October, this will relocate at a later stage to EAU Phase II.

Work is underway to review the Trust's escalation surge plan taking into account winter pressures alongside possible flu and COVID demands.

Interviews took place to appoint a new Divisional Manager for Surgery, Anaesthetics & Cancer – a successful external appointment was made with a start date likely to be end of December/beginning of 2021.

The new Pharmacy robot has gone live with the service currently working through the usual 'go live' snagging.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief People Officer

Workforce metrics: We have seen a significant increase in COVID related absence, primarily this has been due to staff having to self isolate after having their children sent home from school due to displaying COVID like symptoms. This picture has been seen throughout the East of England. As a result we have opened up some internal rapid testing facilities to staff and their families to enable a speedy return to work. This month has also seen a formal resumption of mandatory training and appraisals.

Flu: We have begun this year's flu campaign with over 10% of staff being vaccinated in four days. Like elsewhere in the country demand for the vaccination is expected to be high and therefore we will prioritising allocation to patient facing staff in the first instance.

Staff survey: 1st October will see the launch of this year's Staff Survey campaign with for the first time over 85% of questionnaires being undertaken on-line. We will continue to promote the survey and our goal is to exceed last year's completion rates.

Staff Side: We are working with our Staff Side to review ways of working and to put into place a new working agreement which will help improve and modernise our working arrangements.

Diversity: October will see a number of the Executives complete the first phase of their BAME staff reverse mentoring programme and a review of the programme is intended. Initial feedback is that the programme has been extremely positive. October also sees Black History Month and the Trust will be working with its Connect BAME network to support a number of activities.

Freedom to Speak Up Month: October is also FtSU month and again the Trust will be celebrating and promoting this event with a number of activities being led by the Trust's FtSU Guardian Joanna Bainbridge.

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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 £35m of expenditure incurred in the month. Within the £35m, the COVID-19 pandemic created an extra £1.7m of revenue costs. Additional income is beginning to flow to cover these costs. Before the pandemic, the trust had budgeted for expenditure to exceed income by £0.4m. in August. The 'full reimbursement' meant that the Trust was £0.4m better than the plan that was set at the start of the financial year. Year to date, the Trust is £2.0m better than plan at the end of August.

As the operational restarts continue to 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 51% of the original plan in month, compared to an average of 26% for previous months.
- Outpatient attendances were 70% of the original plan in month, compared to a 55% YTD average.
- A&E attendances 81% of plan compared to a 66% average trend for previous months.

The Trust spent £1.4m on buildings and equipment assets in August. The year to date capital spend stands at £4.9m. Cash flow continues to be healthy through advance block payments and this is supporting the trust's efforts to pay suppliers as quickly as possible.

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.

Further guidance has been issued regarding reimbursement from month 7 onwards. The impact for the Trust is a slight downward adjustment to the mandated block payments from CCGs and an upward adjustment to mandated 'top up' payments to reflect financial regime changes (such as changes to dividends payable). The financial plan is yet to be finalised with our ICS and NHSEI, but the current draft indicates that the Trust requires an extra £11.4m to meet the additional costs in re-establishing capacity and productivity approaching NHSEI targeted activity levels. These costs reflect the need for enhanced protection for patients and staff impacting on normal productivity.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Corporate - ICT

Chief Information Officer

After two challenging months, August saw an improvement in a number of core performance metrics:

Metric	Jun	Jul	Aug
Priority 1 incidents	4	7	2
Priority 2 incidents	17	20	21
Incident backlog	350	415	416
First time fix rate	87%	91%	92%
Customer satisfaction score	7.2	6.6	6.8
Network availability	100%	100%	100%

The two priority 1 incidents in the month related to PACS and ICE. The PACS issue was caused by the Image Retrieval / Query service stopping working and was resolved by Philips by restarting PACS and the ICE issue was incorrectly logged as a P1 as it only affected one user.

Of the 21 priority two incidents, 11 of them related to applications not functioning properly. Over the coming months improving our application performance will become more of a focus for the IT improvement programme. Thus far the focus of IT improvement has been on addressing our infrastructure deficit, i.e. Local Area Network, Servers, Wide Area Network, Telephony etc. With the vast majority of that work complete we now need to improve the way our applications work on our more robust infrastructure platform.

There are four key components of our application improvement plan, as follows:

- Deploying as many Windows 10 devices as we can afford
- Driving forward our EPR programme
- Agreeing a funding mechanism for our digital strategy (which includes application upgrades)
- Upgrading key clinical applications in the short term to improve compatibility and functionality across the estate

We are completing a business case that will support the full deployment of Windows 10 across the entire estate and to upgrade some key clinical applications in advance of a funding mechanism that enables us to start delivery of our digital strategy.

It should be noted that in recent days NHSX have publicly confirmed the expectation (that was set in the phase 3 response to Covid letter) that all Integrated care systems should have shared records in place to ensure patient data can flow between care settings to support direct care by September 2021. As a Trust and a system we will need to work through how and to what extent we can comply with this ambition given the improvement plans we already have in place.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Income and Expenditure August 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	7,620	876	Bii	33,718	37,227	3,509	Fii
	NHS Revenue	336,416	27,810	27,405	(405)	Bi	139,660	136,560	(3,100)	Fi
	Income Unallocated CIPs									
Income Total		**417,340**	**34,554**	**35,025**	**471**	**B**	**173,378**	**173,787**	**409**	**F**
Pay	Medical Pay	(81,314)	(6,763)	(6,887)	(124)		(34,013)	(33,571)	442	
	Non-Clinical Pay	(62,277)	(4,971)	(4,213)	758		(24,412)	(21,024)	3,387	
	Nursing Pay	(79,976)	(6,771)	(6,582)	190		(33,327)	(32,136)	1,191	
	Other Clinical Pay	(30,296)	(2,731)	(2,821)	(91)		(12,624)	(13,138)	(513)	
	Scientific, Technical & Profes	(27,309)	(2,274)	(2,228)	45		(11,380)	(11,485)	(105)	
	Pay Unallocated CIPs	9,386	602		(602)		1,805		(1,805)	
Pay Total		**(271,786)**	**(22,908)**	**(22,732)**	**177**	**C**	**(113,951)**	**(111,354)**	**2,597**	**G**
Non Pay	Clin Supp Serv	(31,253)	(2,471)	(2,151)	319		(12,847)	(10,805)	2,042	
	Drugs	(21,424)	(1,694)	(1,059)	635		(8,807)	(7,579)	1,227	
	OTHER (NON CLIN)	(82,590)	(6,879)	(7,717)	(837)		(34,006)	(37,216)	(3,210)	
	Non Pay Unallocated CIPS	6,257	401		(401)		1,203		(1,203)	
Non Pay Total		**(129,009)**	**(10,643)**	**(10,927)**	**(285)**	**D**	**(54,456)**	**(55,600)**	**(1,144)**	**H**
Recharges	Recharges									
Recharges Total										
Financing Charges	Depreciation	(10,948)	(912)	(906)	6		(4,558)	(4,523)	35	
	Trust Debt Redemption	(5,570)	(464)	(462)	3		(2,328)	(2,318)	10	
	Unwinding Discount	(27)	(2)	2	4		(11)	8	19	
Financing Charges Total		**(16,545)**	**(1,379)**	**(1,366)**	**13**	**E**	**(6,898)**	**(6,833)**	**65**	**I**
Total			**(376)**		**376**	**A**	**(1,926)**		**1,926**	**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 August.
The performance to plan was better by £376k. The performance against plan shown, represents the pre-covid business as usual plan.

B- The overall income position saw an over performance in month of £471k.
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 £27,405k 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 August. The underperformance was £405k. 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 £22,732k which was £177k underspent. Within the pay position, an additional £785k 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 £285k. This includes an additional £961k 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 under spend of £13k.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Finance overview dashboard

Financial Overview 31 August 2020

Month 5 Income & Expenditure

£m	Plan	Actual	Var
Surplus / (Deficit)	(0.4)	(0.0)	0.4

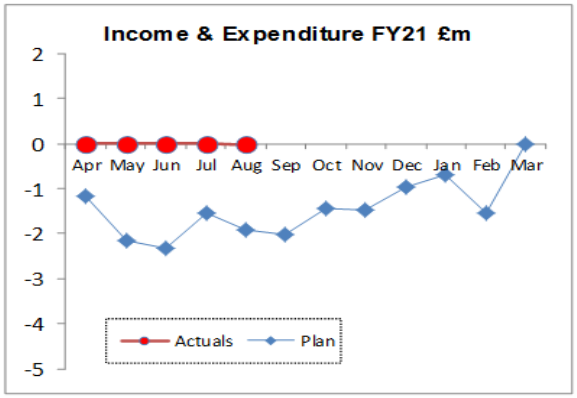
£m	YTD M5 20/21		
Surplus / (Deficit)	(1.9)	(0.0)	1.9

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 31/8/20 equated to 53 days' spend.	G
BPPC	Month 5 performance - 85.5% on number, 84.2% on value (95% target)	A

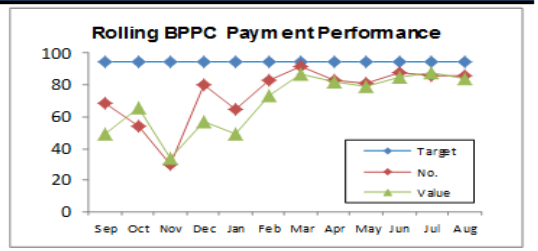
Financial Risk Rating	FY21	2

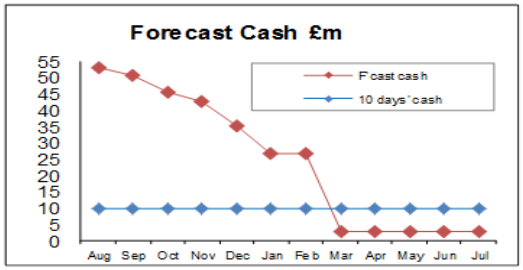
Risk rating on a scale of 1 to 4, with 1 being best and 4 being worst.

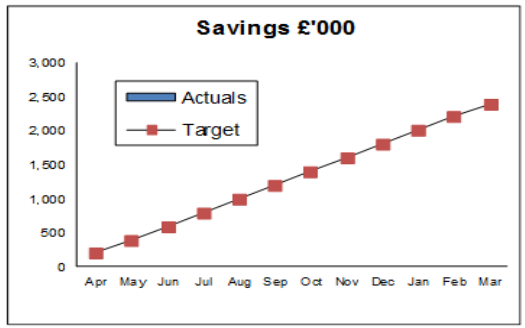


YTD Variance by Division £m

Medicine	(9.1)
Unscheduled Care	(6.1)
Surgery	(14.5)
Women's	(3.4)
Clinical Support	(3.5)
Estates & Facilities	(0.6)
Corporate	(0.3)
Other	39.5
Total	**1.9**







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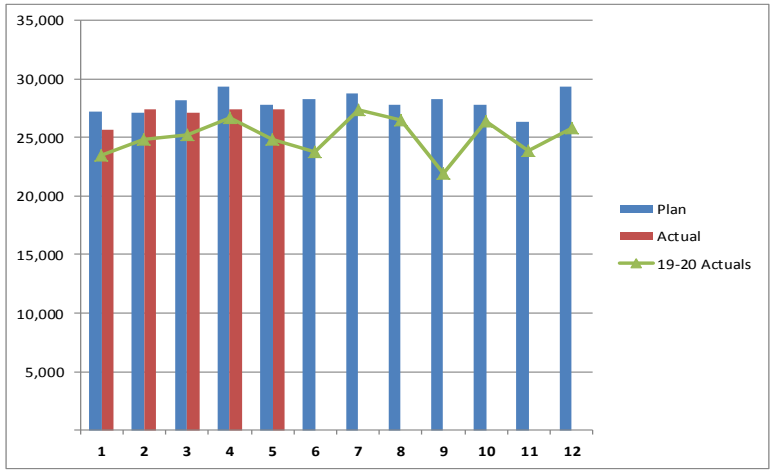
West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Income - August 2020

NHS Revenue: Performance by Month (£s)

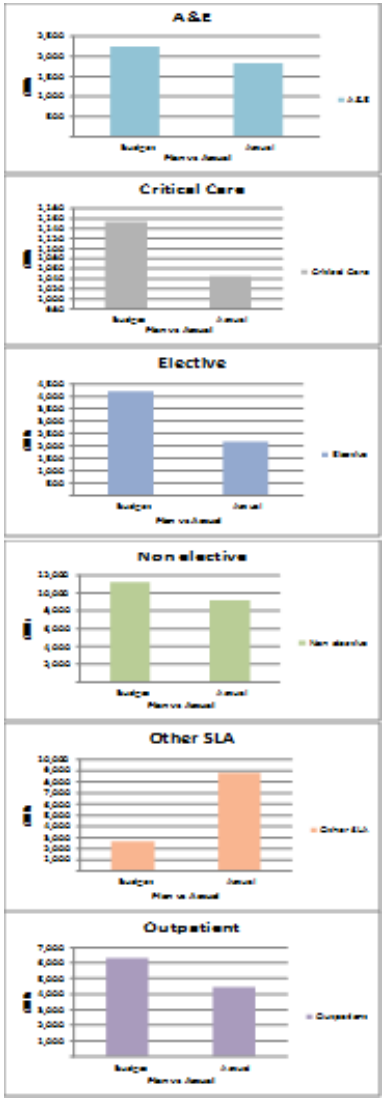


In line with national guidelines, NHS revenue continues to be set at a block amount of £27.4m for the month of August. This resulted in an underperformance against the business as usual plan.

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 £0.4m
In August, the number of covid patients requiring critical care facilities continued to reduce. This is behind the underperformance of £0.1m in month.
The reduction in Elective cases continues to drive a monthly underperformance of £2.04m. This is predominately within the Surgery division.
For Non Elective the in month position showed under performance of £2.06m.
Despite an increase in virtual interactions, the overall fall in Outpatient attendances meant performance was £1.9m away from plan.

The adverse variances above were offset by other SLA income being favorable to plan by £6.08m. 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	2,244	1,832	(412)
	Critical Care	13,664	1,153	1,044	(109)
	Elective	53,207	4,206	2,165	(2,041)
	Non elective	132,024	11,213	9,154	(2,059)
	Other SLA	30,316	2,677	8,766	6,089
	Outpatient	78,721	6,316	4,451	(1,867)
	NHS Rev Unallocated CIPs				
NHS Revenue Total	Total	338,418	27,810	27,406	(404)

In Month Performance (spells)

Expense Type	POD	Annual Budget	In Month (Activity) Budget	Actual	Variance
NHS Revenue	A&E	156,833	13,586	12,532	(1,054)
	Critical Care	14,579	1,232	1,052	(180)
	Elective	47,705	3,771	2,107	(1,664)
	Non elective	64,255	5,445	4,076	(1,369)
	Other SLA	3,174,705	295,092	244,992	(50,100)
	Outpatient	479,834	39,037	28,259	(10,778)
NHS Revenue Total	Total	4,566,909	382,777	291,140	(91,636)

Divisional Income

Divisional income delivered a £876k 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 £1.7m worth of claims for additional covid related expenditure. This is included within the position.

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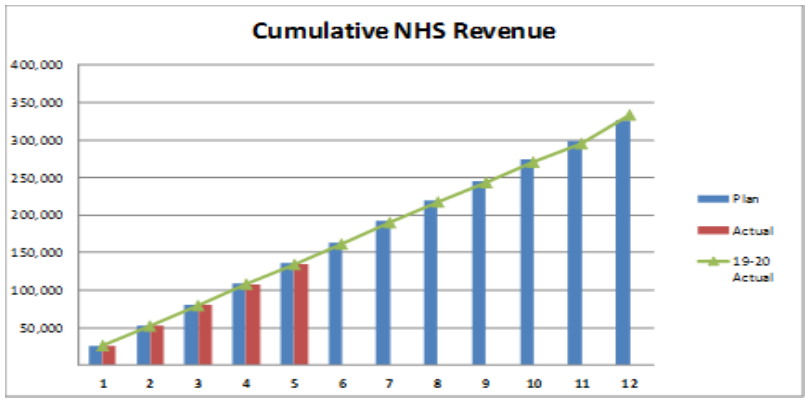
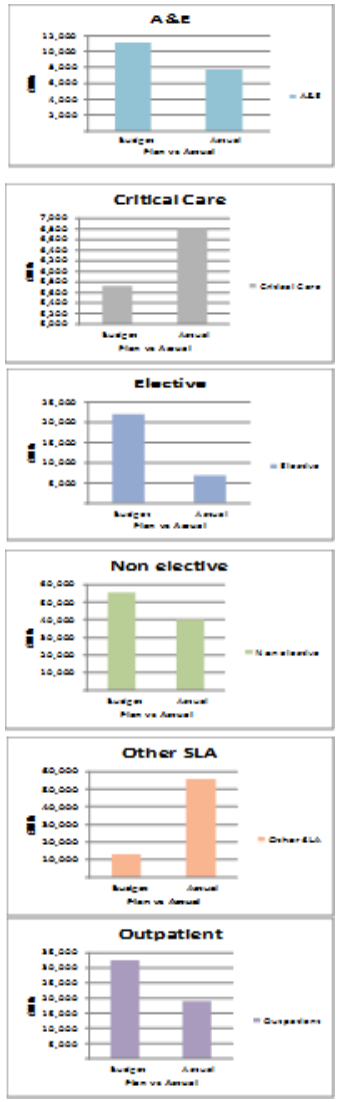
Workforce & Finance : Year To Date (YTD) – Trust Income

NHS Revenue: Performance by Month (£s)



Month5 YTD shows Income under performance of £3.1m. £136.6m has been generated against plan of £139.7m.
A&E has a YTD under performance of £3.4m which is linked to a price and volume variance.
Critical care is £1.1m better than plan and has seen an average occupancy rate of 80%. The increase is linked to the Covid-19 pandemic.
Elective performance is £15.1m 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 £14.9m. This is predominately centred around the Emergency division and is linked to a reduction in emergencies throughout the pandemic.
YTD Outpatient performance shows £13.58m worth of under performance.
Other SLA income is £42.75m above plan. This is driven by a central adjustment to take into account the impact of current interim reimbursement structure.



YTD Performance (£s)

	YTD (£000's)		
POD	Budget	Actual	Variance
A&E	11,094	7,682	(3,412)
Critical Care	5,716	6,814	1,098
Elective	21,872	6,780	(15,091)
Non elective	55,342	40,470	(14,871)
Other SLA	13,149	55,903	42,754
Outpatient	32,489	18,910	(13,578)
NHS Rev Unallocated CIPs			
Total	**139,660**	**136,560**	**(3,100)**

YTD Performance (spells)

	YTD (Activity)		
POD	Budget	Actual	Variance
A&E	78,317	51,665	-26,652
Critical Care	6,111	6,592	481
Elective	19,610	6,479	-13,131
Non elective	26,978	18,352	-8,626
Other SLA			
Outpatient	197,390	102,916	-94,474
Total	**328,406**	**186,004**	**-142,403**

Divisional Income

The YTD divisional income position is now better than plan by £3.5m. 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 August 2020

Trust Pay Performance

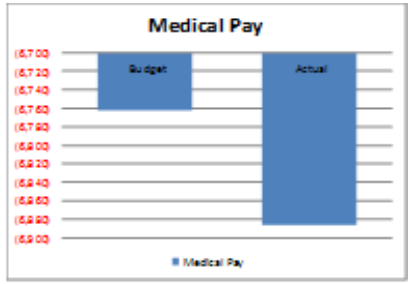
Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	WTE Budget	Actual	Variance
Medical Pay	(81,314)	(6,763)	(6,887)	(124)	711.37	817.55	-106
Non-Clinical Pay	(62,277)	(4,971)	(4,213)	758	1,271.89	1,196.07	76
Nursing Pay	(79,976)	(6,771)	(6,582)	190	1,640.42	1,608.89	32
Other Clinical Pay	(30,296)	(2,731)	(2,821)	(91)	1,045.67	1,125.83	-80
Scientific, Technical & Profes	(27,309)	(2,274)	(2,228)	45	510.90	515.66	-5
Pay Unidentified CIPs	9,386	602		(602)	0.00	0.00	0
Total	**(271,786)**	**(22,908)**	**(22,732)**	**177**	**5,180.25**	**5,264.00**	**-84**

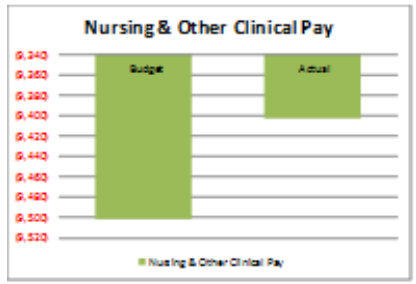
The Trust reported an in month underspend of £177k. This is linked to reduced activity levels performed in month. There was also £785km worth of cost captured in relation to Covid-19.

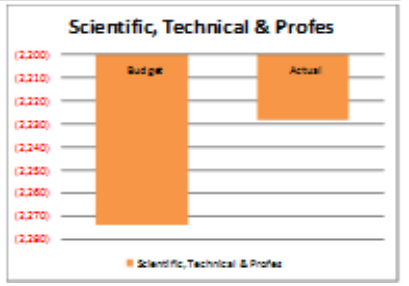
Key areas to note include;

- Medical pay was £124k overspent, this is linked to operational changes in dealing with the covid-19 outbreak.
- Non Clinical Pay- was underspent by £758k. This represents unspent growth reserves across divisions.
- Nursing and other clinical pay showed a combined underspend against plan of £190k. 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 saw a slight reduction resulting in the £45k underspend in month.
- Expected pay efficiencies in month were not achieved and this caused a £602k 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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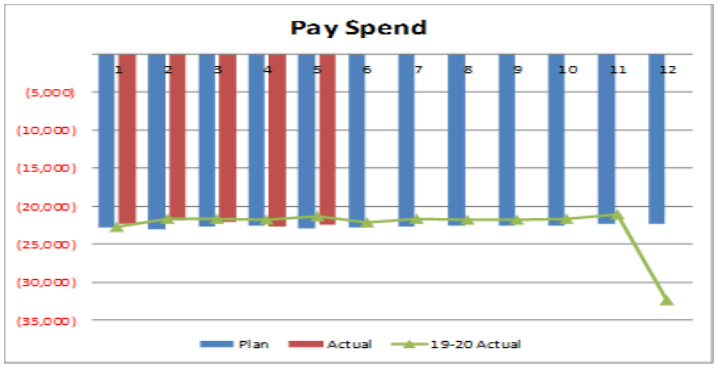
West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Pay August 2020



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

Key year to date themes to note are:

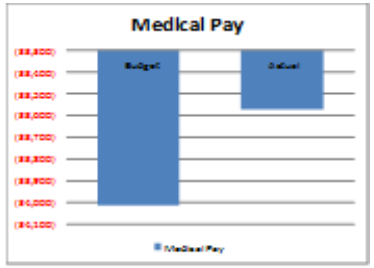
1.Medical pay – is showing an underspend of £0.56m. This reflects operational changes made during the covid-19 pandemic.

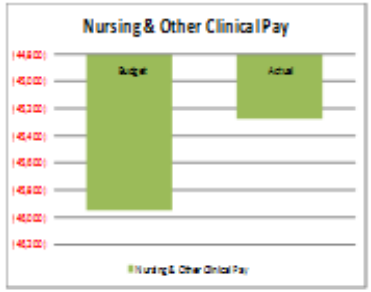
2.Nursing and other clinical pay has a combined underspend of £0.57m YTD. This is driven by a lower bank and agency fill rate and operational changes made to deal with Covid-19 (zonal deployment).
3.Scientific & therapeutic agency premium to cover vacancies across clinical support, theatres and cardiology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

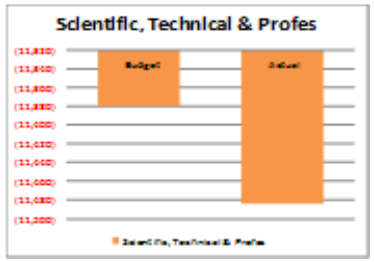
4.The above overspends are buffered by unutilised growth monies sitting on the non clinical pay line.

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)	(34,013)	(33,571)	442
Non-Clinical Pay	(62,277)	(24,412)	(21,024)	3,387
Nursing Pay	(79,976)	(33,327)	(32,136)	1,191
Other Clinical Pay	(30,296)	(12,624)	(13,138)	(513)
Scientific, Technical & Profes	(27,309)	(11,380)	(11,485)	(105)
Pay Unallocated CIPs	9,386	1,805		(1,805)
	(271,786)	(113,951)	(111,354)	2,597

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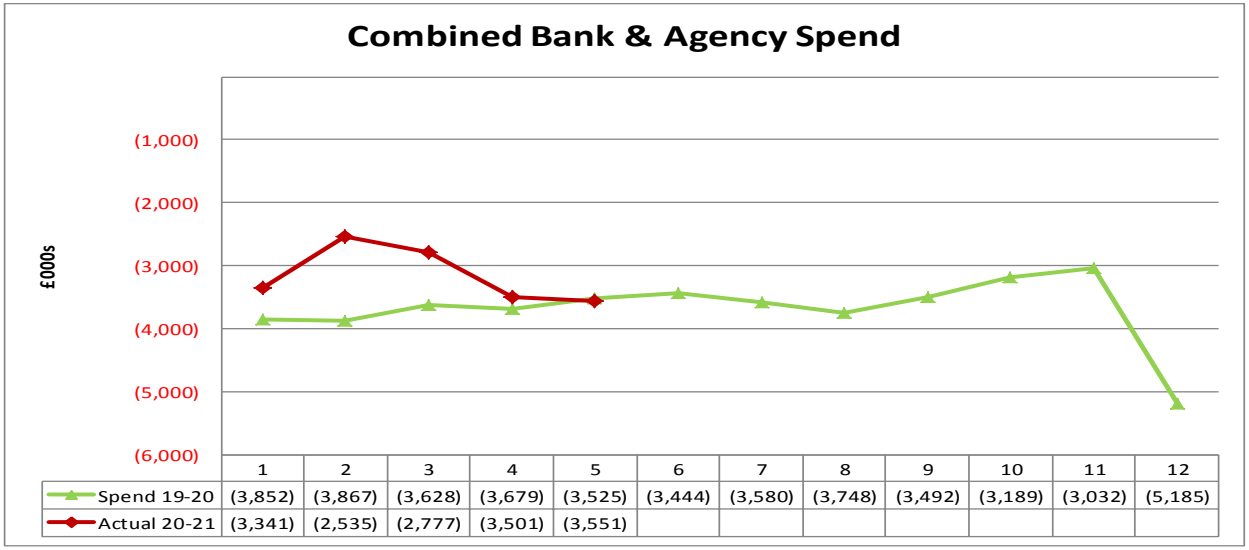
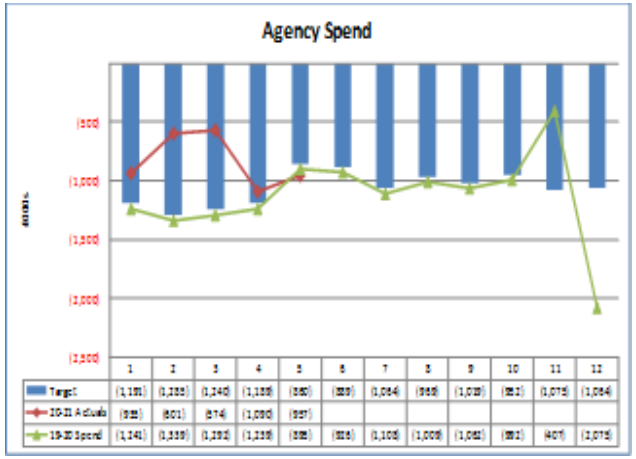
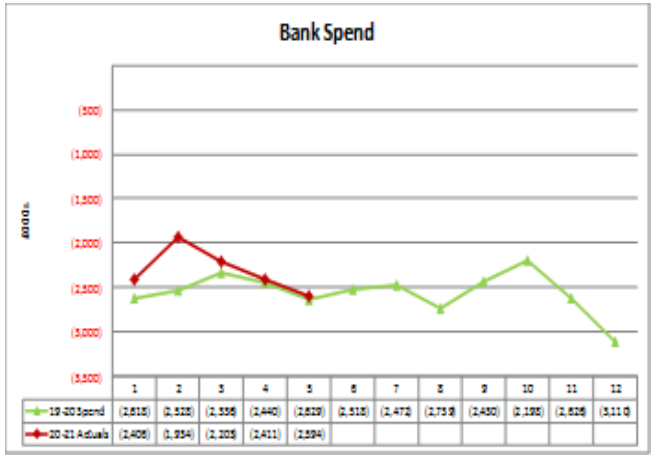
Workforce & Finance: Bank & Agency Spend August 2020



	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)	(3,501)	(3,551)							





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

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

Agency expenditure in the month totalled £1m. This represents an increase on previous months and reflects higher agency requests to deal with activity increases and bank holiday cover.

Of the £1m in-month spend, £0.27m was spent in relation to covid.

Bank spend for August was £2.3m. This is broadly in line with the patterns of spend seen in previous months.

Of the £2.3m spend, £0.36m was spent in relation to covid.

When comparing to the same month last year, the Trust has spent £0.2m less on temporary staffing.

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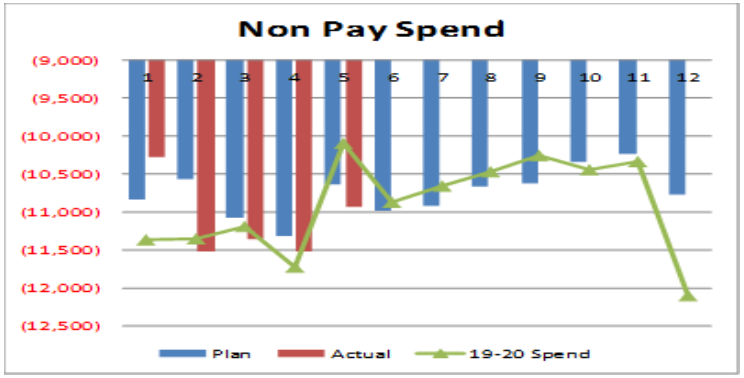
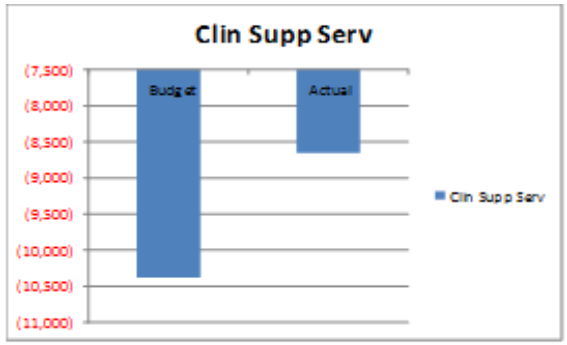
Workforce & Finance: Non Pay August 2020

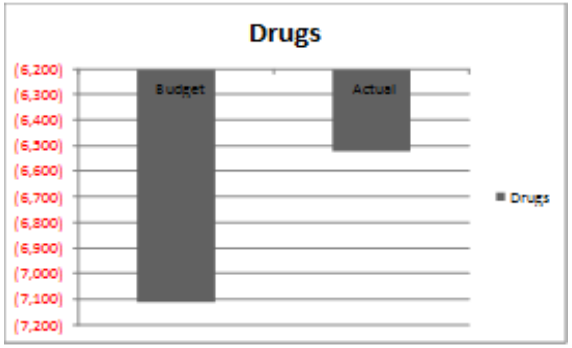
Non Pay Performance

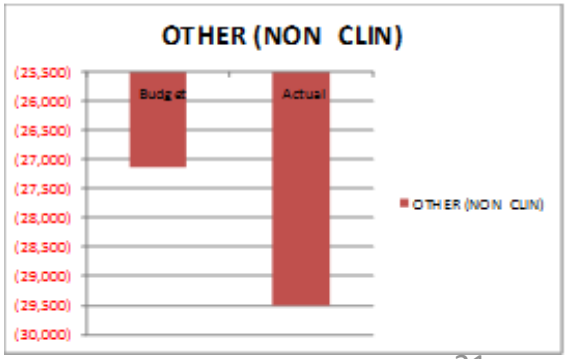
Expense Type	Annual Budget	In Month (£000's)			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
Clin Supp Serv	(31,253)	(2,471)	(2,151)	319	(12,847)	(10,805)	2,042
Drugs	(21,424)	(1,694)	(1,059)	635	(8,807)	(7,579)	1,227
OTHER (NON CLIN)	(82,590)	(6,879)	(7,717)	(837)	(34,006)	(37,216)	(3,210)
Non Pay Unallocated CIPS	6,257	401		(401)	1,203		(1,203)
Total	**(129,009)**	**(10,643)**	**(10,927)**	**(285)**	**(54,456)**	**(55,600)**	**(1,144)**



YTD Performance







The in month non pay position reported an overspend of £0.29m. Actual Spend was £10.93m against a budget of £10.64m.

The main drivers of the position include:

Clinical supplies were £0.32m 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 £0.64m. This reflects the volume and complexity of patients seen in month.
Other non clinical supplies were overspent by £0.84m. The majority of this relates to covid related infrastructure costs.

The position includes a total spend of £0.96m in relation to covid-19 in month.

YTD the position is £1.1m overspent. This includes total YTD covid non pay costs of £7.3m.

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Workforce & Finance: Covid-19 Cost Capture August 2020

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 5
In month 5 the following costs have been captured:

- £785k pay
- £961k non-pay

This has been offset with £1,746k 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	243	1042
	Non-Clinical Pay	124	768
	Nursing Pay	168	884
	Other Clinical Pay	132	393
	Scientific, Technical & Profes	119	638
Pay Total		**785**	**3,725**

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Non Pay	Bedding & Linen		1
	Cleaning supplies & materials	-3	228
	Computer expenditure		54
	Consultancy	13	155
	Dressings		
	Drugs	-134	202
	Estates expenditure	4	959
	Furniture & office equipment	11	12
	Hardware & crockery		
	Healthcare from other NHS Bod	44	64
	Laboratory expenses	318	1203
	Medical & Surgical Equipment	3	1126
	Other non-pay	746	2842
	Patient Clothing		
	Printing & stationery		22
	Provisions	-109	147
	Staff Uniforms	66	232
	Travel & subsistence	1	3
Non Pay Total		**961**	**7,248**
Grand Total		**1,746**	**10,973**

10

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Workforce & Finance: Efficiency Programme

WHHT - FY21 CIP Efficiency Covid 19 impact

FY21 Efficiency Strategy Themes Covid 19 impact (as of 16.09.20) 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 - Sept impact			**4,212**									

WHHT FY21 CIP Efficiency Divisional Target

	Suspended												
Division	**April M1 £000**	**May M2 £000**	**June M3 £000**	**July M4 £000**	**Aug M5 £000**	**Sept M6 £000**	**M7 £000**	**M8 £000**	**M9 £000**	**M10 £000**	**M11 £000**	**M12 £000**	**FY21 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 - Sept impact			**4,212**									

At the time of writing guidance is that the first 6 months of the Trust's FY21 efficiency program have been suspended, it is anticipated that NHSI guidance around impacts beyond Sept will be provided imminently.

WHHT FY21 April to Sept impact is £4.2m

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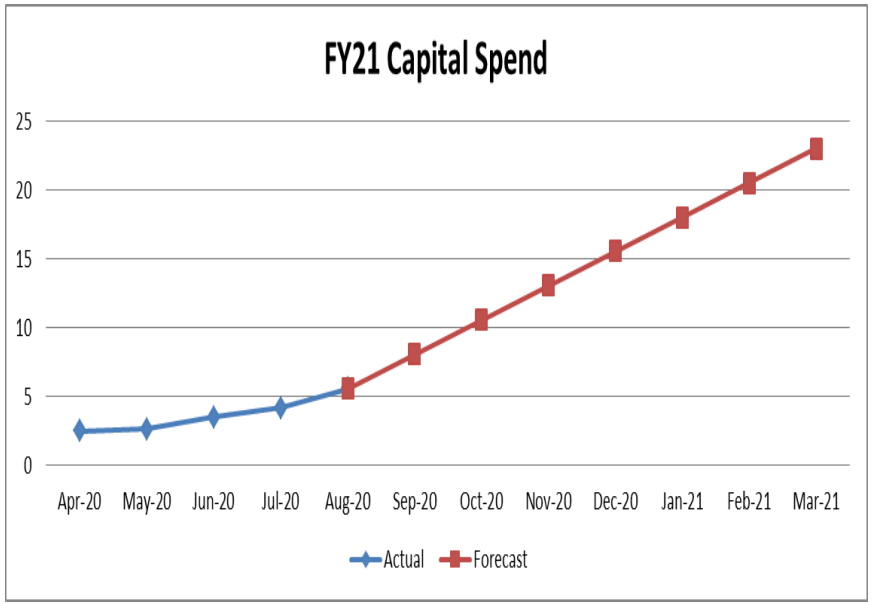
Workforce & Finance: Capital Expenditure August 2020



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**
5	Fire Safety	0.14
5	Your Care Your Future	0.33
5	Medical Assessment Unit	0.05
5	Multi Storey Car Park (MSCP)	0.07
5	Sundry Estates	0.07
5	Covid-19 related projects	0.74
	Month 5 Total Spend	**1.40**
	YTD Spend	**3.48**

West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

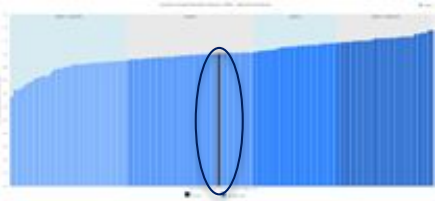
In this reporting period:
The latest available (April 2019 to March 2020) Summary Hospital Mortality Indicator (SHMI) was 100.56 and within the 'as expected' range (band 2). For the 12 month period (Jun 2019 to May 2020), the Trust's overall HSMR of 105.1 was within the 'as expected' range. The COVID 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 this 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

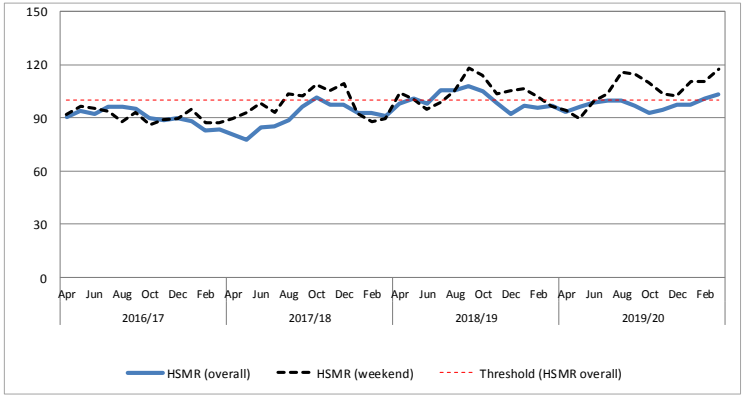
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



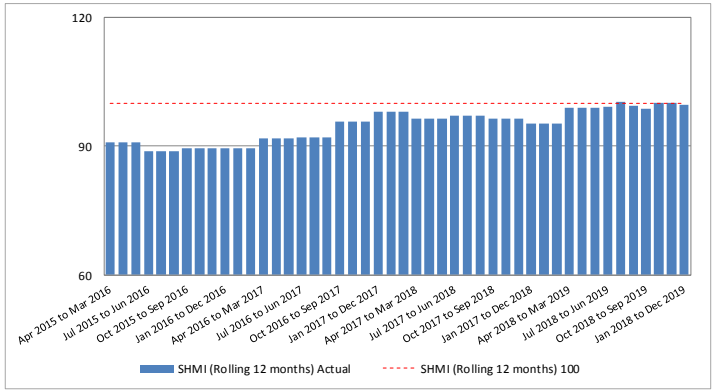
Period: Jan 2020

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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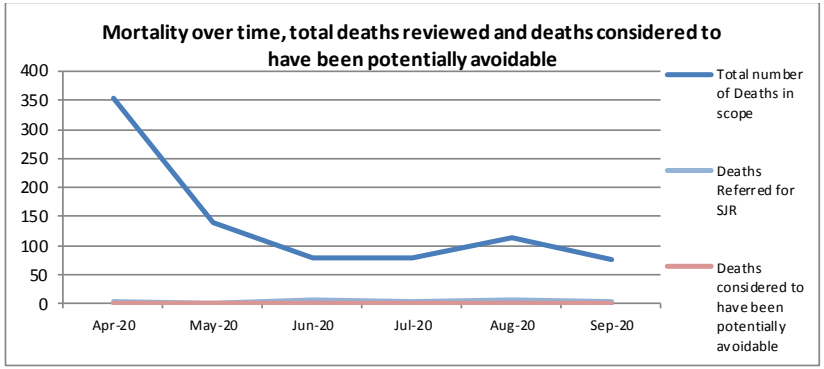
Safe Care & Improving Outcomes: Learning from deaths dashboard

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope *based on date of death		Total Deaths Referred in for SJR **based on date of review		Total that were Tier 2 reviewed		Total Number of Deaths considered to have been potentially avoidable (RCP <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
113	79	7	3	6	3	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
192	575	10	13	9	0	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
767	1652	23	137	9	32	1	2



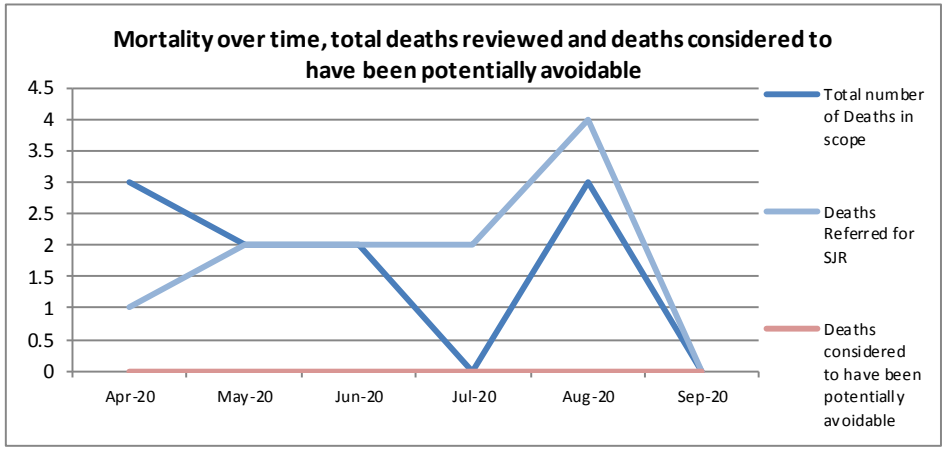
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable		Score 2 Strong evidence of avoidability		Score 3 Probably avoidable (more than 50:50)		Score 4 Probably avoidable but not very likely		Score 5 Slight evidence of avoidability		Score 6 Definitely not avoidable	
This Month	0	This Month	1	This Month	0	This Month	1	This Month	3	This Month	1
This Quarter (QTD)	0	This Quarter (QTD)	1	This Quarter (QTD)	0	This Quarter (QTD)	2	This Quarter (QTD)	4	This Quarter (QTD)	2
This Year (YTD)	0	This Year (YTD)	1	This Year (YTD)	0	This Year (YTD)	2	This Year (YTD)	4	This Year (YTD)	2

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in Scope *based on date of death		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of Deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	0	4	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	7	6	5	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	23	11	23	0	0



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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. In August 2020 2 cases of C diff infection were attributed to the Trust (x1 cat 1 and x1 cat 2) . Total number of Trust apportioned cases April to Aug is 13 cases (cat 1 x7 and cat 2 x6). RCA's have been completed in all cases up to end of July, and August cases RCAs have been commenced . 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 August 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 August no outbreaks were identified

Hand hygiene (HH): Hand hygiene compliance for the month of August 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

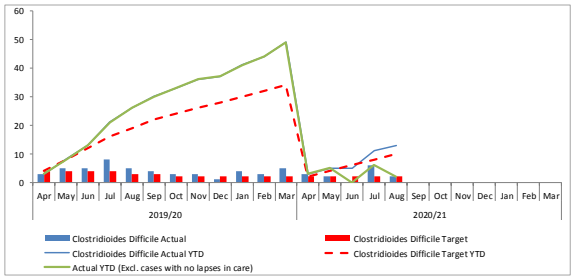
Benchmarking: MODEL HOSPITAL
Rolling 12 month trust apportioned Cdiff infections / 12 month avg occupied bed days

Period: to March 2019

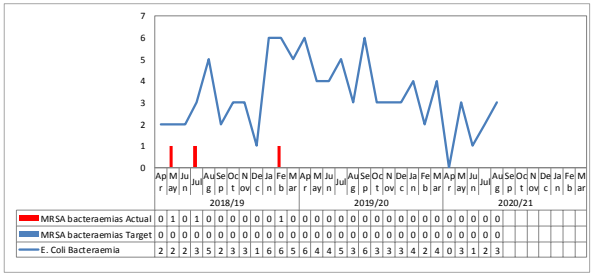
WHHT 6.42 Peer 13.68
National 11.11

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

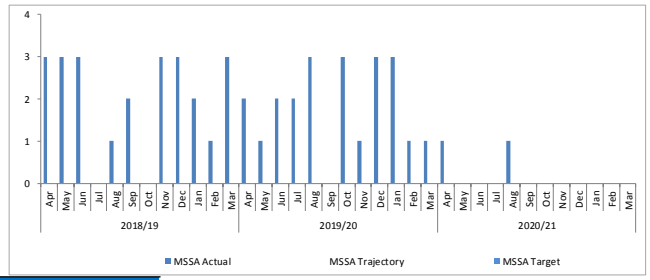
Clostrioides Difficile Infection (CDI)



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 3 post-48hr cases and 27 pre-48 hour cases (non-trust) reported in August 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.

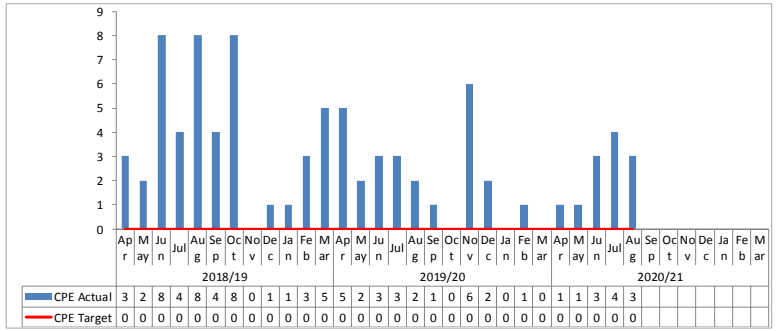
Methicillin-sensitive Staphylococcus aureus (MSSAb):
There was 1 post-48 hour case and 1 pre-48 hour cases of MSSAb in August 2020. Each case is usually reviewed by a microbiologist using an RCA tool to identify and share learning and is to be picked up as part of the Covid19 work.

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.

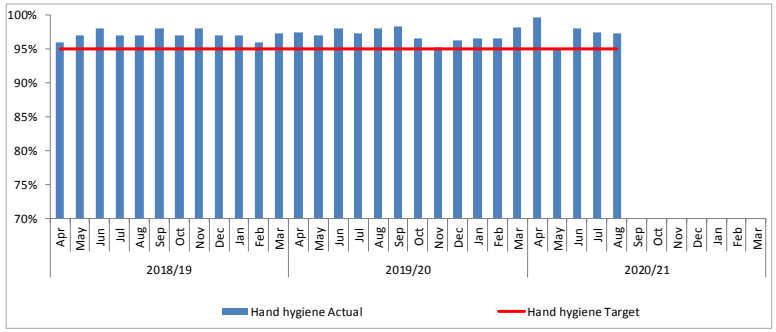
IPC Progress Update: The IPC Code of Practice (CoP) audits have been reviewed to incorporate Covid19 IPC guidance & the BAF. Divisions and wards have recommenced their CoPs audits in their departments, and IPC Team are supporting. During August work on the use of PPE continues for Covid19, . The IPCT 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. Implementation of new IPC guidance is underway, imbedding the 3 pathways outlined for inpatients .

Next steps:. Support for clinical areas around PPE usage and reducing the sessional use , with a focus on basic IPC practices to reduces HCAIs . Work to imbed learning from both C diff and Covid RCAs is in place with divisional action plans.

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

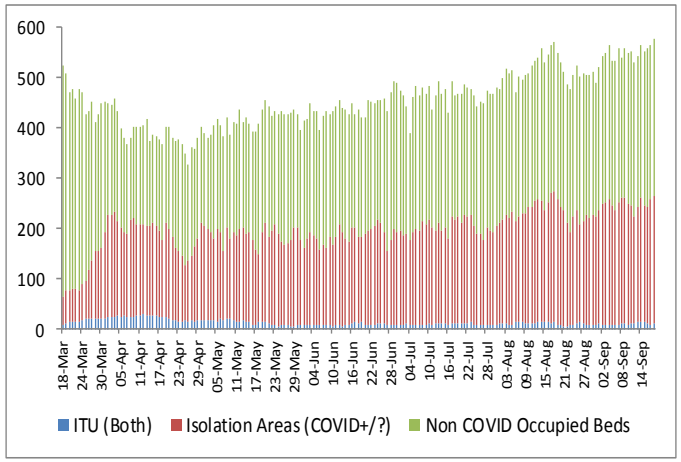
Work around the management of cases throughout the trust has included working alongside clinical areas to ensure that both admission and 7 day screening of inpatients is in place, and to ensure the correct management and placement of patients. Following the NICE guidance issued in July 2020 for elective admission a robust process of screening 72 hours prior to procedure is now in place. This has included making SACH a "green" site with a low risk surgical pathway 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.

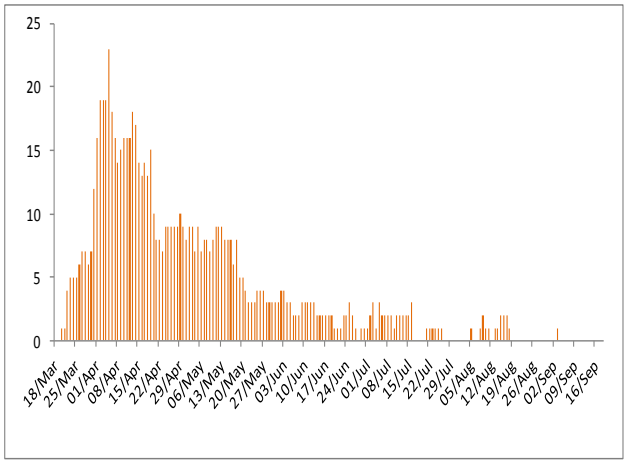
C19 Isolation Wards (including ITU) - discharge status

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

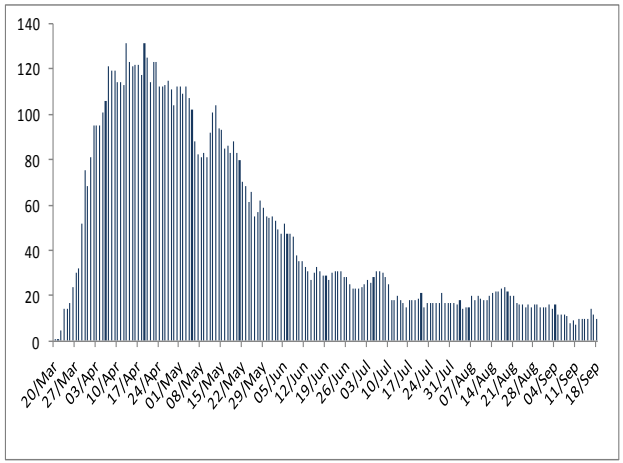
Occupied beds all areas at 0800



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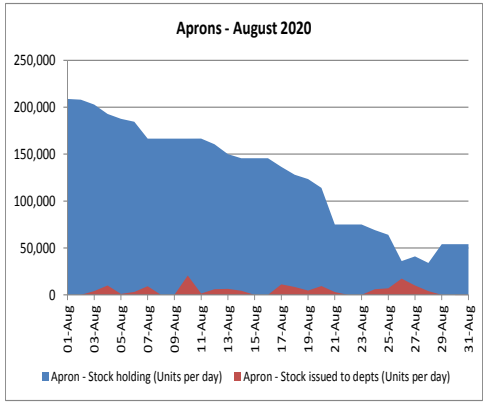
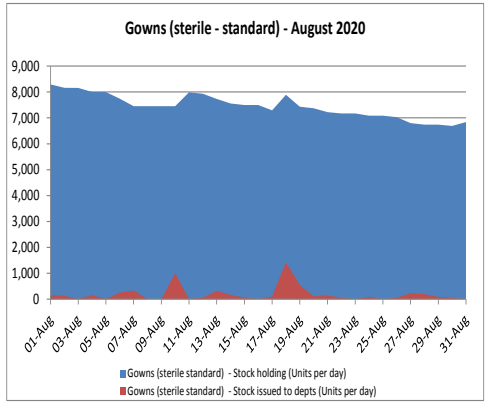
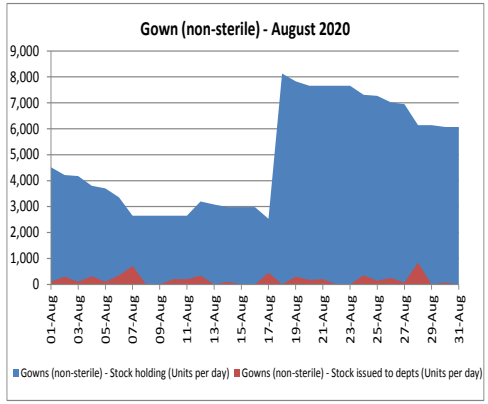
Safe care & Improving Outcomes: COVID-19 (Slide 2 of 3)

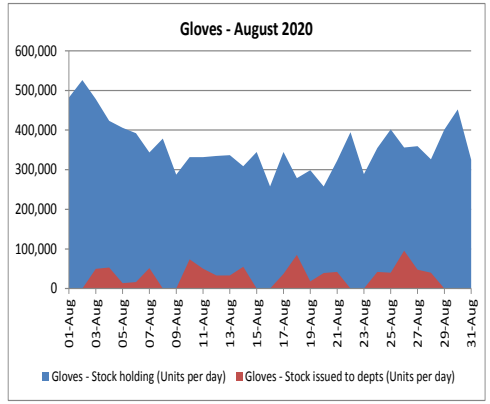
PPE

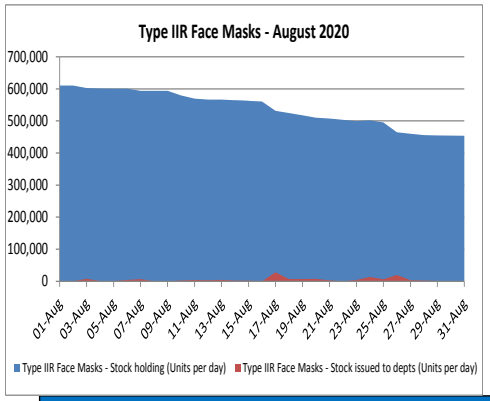
- Central DHSC control of supply and delivery of items from the National Pandemic stock continues.
- The graphs below show at a summary level usage (red block) has remained below stock level although during May stock levels for gowns were under pressure.
- The main current concern remains that National 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.

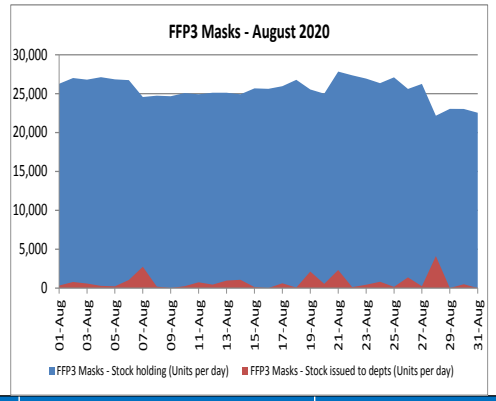


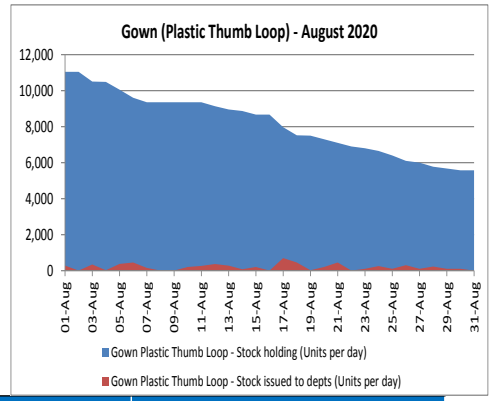


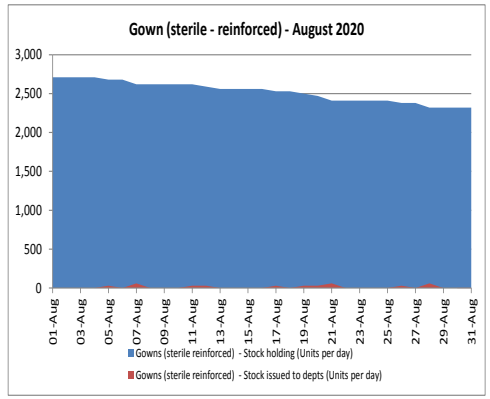












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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

Nosocomial infection cases

COVID19 positive in-patient cases are reviewed each day at joint IPC meeting. 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 Healthcare-Associated), 8-14 days (Hospital onset probable Healthcare-Associated) and 15+ days (Hospital-onset definite Healthcare Associated). All cases a reported to NHSE and RCAs undertaken. During August there were x6 cases falling in to the probable category, no links between any of the cases were identified. Learning from these case included, need for prompt sampling of inpatients (day 5-7), clear documentation and lapses on standards of IPC practice (PPE compliance). Further work and support is in place and a divisional action plans are being developed.

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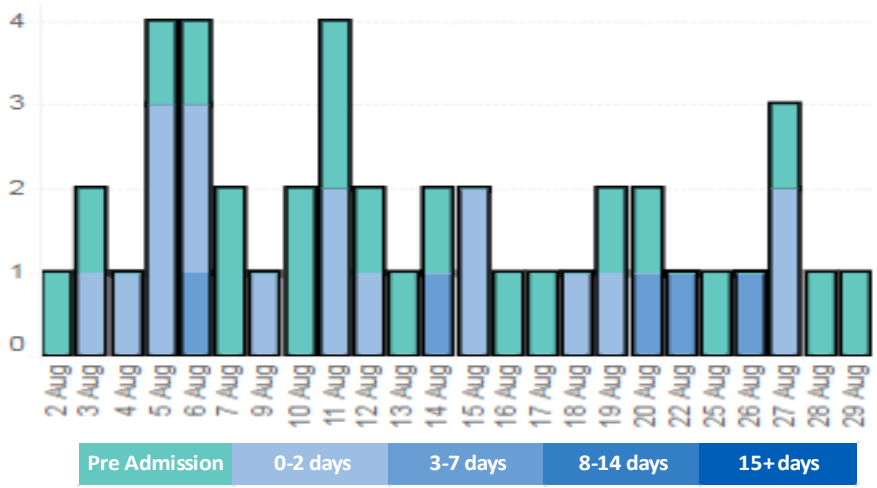
Nosocomial infection cases



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

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	442	13.1%	0	17	1.3%
1	278	8.2%	1	688	51.0%
2	211	6.2%	2	514	38.1%
3	216	6.4%	3	32	2.4%
4	364	10.8%	4	8	0.6%
5	625	18.5%	5	4	0.3%
6	231	6.8%	6	2	0.1%
7	204	6.0%	7	1	0.1%
8+	815	24.1%	8+	84	6.2%

*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)	8	1256	1	1265	0.6%
Total (Staff + Household + Other)	11	1324	2	1337	0.8%

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

10

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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.

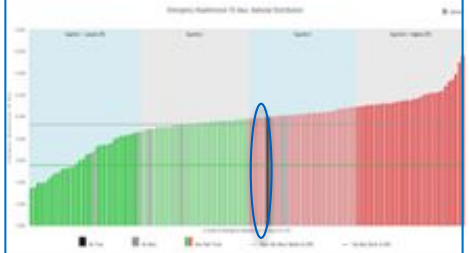
There has been a decrease in emergency readmissions to 12.7%, which is 0.5% lower than the national average of 13.2%.

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.

Latest available data Feb 2020

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Readmission 30 days

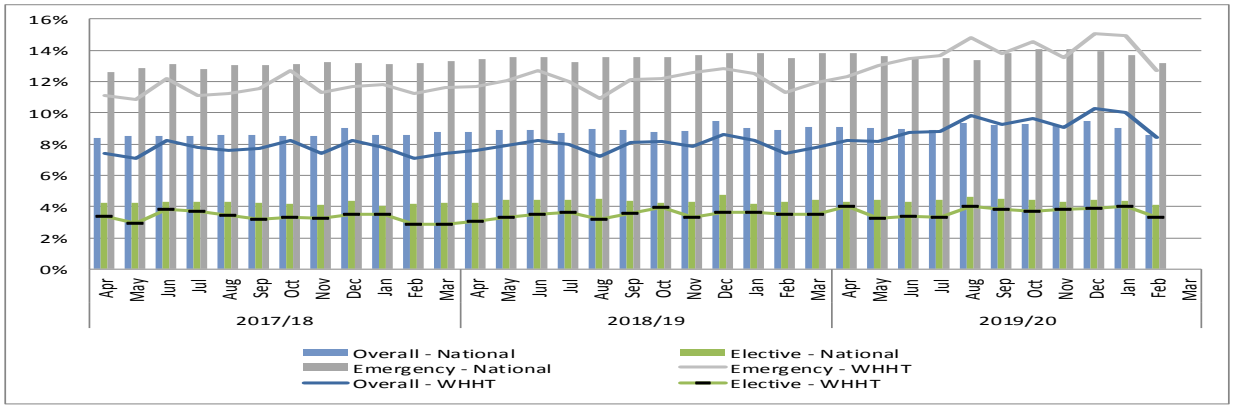


Period: Q1 2020/21

WHHT 10.03% Peer 9.29%
National 9.87%

(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 29.3% (Emergency13.7%,%Elective15.6%).

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

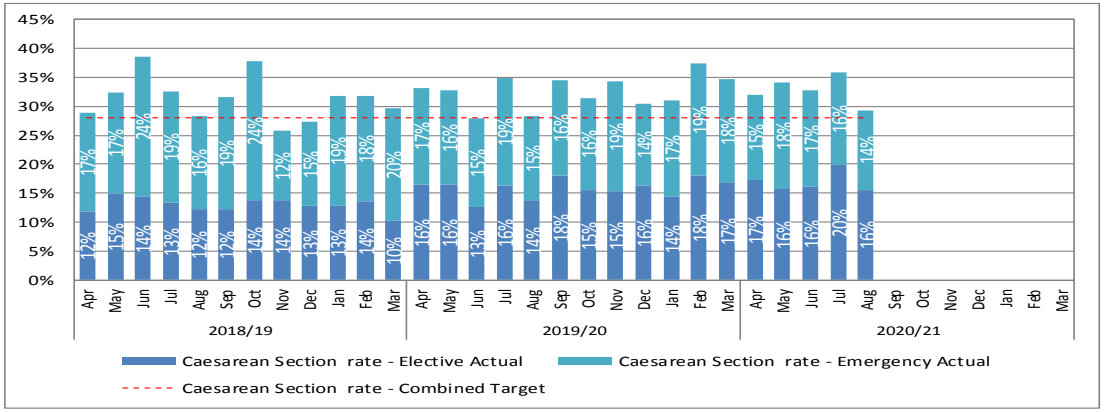
C-sections have been reviewed daily by the incoming teams on call and decision making is reviewed and discussed with the outgoing team.

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 based on understanding of foetal physiology.

The foetal monitoring masterclass , a study day over 2 days, was held on 15th and 16th September to improve understanding of foetal physiology and electronic foetal monitoring. A competency based assessment test was also held.

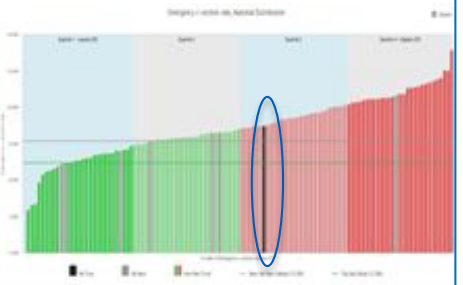
Training in instrumental delivery and foetal monitoring are now also being offered via virtual platforms.
Operative delivery is increasingly consultant led/supervised . The next course of instrumental deliveries is scheduled for 23rd October with a view to improving instrumental delivery skills.

Caesarean section rates



Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate



Period: June 2020

WHHT 17.50% Peer: 15.36%
National: 17.11%

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

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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Safe care & Improving Outcomes: Workforce and CHPPD

In this reporting period:
Nursing and Midwifery staffing is reviewed as part of the daily operational site meeting and at the workforce safe staffing hub at 0830 and 1430hrs, where senior nursing staff support, guide and amalgamate workforce resources using patient dependency and acuity information and professional judgement.

During August the fill rate was 102.7 % (96.5% registered and 104.7% unregistered). ITU overall fill rate was 101.2%. Zone A – Granger: overall staffing was 91.5% to cover four wards (Red, Bluebell, Winyard and Winter). During this period bed occupancy for isolation was reduced due to lower numbers of COVID positive/COVID suspected patients.

Overall 79.9% shifts were RAG rated green, down 4.1% from last month. 20.1% were rated amber, an increase of 4.1% from last month and no red shifts were reported. Ward leaders' supervisory time was 75.8% an increase of 1.2% compared to previous month.

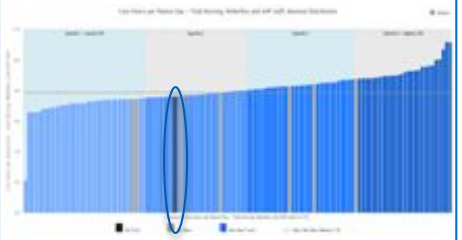
There continues to be an increased demand for temporary staff. A total of 74292 hours were requested (14,842 more than last month). At the workforce meetings chaired by the Deputy Chief Nurse, KPIs indicated good management of e-rostering. Since March, i.e. during COVID the realignment of medicine beds has resulted in there being no designated patients with dementia unit. In addition, with the increased number of mental health patients requiring care, this has led to an increased demand for enhanced care workers. However, over the last two months demand has reduced, during August enhanced care usage was 5099.08 hours a decease of 512.01 from last month.

CHPPD rate is 10.16, an increase of 0.46 from last month (Model Hospital data has not been updated since February 2020). Band 5 nursing turnover is currently at 14.7%. With the reopening of the OSCE test centres in July, overseas recruitment has now recommenced with eleven nurses having arrived. Of our 20 overseas nurses working on the temporary register, nine have now passed their OSCE exam and are waiting their NMC PIN. The remaining eleven have dates for their OSCE Exams.

The Trust has successfully recruited over 57% of its university degree students that had worked as Aspirant Nurses and Midwives during the pandemic. A combination of an incentive package, team building and good educational support has led to this positive recruitment.

Performance stable
Better than target/threshold

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



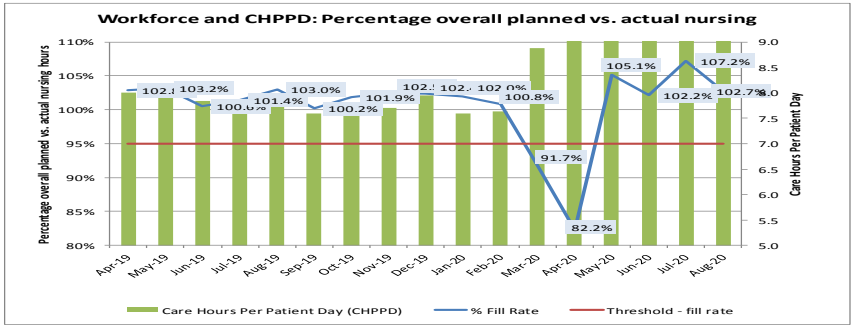
Period: February 2020

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

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

Factors/Themes

- Business case for enhanced care was approved by TMC
- 7th September Oxhey opened as a designated patients with Dementia ward
- Approved Business Case and Designated Safeguarding role approved to facilitate closer working with Mental Health Liaison and CAMS.
- Business Continuity from the 19th – 20th August.
- CNO Phase 3 Workforce Response to COVID19 - funding available to support International Recruitment and raising the profile of HCSWs – Trust to bid as part of ICS.
- COVID staffing is on the risk register (risk 4273), following review at RRG on 11 June the risk score was de-escalated to 12.
- Staff are supported out of hours (incl BH and weekends) by band 7 bleep holders and by a Senior Nurse. In addition, a senior night sister role has been added until March 2021.
- New Data Reporting System being used by NHS Digital
- 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 – August 2020:

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

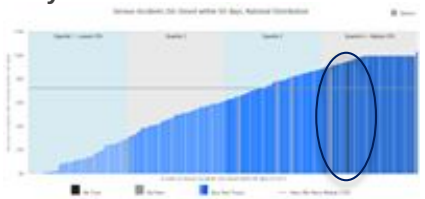
Serious Incidents
One (1) serious incident was declared in August 2020. At the end of August 2020 the Trust had 9 ongoing SIs. Of these, 7 were in date and 1 was overdue. 1 investigation was being undertaken by HSIB.

% of patient safety incidents which are harmful
13% (13) of incidents reported in August 2020 were recorded as having caused moderate or higher level of harm to patients, compared with 14% (12) in July 2020. This demonstrates a slight decrease in the percentage of incidents which were harmful. Although the % of harmful incidents are comparable, the number of incidents rated as "death/catastrophic and severe" were higher in August (i.e. 8 incidents) than in July (i.e. 2 incidents) .

There were two incidents reported in August 2020 with a harm level of "death/Catastrophic":

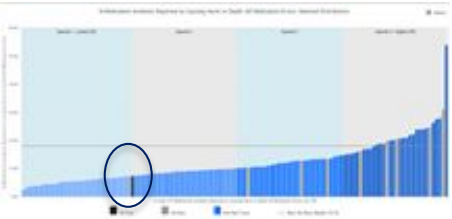
Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



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

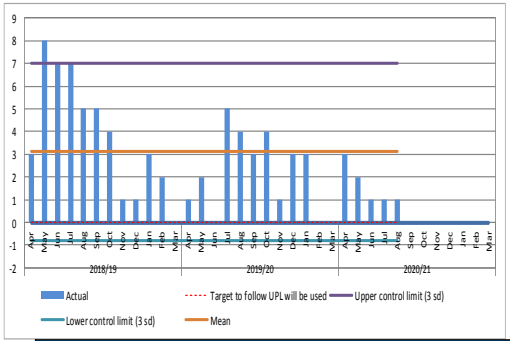
Benchmarking: MODEL HOSPITAL
% medication incidents reported as causing harm or death/all medication errors



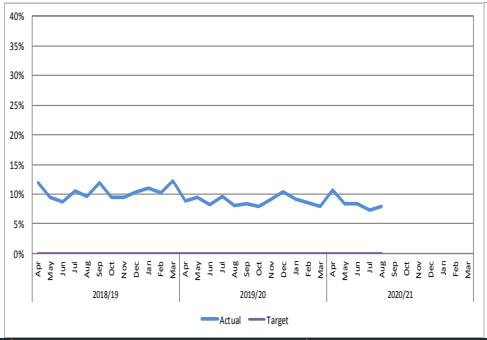
Period: 31/09/2019
WHHT 7.5% **Peer: 18.1%**
National: 10.2%

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

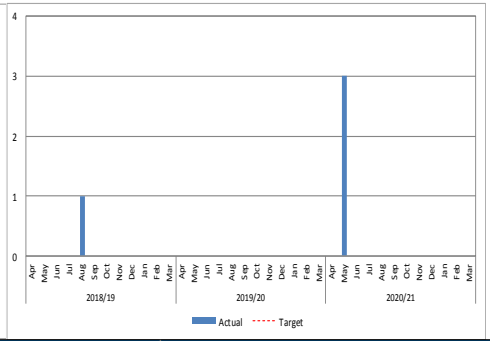
Serious Incidents



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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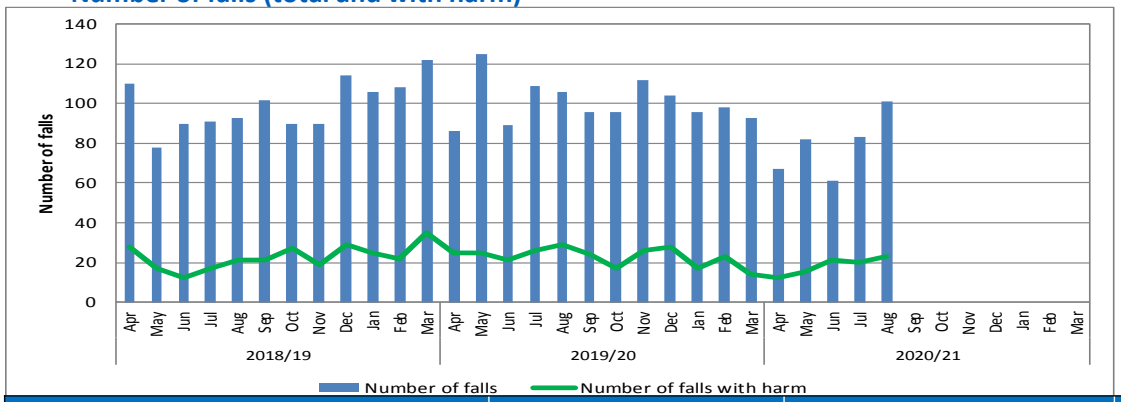
Safe Care & Improving Outcomes: Falls & Falls with harm

In this reporting period:
In August there 100 inpatient falls in total. 19 falls with low harm. 3 falls with moderate harm and 2 falls with severe harm. For falls with harm analysis shows that 18 (75%) were not witnessed, 6 (25%) falls were witnessed,13 incidents occurred during the day shift and 11 during the night shift, 14 (58.3%) incidents with harm involved patients with cognitive impairment. Of these 3 patients reported as having dementia. Most falls 15 (62.5%) occurred around the bed area.
Falls with harm remain low in comparison to the number of falls reported locally and nationally.

Of the 100 falls reported in August, there were 11 recurrent fallers that accounted for 28 (28%) incidents. In August, clinical areas reported higher number of falls; Croxley – 10, Gade – 8, Heronsgate – 7.

Actions:
- Liaise with therapy team to deliver bespoke theoretical and practical falls awareness and prevention sessions
- 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
- Test of change for falls observational questions in TYC audit
- Revise nursing and patient assessments and care plans for individuals at risk of falls
- Link with the SI team to develop a flow chart to ensure leaning / actions from RCA reports is discussed at the falls group meetings

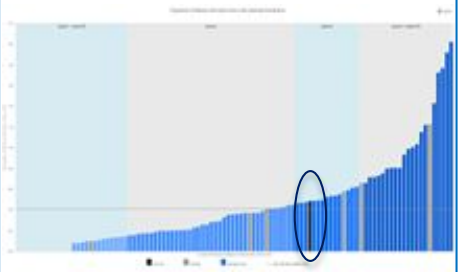
Number of falls (total and with harm)



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)

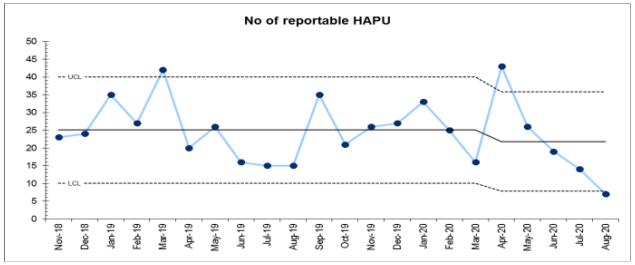
August 2020 monthly report ,indicated a continuous reduction in the reportable HAPUs, from (16) reportable HAPUs in July to (7) reportable HAPUs in August.

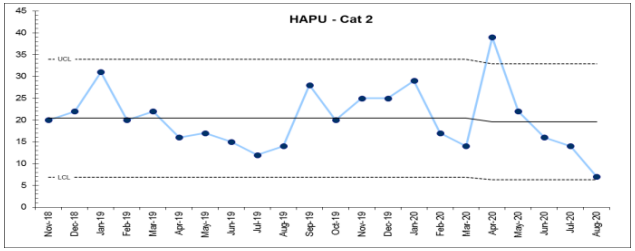
Moisture associated skin damage has increased proportionately to 33, of these,19 were incorrectly categorized as pressure ulcers.

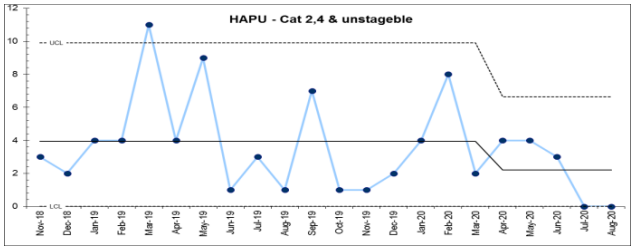
There was a decrease in the numbers of medical device related pressure ulcers – (1) reportable compared to (5) in July. This is likely to reflect a reduction in the number of patients having O2 therapy in this period.

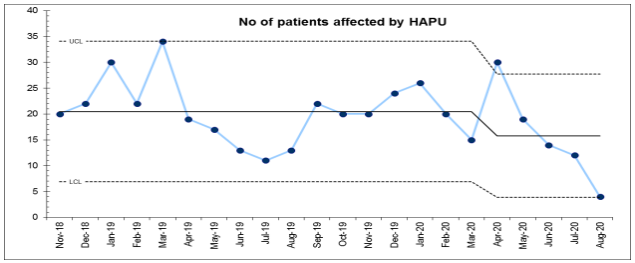
Widespread differentiation in location of pressure damage and anatomical location does not evidence specific causation, apart from the need for increased accurate categorization and effective timely care planning based on identified risk.

Reportable HAPU (August 2020)			
Categories	HAPU	Medical Device Related Pressure Ulcer	Total HAPU
Category 2 (affecting 4 patients)	6	1	7
Category 3	0	0	0
Category 4	0	0	0
Unstageable (possibly category 3 or 4)	0	0	0
Total reportable (affecting 4 patients)	6	1	7
Non-Reportable HAPU			
Category 1 (affecting 2 patients)	2	1	3
Suspected deep tissue injury (SDTI) (affecting 6 patients)	9	2	11
Total non- reportable (affecting 8 patients)	11	3	14









Actions/developments for Pressure Ulcer management

1.Continue to raise awareness during the safety huddles regarding the precautionary and preventative approaches , as per Trust Policy for patients using medical devices

2. TVN team continue to undertake check and challenge exercise across clinical areas.

3. Effective repositioning being highlighted in clinical areas on wards

4. Weekly ward based 30 minute," bite size" Tissue Viability training sessions have now been expanded throughout the Trust as requested

5. Update training has been arranged for all senior nursing staff ,to support them with more accurate validation pressure ulcers
6. Updated Pressure Ulcer Prevention Policy has been ratified and has been uploaded onto the Intranet
7. Review and re-introduce updated versions of the Tissue Viability Resource Folders on all clinical areas
8. QI approach to reviewing data reporting to increase timeliness and accuracy of skin assessment
9. Working with Continence CNS to address moisture 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	**24**
AAU Y1	10
A&E	7
AAU P1	3
UCC	2
AAU B1	1
AAU G1	1
MIU	0
Medicine	**62**
Heronsgate & Gade	12
Red	9
Winter	7
Aldenham	6
Croxley	6
Cassio	4
Bluebell	4
Tudor	3
Stroke	3
Oxhey	3
CCU/ P/G 3	2
Winyard	1
Sarratt	1
AAU B/Y 3	1
Frailty	0
Simpson	0
Surgery	**27**
Flaunden	7
Elizabeth	5
Letchmore	4
Langley	3
ICU	3
Cleves	2
DLM	2
Ridge	1
Grand Total	**113**

Three Months

Emergency Medicine	**92**
AAU Y1	30
AAU P1	18
A&E	14
AAU G1	14
AAU B1	12
UCC	4
MIU	0
Medicine	**199**
Heronsgate & Gade	31
Winter	19
AAU B/Y 3	15
Croxley	15
Oxhey	15
Tudor	14
Winyard	13
Red	13
Cassio	12
Stroke	11
Aldenham	11
Bluebell	10
Sarratt	10
Simpson	5
CCU/ P/G 3	5
Frailty	0
Surgery	**73**
Letchmore	13
Elizabeth	12
Flaunden	11
Ridge	9
Cleves	9
ICU	9
Langley	8
DLM	2
Grand Total	**364**

Six Months

Emergency Medicine	**190**
AAU Y1	55
AAU P1	42
AAU G1	37
AAU B1	29
A&E	20
UCC	7
MIU	0
Medicine	**464**
Heronsgate & Gade	55
Tudor	44
AAU B/Y 3	37
Aldenham	36
Stroke	32
Winyard	32
Bluebell	32
Winter	32
Red	31
Croxley	28
Sarratt	24
Simpson	21
Cassio	21
Oxhey	21
CCU/ P/G 3	17
Frailty	1
Surgery	**199**
Letchmore	35
Cleves	35
Ridge	33
Flaunden	33
ICU	23
Langley	19
Elizabeth	17
DLM	4
Grand Total	**853**

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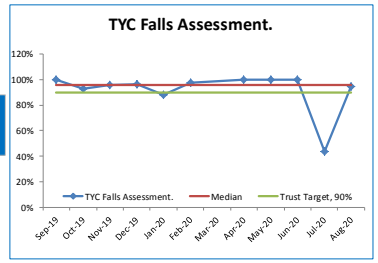
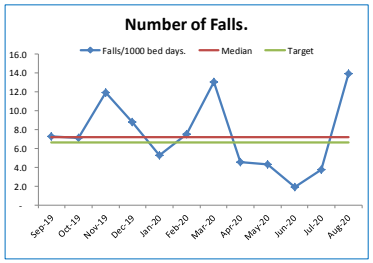
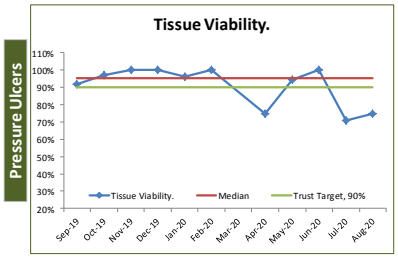
Ward Scorecard – Harm Free Care Improvement Work (overview)

Focus Area: Heronsgate & Gade







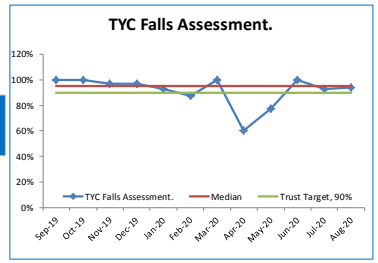
No of HAPU (Cat 2, 3, & 4)

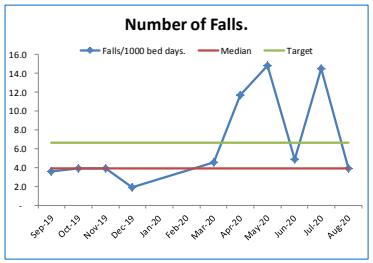
Sep-19	0
Oct-19	1
Nov-19	0
Dec-19	1
Jan-20	1
Feb-20	0
Mar-20	1
Apr-20	0
May-20	1
Jun-20	0
Jul-20	1
Aug-20	0

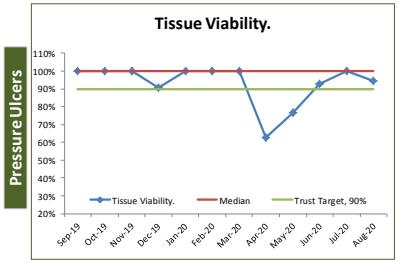
The national average for falls with harm is 6.6 falls per 1000 bed days. Heronsgate & Gade have had above average falls in March and August 2020. There has been an improvement in performance since March 2020 with an exception in August 2020. There is a focus on improving risk assessments compliance, which may lead to a reduction in falls. The plan is to continue to monitor performance prior to any intervention.

Tissue viability assessment performance has declined. Normal variance seen on hospital acquired pressure ulcer. The TVN team will be supporting the ward with staff training.

Focus Area: Cleves







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

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

Cleves ward falls assessment data demonstrates improvement. However, the number of falls per 1000 bed days has been above the national average on 3 occasions in the last 6 months.

Cleves ward skin assessment data demonstrates improvement and there have been no new hospital acquired pressure ulcers reported since March 2020.

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Safe care & Improving Outcomes: VTE risk assessment

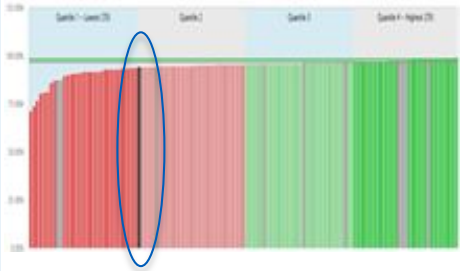
In this reporting period:
The target was achieved this month.

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

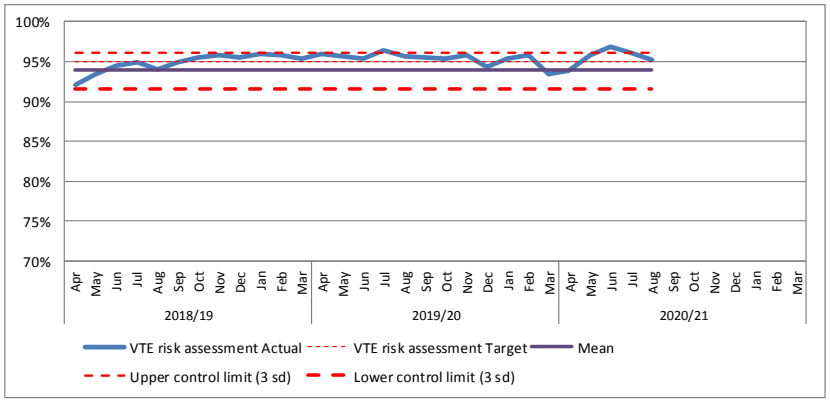


Period: Q3 2019/20

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 – 18.5%
Admission to the Stroke unit within 4 hours is currently not always possible as patients admitted to the Trust have COVID swabs prior to any planned ward transfers and wait in a holding ward until the swab results are available and which can take up to 5 hours. Although they are in holding areas, these patients are reviewed by the Stroke team and continue to receive Stroke specialist care and input whilst awaiting transfer to the Stroke unit.
Patients who are given intravenous thrombolysis are prioritised for transfer to a side room on the Stroke unit for monitoring whilst the COVID swab results are awaited. Positive COVID stroke patients are not admitted to the stroke ward but still receive stroke specialist input.

90% stay on Stroke Unit 84.1% (target 80%)
Though this target was achieved there has been a knock on effect from the pandemic, although over the last couple of months there has been a gradual improvement.

Thrombolised within an hour – 66.7 % (SSNAP target 55%)
Whilst this has been achieved, achievement of the target is variable, depending on several factors but mainly the complexity of cases seen.

Performance stable
Better than target/threshold

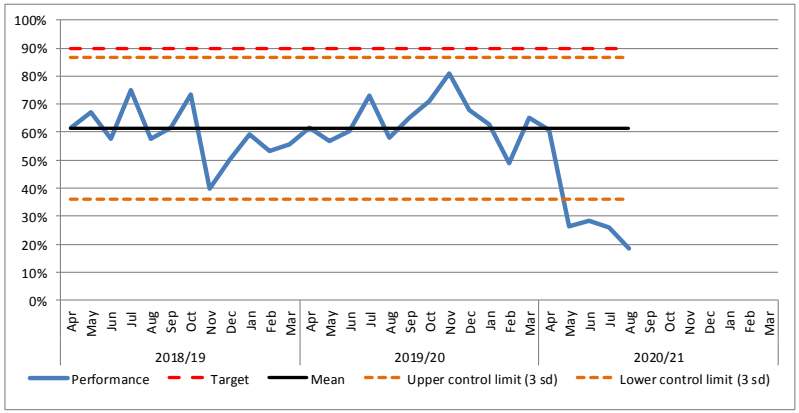
Benchmarking: SSNAP

Period: October to March 2020

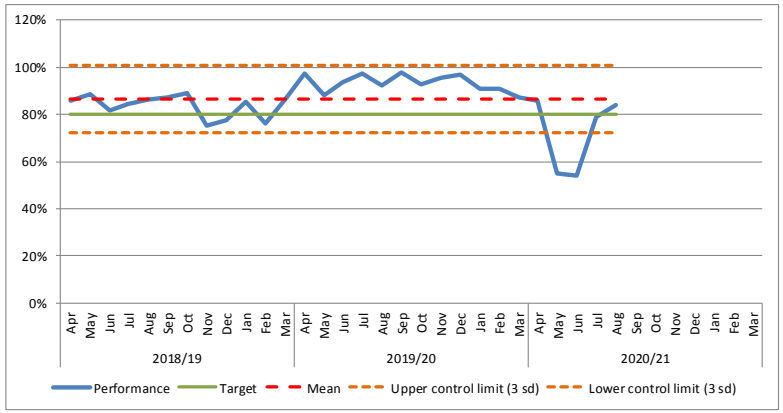
Admission within 4 hours: 54.0%

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

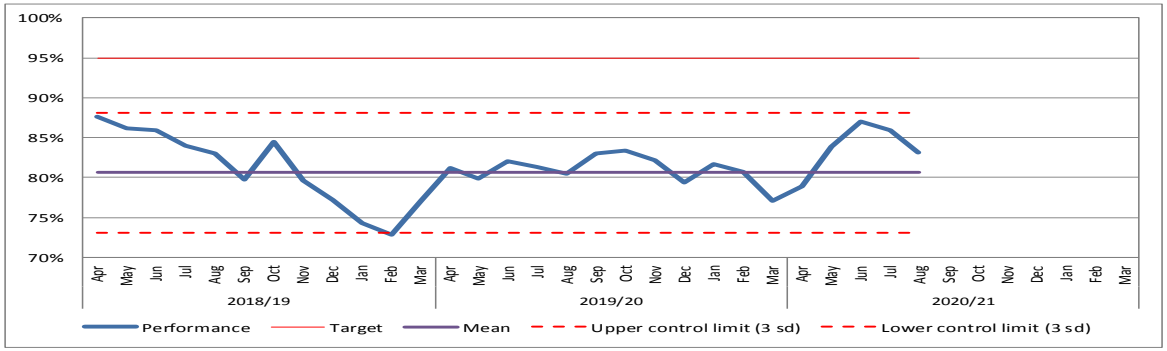
In this reporting period:
At 83%, overall Trust performance was slightly worse than the previous month (85.9%). Compliance with the 95% standard was maintained at HH UTC (99.6%). Type 1 attendances were very slightly up on the previous month by 0.8%. Performance at the UTC was 99.45%. Processes for COVID 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 August by 9.5% on the previous month. MIU remains closed. Total Trust attendances including attendances at the UTC were up 4.8% from the previous month.

In August the number of ambulance patients waiting over 30 minutes rose by 22% from July and the number of patients waiting over 60 minutes to offload rose form 94 in July to 175 in August. The average handover time in August started at 32 minutes and decreased to 19 minutes at the end of August. Conveyances are up 3.4% from the previous year in comparison to 7.3% 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. Business continuity due to bed capacity also impacted on flow in August.

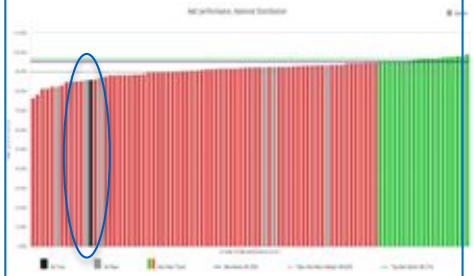
Next Steps:
- The regular check in meetings between the service team and Executive colleagues have restarted.
- The monthly programme board meetings oversee the ambulance work stream with a joint action plan between EEAST and the Trust restarted in May.
- Consultant recruitment has not been successful but a paper to TMC on 23rd Sept outlining a recruitment and retention package is being presented.
- SMART has been limited due to the new COVID pathway but starting 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.
- The new EAU opened in August which has increased the number of patients being seen through the assessment area. An expansion is planned for this area by the end of the year.

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: July 2020

WHHT: 85.92% Peer: 89.82%
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.

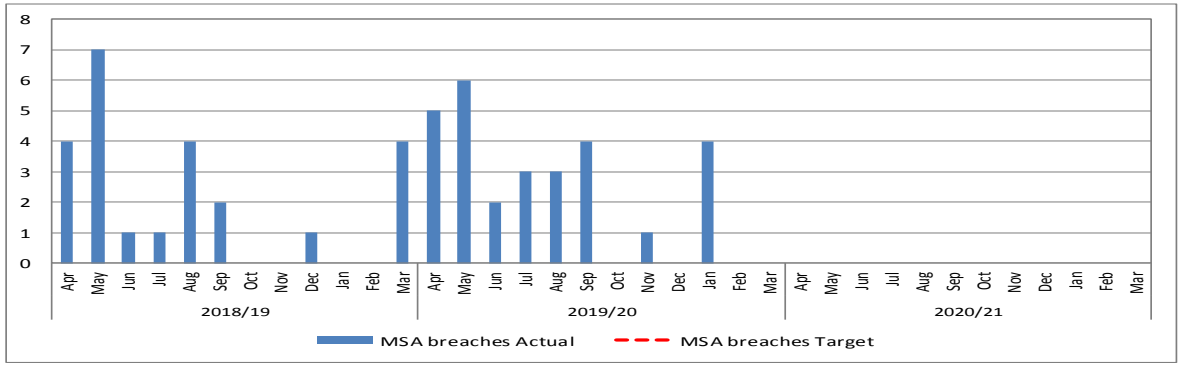
Performance stable
Better than target/threshold

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 below table shows data prior to Feb 2020 and the percentage of beds occupied by patients delayed due to external reasons (using DTOC methodology). From April 2020 external delays have been measured based on medically optimised status and with the potential to bring forward discharge where appropriate. The data has been submitted weekly since the end of April 2020 and reporting changed to fortnightly at the end of August 2020. August's data shows that between 2.7 and 3.5% of the hospital beds are occupied with medically optimised patients who are delayed due to external reasons, this compares to 4.4% for the year prior to COVID (noting that the measures are different, with the current measure more challenging for discharge planning).

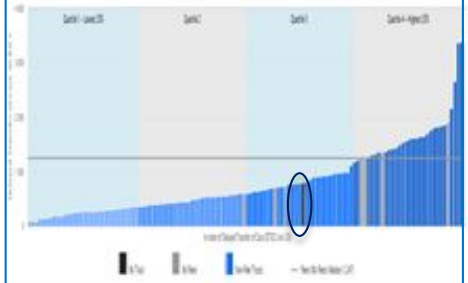
Date		Mar 2019 - Feb 2020	23-Apr	30-Apr	07-May	14-May	21-May	28-May	04-Jun	11-Jun	18-Jun	25-Jun	02-Jul	09-Jul	16-Jul	23-Jul	30-Jul	06-Aug	13-Aug	27-Aug
Medical Optimised People not Discharged on The Day	Total	8861	57	128	109	196	196	191	223	253	200	223	246	275	214	257	237	273	262	389
	External		3	22	21	48	33	41	108	101	109	13	100	136	125	159	109	106	135	271
	Internal		54	106	88	148	163	150	115	152	91	210	146	139	89	98	128	167	127	118
% External			5.3	17.2	19.3	24.5	16.8	21.5	48.4	39.9	54.5	5.8	40.7	49.5	58.4	61.9	46	38.8	51.5	69.7
External Delays as % of Bed Base		4.4	0.1	0.6	0.5	1.2	0.9	1.1	2.8	2.6	2.8	0.3	2.6	3.5	3.2	4.1	2.8	2.7	3.5	3.5

The main external issues impacting on flow are:
Home Care Capacity
Availability of residential and nursing DTA bed, normally impacted upon by flow from those beds.

There are a number of internal issues impacting on flow for medically optimised patients. In August this impacted on 47% of medically optimised patients delays with the following issues cited:
Change in medical status on the day declared as medically optimised
On the day decisions to request further investigations
Requirement to COVID swab / wait for result to support access to care services.
Transport and Medication are also factors but are difficult to identify within the current reporting requirements.

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

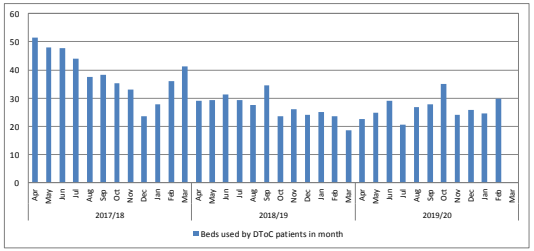


Period: December 2019

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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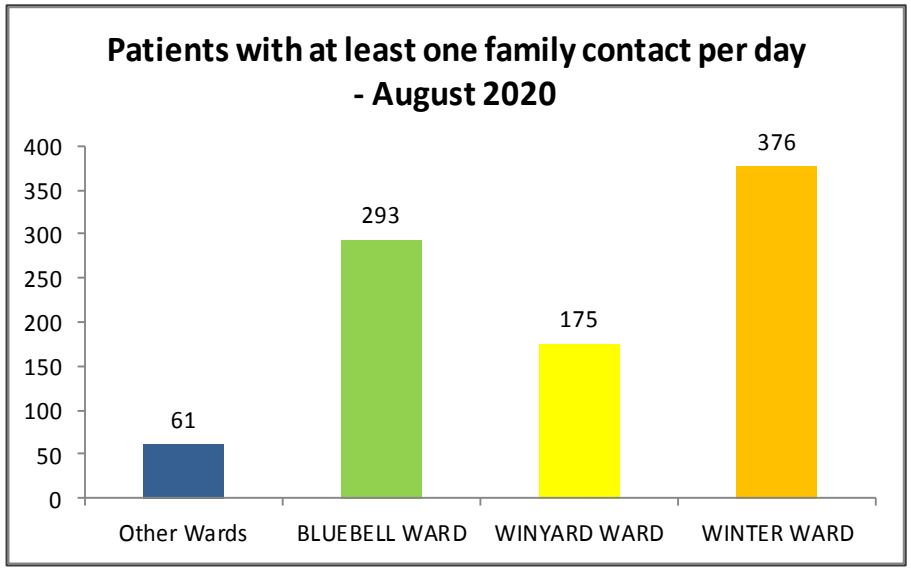
Family Liaison Line and Visitors Helpline

Family Liaison Line (FLL)
The team has now been reduced from 12 to 5 members of staff due to reducing number of calls in the COVID-19 areas. The service continues to operate 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).
1186 relatives have been contacted at least once from 1 August – 31 August 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
A business case request has been submitted for additional staff to help run the line and support more areas across the trust due to reduced visiting. 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
A relative expressed that she appreciates the daily updates given by the team as it is an excellent service.
Another relative said how marvellous and thankful for the service.
A family highlighted how grateful they were for the service and thankful for the updates.



Messages to loved one 1 August -31 August 2020
During the month of August the team have relayed 66 messages to loved ones.
These have consisted of family holiday photos , get well wishes, messages of encouragement and support. Families keeping their relatives up to date on what is happening with family members and how much the families are missing their loved ones.
The emails are being copied onto template and delivered via volunteer hub to wards , who ensure patient receives the message, some examples include:
" I was really pleased to hear that someone from the hospital chaplaincy has been to see you. I have been praying for you and will be thinking of you at Mass on Sunday."

" Hello Ma , I hope you are feeling well today? It was lovely to speak to you on the phone. Take care , I hope this message will bring and smile to your face and I love you very much. "

" We are thinking of you today and sending all our love in the sunshine"

"Hello Great Nanny, How are you? I hope you are feeling better?
I am starting senior school next week and I am really happy and excited. "

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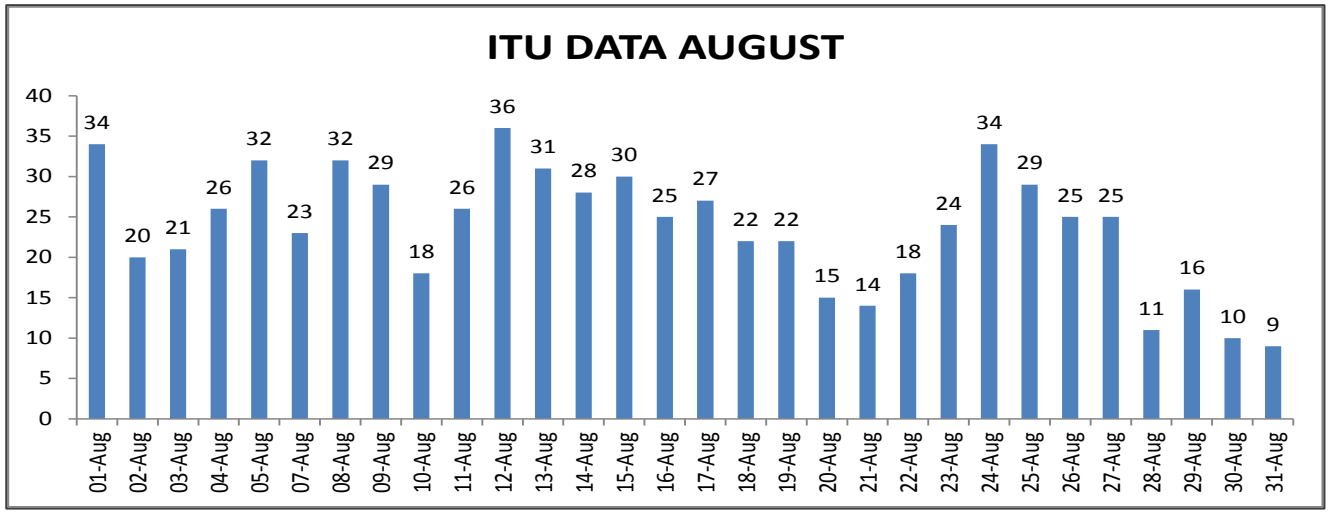
Family Liaison Line – Intensive Care Unit

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 August – 31 August
712 calls were made which was, on average 2.5 calls per patient 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 - 81% in August.
29 new complaints were received as follows:

- 7% (2) relate to Surgery, Anaesthetics and Cancer (SAC)
- 49% (14) Medicine
- 21% (6) Women's & Children's (WACs)
- 14% (4) Emergency Medicine
- 3% (1) Corporate
- 3% (1) CSS
- 3% (1) Environment

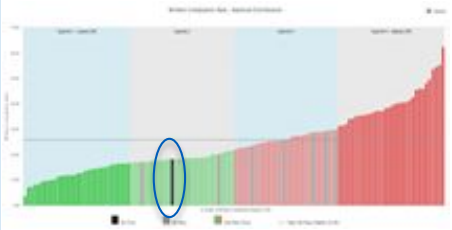
At month end there were a total of 49 live complaints (46 at end of previous month).
35 complaints were closed in the month. 5 complaints were re-opened in August 2020 (3 SAC, 1 EM and 1 Corporate)

Improvement plan:
No complaints are older than 3 months and of 49 open complaints, 5 were overdue at the end of the month. Medicine has seen a significant increase in complaints received and had 19 open complaints at the end of August with Surgery having the next highest with 12. Open complaints remain at a level below those seen last year.

Factors/Themes:
Trust wide, common themes remain all aspects of clinical care (incl. clinical care and treatment) at 53% (15); attitude of staff and communication at 10% (3), appointments 10% (3) Admissions/Discharge 10% (3) and 17% (5) 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)

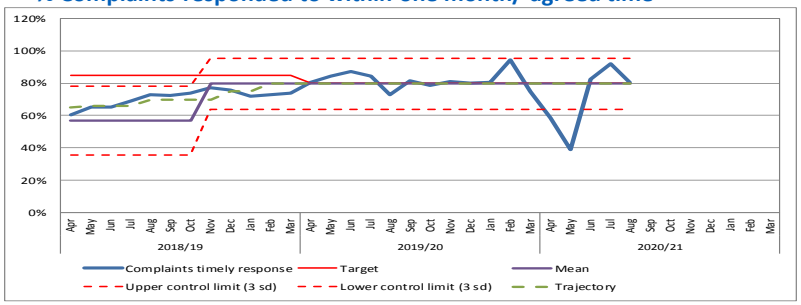


Period: December 2019

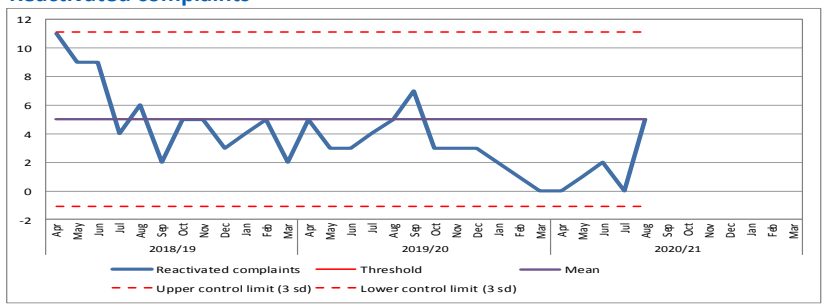
WHHT 18.36 Peer 25.90
National 21.95

(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

10

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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 August 2020 96 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 6 patients in August 2020 who died in a setting that was not their preferred place of death (PPD). For the 3 patients wishing to be at home ,1 patient unexpectedly deteriorated, and the 2 patient's physical symptoms did not permit their transfer home. There were 3 patients who wished to die in a hospice. In one case there was no hospice bed available and 2 patients became too unwell to transfer.

Patients on an Individualised Plan of Care for the Dying Person (IPCD) & Treatment Escalation Plans (TEP)

Of the 10 patients whose deaths were reviewed in August, there were 5 patients who **did not** have an IPCD; 2 patients were excluded from this part of the audit. Therefore of the remaining 5 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.

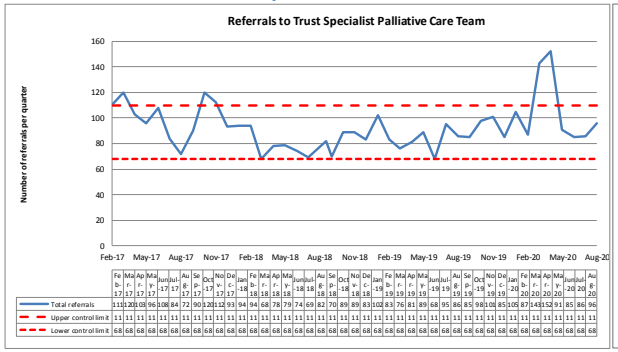
Of the 10 patients whose notes were reviewed, who died in August 2020, 6 patients had a TEP in place; 4 of those patients had had their TEP reviewed as needed and they were appropriate. 4 patients had no completed TEP in their notes.

Stable

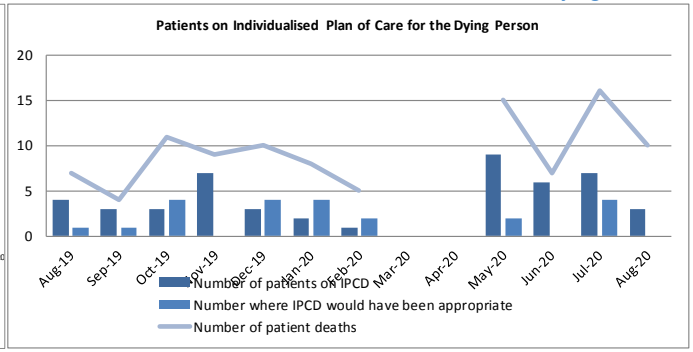
Benchmarking:

Not currently available

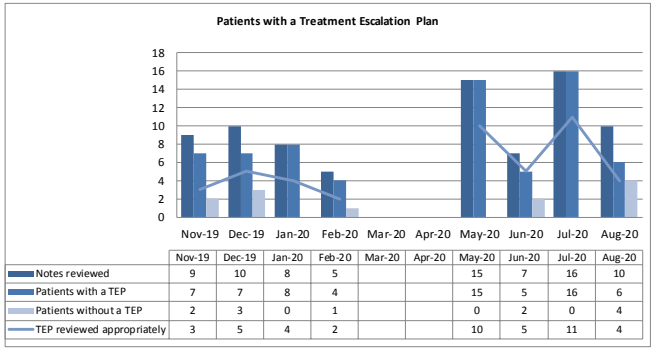
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Notes reviewed	9	10	8	5			15	7	16	10
Patients with a TEP	7	7	8	4			15	5	16	6
Patients without a TEP	2	3	0	1			0	2	0	4
TEP reviewed appropriately	3	5	4	2			10	5	11	4

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 the number of long waits for elective care continues to increase, performance improves due to the increases in compliant pathways largely due to growing numbers of referrals. This month 61% of pathways are less than 18 weeks (up 10% when compared to the previous month's 51%), evidence of an increase in pathways under 18 weeks, largely due to growth in new referrals but also the ongoing activity recovery programme which has contributed to the reduction in the backlog (patients waiting more than 18 weeks). The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was better than the national position (15.0 vs 19.6 weeks) but the 92nd percentile wait time was worse (42.7 vs 40.0 weeks).

At the end of the month there were 670 patients whose waiting time exceeded 52 weeks wait.

Next steps:
Activity recovery is progressing and outsourcing to the independent sector, particularly for some specialties with urgent and cancer cases is ongoing.

Diagnostics
The recovery of diagnostic performance continues in most areas, but due to a growing backlog in DEXA scanning, performance has fallen to 68.4% (from 73.3%). A rapid recovery plan is in development for this area.

Performance improved
Worse than target/threshold

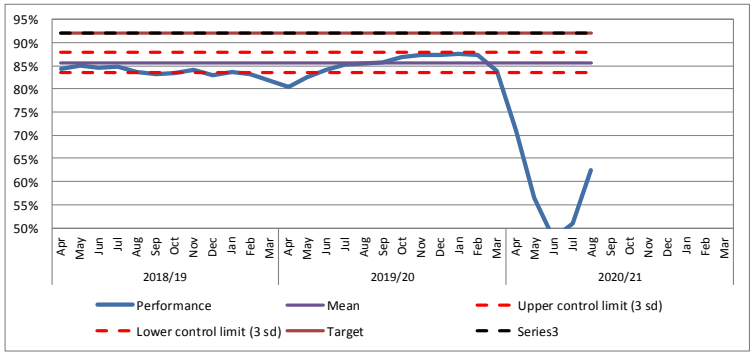
Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

Period: June 2020

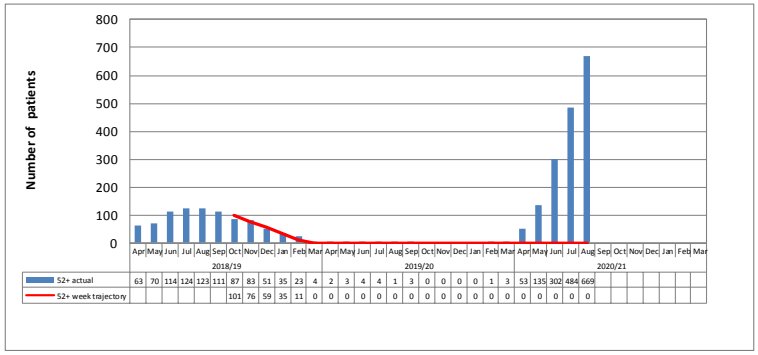
WHHT: 47.75% Peer: 50.32%
National: 51.47%

(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

10

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

2 week waits: The provisional position for August is compliant at 96.6% with 1301 referrals of which 44 were seen beyond 14 days. Of the 44: 9 x skin, 8 x breast, 7 for LGI and 6 for Urology. Testicular had 2 breaches

Referrals have steadily increased since a significant drop in April although August saw a lower level than July.
In August the Trust received 93% of the 'normal average'.

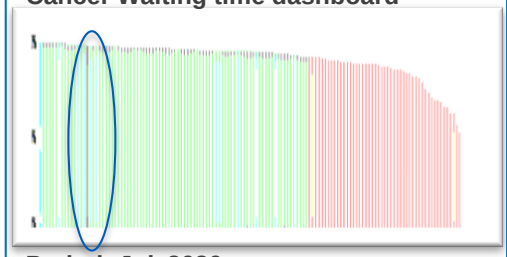
The Trust are monitoring the referral numbers and the numbers of patients diagnosed with cancer. Currently the Trust's conversion rate is lower than usual at 3.3% in August compared with a baseline figure of 6.2%.

2 week wait breast symptomatic: The provisional position for August is compliant at 96.2%.
There were 130 referrals and 5 patients were seen beyond 14 days.

28 day Faster Diagnosis Standard : The provisional position is: 2ww - 80.7% / Breast Symptomatic – 98.5% / Screening – 33.3%

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

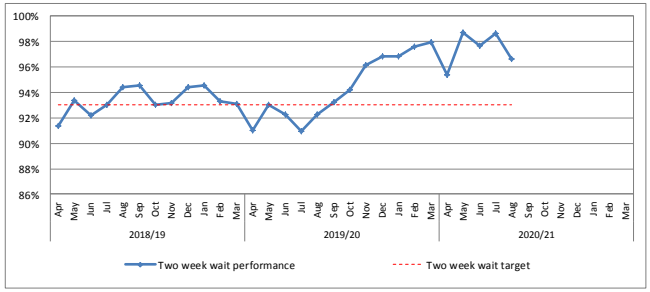


Period: July2020

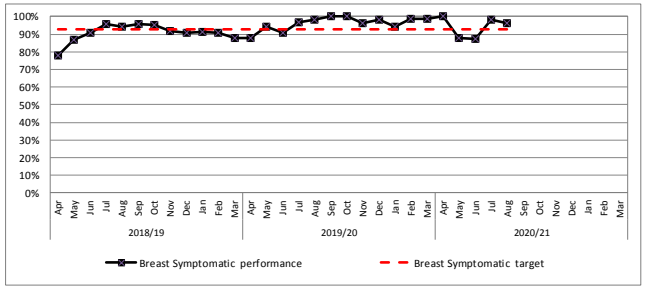
WHHT: 98.6% **Peer: 91.0%**
National: 90.4%

(Peers = East of England region)

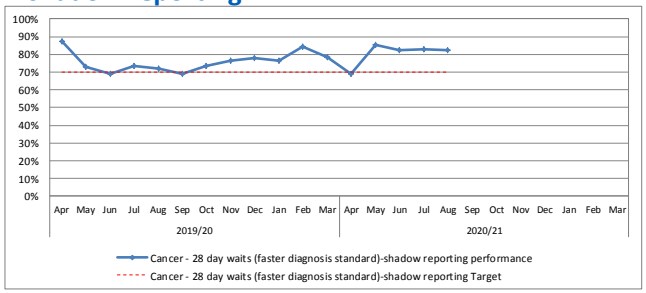
Two week waits: % within target time



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 August is provisionally compliant at 96.4% with 110 pathways with 4 breaches (3 x uroLOGY and 1 x LGI).

31 day subsequent surgery
The provisional position for August is non- compliant at 77.8%, with 9 pathways with 2 breaches. 1 x breast and 1 x LGI

31 day subsequent Drug
The position for August is provisionally compliant with 100% . There were 15 pathways

31 day subsequent palliative and other
The provisional position for August is compliant at 100 % with 7 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

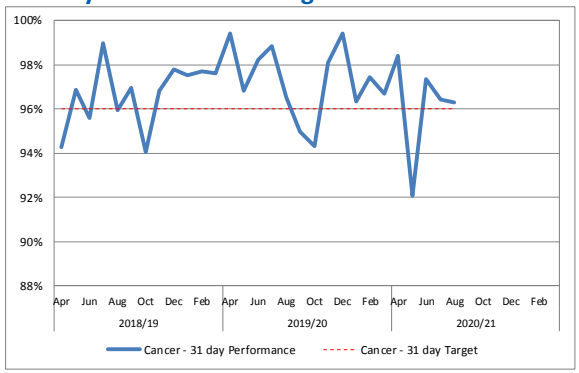
Benchmarking: NHSI Analytics Hub

Period: July 2020
31 day first:

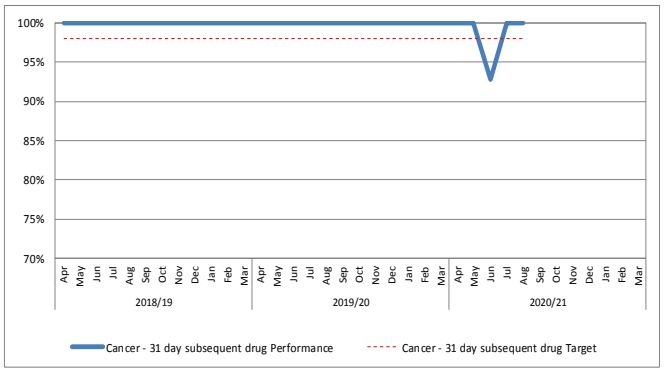
WHHT: 97.1% **Region: 92.6%**
National: 95.1%

31 day surgery:
WHHT: 94.4% **Region: 83.2%**
National: 87.2%

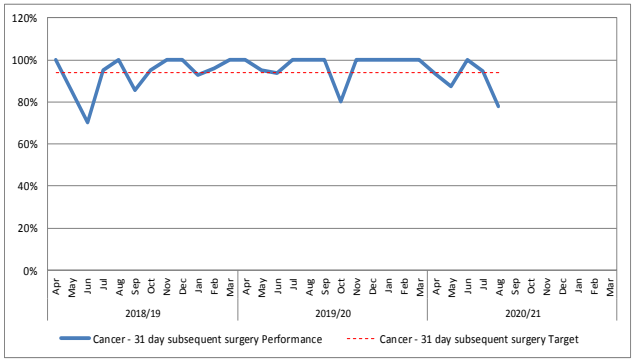
31 day first: % within target time



31 day subsequent drug: % within target time



31 day subsequent surgery: % within target time



DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
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 position for August is non-compliant at 84.7%
Provisionally there are 68 treatments with 10.5 breaches (12 patients). This includes 5 x urology, 1 x H&N, 2 x Lung, 3 x LGI, and 1 x haematology breach.
The number of people that the Trust treated on a 62 day pathway is progressing towards pre-covid levels although July's figure was higher. The average for 2019/20 is 105 patients, July 98 and August 79 patients treated.
A provisional review of breaches indicate that those patients who have had long delays on account of endoscopy are coming through the system with breached treatments in August. There were a few patients who breached because of the 14 day self isolation rules or because they required treatment at WGH

62 day screening referral to first definitive treatment –Performance is provisionally non- compliant at 66.7 % with 4.5 pathways, 1.5 breaches (2 patients, 1x breast and 1x LGI).

62 day consultant upgrade The provisional August position is 80% with 5 pathways with 1 breach (LGI)

104 day breaches open pathways: In August's submission of open pathways over 104 days, there were 48 patients of which 35 were LGI, 4 x urology, 3 x UGI, 2 x breast and 1 Lung, Brain, haem x 1. Of the 48 patients, 2 patients (1 x lung and 1 x urology) had a confirmed diagnosis. Of the 35 LGI patients, all were dated

Closed – In August , the Trust closed 5 patient pathways after 104 days from date of referral. This includes from all types of pathways: 62 days, 31 day, CU and screening patients

Performance improved
Better than target/threshold

Benchmarking: MODEL HOSPITAL
62 day wait from urgent GP referral

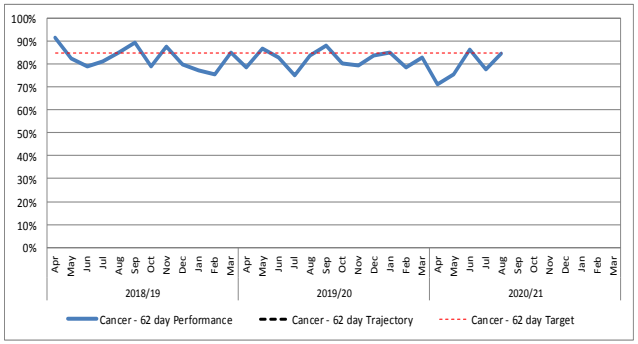
Period: June 2020
WHHT: 86.96% Peer: 76.88%
National: 75.68%

Peers = Nightingale Group – acute multi-site trusts

Benchmarking: NHS Analytics Hub
Period: July 2020
WHHT: 76.6% Peer: 76.6%
National: 78.4%

Peers = East of England Region

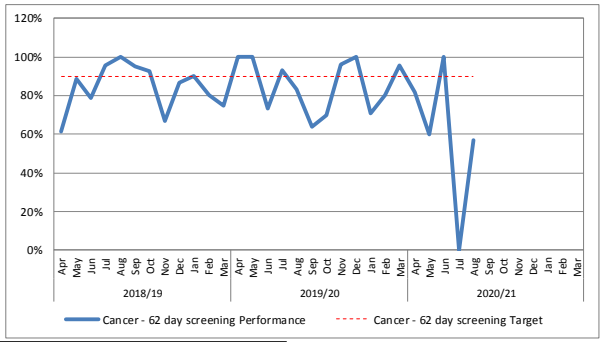
62 day GP: % within target time



62 day GP: Tumour Site

Tumour type	July	August	Q2 (provisional)
Breast	100	100	100
Gynaecological	100	100	100
Haematological	66.7	75	58.3
Head and Neck	0	100	40
Lower Gastrointestinal	52.2	76	68.5
Lung	75	0	37.5
Skin	100	100	100
Upper Gastrointestinal	80	100	94.1
Urological	37.5	64	51.5
Testicular	100	0	100
Other	0	0	0
Sarcoma	0	100	100

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:

Working on re-establishing pre COVID process /SOPS with services as re starts are well underway. Clinic template revisions also on track, now starting to work on second revisions, this will need to be time sensitive to enable reporting.

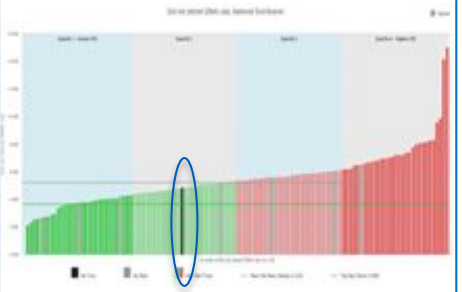
Out-coming review underway to support activity reporting for the Trust and tracking of referrals against activity.

Outsourcing of Medical Records Programme moving forwards against agreed time lines and options will be reviewed.

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%

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Did not attend rate

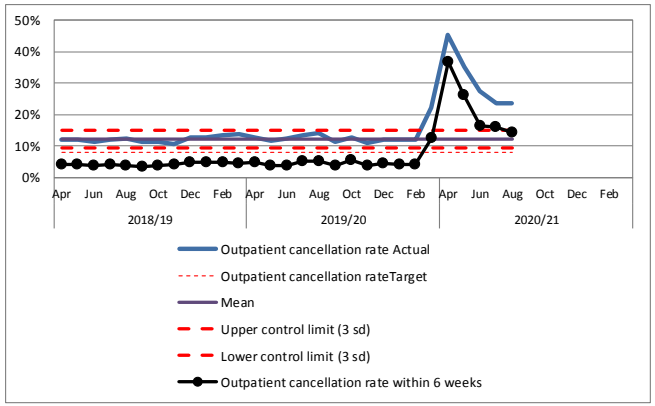


Period: Q1 2020/21

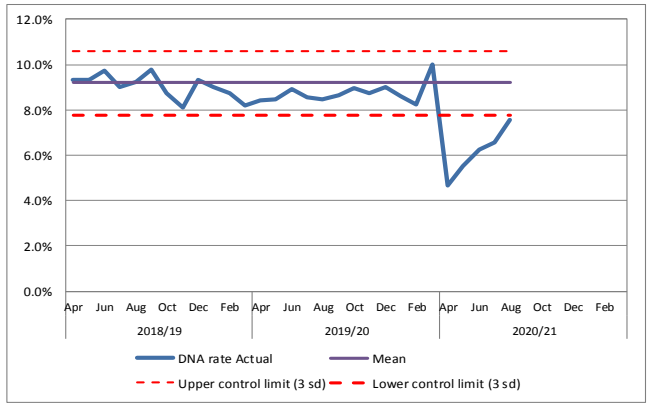
WHHT 4.86% **Peer: 5.22%**
National: 5.37%

(Peers = Nightingale Group – acute multi-site trusts

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

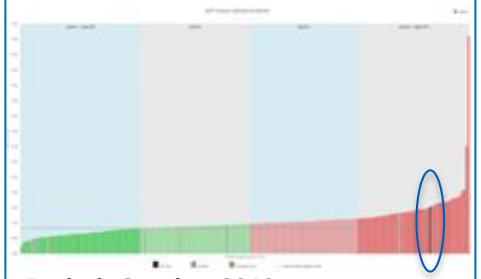
In this reporting period:
Contracted wte staff in post is 4,655 (4,659) wte last month (+142wte) over the last 12 months. NB – some of this increase is due to COVID staffing arrangements such as employing aspirant student nurses.
Vacancies (the difference between the ledger establishment and contracted wte on ESR) is 502 wte or 9.7% of the establishment (9.1% last month). The target rate is 10%. There has been a small reduction in contracted wte and increase in funded establishment over August. NB – I have removed from the establishment a small number of medical rotational posts from Southend when the staff are employed outside the Trust and costs are re-charged.
Sickness – the August rate is 3.5% against a target of 4%. The 12 monthly sickness rate averages 4.7%. The monthly figure was 4.3% last month, and over 11% for April, the highest rate recorded over the last 10 years. The sickness rate a year ago was 3.4%. There are currently approx. 21 staff off sick with COVID symptoms.

Labour Turnover and Number of staff leaving within first year
Turnover is 13.4% (last month 13.6%). 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 10.6% (11% last month). The rolling 3 monthly turnover rate is around 11%, 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 14.7% (15.1% 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%.

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. Twenty 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. Planned numbers for international recruitment are for two groups of 11 for Sept, and a further 20 in October. Obviously, the COVID situation may affect this if government instructions around international travel change. 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

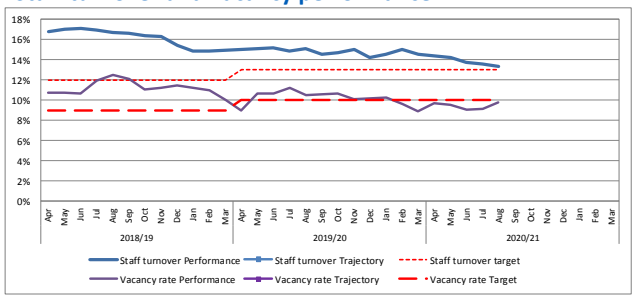


Period: October 2019

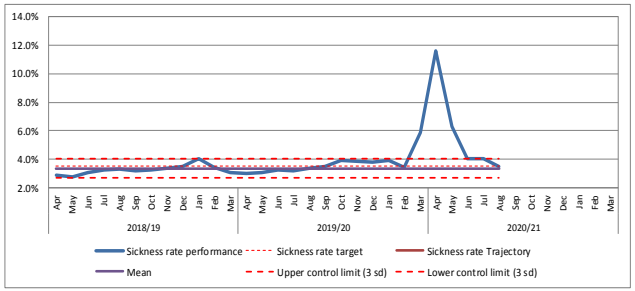
WHHT: 1.54% **Peer: 0.83%**
National: 0.98%

Peers = Nightingale Group – acute multi-site trusts)

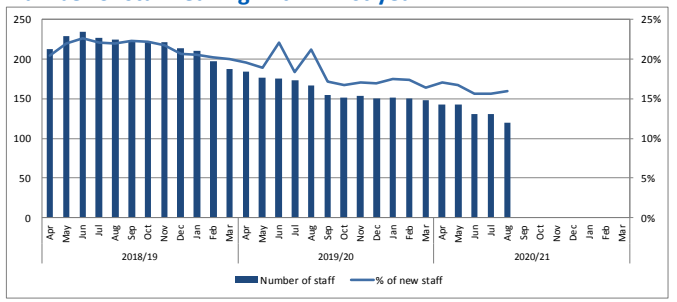
Staff turnover and vacancy performance



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:

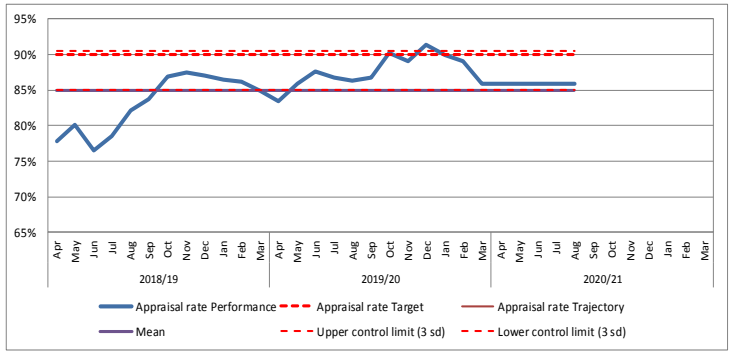
Appraisals

- 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)

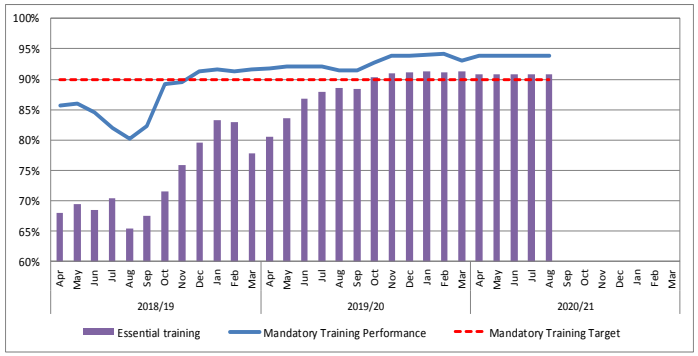
Mandatory / Essential training

- 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



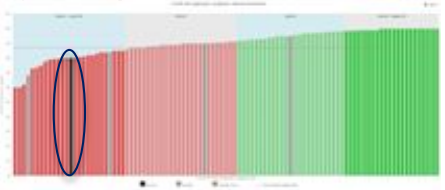
Essential training and mandatory training performance



Performance improved
Better than target/threshold

Benchmarking: Model Hospital

Trust staff with appraisal completed by the required date

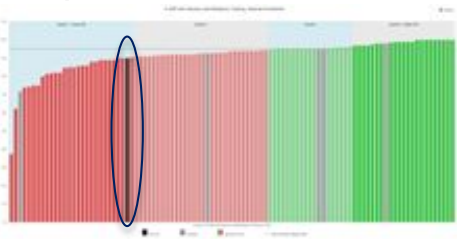


Period: 2018/19
WHHT: 80% **Peer: 87%**
National: 91%

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 14.7% 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% for 3 months in succession. 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, with approx 40 planned to start over Sept / October / November. Final year student nurses have been recruited on fixed term contracts as aspirant nurses, and as many as possible will be recruited.

When measured at March month end, combined appraisals rates at March were slightly below the compliance 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 4.2%. 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 - Aug 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%	10.5%	9.6%	9.7%	10.0%	-0.3%	↗	-3%
Band 5 Nurse Vacancy	11.3%	0.0%	7.4%	9.0%	9.0%	0.0%	↗	0%
Headline Turnover	14.0%	15.1%	14.2%	13.4%	13.0%	0.4%	↘	3%
Band 5 Nurse Turnover	16.3%	15.9%	16.5%	14.7%	16.0%	-1.3%	↘	-8%
Total Sickness	3.6%	3.4%	6.3%	3.5%	3.5%	0.0%	↘	-1%
Non-Medical Appraisal	54%	87.0%	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%	91.0%	94.0%	94.0%	90.0%	4.0%	→	-4%
Agency as a % of Paybill	7.1%	5.7%	4.9%	4.2%	4.7%	-0.5%	↘	-11%
Friends and Family Test (Work)		53.9%	52.2%	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
1st October 2020

Title of the paper	**Annual Report for Serious Incidents and Never Events 2019/20**
Agenda Item	**11/83**
Presenter	**Mike Van der Watt – Chief Medical Officer**
Author(s)	**Charlotte McAlpine, SI Investigator; Mick Salami, SI Lead**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: √
Executive Summary	This report presents an overview of the Trust performance against its key performance indicators of all serious incidents (SI) including Never Events (NE) reported between 1st April 2019 and 31st March 2020. The Trust reported 26 serious incidents externally via StEIS. During the course of the investigation, five of these were de-escalated, leaving 21***** confirmed serious incidents. • The top three categories of all reported SIs by category are as follows: 1. Treatment delay (6) 2. Maternity/Obstetric incident: mother (3) 3. Surgical/invasive (3) • The Trust had three never events declared (surgical/invasive procedures: 2 and diagnostic incident: 1); these occurred at WGH (2) and SACH (1). • The Trust has been fully compliant with Duty of Candour for serious incidents which has been attributed to the revision of processes and systems. • The Trust achieved 93% compliance against a target of 95% for reporting incidents onto StEIS within 48 hours from the date the decision was made. • The Trust achieved 80% against a target of 95% for reports to be submitted within 60 days. • The Serious Incident Review Group (SIRG) reviewed forty five action plans in 2019/2020. • Key learning has been identified from incidents such as treatment delays, maternity/obstetric incidents and never events. • The improvement plan for 2020/2021 includes further development of a learning culture across the trust, continuing to review all serious incidents action plans through the SIRG process, developing robust KPIs for assurance of process implementation and continual engagement with the divisions to encourage ownership for all governance processes. *****The report and analysis that follow will be based on the 21 incidents confirmed as Serious Incident in 2019/2020.
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

11

	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	This report has not been to any group or committee previously
Action required	The Trust Board is asked to note the report as part of its assurance mechanism.

Agenda Item: 11/83

Trust Board: 1st October 2020

Annual Serious Incidents & Never Event Report

Presented by: Mike Van der Watt – Chief Medical Officer

1. Purpose

The purpose of this report is to provide:

- Assurance that each potential serious incident (SI) has undergone a process of review in line with NHS England's Serious Incident Framework (March 2015) national requirements and Trust policy.
- Analysis of serious incidents and Never Events declared between 1 April 2019 and 31 March 2020.
- An overview of the key learning following serious incident and Never Event investigation.
- Next steps to continue improving organisational learning and ongoing management systems.

2. Background

The Trust is committed to working in an open and transparent environment which includes supporting staff to report incidents.

An incident is described as "any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/loss of property" (NHS Executive).This definition includes patient/service user injury, fire, theft, vandalism, assault and employee accident and near misses.

The Trust reviews each reported moderate and above patient safety incident against NHS England's Serious Incident Framework (March 2015). The Framework defines serious incidents as "*an event in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response'.* Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare"

Included within the SI Framework are Never Events, which are classified as serious incidents but don't have to have caused harm. Never Events are entirely preventable incidents based on guidance or safety recommendations to provide strong systemic protective barriers.

Following investigation all serious incidents are reviewed through the Trust's governance arrangements prior to external submission to the Commissioner as per national requirements. Serious incident investigation reports are made available to the patient or family in accordance with Duty of Candour Regulation 20 (Health and Social Care Act 2008 (Regulated Activities).

3. Analysis and Discussion

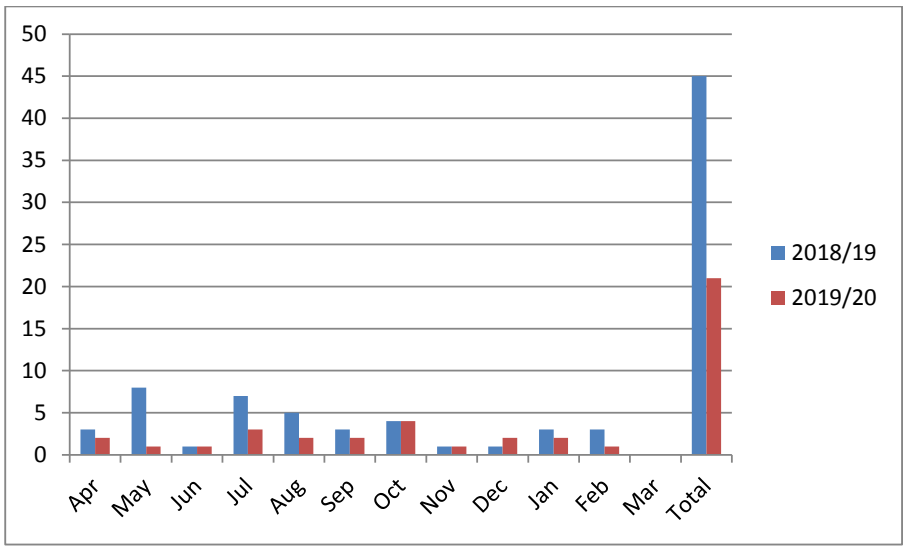
During the period 1 April 2019 to 31 March 2020, West Hertfordshire Hospitals NHS Trust (WHHT) reported 26 serious incidents externally via StEIS. During the course of the investigation, five of these were de-escalated, leaving 21 confirmed serious incidents.

Figure 1 compares the total number of serious incidents (SIs) reported per month against that of the previous reporting year (2018/2019).

When comparing the total number of reported SIs in 2018/2019 a total of 45 were reported, compared to 21 confirmed SIs in 2019/2020; this is a decrease of 24 in the year.

All potential SIs are discussed in detail at each SI panel chaired by either the Chief Medical Officer or Chief Nurse (or their deputy); key stakeholders from the division or specialty are present and a full discussion is undertaken to provide the basis for decision making. This process ensures that a consistent approach to the application of the national SI criteria is achieved.

Figure 1 – Serious Incidents Reported by Month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/19	3	8	1	7	5	3	4	1	1	3	3	0	45
2019/20	2	1	1	3	2	2	4	1	2	2	1	0	21

The number of reported SIs in the year 2019/2020 is significantly lower in comparison with 2018/2019, particularly in May and July. Of the 8 SIs reported in May 2018, there was a cluster of five pressure ulcer incidents included. We also found that of the 7 incidents reported in July 2018, Women and Children division reported 4, whilst Medicine reported 2. Whereas, the number of incidents reported in the corresponding months in 2019 were considerably less.

In terms of reporting culture, there were more potential SIs flagged in 2019/20, but most of these either did not meet the threshold of SI framework or were de-escalated during the course of the investigation process in agreement with the Commissioners.

3.1 Analysis of the SIs declared between 1 April 2019 and 31 March 2020

In 2018/2019, a proportion of 33% (45) of the potential SIs presented to panel were confirmed as SIs. Whereas in 2019/2020, a proportion of 20.4% (21) were confirmed as SIs. Table 1 shows that overall: Women and Children division had the highest confirmed rate of 62.5% (15 of 24) in 2018/2019 and 41% (7 of 17) in 2019/2020. Surgery and Cancer division ranked second highest with 43.4% (14 of 32) in 2018/2020 and 20% (7 of 35) in 2019/2020. Emergency medicine ranked the lowest in terms of potential incidents confirmed as SI. The proportion was 13.6% (2 of 22) in 2018/2019 and 6% (1 of 17) in 2019/2020.

Table 1 presents the total number of incidents presented at SI panel by the divisions and those confirmed as SIs for the reporting period; a comparison against the previous year is also included.

Table 1. Total Number of SIs including Never Events

Division	April 2018 – March 2019		April 2019 – March 2020	
	Incidents considered at SI Panel	Number Confirmed as SI	Incidents considered at SI Panel	Number Confirmed as SI
Corporate	6	1	2	1
Emergency Medicine	22	3	17	1
Medicine	50	12	26	3
Surgery and Cancer	32	14	35	7
Women's and Children's	24	15	17	7
Clinical Support Services	2	0	6	2
	136	45	103	21

The reported number of SIs by month indicates an average of 1.75 SIs reported per month for 2019/2020 which is less than the average amount for 2018/2019 (3.75 per month).

The distribution for SIs reported each month by division is demonstrated in Figure 2. The reporting pattern does not suggest any peaks or troughs in reporting by the divisions. The Trust requested that five SIs were downgraded by the Commissioner as it became apparent during the investigation that they did not meet the SI criteria; all five de-escalations were granted.

Figure 2 – Serious incidents declared monthly by division

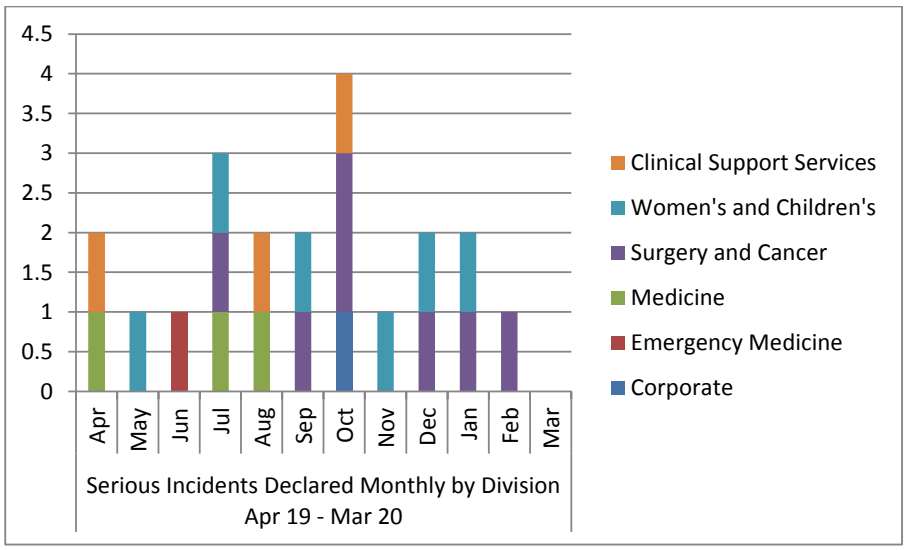


Table 2 presents a breakdown of all reported SIs by category; the top three categories are as follows:

1) Treatment delay (6)
2) Maternity/Obstetric incident: mother (3)
3) Surgical/invasive (3)

Table 2 – Serious Incidents Reported to StEIS by category during 2019/20

SI Category	Number of incidents reported
Treatment delay meeting SI criteria	6
Surgical/invasive procedure incident meeting SI criteria	3
Maternity/Obstetric incident meeting SI criteria: Mother only	3
Maternity/Obstetric incident meeting SI criteria: baby	2
Confidential information leak/information governance breach meeting SI criteria	2
Slips, Trips & Falls meeting SI criteria	2
Diagnostic incident including delay	2
Suboptimal care of the deteriorating patient	1

3.2 Never Events Reported by the Trust 1 April 2019 – 31 March 2020

Never Events (NE) are a subset of serious incidents which are wholly preventable, where guidance of safety recommendations that provide strong systemic protective barriers are available nationally and should be implemented by all healthcare providers; they have potential to cause serious harm or death, and there is evidence that they have occurred nationally in the past.

There were no changes to the list of Never Event criteria in 2019/20. However, an amendment was made in June 2019; this resulted in incidents whereby local anaesthetic which was injected into the incorrect site would no longer constitute a wrong site block.

A total of 3 NEs were reported by the Trust within the reporting year. Table 3 presents the detail by division and StEIS category.

Table 3 – Reported Never Events by StEIS category

Division	Never Event Criteria	Month Reported	Number reported
Clinical Support Services	Misplaced naso- or oro-gastric tubes	August 2019	1
Surgery	Surgical/invasive procedure incident meeting SI criteria	December 2019	1
		January 2020	1

It is noted that both surgical/invasive never events were wrong side blocks; wrong side block (December 2019) and wrong side epidural (January 2020).

3.3 Key learning identified and actions implemented as a result of SI investigations in 2019/20

The Trust continues to strengthen and improve the approaches used to share learning from SIs and monitor the implementation of all actions arising from investigations. A number of learning points from SI actions have led to changes in the Trust's processes and procedures. Some of these can be found below in table 5. The corporate team will continue to work with the divisions with a focus on themes of learning which can be applied across the organisation.

Table 5 - Key Learning: 1 April 2019 to 31 March 2020

Serious Incidents/ Never event	Action Taken
Never events	• Feeding will not commence through NG tubes with a queried location until the x-ray has been reviewed by a consultant Radiologist. • Protocols and standard reporting templates for reporting NG tube positioning to be reviewed and created as required. • Implement the 'Stop Before You Block' process, including drafting an SOP and amending the World Health Organisation checklist. • Human Factor and safety training for staff. • Increase visibility of learning from never events, including 'Stop Before You Block' reminder posters.
Treatment delay	• Review of the booking process for the escalation of ureteric stents and stones. • Implement InfoFlex for urology patients and expand for all surgical specialties. • Review of the Trust policy 'For the Rapid Notification of an Unsuspected Cancer Diagnosis or Significant Clinical Finding'. • Reiterate to medical staff their responsibility to review radiology reports and take action where required. • Include learning on NEWS scoring for middle-grade doctors in ED and as ongoing training for ED staff.
Surgical/invasive procedure	• Staff member attended further training relating to abdominal wall reconstruction at a neighbouring NHS trust. • Further learning from surgical/invasive procedure SIs can be found above under the never event section.
Maternity/Obstetric incident meeting SI criteria: Mother only	• Review of the major obstetric haemorrhage guideline and implementation of a robust system to facilitate the prompt transfer of blood and blood products. • Identification of a named senior doctor in charge of ongoing care in the event of a major PPH. • Ensure the placenta is sent to histology where possible, in the event of a major PPH. • Review of the obstetric anaesthetic guideline to consider implementing the use of early invasive arterial monitoring for patients in time-critical events. • Ensure all staff on delivery suite attend resuscitation and PROMPT training annually. • Ensure all staff are trained in the process of signing blood and blood products. • Ensure agency staff have completed CTG interpretation training. • Learning is shared in the Maternity Risk Newsletter and presented at the Women and Children's clinical governance meeting.
Maternity/Obstetric incident meeting SI criteria: baby	• Checklist created to ensure Gap and Grow calculation is generated and risk assessed following delivery and prior to transfer to the ward. • Breastfeeding assessment tool and feeding plan must be completed and used on the postnatal ward.

Serious Incidents/ Never event	Action Taken
	• Quality Improvement Project to develop point of care screening testing for neonatal infants admitted through CED with feeding concerns. • Human Factors training on error management to be developed by the team.
Confidential information leak / information governance breach meeting SI criteria	• Update clerical induction processes. • Revise flow charts regarding communication with patients. • Introduction of site based supervision for clerical staff. • Training for staff on dealing with emotional situations. • Identify quiet places on each site for private conversations with patients. • Update all trust systems with the patient's correct address. • Develop a standard operating procedure for change of patient contact details. • Patients to be asked to confirm contact details at every contact.
Slips, Trips & Falls meeting SI criteria	• Staff to ensure that the Mental Capacity Act (MCA) assessments are undertaken as required and staff complete MCA training. • Consultants reminded of the requirement to complete TEPs on admission and on review or change in patient condition. • Strengthen effective communication between MDTs relating to falls risks. • Therapy staff to document the patient's mobility and inform nursing staff. • Lying and standing blood pressure to be taken for all patients at risk of falls. • Present learning at surgical and medicine clinical governance meetings and at the trust's Falls Group.
Suboptimal care of the deteriorating patient	• Staff to complete NEWS update training. • All ward staff to read and sign that they have understood the monitoring and recording of physiological observations policy.

3.4 Monitoring Compliance for the implementation of Actions from Serious Incidents.

The Serious Incident Review Group (SIRG), chaired by the Associate Chief Nurse (Quality), meets every two months. The Panel is responsible for ensuring that the actions resulting from investigations have been completed and has valid supporting evidence of learning prior to closure. The divisional teams are invited to attend and present the evidence. Table 4 provides an overview of the number of submitted and closed SI action plans as received by SIRG during 2019/2020.

Table 4 – Action Plans Presented to SIRG

	Apr-June 2019	July-Sept 2019	Oct–Dec 2019	Jan-March 2020	Total number of action plans
Presented at SIRG for the first time	8	7	1	9	25
Outstanding action plans presented at SIRG	8	10	0	2	20

It is noted that the number of action plans presented in October to December 2019 and January to March 2020 is low. This was due to reduced capacity within the serious incident team due to unplanned leave, maternity leave and increasing pressures due to the onset of the Covid-19 pandemic.

25 action plans were presented to SIRG for the first time in 2019/20, plus those that still remained outstanding from the previous financial year. Actions outstanding or partially completed are captured within the monitoring arrangements of SIRG. Items are removed from the actions log only once all evidence is submitted.

3.5 - Performance against Key Performance Indicators (KPI's) (Serious incidents & NE)

The Commissioners agreed to a target of 95% compliance for reporting a serious incident onto StEIS within 48 hours from the date the decision was made. Compliance with this indicator is monitored on a monthly basis and reported through the Trust's governance arrangements. Trust performance was slightly lower than the target, at 93% between April 2019 and March 2020.

Table 6 - Compliance against the 48-hour Target Reporting Criteria and Submission to CCG within 60 days

	% Target	% Actual performance
Compliance against 48h target	95	93
Percentage of SIs submitted to CCG within 60 days	95	80

To note, two months (December 2019 and January 2020) had low compliance against the 48-hour target; averaging 67% for both months. This brought down the yearly average, despite 100% compliance in the other months.

Similarly, two months (February and March 2020) scored 0% for SIs submitted to the CCG within 60 days. This brought down the yearly average, despite 100% compliance in the other months.

During 2019-20 there were changes to the staffing of the SI team which contributed to lower than expected compliance. The SI team now have a full complement of staff for 2020-21, the expectation is that there will be improved performance against the KPI's in 2020/2021.

3.6 Duty of Candour

All serious incidents reported onto StEIS require the division of origin to allocate a Duty of Candour lead who is responsible for communicating directly with the patient or relative to ensure timely openness and transparency and to be the Trust's link. The written notification for SI's is undertaken by the SI team in partnership with the divisional lead. Table 7 presents Trust compliance against the completion of DoC for SIs during the reporting period.

Table 7 – Serious incidents - Compliance against Duty of Candour.

Month	Percentage compliance with DoC
April 2019	100%
May 2019	100%
June 2019	100%
July 2019	100%
August 2019	100%
September 2019	100%
October 2019	100%
November 2019	100%
December 2019	100%
January 2020	100%
February 2020	100%
March 2020	100%

3.7 Quality Improvement Plan for Serious incidents 2020/21

- Key Learnings and Actions identified:
  - Action plans and organisational wide learning
    - To further develop the learning culture within the Trust; cross-divisional and Trust-wide learning.
    - To continually review all serious incidents through the SIRG process and ensure lessons are learned and actions have been implemented.
  - Duty of Candour – moderate harms
    - The Trust performs well against DoC for all serious incidents. The systems and processes to ensure that moderate harm incidents are managed in accordance with DoC requirements need to be strengthened, particularly documentation of DoC on our incident management system (Datix).
    - To develop robust KPIs for assurance of process implementation by the end of September 2020
    - To continue engagement with the divisions to encourage ownership for all governance processes.
  - National Patient Safety Strategy
    - Benchmark the Trust position against the strategy in readiness for full implementation.

3.8 Summary and Conclusion

- A total of 21 were confirmed as SIs in 2019/20 – a decrease of 53% compared with 45 SIs reported in 2018/2019.

- The top three categories of all reported SIs by category were treatment delay, maternity/obstetric incident, and surgical/invasive.

- The Trust had 3 never events declared (surgical/invasive procedures: 2 and diagnostic incident: 1). These occurred at WGH (2) and SACH (1).
- The Trust has been fully compliant with Duty of Candour.
- The Trust achieved 93% compliance against a target of 95% for reporting incidents onto StEIS within 48 hours from the date the decision was made.
- The Trust achieved 80% against a target of 95% for reports to be submitted within 60 days.
- Key learning has been identified from incidents such as treatment delays, maternity/obstetric incidents, and never events.

4. Risks

Risk 3748: QIP – Risk management processes insufficiently embedded risk score 9.

5. Recommendations

The Trust Board is requested to note this report for information and assurance.

Director: Mike Van der Watt, Chief Medical Officer

Date: October 2020

Trust Board Meeting
01 October 2020

Title of the paper	Mortality and Learning from Deaths Quarter1 2020/21
Agenda Item	12/83
Presenter	Dr Anna Wood – Director of Governance
Author(s)	Deborah Wadsworth
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	This report reviews mortality and learning from deaths during quarter 1 2020/21, with an update on current position. It also references the Intensive Care National Audit and Research Centre report on COVID-19 in critical care at The Trust. The July 2020 Dr Foster report shows HSMR as 100.7 with an adjustment for the early part of month 13 of 101.3 and SHMI as 103, with an early adjustment of 102.1. Both measures are within the expected range. Palliative care coding is slightly higher than the national rate at 4.26% versus 4.22%. Currently the conditions listed below are alerting as SMR outliers: • Viral infection (new) • Septicaemia except in labour (new) • Secondary malignancies (continued) Viral infection includes all COVID-19 deaths The structured judgement review (SJR) process was partially suspended during the period of lockdown and was restarted towards the end of June. 15 referrals were made for SJR, in 2 of these cases (0.34 % of all deaths), care was considered to be poor. The full SJR process is in the process of being restored and additional help has been recruited in to assist with this. The Mortality Review Group meeting was last held on 14 July.
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	☐Is there the leadership capacity and capability to deliver high quality,

12

<table>
<tr><td>key lines of enquiry</td><td>sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Quality Committee</td><td>24 September 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 information and assurance on Trust mortality and learning from deaths scrutiny.</td></tr>
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West Hertfordshire Hospitals NHS Trust

Agenda Item: 12/83

Trust Bord

Mortality and Learning from Deaths Quarter 1 2020/21

Presented by: Dr Anna Wood
Author: Deborah Wadsworth

1. Purpose

1.1 This paper aims to provide a review of trust mortality and related workstreams across quarter 1 2020/21 (1 April – 30 June 2020) and to provide an update on current position (August 2020).

1.2 It should be noted that some mortality review workstreams were temporarily suspended during this time period due to the significant impact of COVID-19 on the availability of consultant reviewers.

1.3 The last Mortality Review Group meeting was held on 14 July 2020.

2. Background

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

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

2.2 It allows close scrutiny of mortality trends, highlights outlying groups, when they arise and triggers review to determine influencing factors, including poor care; this provides an opportunity to learn from deaths and make changes to reduce future risk.

12

3. Mortality risk metrics

(From early August 2020 Dr Foster update which encompasses data from March 2019 to March 2020)

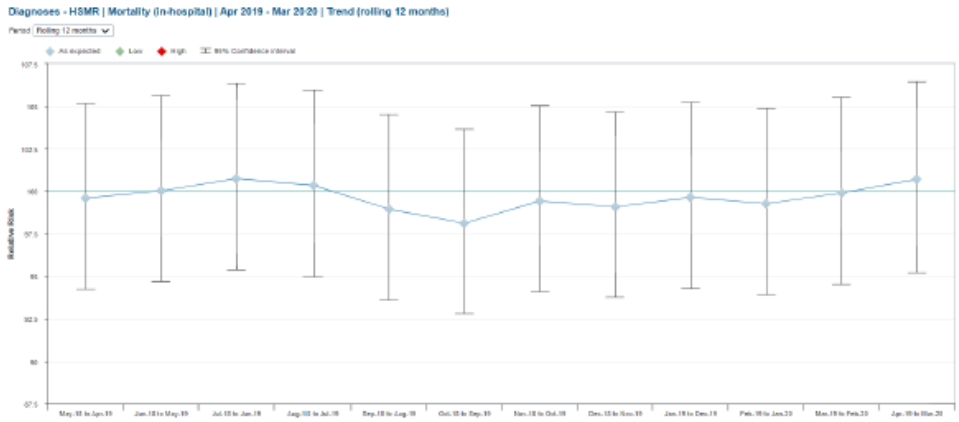
- **HSMR** is 101.6
- **SHMI** is 102.1 both of which are within the expected range.
- Palliative care coding is slightly higher than the national rate at 4.26% versus 4.22%.
- Crude Mortality is 3.7% (vs 3.1% for the peer group)

3.1 Overall quantitative performance (the metrics)

3.1.1 HSMR rolling 12 months (last point is March 2020)

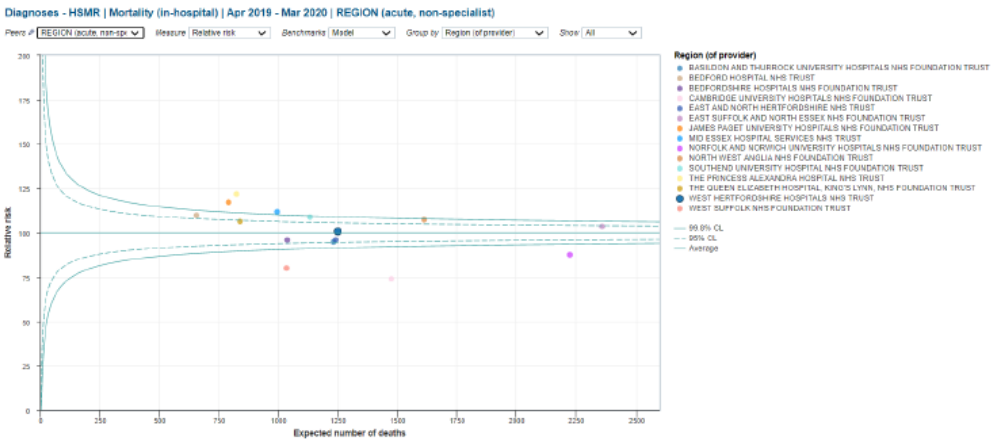
a) Chart 1 Monthly Trend

Figure 1.1 – HSMR Monthly Trend (rolling 12-months)



b) Chart 2 Peer comparison

The Trust is 1 of 5 Trusts within the East of England peer group of 15 with an HSMR within 'as expected' range.



3.1.2 Chart 3 SHMI Last available 3 years

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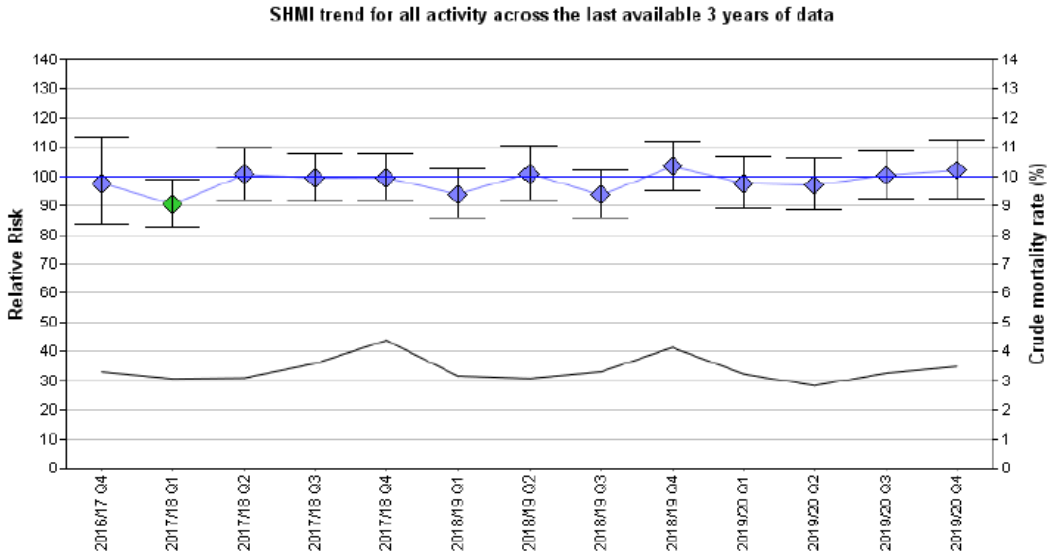
4

SHMI trend for all activity across the last available 3 years of data



3.1.3 In conclusion, the metrics of HSMR (The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths) and SHMI demonstrate no excess of risk adjusted deaths overall in the 12 month period in the disease groups defined by them.

3.2 Outlying SMR and HSMR diagnoses

3.2.1 The standardised mortality ratio (SMR) is the ratio of observed deaths to expected deaths with a specific diagnosis) where expected deaths are calculated for a typical area with the same case-mix adjustment

3.2.2 Preliminary month 13 data identifies two new outlying SMR groups:

- Virus infection
- Septicaemia except in labour

The group ‘virus infection’ is where COVID-19 deaths are mapped to.

3.2.3 The process agreed and used on every occasion that an outlying group is identified by Dr Foster is being applied to the above and case note reviews are currently being undertaken by Structured Judgement Review methodology of patients who have died due to COVID-19. This is part of an EOE collaboration. Review outcomes will be discussed at trust level.at an appropriate Trust Mortality Review Group

4 ICNARC (Intensive Care National Audit and Research Centre Report)

4.1 The ICNARC report was completed on 12 June 2020 and covers the period 1 March 2020 to 4 June 2020. This report presents data of patients critically ill with confirmed COVID-19 reported to ICNARC. In total 97 patients were included in the study, with 89 confirmed outcomes. 8 patients were still receiving critical care at the time of publishing.

4.2 The report sets out a patient profile, with focus on age, sex, ethnicity, deprivation, pregnancy status, BMI and comorbidities. It then aligns these profiles with clinical outcomes.

4.3 Of the 89 patients admitted to critical care with reported outcomes, 34 or 38.2% were subsequently discharged and 55 or 61.8.1% died. This is in comparison with the national picture, which reports that 57.6% of critically ill patients were discharged and 42.4% died and shows a reverse or adverse pattern

4.4 The report also looks at the provision of organ support to the same cohort of patients. A variety of organ support interventions were utilised locally and nationally. The table in the appendix 1 sets out those most frequently required (in order of frequency).

- Fewer patients at WHHT were ventilated compared to nationally (59.6 %cf 72.4%)
- Median duration of ventilator support at WHHT was shorter (10 days vs 12 days)
- 40 or 75.5 % patients on ventilators at WHHT died cf 51.2% nationally
- 13 or 24.5% patients on ventilators were discharged alive from WHHT.

4.5 Indicators of Acute Severity:

In those 55 (57.3%) patients who were mechanically ventilated within the first 24 hours (cf nationally 61.2% there was a marked difference in oxygenation (paO2/ FiO2 ratio) at WHHT 10.6 cf 15.7 nationally and this may be an area requiring further analysis by ITU and respiratory colleagues.

4.6 Patient Characteristics: medical history and indicators of acute severity

Of 97 patients admitted to ITU, the % of patients with very severe co-morbidities in 7 disease categories were similar to the national picture (admission co-morbidity characteristics similar) and WHHT had 4 patients in total in the very severe category (1 renal and 3 immunocompromised)

4.7 COVID-19 Critical care mortality by patient characteristic may be found at appendix 2

4.8 The ICNARC report will be presented in full at the next Trust Mortality Review Group meeting in September by the. Clinical Lead for ITU and the Divisional Director for Surgery and Anaesthetics will be in attendance

5 Dr Foster bespoke COVID-19 report

5.1 Dr Foster was commissioned in July 2020 to provide a bespoke report on COVID-19 mortality. This report will be produced monthly for the next 6 months. Each report will be discussed at the Trust Mortality Review Meeting.

5.2 Findings from the first report are as follows:

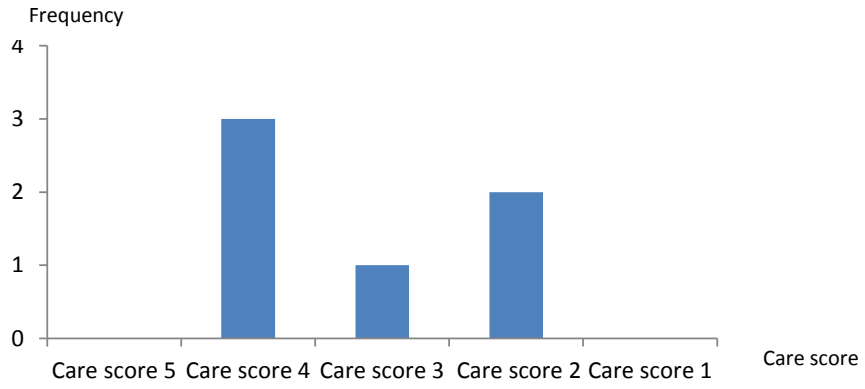
- The mortality rate for all COVID-19 positive patients is 35% and is generally decreased over time.
- 10% of patients spent time in critical care and the mortality rate for those was 56%
- Mortality rate increased with age and the largest proportion of patients were in the 85+ age group.
- There was a higher mortality rate in males to females (41% and 29% respectively)
- Most patients were in the white ethnicity group. The mortality rate was similar to other ethnicity groups where the numbers were not small.
- The population skewed towards the lesser deprived deciles and there was a higher mortality rate amongst patients in these groups
- The largest diagnosis group for comorbidities was hypertension, which accounted for 35% of patients with COVID-19, followed by chronic endocrine conditions (including diabetes), chronic heart disease and chronic respiratory conditions. Palliative care patents accounted for 32% of all deaths.
- 17% of patients received ventilation in hospital and of those 61% died in hospital

5.3 The report found that the age, gender and ethnicity split for in hospital deaths at the Trust was very similar when compared with the national distributions.

6 Structured judgement review (SJR)

6.1.1 Between 1 April 2020 and 30 June 2020, 15 referrals for structured judgement review were made. 6 completed reviews were received back from consultant reviewers, with overall care scores ranging from 2 to 4. Of the 6, 3 scored a 4 (good care), 1 scored a 3 (adequate care) and 2 scored a 2 (suboptimal care), representing 0.34% of all deaths. No cases scored 1 (poor care).

6.1.2 Chart 4 SJR care scores for quarter 1 2020/21

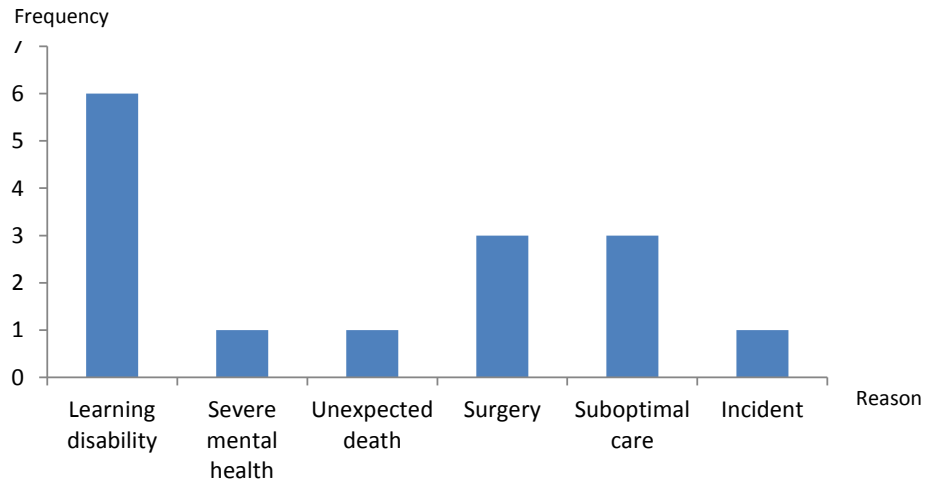


6.1.3 Potential avoidability of death

As a consequence of COVID-19, the SJR service was partially suspended during quarter 1 and no tier 2 avoidability panel meetings were held.

6.1.4 Reasons stated for SJR referral

Chart 5 Reasons for the 15 SJR referrals between 1 April 2020 and 30 June 2020



The reasons for SJR referral demonstrates compliance with our trust policy.

6.2 Current position

6.2.1 At the time of writing there were 3 cases awaiting allocation for structured judgement review and the backlog which arose during the COVID-19 pandemic has been well managed.

The last avoidability panel meeting took place on 18 August 2020. Cases reviewed at this and subsequent meetings will be incorporated in the Q2 report.

6.2.2 **COVID-19 deaths**

It has been debated and agreed that SJR is not an ideal tool to use to assess care provided as COVID-19 is a new disease with continuous learning to be gained internationally and from clinical therapeutic trials which have started. Judging the clinical care of a patient who died from COVID-19 in the absence of clear published standardised care guidelines by SJR is therefore difficult. However benchmarking outcomes may be useful for future waves and we are currently participating in an EOE network outcome review of 100 cases which has been developed by another trust using a detailed dataset but within an SJR structure.

Speciality Morbidity and mortality meetings will also scrutinise their COVID-19 deaths and Dr Foster will be producing benchmarking outcome metrics (outside of the usual HSMR and SHMI metrics) The first report has been published (see section 5) and will be discussed at the next Trust Mortality Review Group

6.3 SJR themes and learning

6.3.1 SJR themes are ordinarily analysed and recorded 6 monthly. Prior to service suspension, this information was being updated and was to be captured in a new format.

6.3.2 There is an agreed governance process for SJR. In summary, completed SJRs are shared with Clinicians by 1) disseminating all completed SJRs at Divisional level, 2) summarising the 6 monthly thematic collation of SJRs at Divisional Governance half days and 3) dissemination of completed SJRs to individual specialities for review and feedback of local implementation of actions. Reviews of learning disability deaths are shared with the LeDeR team and themes are starting to be collated and reported at Trust Mortality Review Group by the Safeguarding Clinical Lead. Medical Examiners also receive the completed SJR if they have originally referred the case.

Theme analysis will resume once the service becomes fully reinstated.

7 Medical Examiner service

7.1 During quarter1, the Medical Examiners referred 15 cases for SRJ. Between 1 April 2020 and 30 June 2020, some of the Medical Examiners were deployed to clinical work during the pandemic and partook in medical death certification so scrutiny work ceased during the pandemic in the true sense of the definition. There was an

amendment to the Coronial law during the pandemic which meant that cremation form 5 completion was no longer required.

7.2 From October there will be a reconfiguration of the Medical Examiner Service in view of the changes to the activity post pandemic.

7.3 The Medical Examiner service has been operational for almost two years and a number of changes are planned to increase the number of Medical Examiners to allow for flexibility of cover and to future proof the service. It is proposed that additional Medical Examiners be appointed and with that in mind the posts have been advertised internally, with a view to recruiting Trust Consultants to the role. Interviews are expected to take place in early October and panel members will be joined by the County Coroner.

7.4 A business case for the Medical Examiner Officer role (1.6 WTE) was approved in July and those posts will also be recruited to in the near future.

8 Next steps

8.1 Next steps planned include:

- Recruitment of additional Medical Examiners
- Recruitment of the Medical Examiners Officers
- Refreshing the service plan
- Updating the analysis of themes and identifying any quality improvement opportunities

9 Risks

9.1 None identified.

10 Recommendation

10.1 The Board is asked to note the report for information and assurance.

Tracey Carter
Chief Nurse and Director of Infection, Prevention and Control
September 2020

Appendix 1

Organ support interventions utilised locally and nationally (ICNARC Report)

Organ support WHHT	Frequency % (national figure in brackets)
Basic cardiovascular support	98.9 (92.5)
Basic respiratory support	68.5 (65.4)
Advanced respiratory support	59.6 (72.4)
Advanced cardiovascular support	36 (28.9)
Renal support	24.7 (25.6)
Liver support	0 (0.9)
Neurological support	0 (7.9)

Appendix 2

ICNARC Report: Critical care mortality by patient characteristic at the Trust and nationally

Critical care COVID-19 mortality by patient characteristic at the Trust and nationally		
Patient characteristic	**WHHT (% of characteristic cohort)**	**National (% of characteristic cohort)**
Age		
16-49	29.4	20.4
50-69	67.3	43.3
70+	76.5	62.5
Sex		
Male	63.2	44.6
Female	59.4	36.9
BMI		
<25	57.9	43
25-<30	67.9	46
> 30	59.5	38.6
Assistance required with daily activity		
No	50.6	41.1
Yes	92.3	50.9
Severe comorbidities		
No	60	41.4
Yes	100	52.6
Respiratory support		
Basic	44.1	19.6
Advanced	75.5	51.2
Renal support	59.1	62.3

Trust Board
1 October 2020

Title of the paper	*Bi-annual Establishment Review – Adult Inpatient Wards*
Agenda Item	13/83
Presenter	Tracey Carter, Chief Nurse Director Infection Prevention & Control
Author(s)	Jo Prytherch, Lead Nurse Workforce and Education David Thorpe, Deputy Chief Nurse
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: x
Executive Summary	The establishment review has been discussed fully at the People Education and Research Committee and evidence of assurance of safe staffing was provided with the current agreed establishments and the review for Covid templates. The committee has also provided evidence of assurance to the Trust Board around safe staffing on adult inpatient wards, following workforce establishment reviews undertaken in September 2019 and February 2020. An additional review of safe staffing during COVID 19 pandemic has been completed and reported to the Quality Committee dated 30 April 2020. In addition, a risk assessment has been completed for nursing workforce in accordance with the Operating framework for urgent and planned services in hospital settings during COVID-19 (NHS May 2020). A nursing workforce escalation process has been instigated where, clear boundaries of movement for nurse staffing is in operation. Staffing when shortages are observed can be moved between green areas (clean) and from green to blue (positive areas) but organisational guidelines indicate this process cannot be reversed i.e. blue to green. This paper presented to Trust Board has been discussed and presented to PERC. I can confirm my professional review and that the levels meet safe staffing; we will continue to review the ward templates (see appendix 1) and quality impact assessments in light of changes within Covid areas. The reviews undertaken support the elements of the three-point Chief Nursing Officer (CNO) strategy: helping nurses deliver the Long Term Plan in building a workforce 'fit for the future' that ensures we have enough staff with the right skillset. The established reviews looked at the twenty five inpatient areas which included Simpson ward following its return to West Hertfordshire Hospitals NHS Trust. (WHHT). In Septembers review only three changes were made to establishments within: Aldenham Ward; Simpson Ward and Sarratt Ward. These changes were made in support of additional night presence, to have senior cover 7 days a week and to increase senior overview at night. To note: all divisions were successful in encompassing all changes within their financial envelope. Both September 2019 and February 2020 reviews used Safe Care; this is a component of e-roster that reports on daily patient dependency and acuity. In

	order to ensure that the data input at ward level is quality assured, data checks are undertaken daily with the clinical lead for safe care and matrons, scoring is reviewed using check and challenge as part of quality controls and where necessary changes are made and recorded on safe care. The triangulation of data and information is paramount to a successful review and include: Safer Nursing Care Acuity scores; finance which included vacancy and agency spend, KPI metrics attributed to the nursing workforce around e-roster templates, productivity and reviewing of the ward score card around workforce and quality indicators 'How safe is my ward' – Hand Hygiene, Hospital Acquired MRSA, C Difficile, pressure Ulcers, Falls and Test Your Care scores and trends. The reviews also looked at staff compliance with Statutory and Mandatory Training and information gained from Friends and Family Test (FFT). Care Hours Per Patient Day data from model hospital were reviewed which enabled the benchmarking of the Trust both nationally and with our peers; this has showed that we are comparable with others both locally and nationally. In September the Heads of Nursing (HON), Matrons and Ward managers reviewed their budget with the finance team and added professional judgement for each of their areas. The review also looked at any reported National Institute Clinical Excellence (NICE 2017) Red Flags related to staffing and its impact on patient care. Following the introduction of Nursing Associates and Associate Practitioners (at Band 4 level) into the establishments, quality impact assessments were completed and have been reviewed as part of this establishment process. This change in skill mix in the workforce has demonstrated change in registered to unregistered ratios. National recommendations are 1:8. However within the Trust this fluctuates on the day 1:5 – 1:11 and at night of 1:5 – 1:10. Where the RN to patient ratio is below 1:8 this is due to being a small ward for example Oxhey, where the registered nurse numbers cannot be reduced any further. The workforce KPI's are monitored within the divisional monthly workforce meetings, that have Head of Nursing, Matrons and Ward Leaders present. Any safety or red flag shifts are monitored and discussed. The monthly Quality Improvement Forum monitors ward safety and quality. Within this meeting any ward level concerns are openly discussed and immediate actions or additional surveillance is instigated and reported on. Safety within adult inpatient wards are monitored and discussed at 8am operational meeting and reviewed throughout the day. In addition two daily professional staffing meetings chaired by Deputy Chief Nurse, with Heads Of Nursing for Surgery and Medicine and matrons in attendance to provide assurance around safe staffing, including staff deployments and mitigations. To note; that although not counted within the ratios the ward manager are 100% supervisory. Over the last six months due to operational pressures, on average 75% supervisory time has been recorded, where the ward leader is available to support the junior workforce and drive quality. A change in reporting has been instigated as previously, annual leave of ward managers had been calculated within lost supervisory time. To give more accurate information this has now been divided into actual loss and loss due to annual leave. In September all areas were professionally reviewed and signed off by the Ward Leader/Manager, Matron, Head of Nursing and final professional sign of by the Chief Nurse, to provide assurance of full participation and that the Trust was meeting National Quality Board's Guidance (2016) and that it is embedded in safe staffing practice.

	Due to COVID 19 the February review, although agreed and signed off it was reported by exception. The establishments remained the same as per September 2019 review.

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***
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?
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☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?

Previously considered by

Committee/Group	Date
Trust Management Committee	20.6.20
People, Education and Research Committee	27.8.20

Action required

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

13

Agenda Item: 13/83

Trust Board: 1 October 2020

Biannual Establishment Review – Adult Inpatient Wards

Presented by: Tracey Carter Chief Nurse Director Infection Prevention & Control

1. Purpose

1.1 This report is to provide assurance to Trust Board of safe staffing for adult inpatient wards, following establishment reviews undertaken in September 2019 and February 2020.

2. Background

2.1 The National Quality Board (NQB) 2016 guidance provides Trusts with the expectations needed to make local decisions that will deliver high quality care for patients within the available staffing resource. The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Developing Workforce Safeguards (DWS) (2018) requires NHSEI to assess the Trust's compliance with the 'triangulated approach' to deciding safe staffing by ensuring the use of evidence based tools, professional; judgement and outcomes to ensure right staff are in the right place and at the right time. This will be based on patients' needs, acuity, dependency and risks. **The Trust is compliant with DWS**.

Demonstrating safe staffing is one of the six essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014).

As set out in the Five Year Forward View it is vital that we have a single, shared goal to maintain and improve quality, to improve health outcomes, and to do this within the financial resources entrusted to the health service. This means a relentless focus on planning and delivering services in ways that improve productivity whilst maintaining quality.

This review supports elements of the three-point CNO strategy: helping nurses deliver the Long Term Plan in building a workforce 'fit for the future', that ensures we have enough staff with the right skillset; improving retention by at least 2% by 2025; and developing leadership across all levels of nursing that tackles inequalities that exist within the NHS, and creating and infrastructure to allow more volunteers to support staff.

The CNO states that three priorities that will help 'fulfil that mission' – addressing workforce shortages; enhancing the reputation of the profession; and helping nurses and midwives lead change across the NHS.

2.2 Developing Workforce Safeguards (DWS) (2018) recommends that the Trust uses an evidence based tool in undertaking staffing reviews. WHHT is compliant and uses the Safer Nursing Care Tool (SNCT) Adult and Child inpatients. Both are recognised National evidence based tools used to inform evidence based decision making on staffing and workforce; WHHT has obtained the licence to use these from Imperial Innovations.

2.2 NHSI 2018 published guidance on Care Contact Hours' (2018). In September 2019 it became mandatory for Trusts to report Care Hours Per Patient Day (CHPPD) monthly via the Safe Staffing Strategic Data collection; this provides the Trust with the opportunity to benchmark both nationally and against our peers. CHPPD provides a single consistent way of reporting deployment of staff working in inpatient wards/units. It forms part of the national safer staffing programme and part of an integrated ward/unit level quality framework and dashboard encompassing patient outcomes, people productivity and financial sustainability. **WHHT is compliant in reporting and are comparable with other organisations**

2.3 July 2019 NHSI updated its guidance to include Nursing Associates and Allied Health Professionals (AHPs) who are rostered to the in-ward establishment to be included as part of the CHPPD reporting.

2.4 We continue to work closely with NHSEI on establishment reviews and workforce productivity. They continue to have confidence in our 'commitment, enthusiasm and progress' around our KPI eroster metrics which we check and challenge and empower each head of nursing, matron and ward manager at our monthly workforce review meetings.

Areas of scrutiny include:

- Unused hours
- Leave – Annual, Maternity, Study leave
- Roster Approval
- Missing skills, Duties with Warnings
- Sickness
- Temp staffing Induction completed
- NHS Professionals % interface Usage and % Retro Bookings
- We have gone on to progress work around auto rostering and ensuring e-roster templates reflect budgeted establishment and staffing assigned on ESR.

3. Analysis/Discussion

3.1 Analysis is based on SNCT Whole Time Equivalent (WTE) excluding ward clerks and house keepers. In addition the tool offers an inbuilt supervisory role of 20% for band 7s however, as discussed previously, to support our junior workforce, aid retention and quality initiatives and to meet the CNO strategy for staff with the right skill set. Current analysis has indicated an average of 75% compliance with Whht target of 100% supervisory which signifies 25% redeployment into staffing levels within their wards to maintain quality of care. A recent focus has been the review of time lost as annual leave was previously incorporated within the lost hours; this has now been split to understand more fully the hours lost due to pressures on the ward.

3.2 Reviews were conducted for the thirty days in September 2019 and the twenty nine days February 2020 using Safe Care. The patient dependency and acuity census is completed twice a day by the nurse in charge or ward manager. In order to provide quality assurance around the reporting the data was peer reviewed by the Clinical Lead for Safe Care and the analysis showed a good comparison. In addition, audits were undertaken focusing on staff knowledge and understanding in recording patient dependency and acuity, targets of 100% were set with any areas falling below this being provided with additional training and support.

The data was then extracted in its purist form and inserted into Shelford Safer Nursing Care excel data sheet which include the national evidence based multipliers; the tool then calculates the ward wte recommend for registered and unregistered staff.

In order to help inform the decision making process, Heads of Nursing, Matrons and Ward managers were provided with the following: vacancy data; quality indicator data that includes; pressure ulcers, falls, MRSA, hand hygiene, test your care performance; friends

and family data, as well as any incidents that occurred during the month; how well they manage their roster data and SNCT data. It was through the triangulation of this information and adding professional judgement that the Heads of Nursing were able to provide assurance and agreement regarding their staffing levels for each of their areas of responsibility.

3.3 Professional review is a vital element and was supported by a meeting in September with the workforce team, finance, ward manager, matron and heads of nursing. Shift patterns were reviewed in relation to the planned and actual budget. This proactive approach enabled senior nurses to be engaged and empowered in the management of their services.

Professional challenge is encouraged and evident throughout; this enables a healthy culture of scrutiny to further develop. In addition, this gives assurance to the Chief Nurse that ward sisters and matrons were sighted and in agreement with the establishment review process and final decision. Any major changes were supported by a quality impact assessment and reviewed within this biannual process.

The impact of having small wards of bed numbers ranging from 11 beds to 18 beds does have an impact on these figures.

A summary of factors that have affect the ratios are:

- Introduction of Band 4 Nursing Associates from June 2019
- Where there are not enough band 4s in the establishment shifts are filled with band 5's
- Band 5 vacancy and turnover
- The number of patients requiring enhanced nursing care. There has been a significant reduction in demand following the introduction of a clear strategy which include assessment and review controls
- Ratios are also influenced when reviewing patient demand and acuity for our smaller wards for which the Trust has nine of its inpatient areas with a bed capacity of 18 beds or less. In addition, a number of wards in the Trust have complex layouts due to estates.

3.1 **Division of Medicine Review September 2019** resulted in changes in Aldenham and Sarratt establishments. Both have been managed with the financial envelope of the division.

Aldenham is 27 bed acute respiratory ward, following the September 2019 review it was agreed to increase/ uplift one HCSW at night.

Between both establishment reviews a business case was developed and agreed and is now being actioned and recruited to.

Sarratt is a 36 bed Care of the elderly ward, following the review it was agreed to align templates to a 7 day service.

Simpson was a 21 bed re-enablement ward that returned from Herts Community to West Hertfordshire Hospitals NHS Trust on the 1st October 2019 and is now closed.

3.2 **Division of Surgery Review** –No changes made within the Division.

3.3 **In February 2020 there were no changes in establishments in Medicine or Surgery; therefore, budgets have been set for 2020-2021 in accordance with the establishment review and agreed templates conducted in the September 2019 review.**

3.4 **Red Flagged Shifts**

In 2017 NICE updated its Red Flag list – As part of the Trust's monthly performance slide the Trust reports on safe staffing 2 of the Red flag triggers; less than 2 registered nurses

and more than 8 hours less than planned in the ward scorecard. The further 6 red flags are monitored as part of safe staffing and ward score card and reported on both at monthly workforce and IPR. In addition, any Red Flags raised through safe care are escalated to ward manager and matron for review and any actions or mitigations taken are recorded on safe care and if appropriate a datix is completed. At the Daily staffing meeting at 8 am Senior Leaders are asked to report on any patient safety or quality issues that have resulted from staffing decisions made in the previous 24 Hours for all inpatient and surge areas and a datix completed. These are reviewed as part of the establishment review to enable scrutiny of quality and any safety concerns.

4. Developing workforce safeguards (DWS)

4.1 NHS Improvement (NHSI) has published Developing Workforce Safeguards - supporting providers to deliver high quality care through safe and effective staffing (October 2018). It contains new recommendations to support WHHT in making informed, safe and sustainable workforce decisions. NHSEI will assess trusts' compliance with this; by the information collected through the Single Oversight Framework (SOF), they will then ask trusts to include a specific workforce statement in their annual governance statement.

For Nursing and Midwifery the trust is compliant with DWS.

5. Next Steps

- Continue to monitor progress N&M compliance against NHSEI DWS Oct 2018
- Continue to monitor progress N&M compliance against NHSEI Level of Attainment
- Due to service reconfiguration and ward layout changes we continue to monitor and review.
- Continue to progress other areas establishment reviews i.e. outpatients
- Ensure Quality Impact Assessments have been completed and reviewed for all areas
- Next Adult inpatient establishment review is scheduled for September 2020

6. Risks

6.1 Continue to monitor the band 5 nursing band turn over which is currently impacted by our inability to recruit from overseas due to COVID 19 – Risk Register No 3912 and COVID staffing Risk Register 4273.

7. Trust Board action

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

Name of Director – Tracey Carter
Title: Chief Nurse Director Infection Prevention & Control

Date: September 2020

Appendix 1

	February 2020					
	DAY			NIGHT		
WARD	Registered Nurse	AP	Unregistered Staff	Registered Nurse	AP	Unregistered Staff
AAU L3 BY	6	0	7	6	0	3
Red	2	1	2	3	0	1
Bluebell	2	1	5	2	1	5
Winyard	2	1	2	2	1	1
Tudor	3	1	4	3	1	4
Oxhey	2	0	1.5	2	0	1
Stroke	6.5	1	3	6	1	3
Croxley	3	1	4	3	1	3
Heronsgate and Gade	5	0	5	4	0	5
Sarratt	5	1	4	4	1	5
CCU	6	0	2	5	0	1
Cassio	2	1	2	2	1	1
Aldenham	5	1	3	4	1	2
Simpson	3.5	0	3	3	0	2
AAU L1 B	3	0	2	3	0	2
AAU L1 Y	3	0	2	3	0	2
AAU L1 G	3	0	2	3	0	2
AAU L1 P	3	0	2	3	0	2
Ridge	4	1	3	4	0	3
Langley	2	0	2	2	0	1
Cleves	2	1	2	3	0	1
Flaunden A+B	3	1	4	4	0	2
Letchmore	3	0	3	3	0	2
Elizabeth	3	1	3	3	0	2
DLM/Beckett	5	1	4	5	1	2

Trust Board
01 October 2020

Title of the paper	**Strategic Priorities Update**
Agenda Item	14.1/83
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.
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.

Agenda Item: xx/xx

Trust Board– 01 October 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	✓		✓	
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				✓

2. Clinical Strategy

2.1 The **Clinical Strategy** work is progressing well, and there are a number of clinical and stakeholder engagement events scheduled for September to test the direction of travel and seek input into some of the key questions.

2.2 **The Interventional Radiology (IR)** project is currently at the design stage with work in progress to confirm the operational policy and activity profile for this service. Plans are now underway that would free up space for the IR suite in AAU Level 2 by the end of the financial year, making early 2021/22 the target date for work to commence, subject to identification of the necessary capital.

2.3 There is no significant change to the **Mount Vernon Cancer Centre Review** received in August although the WHHT team has continued to liaise with the MVCC review team and agreed a set of actions to progress clinical discussions and technical estates appraisal to understand whether co-location of some elements of service would be feasible if this is the outcome of the review process A further update is expected following the Programme Board meeting in early October, which will feed into an October TMC paper.

2.4 The Respiratory team have commenced with the **SMART (Senior Medics Assigning & Re-designing the Take)** virtual pilot, however, unfortunately due to staffing issues within Cardiology, the service has not been moved into a virtual setting. The Cardiology rota is currently staffed by locums; the team are working towards a largely substantively staffed rota for the virtual pilot.

The Royal College of Physicians have responded favourably and provided guidance for the team. Communications are being refreshed with the affected teams to include the Junior Doctors. The team have carried out the first weekly pilot review & respond meeting; some process changes for the Doctors recording methods were agreed in addition to additional equipment requirements. The team will continuously review and respond in an agile manner as the pilot continues for the next seven weeks

2.5 **The Vascular Hub** project is currently at the impact assessment/Outline Business Case (OBC) finalising stage. The full financial and workforce impact is being assessed, with the hub team leading the work at East and North Herts securing additional resource to support this work. The WHHT vascular team are engaged with an internal project team in place at WHHT.

2.6 **Integrated Care Partnership (ICP)**.Work to evaluate the four priority system transformations that were enacted as a response to Covid-19 is underway. These are:

1. Discharge to assess;
2. Support to care homes;
3. Respiratory virtual hospital and
4. Virtual consultations

Multidisciplinary teams from across the six partners have been formed to complete the evaluations. These are more complex than initially anticipated and will be completed by the end of the year.

Discussions have begun across the ICP to ensure that the assumptions underpinning the development of the WHHT OBC are understood and to seek commitment to the delivery of the system transformation schemes which are designed to partially mitigate future acute growth.

This ICP approach has been welcomed and the finance group are taking ownership of the initial conversations, which will then be widened out to include clinical and operational staff.

There have been positive conversations between the Trust and Herts Valleys CCG to identify additional resources to support the ICP development, which will help to ensure that key milestones can be achieved.

3.0 Integrated Care Joint QIPP (part of Transformation Plan)

3.1 **Integrated Care Joint QIPP** (including **Frailty, Outpatient Transformation** and **Children's and Young People**) are all longer term pieces of work that are still on going and all are on track against the project plans that are in place for each area.

3.2 **Urgent Treatment Centre WGH** – The first contract review meeting is now planned for October with a lessons learned session scheduled for November.

3.3 **Urgent Treatment Centre HHGH** – A decision has been taken to pause procurement of service and review in January 2021. Current contract arrangements with Herts Urgent Care (HUC) have been reviewed and formal sign off is due in September 2020.

3.4 **SACH Minor Injury Unit / Urgent Treatment Centre development** – The MIU remains closed for the foreseeable future. WHHT and Herts Valleys CCG are working together to develop a plan for potential urgent illness provision, however no decisions have been made to date. Future plans will be aligned to the national strategy, taking in to account the needs of the locality population and the Trust's future plans for St Albans City Hospital.

4.0 Capital Programme

4.1 The capital team have arranged a pre commencement meeting with the successful contractor of the **WGH Theatres Reconfiguration** project in September to finalise the Joint Contracts Tribunal (JCT) contract particulars, agree mobilisation plans and establish a phased programme of works that are currently expected to start around the end of October and complete within thirteen months.

There are some residual "Pre-Enabling" works that will be undertaken on PMoK Level 7 in September for six weeks to help vacate the area designated for the new Theatre. Works for the new Theatre are planned to commence towards the end of February 2021, enabling operational completion by August 2021.

4.2 The **Emergency Department Development Project** is continuing to progress with the detailed design stage in preparation for the Full Business Case (FBC), following delay due to clinical and supplier availability issues caused by the Covid-19 pandemic.

4.3 The final phase of the **MAU Expansion Plans (part of Winter Plans** 2019-20) to create further assessment space in the ground floor of the Shrodells unit, is not expected to complete until late 2020. Initial drawings of options is underway, though pathways and final designs will need to reflect learnings from managing Covid-19 patient flows.

A CT scanner is now in place and in use in the Emergency Department, however waiting room works have been delayed due to Covid-19.

4.4 The **Local Area Network** (LAN) upgrade is progressing well. 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 third week of September. Windows 10 roll out is proceeding as planned.

4.5 The **Off Site Back Office project** (Administrative Staff Project) 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 Project Team are resubmitting a paper for approval (date tbc) from TMC, FPC and Board to pursue Unit 11 Thomas Sawyer Way (subject to change in planning permission use and Trust funding being available).

4.6 The project initiation document working draft has been completed for the **Health Records business case** and is now in use to direct and govern the project. The first draft of the project plan has been completed and is being reviewed to refine overall timeline/milestone events and dates. Work is now underway drafting baselines and initiating procurement processes (ahead of full business case creation).

4.7 An amended **Cardiac Catheter Labs** paper (previously approved at the Capital Finance Planning Group) was presented to the August TMC, with updated supporting narrative explaining the rise in costs.

Although the clinical team have agreed on the scope of works required, the final sign off is currently being collated to include additional radiation projection requirements received this week. As of next week; the team need to achieve sign off, to ensure the programme's delivery within the financial year. Once the team receive the full sign off, the purchase order will be raised for the building works allowing the supplier to confirm timelines, which are currently estimated.

4.8 The 2020/21 Capital Programme includes a significant investment to address prioritised "High and Significant" **Backlog Maintenance Programme** (BLM) works, for which the Capital Finance Planning Group (CPFG) have initially advanced £100k of the £2.5m BLM investment to instigate surveys to facilitate better scope definition for tender documentation.

An additional investment of £1.5m has been agreed to address a further list of "High and Significant" BLM works sponsored by the Critical Infrastructure Fund. This creates a control total of £4m for BLM works and around 22 projects to progress.

A project manager is in place to advance the programme of works, with an initial challenge of getting all of the projects to a tenderable position, at which point the works can then be evaluated and costed.

4.9 A range of **Fire Safety Improvements** are underway across the Trust, these include: fire door installations, fire compartmentation works, emergency lighting and fire alarms.

It was noted at the Capital Finance Planning Group (CPFG) that the £2.5m allocated in the 2020/21 Capital Programme is the subject of Emergency Funding, but is not dependent on it. This is especially important as the Capital Team have not delayed instructing works to address high risk works.

Of the £2.5m, effectively £830k is ring fenced for the Installation of the 375 fire door sets that were fabricated and purchased as part of last year's Capital Programme. £530k is notionally allocated to the conclusion of the Fire Compartmentation remedial works and the costs related to individual elements of the fire safety works will be fully determined as a result of reviews currently in progress for the replacement and extension of fire alarms and emergency lighting (St Albans City and Hemel Hempstead Hospitals).

4.10 The FBC completion for the **Multi-Storey Car Park** (MSCP) has been delayed by three weeks due to the requirement to revisit the procurement route, however this is now expected to be completed mid-September 2020.

The construction contract is scheduled to be signed on 01 November 2020 and the MSCP completion dates remains the 26 March 2022

5.0 Recommendation

The Board is asked to note the update on progress with key strategic projects.

Trust Board –1st October 2020

Title of the paper	Trust Strategy – Strategic Objectives delivery report.
Agenda Item	14.2/83
Presenter	Helen Brown
Author(s)	
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	This paper provides an update where available, on delivery and progress made towards the Trusts' strategic objectives within the Trust Strategy, 2020-2025. Following the publication of the Trust Strategy, over 315,000 UK citizens have been affected by COVID-19. The Trust is prepared for a second wave that will likely coincide with the seasonal winter pressures. How we deliver care has changed. The Trust continues to adapt the estate, ways of working and to resume elective work, reopen pathways and activities that had been suspended. The original ambitions published within the Trust Strategy still stand. The Board Assurance Framework has been amended to reflect the corporate risks posed by Covid19, (potential and actual) to the organisation. Data lags behind real time events and as such Covid19 impacts will be included in the second version of this delivery report in January 2021. For governance purposes it is necessary to report on the Trust strategic objectives. It is recognised that this repeats content from the IPR. Additional narrative is supplied from subject leads. This report is for noting.
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	*For noting.* *Next report scheduled for January 2021.*

Agenda Item: *14.2 / 83*

Trust Board meeting 1st October 2020.

Trust Strategy – Strategic Objectives delivery report.

Presented by: Helen Brown – Deputy Chief Executive

1. Purpose

1.1 The purpose of the report is to ask the Board to formally note progress against delivery of the Trust's strategic objectives for 2020/2021, set out within the Trust Strategy. The report provides summary of delivery and progress against the objectives and ambitions. Note this is year one of a five year strategy.

2. Background

2.1 The Trust strategy summarises our key aims and priorities for the next five years. Working in partnership to deliver an integrated care model is integral to the delivery of the four key aims of best care, best value, great team and great place. Underpinning this are more detailed strategies and improvement plans. The clinical strategy is in development with a comprehensive engagement plan in progress. This will be presented to the Board for approval in Dec 2020.

2.2 Since publication of the Trust Strategy, breakthrough objectives and measures have been added to the Board Assurance Framework. Each of the strategic ambitions has specific objectives that will take us further and fastest towards achieving our ambitions and the overall vision of '*the very best care for every patient, every day'*. As such they are short term indicators that tell us if we are heading in the right direction.

2.3 Strategy delivery and the improvement programmes are reported to their associated committees.

Best Care	Best Value	Great Team	Great Place
Quality Improvement programme (Quality Account) Quality Committee	Long term financial recovery plan Finance and Performance Committee	People Programme People, Education and Research Committee	Digital transformation programme Finance and performance committee
Integrated care partnership/service development improvement programme Quality committee	Annual cost improvement plan Finance and performance committee	Research and development programme People, education and research committee	Estate transformation programme Finance and performance committee
Access Improvement Programme Finance and performance committee	Raise – Charity Strategy Charity Committee		
Communications and engagement strategy Trust Management Committee			

2.4 This is the first Board report of the Trusts Strategic Objectives. Future reports are scheduled at quarterly intervals which are October, January and April and July 2021.

3 Analysis/Discussion

3.1 Tables below shows current performance from available data and is in the main extracted from the IPR.

Ambition	Measure	WHHT position	National Average	Performance Benchmark (standard/target)	Current Performance Benchmark	Data Period for WHHT position	Delivery Update August IPR extracts.	Aug-20
Mortality (SHMI & HSMR): 'as expected' or 'better than expected' for HSMR and better than national average for SHMI.	SHMI	99.1	100	100	As expected' band 2	Mar19-Feb 20	Page 6 & 26 of IPR Latest data available up to Feb 2020. April /May mortality indicators available from October 2020 and will be reported with next scheduled report. Delivery shows % of deaths scrutinised is between 90-100% with learning from deaths well established within the divisions.	G
	HSMR	103	100	100	As expected.	Jan 20- Mar 20	Continued from above. Latest data available up to Mar 2020.	G
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 healthcare associated gramnegative blood stream infections (GNBSI).	New pressure ulcers	1.6%	1.0%	National standard not available for this component of harm free care	National benchmark not available for this component of harm free care	Mar-20	Page 6 of IPR. Page 39 harm free care involvement work. Submissions suspended.	n/a
	Falls with harm	0.2%	0.5%			Mar-20		n/a
	New VTE	0.0%	0.5%			Mar-20		n/a
	Patients with catheter & UTI	0.6%	0.7%			Mar-20		n/a
	E-coli	47	data not available	40	benchmark data not available	19-20	Page 6 & 27-28 of IPR. 47 @ full financial year 19-20; Current YTD @ June 2020 = 4	n/a
Breakthrough objective = * Reduce the gap between weekend and week day mortality. Breakthrough measure = %deaths reviewed by a medical examiner evidence of learning from deaths (bi annual report to QC)	Weekend and weekday mortality numbers are not reported in the IPR. Data sourced from Dr Foster provides a 3 month rolling average per month. Most recent data is May 2020. March: Weekend 117, Weekday 98, % Difference between 28.7 Apr: Weekend 126, Weekday 116, % Difference between 8.1 May: Weekend 142, Weekday 108, % Difference between 18.6 Dr A Woods leads for the Medical Examiner service. The % of deaths scrutinised is now between 90 and 100%, with learning from deaths occurring by engagement of the learning from deaths team, with Divisions and specialities, by a mechanism of a feedback loop. The SJR is sent and feedback requested after reflection from the Divisions and is working well. Executive leads have agreed job planning principles which have been shared widely. HR have developed a FAQ about staff testing, working on a green site and moving between sites i.e. bank work. Trust continues to develop planning according to national guidance. This is also reported through our trust governance process for Covid19.							
Breakthrough objectives - * To prevent Covid 19 outbreaks in a hospital setting. * To develop blue and green pathway staffing templates. Breakthrough measure = 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. Breakthrough measure =90% staff trained in correct PPE usage	The Trust reviews outbreaks daily and have implemented a 7 day admission testing of patients and clear pathways through the Covid19 HUB for staff testing. At this time the Trust is not an outlier for nosocomial infections. Page 30 of IPR- The breakthrough objective is for 90% of staff trained in correct PPE usage. The data collected is crude and does not easily align to this broad % measure. A more practical measure would be 90% of clinical staff. Non clinical staff in the main are wearing face coverings and do not require PPE training. March to June data collation was paper based. The system is now largely paperless. Therefore more accurate reporting can be achieved through Q2 on. The Trust has 5796 staff on record. 3136 staff has been fit mask tested with at least 8 different types of mask. Of those, 2712 passed the fit mask testing and 424 failed. Of those who failed, approx. 34 have been successfully tested with hoods.							
Breakthrough objective and measure =25% reduction in e.coli by 2021	There were 4 E-coli cases in Q1 which tracks as 0 cases in April, 3 in May and 1 in June. Objective and measure have been met and on trajectory to achieve target of a 25% reduction by 2021.							

Ambition	Measure	WHHT position	National Average	Performance Benchmark (standard/target)	Current Performance Benchmark	Data Period for WHHT position	Delivery Update August IPR extracts.	Aug-20
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).	A&E	85.9%	92.1%	95%	2nd quartile	Jul-20	Page 7 & 42 of IPR	n/a
	RTT	51.0%	52.0%	92%	2nd quartile	Jul-20	Page 7 & 49 of IPR (inc 52 week waits) Note: National average position is at May 2020	n/a
	Diagnostic waiting times	73.3%	52.2%	99%	1st quartile	Jul-20	Page 7 of IPR Note: National average position is at May 2020	n/a
	Cancer 62 day urgent GP referral	82.0%	73.3%	85.00%	3rd quartile	Jul-20	Page 7 and 50-52 of IPR Note: National average position Q4 2019-20	n/a
	Cancer 2WW	98.5%	92.0%	93%	3rd quartile	Jul-20	Page 7 and 50-52 of IPR Note: National average position Q4 2019-20	n/a
	FDS (2WW, breast symptomatic & screening)	82.4%	N/A	75%	benchmark data not available	Jul-20	Page 7 and 50-52 of IPR Note: National average position Q4 2019-20	n/a
Breakthrough objective - * Implement primary care led urgent treatment model at Watford and procure UTC's at HH and SACH from 1st April 2021. * Deliver agreed improvement trajectories for key standards. Breakthrough Measure = % of patients seen in primary care led UTC model & performance against trajectories (project).	Target activity = 55%. Soft performance data shows activity at c38%. 2 KPI's in contract are: Percentage of patients who are streamed within 15 mins ≥ 95% and Percentage of UTC attenders that breach the max 4 hour wait standard ≤ 2%. These KPI's are linked to contract value. Improvement trajectories have not been agreed. Measured data not available. All teams at the UTC at WGH continue to work together to embed the service, with on-going reviews of pathways and processes. The first formal contract quality review and management meeting is planned for October 22nd and performance against KPI's and other elements in the contract will be reviewed. At HH, 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. The SACH MIU remains closed for the foreseeable future in the context of Covid19 recovery and the need to maintain a fully Covid19 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.							

Ambition	Measure	WHHT position	National Average	Performance Benchmark (standard/target)	Current Performance Benchmark	Data Period for WHHT position	Delivery Update August IPR extracts.	Aug-20
Patient Experience: improve our scores on the Friends and Family Test and national patient survey result to better than national average.	FFT - Inpatient % patient rate	95.1%	95.9%	95%	2nd quartile	Feb-20	Page 7 of IPR Returns suspended since Mar 2020	n/a
	FFT Maternity	91.0%	96.9%	95%	2nd quartile	Feb-20	Page 7 of IPR Returns suspended since Mar 2020	n/a
	FFT A&E % positive	92.1%	85.0%	95%	4th quartile	Feb-20	Page 7 of IPR Returns suspended since Mar 2020	n/a
	FFT Out Pt % positive	94.6%	93.9%	95%	2nd quartile	Feb-20	Page 7 of IPR Returns suspended since Mar 2020	n/a
Breakthrough objective - * improve communication with our patients and carers. Breakthrough measure = 25 selected questions from 9 of t he 12 sections from inpatient survey. Breakthrough objective - * Implement new outpatient pathways to improve patient experience. Breakthrough measure = Dropped call rate/local patient survey.	The national collection and reporting of the friends and family test feedback survey is paused due to Covid19 and due to recommence reporting from Dec 2020. Alongside this the Trust has changed provider contracts transferring from IQIVIA to PICKER. The ambition to transition to electronic surveys has been assisted by RAISE charity funding the purchase of i-pads, of which 85 are in use. Outpatient pathways work continues and is reported regularly to QC and Trust Board regularly. The patient survey has a planned four phase roll out of the i-pads concluding week commencing 14/09/2020. The initial roll out is of the general FFT template and will proceed to include surveys available in different languages, easy read and include a specific friends and family survey. The survey link is available on the Trust website and will be as a QR code in all patient facing areas. Volunteers are being trained to support wards to achieve the mandated targets for the FFT. The Trust is making good progress towards meeting its breakthrough objective of improving communication with our patients and carers. No data available for Q1 or ytd. Project is compliant with plan.							
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).	Cost per WAU	£3,596	£3,500	£3,500	3rd quartile (mid 1/3rd of 129)	2018-19	Page 8 & 14-24 of IPR WHHT position £3,596 against peer at £3,545. 2019/20 data due Nov/Dec.	A
Breakthrough objective = Ensure that there is an improvement in costs per weighted activity unit in comparison to other acute trusts. Breakthrough objective = Ensure that revenue income balances with revenue for each of the next two years. Measure =Deliver financial plan for 2021 and ensure that all clinical divisions are able to either demonstrate costs are within 2020/2021 budget or an improvement in patient care productivity.	2015/16 and 2017/18 were just below the middle of the quartile. 2018/19 was slightly above. 2016/17 was exactly on the median. 2019/20 data out late November or December in a normal year. Year Trust Peer National Quartile position 2018/19 3,596 3,545 3,500 Mid third quartile (out of 129) 2017/18 3,546 3,482 3,486 Mid third quartile (out of 134) 2016/17 3,484 3,561 3,484 Top second quartile (out of 135) 2015/16 3,534 3,527 3,480 Mid third quartile (out of 136) The cost per WAU is dependent upon costs and activity. The Trusts absolute I&E position improves year on year, which is in part due to central one-off funding, designed to get us to break even. This situation acknowledges that trusts require funding to ensure continued financial viability. The Trust financial planning, accounts for uncertainties around activity levels, as services resume. Annual CIP and Long term financial recovery plan reports to F&P Committee.							

Ambition	Measure	WHHT position	National Average	Performance Benchmark (standard/target)	Current Performance Benchmark	Data Period for WHHT position	Delivery Update August IPR extracts.	Aug-20
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.	Staff Survey Results	7.02	7	Top 20%	1st quartile	2018	Would need to score 7.22 or higher to be in the top 20% for 2020.	G
Breakthrough objectives - * Ensure that all our staff feel engaged and included (equality, diversity and inclusion) and reduce vacancy rates in hard to recruit 'hotspots'. Measure = Trust wide vacancy rate less than 10% Measure = Equality, diversity and inclusion domain of the staff survey show improvement to above national median.	For 2019, WHHT achieved a top quartile position at 7.02.The Trust would need to score 7.22 or higher to be in the top 20% for 2020. The People Programme, includes a high level staff engagement plan which includes equality, diversity and inclusion and reports to the People, Education and Research Committee. Page 8 of IPR. Vacancy rate is 9.1%. 2020 national staff survey results will be reported Q3.							
Paperless hospital by 2025 New hospital facilities - building work to commence 2023							See associated Great Place Programme Board update	G
Breakthrough objective- *IT Infrastructure - increased time to care; Breakthrough measure = Reduced log in times, reduced downtime. Breakthrough objective - *Redevelopment OBC approved; EPR secure funding and FBC mobilised; Breakthrough measure =Key milestones. Breakthrough objective - * Multistorey car park - FBC completed, approved and work commenced. Breakthrough measure = MSCP key milestones - FBC/work on site/completion date.	IT KPI's have yet to be agreed and work is underway to provide comparative Q1 data for reduced downtime & login times. Redevelopment - The current objective is to get the Outline Business Case to the Trust Board by the end of 20/21. Key current priorities are to work with user groups to develop service packs, to complete the activity model and agree functional content / schedule of accommodation. A proposed shortlist of options for more detailed appraisal is being presented to teh October Board for approval. There has been an active programme of stakeholder engagement over the summer. An architect led design team has been appointed. EPR Funding - Resulting from discussions between the Trust and regulators, the Trust's Chief Financial Officer has put forward a proposed funding model for the EPR. On the 11th September 2020 NHSEI Joint Investment Committee approved the signing of an interim contract and the proposed funding model. NHSX have released £5.5m of the committed total. The revenue funding will be covered by cash releasing savings from the programme. Through developing the FBC there has been a re-evaluation of the finances to deliver the project and the costs and benefits have been developed in conjunction with Finance to ensure that the impacts are known, understood and presented in this FBC. With the support of NHSE/I and a capital contribution from NHSX, the Trust has identified funding sources for the programme's capital costs. The cash releasing benefits of the programme return a revenue surplus over the ten year term of the contract. FBC work officially commenced on the 11th August, 2020. Current Engagement is scheduled to run for 7 weeks based with a draft due on the late September 2020.Through developing the FBC there has been a re-evaluation of the finances to deliver the project and the costs and benefits have been developed in conjunction with finance to ensure that the impacts are known, understood and presented in this FBC. With the support of NHSE/I and a capital contribution from NHSX, the Trust has identified funding sources for the programme's capital costs. The cash releasing benefits of the programme return a revenue surplus over the ten year term of the contract. Multi-storey car park now reports to TMC. The FBC completion for the Multi-Storey Car Park (MSCP) has been delayed by three weeks due to the requirement to revisit the procurement route, however this is now expected to be completed mid-September 2020. The construction contract is scheduled to be signed on 01 November 2020 and the MSCP completion dates remains the 26 March 2022.							

current benchmark performance key		
1st quartile	top 25%	best
2nd quartile	↓	↓
3rd quartile	↓	↓
4th quartile	bottom 25%	worst

3. Recommendation

3.1 This report is for noting. Next report scheduled for January 2021.

Helen Brown
Deputy Chief Executive

23rd September 2020

Trust Board Meeting
01 October 2020

Title of the paper	Corporate Risk Register Report
Agenda Item	17/83
Presenter	Mike Van der Watt, Chief Medical Officer
Author	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 15 September 2020. Data for this report was extracted from Datix on 5 September 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 quarterly basis. Due to the volatility of the pandemic, Risk Leads are required to provide updates on these risks on Datix at least once a month. 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 24 September 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? ☒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 15 September 2020 • Quality Committee on 24 September 2020
Action required	The Trust Board is asked to review the corporate risk register and endorse the changes to the CRR.

Agenda Item: 17/83

Trust Board Meeting – 01 October 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 the 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 open risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to the relevant subcommittee of the Board to agree future action.

3. Corporate Risk Register

3.1 This report captures the decisions made by the Risk Review Group (RRG) on 15 September 2020. Data for this report was extracted on 5 September 2020 with a few updates made following 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 15 September 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		Sep 2020	
Clinical Informatics	3894	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	16	↓	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	→	**16**	→
	3899	20	→	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	→	16	→	**12**	↓
	4116	16	→	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	→	**16**	→
Clinical Support Services	3965	16	→	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	→	**16**	→
	2765																																							**15**	
Corporate	3828	20	→	20	→	20	→	20	→	15	→	20	→	20	→	15	↓	15	→	15	→	15	→	15	→	15	→	15	→	12	↓	15	↑	15	→	15	→	20	↑	20	→	**20**	→
	3120	20	→	20	→	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	→	**15**	→
	4207																	16		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→
	3949																					15		15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**9**	↓
	4269																													25		25	→	25	→	25	→	25	→	**25**	
	4292																																	15		15	→	15	→	**15**	→
	4280																																			20		15	↓	**20**	→
	4304																																					15			
	4319																																							**20**	
Emergency Medicine	3995									16	→	15	→	15	→	15		15	→	16	↑	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	→	16	→	**16**	→
	4154									16	→	16	→	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	→	16	→	**16**	→
Finance	4205																	15		15	→	**15**	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	10	↓		

Medicine	4287																																	15		15	→	15	→	15	→	**15**	
	4301																																							20			
Surgery & Cancer	2951																											16		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 15 September 2020:

3.4.1 New/Escalated risks (2)

Two risks were presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR) and were both **accepted**:

ID	Division	Current Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
2765	Clinical Support	**15 L5 x C3**	Lack of Interventional Radiological Suite at WGH	There is no comprehensive Radiological interventional service at WGH. Certain procedures are not offered i.e. uterine embolisations and stenting of GI bleeds. Angioplasty, EVAR and nephrostomy avialable 09.00 5.00 Mon -Fri but only available out of those hours if Radiologist, Nurse and Radiographer are available to come in. This is reliant on good-will. The current risk rating has increased from 12 to 15. Funding was approved at August CFPG to progress design plans for new IR suite.	The Group discussed the risk and approved its escalation to the CRR/increase in risk score. Design plans for the new IR suite are being progressed.	**MVdW**
4319	Corporate Services	**20 L5 x C4**	Inability to deliver the Trusts recovery plan, during COVID-19 and in the event of a second wave and influenza.	In the event of a second wave of COVID19 alongside the usual influenza season, this has the potential to impact on the Trust to deliver their recovery plan and provide sustained health care services. There may also be a reduction or stopping of non-urgent activity; financial distress against planned budgets and available revenue; increased demand on staffing and available resource to deliver safe care and wellbeing of staff.	The Group discussed the risk and accepted it onto the CRR. It was agreed that the impact of staff being off due to the 14 day self-isolation should be reflected in the risk record. The risk record is being updated to reflect the impact to staff. In addition to considering if a separate risk should be identified in relation to staff absence.	**MVdW**

3.4.2 De-escalated risks (2)

Two risks were presented to the Group for de-escalation to Divisional risk registers and were both approved:

ID	Division	Risk Rating	Risk title	Rationale	Update from Risk Review Group	Exec Lead
3949	Corporate Services	15 ↓ 9 **L3 x C3**	Patient experience and patient safety is compromised due to ongoing challenges with current non-emergency transport provider	The following element has now been included within the contract: - Mental Health informal transfers Herts Valleys CCG are currently providing 2x spot purchase vehicles per day which is enabling the out of contract activity to be undertaken. As a result of this spot purchase arrangement the likelihood has reduced.	The Group discussed this risk and approved its de-escalation to the Corporate Service Risk Register.	ST
3897	Clinical Informatics	16 ↓ 12 **L3 x C4**	Cyber Risk	The current risk rating is reduced to 12 following significant progress in this area. EUD's patched, XP devices removed from the estate or placed in a safe citrix bubble. Windows 10 is the final piece of the jigsaw.	The Group discussed this risk and approved its de-escalation to the Clinical Informatics Risk Register.	SG

3.4.3 Closed Risk (1)

One risk on the CRR was tabled for closure at the RRG meeting:

ID	Division	Risk Rating	Risk title	Rationale/Update from Risk Review Group	Exec Lead
4269	Corporate Services	25 **L5 x C5**	Risk to service delivery from COVID-19 (Coronavirus)	The Group agreed to close this risk as it has been replaced by the new overarching Covid-19 risk - ID 4319 (Inability to deliver the Trusts recovery plan, during COVID-19 and in the event of a second wave and influenza).	ST

3.4.4 Reduced risk score (0)
No risk was considered for reduction in current risk rating at the RRG meeting.

3.4.5 Increased risk score (0)
No risk was considered for increase in current risk rating at the RRG meeting.

3.4.6 Merged Risk (0)
During this reporting period, there were no merged risks to consider.

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. Due to the volatility of the pandemic, Risk Leads are required to provide updates on these risks on Datix at least once a month.

4.2 **Emerging Risks**

There was no emerging risk proposed to the RRG for consideration.

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

September 2020

Appendix 1

Corporate Risk Register – Data extracted from Datix on 5 September 2020 (by Division)

COVID-19 RELATED	ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	PROGRESS NOTE	RATING (CURRENT)	EXECUTIVE LEAD
Clinical Support Services (3)							
No	2755	28/07/2011	Risk of failure of the MRI scanner at HHGH and deterioration in image quality	16	Parts availability ok, progressing modular MRI SACH.	16	Sally Tucker
No	3965	11/12/2017	Delays in imaging of patients requiring interventional radiology procedures	16	Funding approved at July CFPG meeting to proceed with design work.	16	Patrick Hennessy
No	2765	11/08/2011	Lack of Interventional Radiological Suite at WGH	12	Increased score to 15 Funding approved at August CFPG to progress design plans for new IR suite	15	Mike Van der Watt
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. Full Business Case is going to Board in October.	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 4 of updating. All servers are in Atos world are patched monthly. 50% of the onsite servers are now patched up to date - the problem area is Pathology, namely due to the age and importance of the current tasks in hand (covid related).	16	Sean Gilchrist
No	3894	12/06/2017	ICT Applications reduced availability, poor reliability & performance	20	No change in the risk as 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	WGH is planned to complete weekend ending 19 & 20/09/20. There will then be a review and lessons learnt captured. Project will then go through the usual closure activities.	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 (7)							
No	4191	10/07/2019	Risk of a financial liability to Trust following outcome of legal case 'Flowers'	20	Risk reviewed at the September 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	Our WRES report with 2 year action plan is currently being drafted in consultation with a number of individuals, departments and staff networks. It also draws on feedback from staff and Connect following the safe space sessions. Resilience in relation to a second spike will also be built into the plan.	15	Paul Da Gama
No	4207	12/09/2019	Inadequate post in-patient discharge appointment booking processes	20	The risk was discussed at the RRG meeting on 15/9/20. DIP sampling will be brought back to the October RRG meeting and will inform direction of travel of the risk.	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	4319	09/09/2020	Inability to deliver the Trusts recovery plan, during COVID 19 and in the event of a second wave and influenza.	25	The Group discussed the risk and accepted it onto the CRR. It was agreed that the impact of staff being off due to the 14 day self-isolation should be reflected in the risk record. The risk record is being updated to reflect the impact to staff. In addition to considering if a separate risk should be identified in relation to staff absence.	20	Mike Van der Watt
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

Agenda Item: xx

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**01 October 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 12 August and 26 August 2020

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 12 August (urgent meeting)

- The Committee supported a business case to increase the establishment within the enhanced care team
- Supported a proposal for £840k investment in PAU workforce
- TMC agreed to support the business case for band 6 for the medical examiner's office.
- COVID-19 staff testing business case approved.
- The Committee supported the accelerated EPR business case.

Topics covered at the meeting of 26 August

- An update on COVID-19 recovery and it was noted a potential second wave is being planned for.
- The Committee supported an increase in the in the enhanced care team establishment to 10 nurses per shift, with an evaluation in six to nine months.
- Frontline healthcare workers seasonal influenza campaign 2020/21 - the Committee authorised funding of £64,951 to secure the staff required to deliver a successful campaign.
- Healthwatch co-production – the deputy chief nurse presented recommendations on patient involvement and engagement model for

WHHT, with a focus on “no decision about me, without me” creating an equal partnership and shared responsibility. The Committee approved a model whereby patient groups and clinical divisions feed into the co-production board.

- CQC national NHS maternity survey 2019 – the Committee commended te results and were pleased to note that patient experience had improved over the past few surveys, reflecting sustained improvement.
- Cardiac catheter lab refurbishment update.
- Financial update.
- Emergency care long list options framework appraisal for acute redevelopment programme
- NHS people plan

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

Urgent Matters Only Meeting

Held on 12 August 2020

Virtual

Meeting Room, Watford Hospital

Name	Title	Attendance
Allen Christine	Chief Executive	virtual
Members		
Brown Helen (HB)	Deputy Chief Executive	virtual
Ball Adrian (Aba)	Divisional Manager, WACS	virtual
Banks Freddie (FB)	Associate Medical Director, Clinical Strategy	
Barlow Andy (AB)	Divisional Director, Medicine	virtual
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	virtual
Da Gama Paul (PdG)	Director of Human Resources	virtual
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	virtual
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	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)	virtual
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	virtual
Van Der Watt Mike(MVDW)	Chief Medical Officer	virtual
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	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**)	virtual
Tania Marcus	Deputy Director of HR, People Services	virtual

Summary of the Trust Management Committee

Held on 26 August 2020

Via MS Teams

Name	Title	Attendance
Allen Christine	Chief Executive	Apologies
Members		
Brown Helen (HB)	Deputy Chief Executive – Meeting Chair	Yes
Ball Adrian (Aba)	Divisional Manager, WACS	Apologies
Banks Freddie (FB)	Associate Medical Director, Clinical Strategy	Yes
Barlow Andy (AB)	Divisional Director, Medicine	Yes
Bannister Paul (PB)	Chief Information Officer	Yes
Bhatti Mary (MBh)	Divisional Manager, Medicine	Yes
Borkett-Jones Howard (HBJ)	Associate Medical Director for Appraisal and Revalidation	Yes
Carter Tracey (TC)	Chief Nurse and Director of Infection, Prevention and Control	Yes
Cato Sarah (SC)	Lead Nurse, Emergency Medicine	Yes
Da Gama Paul (PdG)	Chief People Officer	Yes
Forson William (FW)	Divisional Director WACS	Yes
Gaunt David (DG)	Chief Clinical Information Officer	Yes
Gertler Fran (FG)	Director of Integrated Care	Yes
Gilchrist Sean (SG)	Director of Digital Transformation	Apologies
Halfpenny Louise (LH)	Director of Communications	Yes
Hennessy Patrick (PH)	Director of Environment	Yes
Hoey Rachel (RH)	Divisional Director, Emergency Care	Apologies
Johnson Stephanie (SJ)	Divisional Manager, Medicine	Yes
Keble Martin (MK)	Chief Pharmacist and Divisional Director, Clinical Support Services	Yes
King Paula (PK)	Head of Nursing, Surgery, Anaesthetics and Cancer	Yes
Mason James (JMa)	Head of Emergency Planning & Resilience	Yes
McKee Jason (JMc)	Divisional Manager, Surgery, Anaesthetics and Cancer	Apologies
Mannion Collette (CM)	Director of Midwifery and Gynaecology	Yes
Miles-Kemp Natalie (NMK)	Head of Strategy Delivery	Apologies
Moors Esther (EM)	Assistant Director Strategy (Redevelopment)	Yes
Clare Parker	Director of Strategy and Integration	Yes
Pindai Rodney (RP)	Director of Contracts, Efficiency and Commercial Development	Yes
Richards Don (DR)	Chief Financial Officer (Chair)	Yes
Reece Ashley	Associate Medical Director for Medical Education	Apologies
Shentall Jane (JS)	Director of Performance	Apologies
Thorpe David (DT)	Deputy Chief Nurse	Yes
Tucker Sally (ST)	Chief Operating Officer	Yes
Van Der Watt Mike(MVDW)	Chief Medical Officer	Apologies
Wellman Angela (AW)	Head of Nursing Medicine and Emergency Medicine	Yes
Walker Karen (KW)	Head of Nursing, Children's	Yes
West Simon	Divisional Director, Surgery, Anaesthetics and Cancer	Yes
While Rod	Trust Secretary	Yes
Whittle Natalie	Divisional Manager for Clinical Support Services	Yes
Wood Anna (AWo)	Director of Governance	Yes
In attendance		
Laura Abel	Assistant Trust Secretary (notes)	Yes

Agenda item: 18.2/82

20

Report to: Trust Board

Title of Report: Assurance report from Finance and Performance Committee

Date of meeting: 01 October 2020

Recommendation: For information and assurance

Chairperson: John Brougham, Non-Executive Director

Purpose The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 24 September 2020.

Background The Committee meets monthly and provides assurance on scheduled reports from all Trust operational committees with a finance, investment and access performance brief according to established work programmes.

Access Performance

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

The Committee also reviewed the Trusts plans to deliver the national phase 3 recovery targets to return to near normal levels of pre Covid activity for the remainder of the year, following the earlier suspension of all but the most urgent elective activity.

Whilst still well below pre Covid levels the RTT 18 week performance target continues to improve, up from 51.0% in July to 62.5% in August. The Committee noted that the latest benchmarking, in June, showed that the Trust's performance of 47.7% was below the national median of 51.4%, and that the highest performer was 71.7%, 20% away from the national standard of 92%.

As expected, due to the suspension, waits of 52 weeks or more continue to grow, up from 484 in July to 669, compared to 3 in March.
Diagnostic testing, which has a pre Covid track record of consistently meeting the 99% waiting time standard, achieved 68.4% in August, down from 73.4% in July, but up from 64.8% in June, the latest date for benchmarking, which was marginally ahead of the national median of 64.4%.

The nationally set Phase 3 recovery targets are aimed at achieving the

same levels of activity as the second half year of last year.

The Committee supported the Trust's initial plans to achieve them, recognising that there are a number of factors still to be assessed , including the level of support activity from the independent sector, and the impact of scenarios of both a second Covid peak and the extent of winter pressures.

The plans cover elective, outpatient and diagnostics, and scheduled for final submission to NHSE/I in October.

Five of the eight national waiting time standards for cancer were met in August, with the 62 day referral for suspected cancer, provisionally recorded at 84.7% compared to the standard of 85%, yet to be finalised. The Committee noted that the latest benchmarking data for June showed that the Trust's 62 day performance of 86.4% in June, was well ahead of the national median of 75.6% and in the top quartile of all Trusts.

The A&E 4 hour waiting time performance dipped from 85.9% in July to 83.1%, with an increase in attendances of 5%. The 95% standard was met by the UTCs at Hemel Hempstead and Watford, with the CED just below at 94.4%. The flow of Majors patients at Watford remains a challenge, with a performance of 57.7% in August, down from 66% in July. A number of initiatives to improve flow are underway and progress will be reviewed monthly by the Committee, as will addressing the increasing number of ambulance handover delays of more than 30 minutes.

The Committee noted that from the latest benchmarking data available, the Trust's performance of 87.1% in June compared to the national median of 88.3%.

The Committee was assured that appropriate harm reviews were in place for all patients with long waiting times.

Integrated Performance Report (IPR)

The Committee reviewed the report to ensure its effectiveness in providing an oversight on key performances and trends against targets covering safety, care, responsiveness, workforce and finance. The chief officers key messages for the Board, in the IPR, are often incomplete at the Committee which is typically one week before the Board. The Trust Chair asked that time is allowed for the Chief Officers attending the Committee to give a brief verbal update on their key messages, and 15 minutes will be added to future meetings to accommodate this.

The Chief Medical Officer pointed out that the latest HSMR mortality ratio, which has consistently been in, or better, than the expected range, was outside of the normal range, was under review and the Committee was assured this would be covered at the Quality Committee later in the morning.

Financial Performance

(i) Income and Expenditure

In line with national guidelines, to manage the Covid 19 pressures, the Trust continues to match expenditure with income to reach a break even position in the first half year.

In August revenues of £35.0m were offset by pay costs of £22.7m and non pay costs of £12.3m. Year to date revenues of £173.8 are offset by pay costs of £111.4m and non pay costs of £62.4m. Compared to the pre Covid budget to date, revenues are £0.4m higher, pay costs are £2.6m lower, and non pay costs are £1.1m higher, with the actual break even better than the budgeted deficit of £1.9m.

The Committee was assured that during this period of guaranteed matching of income with costs there was no relaxation of tight financial controls. This is evidenced by the monthly clinical division reviews which compare actual costs and revenues, with the matching of the Trust's income with expenditure done centrally.

Revised national guidance has now been received on the reimbursement structures for the second half year. The guidelines are designed to take account of the recovery of elective activity, and further Covid 19 costs, but still require further clarity in a number of areas, including Covid reimbursement and the ICS roles in determining funding at Trust level. Final submissions of the I&E forecasts at system level are due to be submitted to NHSI/E in October and the Committee recommends that the Trust's latest I&E forecast for the year is presented to part 2 of the October Board.

The Committee also noted that national guidance on CIPs, which were suspended in the first half year, is awaited to cover the second half year.

(ii) Capital Spend

Capital spend of £1.4m in August brought year to date spend to £5.6m, including £1.5m Covid related. The challenging forecast spend for the full year is £47.3m, excluding Covid. Much of the acceleration of spend in the remaining 7 months is due to the major projects that are either already approved or in the final stages of the approval process, including the Multi Storey Car Park, expansion of A&E, Electronic Patient Records and theatres refurbishment.

The Committee will continue to monitor progress on the execution of all this essential spend to deliver much needed improvements in both patient experience and productivity.

Electronic Patient Record (EPR) Programme, Full Business Case (FBC) The Trust Board in April approved an Outline Business Case (OBC) to deploy an EPR solution for the Trust, via an integrated enterprise wide solution. In late May the Board reviewed an opportunity to deliver the solution much earlier by joining with the Royal Free Hospital in their implementation with their enterprise wide supplier.

The Trust Board in August reviewed and approved the revised OBC, which targets a significant increase in cost savings, and delivering the solution 18 months earlier, targeting early 2022.

The Committee reviewed the FBC's strategic, economic, commercial, financial, and management cases, together with associated risks and timescales.

The plan is to enter into an interim contract to enable the Trust to catch up with the Royal Free, followed by a 10 year contract.

The Committee recognises that a fully functional EPR is critical to provide best in class care to patients and in productivity and efficiency and it is essential that it is embedded within the Trust in advance of the site redevelopment.

The projected Capital spend is £22.5m. Funding of £5.4m has been agreed with DHSC, and £10.0m with NHSX. This leaves £6.9m for the Trust to fund from its own resources, with the largest amount, £4.4m in 2021/22.

Cumulatively operating savings are projected to exceed operating costs by 2025/26.

The Committee gave its full support to the FBC and recommends it is presented to the October Board for approval.

Business Case Updates

Back Office Relocation

The February Committee reviewed and approved the relocation of more than 100 HR and finance staff to nearby fit for purpose premises to address the urgent need to provide additional clinical space at Watford. The recommended relocation has not taken place as the offer to release one floor lost out to an offer to lease four floors.

A review of alternative office space has been carried out and the recommended option is to secure premises within 3 minutes walk of the Watford site, which is much more convenient for staff.

The proposed site requires planning permission to convert from warehouse space to office, and would not be ready to move into until July 2021, and will require temporary office accommodation off site until then. The plan is to enter into a 10 year lease.

Refitting the proposed location, and other one off costs are estimated to be around £2m and ongoing revenue costs, including lease, utilities and IT are expected to be in the region of £0.3m per year.

Financially the proposal is better value for money than alternatives, and should be more convenient for staff.

The Committee recommends the business case is presented to the October Board for approval and asked for the exec summary to be

changed to be clearer on costs and risks.

Corporate Risk Register (CRR) and Board Assurance Framework (BAF)

The Committee reviewed the risks on the finance risk register, and agreed that all had appropriate actions and mitigations. None of the risks for which the FPC is the primary assurance Committee currently meet the threshold to be on the CRR, but the Committee asked for the risk of not meeting the breakeven I&E budget for the year be reviewed, at the meeting in October, in light of the currently unclear guidance on revenue reimbursement in the second half year.

Following the approval by the September Board of the refreshed BAF the Committee asked that review of the risks aligned to the Committee are reviewed at every meeting.

Risks to refer to risk register

See above

Issues to escalate

The Committee recommends the following to the October Board

For information and discussion:

- The I&E forecast for the year.

For approval:

- The EPR FBC
- The back office relocation FBC

Attendance record

Present
John Brougham, Non-Executive Director (Committee Chair)
Mike Van Der Watt – Chief Medical Officer
Tracey Carter, Chief Nurse and Director of Infection Prevention and Control
Don Richards, Chief Financial Officer
Phil Townsend, Trust Chair
Christine Allen, Chief Executive Officer
Jane Shentall, Director of Performance

Apologies
Sally Tucker, Chief Operating Officer
Stephen Dunham, Associate Director of Risk, Efficiency

In attendance
Rodney Pindai, Director of Contracting, Efficiency & Commercial Development
Soheb Rafiq, Associate Director, Financial Management

Minutes

Laura Abel, Assistant Trust Secretary

Agenda Item: 22/83

Report to:	Trust Board
Title of Report:	Charity Committee Assurance Report to Board
Date of meeting:	17 September 2020
Recommendation:	For Information and Assurance
Chairperson:	Jonathan Rennison, Non-Executive Director

Purpose

The report provides an update to the Corporate Trustee on actions since the last Charity Committee in July 2020.

Background

The Committee meets quarterly and provides assurance to the Board:

- that robust processes are in place to manage charitable funds and to ensure they are implemented;
- that donated funds are utilised in a way that takes into account any stipulations set out by donors and ensure best value is obtained from the funds donated;
- that further donations are being encouraged;
- that systems comply with regulation and governance of NHS Charities.

Charitable Funds Committee,

September 2020

Items to Report to the Board

1. The Committee received a presentation on the performance of our investment portfolio, which confirmed that our current strategy and risk profile is appropriate and is providing protection to our funds. At the 31st August 2020, the value of the portfolio is £667,436, with an estimated income of £17,935, giving a yield of 2.7%. The following table provides a summary of the investment portfolio performance since it transferred to Rathbones.

West Hertfordshire Hospitals NHS Trust Charity

Performance Table

Consolidated portfolio performance during periods to 31 August 2020 (after all fees)

Portfolio	Quarterly	1 Year	Since Inception
West Hertfordshire Hospitals NHS Trust Charity - Total Returns	2.7%	1.9%	5.8%
ARC Charity Cautious GBP TR	1.5%	0.7%	4.7%
CPI + 1%	0.7%	1.6%	5.3%
FTSE All-Share TR	0.3%	-12.6%	-14.0%
FTSE UK Gilts All Stock TR	-3.2%	2.4%	13.7%
GB Charity Risk 2	-0.6%	0.1%	6.9%

While performance this year is down due to market volatility, overall the portfolio value has been maintained. Rathbones advised the committee that our current low risk strategy was performing and achieving its objectives – ensuring the fund does not lose value and providing a modest return. On this basis the committee confirmed that it wished to remain with the current strategy. Recommendation to CT: To continue with the current strategy and risk profile for our investment portfolio.

2. We received an update on the charity's strategy and progress this year. This year income is up considerably in comparison to the same period last year

Income 5 months to August 2019	Income 5 months to August 2020	Variance	% Variance
£295,161	£443,414	£148,253	50%

This significant increase can largely be attributed to Covid-19 and the charity's Covid-19 Appeal. The Covid-19 appeal accounted for £312K (70%) of income for the year to date. This provides the charity with a significant number of new supporters and donors who are aware of the charity and can support again in the future. There is a strong appetite in the community to support their local hospitals. At present, we do not know who Covid-19 Appeal

supporters are by donor group (individuals, companies, trusts and foundations). The income has not been coded in this way. Understanding this will be important for the development of future campaigns and knowing how best to target them for maximum return.
Other key items in the progress report included:

- an update on the Charity Lottery for our hospitals, the launch of the lottery had been delayed due to Covid-19, but is now progressing again with marketing and promotion materials being produced. It will be launching later this year.
- The charity is preparing for our annual Raise a Smile Christmas Appeal. This year the campaign is seeking to focus on raising cash to purchase gifts, rather than donations of gifts.
- The charity has developed a template KPI dashboard for reporting purposes. The first draft, which was reviewed by the committee was fully supported. Feedback to the charity is that this current draft focuses purely on income and fundraising metrics and the KPI dashboard needs to incorporate all activities that the charity engages in, so that we can more easily monitor progress against our plan.
- The process for outsourcing the charity finance function is proceeding. In preparation for this, it has been agreed that a dedicated finance consultant will be assigned to work with the charity and report to the charity director, with a dotted accountability line to finance, to support this transition. Simplifying the way the service is provided by having a single point of contact from the finance team within the charity is important in preparing for the transition to a new provider and this was fully supported and approved by the committee. **Recommendation to CT:**

    - To approve the allocation of specific finance support reporting to the charity director to support the transition to an external finance provider.
    - To approve the recommended transition to an external provider (subject to a successful procurement process).

3. The Committee was provided with a review and update on current risks on the charity risk register, which set out current mitigations and changes to risks.

4. The Committee received the annual report and accounts. These were reviewed and while no material changes are required, the document needs a detailed edit and the presentation was not in the charity brand. It is currently being reviewed and updated before final review by the Committee. It will be presented to the CT at the November Corporate Trustee meeting for approval and sign-off.

5. Requests for funds – the Committee received two requests for funds:

a. Purchase of an Endoscopy Simulator
    i. the total cost of the purchase of this simulator is £74,400.
    ii. This simulator is being largely funded by an independent charity - £40,000 has been confirmed towards the cost of the simulator.
    iii. Endoscopy training revenue is being used to fund £34,400 of the costs.
    iv. £10,000 is requested from a designated fund held by Raise.
    v. The committee approved the request of £10,000 subject to confirmation that this project has been through the correct approval and governance processes

within the Trust. While it seems to have been through most of the appropriate processes with the Trust, there was a lack of clarity in some areas. The Committee has asked that these are clarified and confirmed back to the committee, prior to any funds being released. This is a conditional approval.

b. Request for Support for Staff Well-being Facilities
    i. The total cost could not be confirmed, but the known expenditure is £100,000, and the final elements could cost up to an additional £50,000.
    ii. The request is to support an upgrade to the internal and external areas of the Kitchen restaurant at Watford General to provide a better and more enjoyable experience for staff when taking a break and having lunch – **accurate costings provided**.
    iii. To decorate and upgrade staff rooms/staff facilities within the ward areas on each site (Watford, Hemel Hempstead and St Albans) – **costings provided, but further work required to confirm**.
    iv. To upgrade the restaurant areas at St Albans and Hemel Hempstead to create better spaces for staff to take a break from work. – **costings to be confirmed**.
    v. The committee acknowledged that the solutions proposed to support staff wellbeing were much needed and responded to staff requests, while also being possible to achieve within the constraints of our estate and work demands.
    vi. After careful and detailed discussion the committee agreed to recommend approval of up to £150,000 subject to confirmation of costs and the provision of appropriate costings from the Estates team.

c. Recommendation to CT:
    i. Approval of £10,000 grant for the purchase of the Endoscopy Simulator, subject to confirmation of completion of the appropriate governance within the Trust.
    ii. Approval of up to £150,000 for the support of Staff Well-being Facilities at Watford, St Albans and Hemel Hempstead, subject to confirmation of final costs.

Agenda item: 23/83

Report to:	Trust Board
Title of Report:	Assurance report from Great Place Committee
Date of meeting:	01 October 2020
Recommendation:	For information and assurance
Chairperson:	Helen Davis, Associate Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Great Place Committee at its first meeting on 17 September 2020.
Background	The Committee will meet bi-monthly and gain assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and provide senior level leadership to shape and drive the implementation of these key elements of the Trust's strategy.

23

Terms of Reference (ToR)

The Committee noted that the Board had approved the ToR on 03 September 2020. The Committee was assured that the ToR covered the communications and engagement aspects of the hospital redevelopment programme.

Work plan

It was agreed that there would be deep dives into different areas at each meeting. One of these would be stakeholder engagement.

It was noted that it was important not to duplicate with the remit of other committees.

Acute redevelopment programme overview

The Committee received a summary overview of the acute redevelopment programme which included a summary of the key milestones, the key achievements for the programme and the next steps to the preferred option.

1. The Committee was assured by the enhancement of the programme team which comprises:
   - Internal programme team
   - Specialist consultancy support
   - Technical estates teams

Site feasibility report

The Director of Property, Royal Free London Property Services Ltd. and a representative from Montagu Evans joined the meeting.

They provided an overview of the site feasibility review, the purpose of which was to inform the evidence base for the longlist appraisal on the suitability and deliverability of the different site options:
As part of the consultancy team, Montagu Evans has provided town planning and development consultancy advice and Currie & Brown has provided costing advice.

The Committee received assurance that this site feasibility review team had the requisite skills and expertise to undertake the work, and noted that review team members were bound by the Royal Institute of Chartered Surveyors professional duty of care to give advice based on an impartial assessment of the objective evidence.

Deliverability had been assessed against the Trust's primary Critical Success Factor: achieving a substantially completed new facility in 2025 or soon as possible thereafter .

The Committee discussed the report and was assured that it demonstrates that the greenfield options carry far greater risk and complexity compared to the Watford General Hospital site options (being the existing site or the existing site plus the adjacent Riverwell site) as evidenced in the projected achievable timelines.

The Committee received assurance that the proposed changes to current planning laws were unlikely to have an impact as the White Paper focused on delivering greater housing stock and would not impact within the proposed timeframe for the redevelopment. Further, the presumption around existing constraints regarding Green Belt was that they would still be in force (which was of relevance to the Chiswell Green option).

The Committee also asked for and received assurances in respect of maintaining clinical services during the redevelopment process for existing site options: this varies between the options but essentially there will be a build, move, demolish, build approach. Further assurances were provided about how this would be done using a formalised environment management risk management methodology ,with full assurance required to be provided to the relevant local planning authority as part of the town planning process.

The Committee requested that the delivery risks and mitigations as discussed be more clearly articulated in the report to the Boards.

Overall, the committee was assured that the independent site review report provided an objective evidence base and could be relied on by Board members to inform decision making on the proposed shortlist and recommended preferred option.

Option appraisal paper

The Committee received an overview of the work to date in developing

the short list of options for further review within the Outline Business Case (OBC); this appraisal has encompassed both emergency care and planned care options for the acute redevelopment programme.

The Committee was assured that the pre-scored appraisal pack for emergency care had been fully discussed and reviewed by a panel included representatives from Healthwatch, HVCCG, NHSE & I regional team, the Trust clinical leadership team and the acute redevelopment programme team. The outcome, including changes to the pre-scored appraisal, was agreed by all attendees. Healthwatch attendees had confirmed that they were satisfied that the process and documentation had been thorough.

Further discussions had been undertaken after this with the NHSE & I regional team and colleagues at DHSC, who took the view that describing option 3 as the do minimum and the quantum difference between Option 1 (at c£92m) and Option 2 (at c£350m) meant that, in their view, there was no meaningful intermediate option to assess as the real do minimum. It was therefore agreed with regulators that the option shortlist would be revised to include a 'do minimum' option between BAU and 2019 SOC option one.

It has been determined that the planned care options do not require full reappraisal and that the preferred way forward from the 2019 SOC for planned care should be carried forward (i.e. retaining and improving HHGH and SACH sites) along with an option that would enhance the proposed solution to ensure that the investment objective to achieve condition B and suitability B for all elements of the estate is fully met.

Following discussion, the Committee was assured that that the HM Treasury Green Book process had been followed and that the process had been robust.

Communications report – options appraisal stakeholder engagement plan

The Committee received a summary of the communications and public engagement activity which has taken place from June – September 2020. The draft document would be further developed before the Board meeting which takes place on 1 October.

Notably, the final version would include a summary of the shortlist survey feedback and how the Trust planned to respond to any public concerns identified through the survey.

The Trust's legal advisers, Capsticks, has provided assurance that the engagement approach undertaken by the Trust and CCG has been proportionate and should enable both the Trust and CCG to demonstrate that they have met their statutory duty to involve as set out in s 242 of the Health Act

The Committee was assured that the engagement process outlined in the paper would provide sufficient evidence to enable the Board to make an

informed decision at the meeting with Herts Valleys Clinical Commissioning Group on 01 October 2020.

Risk management process – incorporating Orange Book principles

The Committee received an overview of the key principles of the Orange Book, which is a risk management guidance document produced by HM Treasury.

The Committee was assured that the appropriate approach has been incorporated into the acute redevelopment programme at work stream, steering group, and programme board levels.

Review of key red risks and mitigating actions

The sub-committee received a report summarising the key acute redevelopment programme risks. The committee noted the high level of stakeholder interest in the shortlist decision, the risk of judicial review and the reputational risks to the organisation arising from the programme. A deep dive into this risk will be undertaken at the next meeting.

Digital Transformation

The sub-committee received a verbal update from the Chief Information Officer who reported:

- LAN refresh and Windows 10 roll out proceeding to plan.
- EPR FBC to be presented to the October Board for formal approval following a positive discussion with the NHS E / DHSC Joint Investment Committee (JIC)
- That a draft Digital Strategy has been developed with good engagement from clinical teams and the Trust Executive team. Further work is required to define the funding strategy before the final strategy is presented for formal approval via the committee and Trust Board.

Risks to refer to risk register	None
Issues to escalate	The Committee recommends the following update for information to Part 1 of the October Board:

Attendance record

Present

Apologies

In attendance

Minutes
Laura Abel, Assistant Trust Secretary