TRUST BOARD MEETING IN PUBLIC
AGENDA

05 November 2020 at 09.30 – 12.00
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 436 284

Time	Item ref	Title	Objective	Accountable officer	Paper or verbal
09.30	01/84	**Opening and welcome**	Information	Chair	Verbal
	02/84	**Patient story**	Information	Chief Nurse	Verbal
09.50	03/84	**Apologies for absence**	Information	Chair	Verbal
	04/84	**Declarations of interest**	Information	Chair	Paper
	05/84	**Minutes of the meetings of the WHHT and HVCCG Boards on 1 October 2020**	Approval	Chair	Paper
	06/84	**Minutes of previous meeting on 1 October 2020**	Approval	Chair	Paper
	07/84	**Board decision log.**	Information	Chair	Paper
	08/84	**Board action log**	Approval	Chair	Paper
	09/84	**Chair's and Chief Executive's report**	Information	Chair / Chief Executive	Paper
10.00	10/84	**Board Assurance Framework**	Information and assurance	Chief Executive	Paper
10.05	11/84	**Activity Recovery Update & Access Standards Performance**	Information and assurance	Chief Operating Officer	Paper
	12/84	**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
10.20	13/84	**Complaints and PALs Annual Report**	Information and assurance	Chief Nurse	Paper
10.30	14/84	**Annual Report on Infection Prevention and Control**	Information and assurance	Chief Nurse	Paper
10.45	15/84	**Annual disability equality standard report**	Information and assurance	Chief People	Paper

				Officer	
10.55	16/84	**Annual NHS workforce race equality standard report**	Information and assurance	Chief People Officer	Paper
11.05	17/84	**Strategic Priorities Update:**	Information and assurance	Deputy Chief Executive	Paper
11.15	18/84	**Approval of updated standing orders, standing financial instructions and scheme of delegation**	Approval	Chief Financial Officer	Paper
11.20	19/84	**Corporate risk register report**	Approval	Chief Medical Officer	Paper
11.40	20/84	**Assurance report from Trust Management Committee**	Information and assurance	Chief Executive	Paper
	21/84	**Assurance report from People, Education and Research Committee**	Information and assurance	Chair of Committee/Chief People Officer	Verbal
	22/84	**Assurance report from Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
	23/84	**Assurance report from Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	24/84	**Assurance report from Audit Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
11.50	25/84	**Any other business previously notified to the chair**	N/A	Chair	Verbal
11.55	26/84	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal
	27/84	**Questions from our patients and members of the public**	N/A	Chair	Verbal
12.00	28/84	**Date of the next board meeting: 4 December** Executive Meeting Room and via Zoom, Watford Hospital	Information	Chair	Verbal

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Acronyms and abbreviations

A

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

B

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

C

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

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

D

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

E

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

F

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

G

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

H

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

I

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

J

JSNA	Joint Strategic Needs Assessment

K

KLOE	Key Line of Enquiry
KPI	Key Performance Indicator

L

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

M

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

N

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

O

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

P

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

Q

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

R

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

S

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

T

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

U

UCC	Urgent Care Centre
UTI	Urinary Tract Infection

V

VFM	Value For Money
VSM	Very Senior Manager
VTE	Venous Thromboembolism

W

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

Y

YTD	Year to date
YCYF	Your care, your future

NHS
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Declarations of board members and attendees interests
05 October 2020

Agenda item: 04/84

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 (ended 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) (ended October 2020) • 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

DRAFT – SUBJECT TO BOARD APPROVAL

WEST HERTFORSHIRE HOSPITALS TRUST AND HERTS VALLEYS CCG BOARD MEETINGS IN PUBLIC
01 October 2020
Executive Meeting Room, Watford and via Zoom

Name	Title	Attendance
West Hertfordshire Hospitals Trust		
Voting Members		
Phil Townsend (PT)	Chairman	Yes
Christine Allen (CA)	Chief Executive	Yes
John Brougham (JB)	Non-Executive Director	Yes (virtual)
Helen Brown (HB)	Deputy Chief Executive	Yes
Tracey Carter (TC)	Chief Nurse and Director of Infection Prevention and Control	Yes (virtual)
Paul Cartwright (PC)	Non-Executive Director	Yes (virtual)
Ginny Edwards (GE)	Non-Executive Director (Vice-Chair)	Yes (virtual)
Jonathan Rennison (JR)	Non-Executive Director (Senior Independent Director)	Yes (virtual)
Don Richards (DR)	Chief Financial Officer	Yes (virtual)
Dr Mike Van der Watt (MW)	Chief Medical Officer	Yes (virtual)
Non-Voting Members		
Dr Andy Barlow (AB)	Divisional Director, Medicine	Yes (virtual)
Paul Da Gama (PDG)	Deputy to the Chief People Officer	Yes (virtual)
Helen Davis (HD)	Associate Non-Executive Director	Yes (virtual)
Natalie Edwards (NE)	Associate Non-Executive Director	Yes (virtual)
Sally Tucker (ST)	Chief Operating Officer	Yes (virtual)
Simon Vaughan (SV)	Director of IT (on behalf of Paul Bannister, Director of Information)	Yes (virtual)
Dr Anna Wood (AW)	Director of Governance	Yes (virtual)
Dr Simon West (SW)	Divisional Director, Surgery, Anaesthetics and Cancer	Yes (virtual)
In Attendance		
Meg Carter	Hertfordshire Healthwatch	Yes (virtual)
Tim Duggleby (TD)	Associate Director Strategic Estates Redevelopment	Yes (virtual)
Louise Halfpenny (LH)	Director of Communications	Yes (virtual)
Paddy Hennessy (PH)	Director of the Environment	Yes (virtual)
Duane Passman (DP)	Programme Director, Redevelopment Programme	Yes (virtual)
Rod While	Trust Secretary (notes)	Yes
Herts Valleys CCG		
Nicolas Small (NS)	Chairman	Yes (virtual)
Stuart Bloom (SB)	Lay member	Yes (virtual)
Corina Ciobanu (CC)	GP member (Dacorum)	Yes (virtual)
Clare Molloy (CM)	Deputy Director of Nursing and Quality	Yes (virtual)
Rami Eliad (RE)	GP member (Watford and Three Rivers)	Yes (virtual)
David Evans (DE)	Managing Director	Yes (virtual)
Asif Faizy (AF)	GP member and Locality Chair (Watford and Three Rivers)	Yes (virtual)
Trevor Fernandes (TF)	GP member (Dacorum) and Deputy Clinical Chair	Yes (virtual)
Alison Gardner (AG)	Lay member	Yes (virtual)
Jane Halpin (JH)	Accountable Officer	Yes (virtual)
Catherine (Kate) Page (CP)	GP member (Hertsmere)	Yes (virtual)

Name	Title	Attendance
Alan Pond (AP)	Chief Finance Officer	Yes (virtual)
Paul Smith (PS)	Lay member	Yes (virtual)
Thelma Stober (TS)	Lay member	No
Elke Taylor (ET)	Deputy Chief Finance Officer	Yes (virtual)
In attendance		
Jill Ainsworth-Beardmore (JAB)	Patient Representative	Yes (virtual)
Lynn Dalton (LD)	Director of Primary Care	No
Brian Gunson (BG)	HealthWatch Hertfordshire Representative	No
Iram Khan (IK)	Corporate Governance Support Manager	Yes (virtual)
Katy Patrick (KP)	Interim Head of Corporate Governance	Yes (virtual)
Juliet Rodgers (JRo)	Associate Director of Communications and Engagement	Yes (virtual)
Avni Shah (AS)	Interim Director of Commissioning	Yes (virtual)
Hein Scheffer (HS)	Director of Workforce & Organisational Development	No
John Wigley (JW)	Patient Representative	Yes (virtual)

Name	Title	Attendance
Additional External Attendees		
Paul Burley (PB)	Partner, Planning, Montagu Evans	Yes (virtual)
Peter Martin (PM)	Peter Martin - Strategic Development Manager, Royal Free London Property Services Ltd	Yes (virtual)
Maggie Robinson (MR)	Director of Property, Royal Free London Property Services Ltd	Yes (virtual)
Howard Williams HW	Partner, land valuation, Montagu Evans	Yes (virtual)

Approximately 45 members of the public were in virtual attendance

MEETING NOTES

Agenda item	Discussion
01/83	**Opening and welcome**
01.01	PT welcomed all to the meeting, noting that the West Hertfordshire Hospitals Trust (WHHT) Board was present as was the Board of Herts Valleys Clinical Commissioning Group (HVCCG). He noted that the meeting was a meeting in public and not a public meeting, though a number of members of the public would be making representations either in writing or verbally.
01.02	PT also noted the following: • The discussion regarding the future of the WHHT service was not new. The current Outline Business Case (OBC) had a direct link to the “your care, your future” programme which began in 2014. It also built upon the 2017 and 2019 strategic outline cases. • Providing improved hospital buildings and delivering more care closer to home remained at the heart of the plan. The decision to be taken at the meeting would be an important milestone. • He assured members of the public that the Trust took very seriously its responsibility to deliver the best possible care for all its patients.
02/83	**Declarations of interest**
02.01	There were no changes to the published declarations of interest for both Boards.

Agenda item	Discussion
03/83	**Representations from members of the public**
03.01	LH introduced the item and noted that eight people would be making representations to be covered in two minutes per person.
03.02	Graham Cartmell noted the following: • The discussion wasn't new and he noted that there was a judicial review pending. • The stakeholder reference group was little more than a sham. Input into the long list had been promised but this did not happen. • The feasibility study was not independent and not expert, there were glaring omissions. Risks associated with the Watford hospital site had been omitted. No due diligence had been carried out. Bed capacity and transport access had been ignored.
03.03	Vicky Houghton noted the following: • She supported the redevelopment of the Watford site because disruption would be less and the majority of staff had bought houses or lived near to the site. Many did not use transport and were able to walk to work. If the redevelopment was on a new site, people would need to move or find different modes of transport. • Having a COVID free site was the way forward and the presence of an alternative site was desirable. If there were a new build on a single site, this represented a risk as there would be no COVID free site. Whilst COVID would disappear, other infections would appear. • The redevelopment at Watford would be at the Riverwell site so normal business would continue with minimal disruption. This would boost staff morale as they would see the redevelopment taking place.
03.04	Peter Ingram stated the following on behalf of Herts Valleys Hospitals: • The Trust had apparently no alternative but to redevelop the Watford site. • It was clear how this position had evolved. • Central Governments between 1979 and 2019 were responsible. • The new Central Government offered a fresh approach across several departments. • The Herts Valleys Hospitals project was in tune with the ambitions of Central Government. • The project will therefore be taken to Central Government as well as the local community and NHS staff. • Collaboration with the Trust would continue in order to achieve the best result. • The project will be promoted following the meeting. • When Central Government enabled the west Herts community to become actively involved in a hospital scheme that benefitted all west Herts, Herts Valleys Hospitals would be happy to work with the Trust again.
03.05	Councillor Asif Khan stated the following: • The Watford Labour party had a good relationship with the Trust. • There had been a number of delays in redevelopment for a variety of reasons • The Trust had engaged with residents of all ages and levels of health. Strong opinions were heard but the love for the hospital shone though. • The redevelopment must take place on the current site. People could not wait any longer for a new hospital to be created at new site. • The Watford Labour party was fully supportive of the Trust.
03.06	Dean Russell, MP for Watford, stated: • He had volunteered on the Watford site for six months and had seen first-hand the dedication of staff and witnessed the need for better working conditions. • The Watford site was the only site with the necessary transport links, existing planning and staff proximity to make it the right location. • He urged the Boards to choose the current sites for redevelopment rather than gamble on a new site which could take much longer.

Agenda item	Discussion
	• Watford was the right site, the alternative would introduce delays.
03.07	Peter Taylor, mayor of Watford stated the following: • Watford Borough Council was completely committed to the Trust's outline plans. • This was an important decision for the whole of the region and Watford was the centre for many regional organisations and the hospital had good transport links. • The Watford scheme was ready to go, it was a big site and the plans included 90% rebuild. • 40% of staff live close to the current site and this could not be ignored.
03.08	Chris White, leader of St Albans District Council stated the following: • If there were more money being offered and a suitable site available he would be supporting a single hospital on a Greenfield site. • However he did not believe that additional funding would be available and the Chiswell Green and Radlett aerodrome sites present many challenges that would be difficult to resolve. • The opportunity must be taken now to use the investment wisely to rebuild the Watford site and improve the other two hospitals. Other proposals for new sites were not realistic as they were not affordable and would take too long.
03.09	Councillor Margaret Griffiths stated the following: • She appreciated that the Boards, unlike Councillors were unelected and not democratically accountable. • Dacorum Borough Council served 160,000 people, the largest of populations in Hertfordshire. The Council supported the building of a new hospital on a new site rather than wasting money at the Watford site. • People who did not agree with the Trust's proposed shortlist had not been invited to the meeting, Mike Penning was not invited and Dacorum did not receive a formal invitation to the meeting. • The Trust had carried out a public and staff survey in September, but she questioned how this had been promoted and how steps had been taken to reach all members of the community. • The Watford site was unsuitable, for example because of the steep climb between the car park and the hospital.
04/83	**Site Feasibility Study**
04.01	HD, chair of the Trust's Great Place Committee made the following points: • At the recent Great Place Committee meeting a presentation on the site feasibility study had been received from the Royal Free property team and Montagu Evans. • At the meeting the committee tested the findings and recommendations,and were assured that the team had the relevant expertise and the methodology and findings could be relied on to support decision making. Given the importance of this issue it was felt appropriate for both Boards to hear the presentation directly and have the opportunity to ask questions.
04.02	MR of Royal Free London Property Services introduced the item with the following points: • RFL Property Services had been commissioned by the Trust to carry out an independent review of six site options for redevelopment. • A consortium team approach was adopted as a multidisciplinary team was required for this work. This included the Montagu Evans planning advisory team and Currie & Brown cost consultancy team, and was led by Royal Free London Property Services limited. • MR confirmed that the criteria for the appraisal were outlined within the paper and objective and transparent methodologies had been used. • MR noted that the professionals involved were bound by professional codes of conduct to ensure that an unbiased opinion was delivered.

Agenda item	Discussion
	• She drew attention to slides 12 and 13 of the pack where the outcomes of the feasibility assessment were summarised. The two Watford sites were associated with the least deliverability risk.
04.03	The following points were made: • HD noted that a critical success factor was for a substantial completion by 2025. She asked for confirmation of the drivers of longer timelines for new site options. MR noted that a benchmark end to end programme had been developed. From this starting point, different variables, such as risks regarding Town Planning or land ownership, had been applied to each of the options to provide the different programmes. • PB noted that local authorities had also been approached to understand how planning decisions would be made on all sites. • PS noted that that some of the public representations had stated that the treasury's green book process had not been followed in moving from long listing to short listing. He asked how the Boards could be assured that the treasury's guidance had been followed. HB noted that this would be picked up as part of the next item. • TF asked whether some of the concerns raised by the public representations, for example complications with the Watford site, had been addressed within the appraisal. MR noted that Watford had a sloping site and assured the Boards that this was taken into account within the construction programme. She also noted that the assessment had allowed for issues such as asbestos contamination at the Watford site that would need to be addressed during construction. • RE asked how access and parking would be addressed during the rebuild. MR noted that this had not been within the scope of the appraisal, though accessibility, public transport and road access had been evaluated for each site. The provision of car parking on any of the new sites had been reflected in the appraisal. HB noted that there was a well progressed plan to deliver a new car parking facility on the Watford site by March 2022. HB confirmed that the discussion regarding the impact of disruption would be picked up as part of the next item.
05/83	**Long list appraisal, recommended shortlist and stakeholder feedback**
05.01	HB introduced the agenda item and made the following points: • Three papers had been provided to the Boards including an appraisal paper setting out the process followed in line with the green book. This covered the investment objectives and the critical success factors. • The Trust was making the case for as much funding as possible but would need to evidence that the most economically advantageous option was being chosen that meets the Critical Success Factors. • Much of the discussion over the past few years had focused on the location of the emergency care hospital but if the proposed shortlist was approved, this would mean investment in all three current sites. • The key focus of the current discussion was around the Critical Success Factor of deliverability and the recommendation from the independent site review was that the new site options did not pass the CSF. • All options passed the initial value for money and affordability criteria at long list stage so no options had been excluded from the shortlist on the basis of cost. • It was important to only shortlist options that were viable and meet the Critical Success Factors, it would take significant time and resource to look in more detail at new site options and the programme team's view was that this would not be a good use of time or resource and would slow the overall appraisal process down.
05.02	DP made the following points:

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	• There was a high level risk assessment on Watford site options provided as part of the Board papers, and this was undertaken with the professional estates team to compare risks. This was not an objective view but a subjective view comparing each of the options. • The majority of hospital redevelopments that have taken place in the NHS had been on existing hospital sites. • Any of the recommended options for the Watford site are manageable but options with a greater degree of new build would be easier and quicker to deliver.
05.03	HB provided an overview of the stakeholder engagement work: • There had been a good response to the shortlist survey. It was clear that 'geography' was a significant factor and the further people lived from Watford the more likely they were to support a new site option and express concerns about WGH options. . • It was also clear that there was a preference for a new build over existing sites and this was understandable. The Trust's preference was for as much new build as possible; but the appraisal would need to demonstrate that the indicative preferred option represented the most economically advantageous solution. • Staff responses to the recent survey were mostly in favour of the proposed shortlist. • It is understood that some stakeholders would be very disappointed should the proposed shortlist be approved. A number of recommendations are set out in section 13 of the report setting out actions to be taken to mitigate concerns raised by stakeholders through the engagement process.
05.04	The following points and questions were made in discussion: • JR noted there was a strong focus on prioritising emergency care. He asked for assurance from a clinical perspective that this was the right decision. MW stated that extensive consultation had taken place with clinical colleagues across all divisions and the feedback was that the priority must be emergency care. This reflects the higher clinical needs and provision of the majority of inpatient care on the emergency care site, as well as the poor condition and suitability of the current facilities. • JR asked whether the balance of services across the three sites was correct. MW noted that the plan was to have in place a surgical cold site, a medical cold site and hot site which incorporates all specialties. • JR asked how population growth had been factored into the thinking. MW noted that even with the current population size, to have an emergency department fully staffed was a challenge and it was not practical to have two emergency departments as they would run at very low staffing levels. • CM asked how patient safety would be maintained in the proposed shortlist, especially with building works taking place. HB noted that the range of options under consideration on the Watford site range from "do minimum" to "do maximum" and how this would be managed from a patient safety perspective varied accordingly. DP noted that most NHS and private healthcare construction works took place alongside operational services and that the Trust would be required to produce a construction environmental management plan to ensure safety during construction. PH noted that the Trust was well versed in this in terms of internal refurbishment of existing buildings and was confident that this could be safely managed. • DCC asked whether the option at Watford with a new car park would have a level access. HB confirmed that this would be the case. . • DCC asked for clarification on demographic changes and whether the proposed options had included these factors. HB stated that there was a demand and capacity model which would be updated for outline business case stage. It considered

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	population growth, trends in demand, housing growth and changes in clinical practice. The modeling assumptions were the same for all options and HB confirmed that all options would be able to deliver the required capacity. • DE asked for assurance on how health inequalities had been addressed in arriving at a proposed shortlist. HB stated that in her view this was driven primarily by the service models, though when considering location, there were differential impacts depending upon where people lived and for older people the access challenge could be compounded. In 2017 and 2019 the Trust undertook comprehensive equality impact assessments and this would be carried out at shortlist and preferred option stage. The previous assessments concluded that improving facilities had a significant positive overall impact on health inequalities. • GE asked how confident the Trust was that it would receive the necessary investment for the preferred option. HB stated that the Trust had been confirmed as part of the HIP 1 programme and a funding envelope of £400m was confirmed as part of this. Subsequent to that there had been further ongoing discussion with regulators to request further funding if possible. The letter from regulators allows the Trust to consider higher cost options but stressed that further funding is not guaranteed. The cost of COVID had been highly significant however and it is expected that government finances and future investment may be constrained as a result. • SB noted that there was a general election due to take place in May 2024 and asked what were the risks if building work had not commenced by that point. HB noted that the Trust needed to have an approved Full Business Case and to have started work well before that point in order to secure funding and to deliver the new facilities in line with the target timeline. • RE asked how the preferred options help local patients in the medium term and the long term. HB noted that there would continue to be future discussions on clinical models with colleagues in primary and community care and there remained a strong commitment to continue to drive towards greater integration with primary care, which was clearly beneficial for patients. • DP clarified adherence to the treasury's green book process in the process and stated that he had re-read all guidance when he joined WHHT in June and gave assurance that guidance had been fully adhered to by all parties in the longlist to shortlist process. • AP noted there was an option that delivered all of the required clinical benefits, was deliverable within the timeframe and was less expensive than a new site option. This could be delivered now and it made sense to go with this option rather than a more speculative new site option.
06/83	**WHHT Board Decision**
06.01	MW made the following points: • There was an opportunity for the Trust to deliver excellent care in state of the art facilities supported by state of the art IT. • Co-location of relevant specialties would improve and maximise the efficiency of the hospital and at the same time deliver a safe environment. • This would also drive the delivery of a comprehensive healthcare system in the community particularly with regard to paediatrics and care of the elderly. • He fully endorsed the proposed shortlist.
06.02	TC made the following points: • There was a great opportunity to provide a great environment for staff and patients and to provide the services that the community deserved via improved pathways,

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	integration and personalisation. • She fully endorsed the opportunity to integrated women's and children's services and provide modern environments to support patient safety and infection prevention and control. • She fully endorsed the recommendations.
06.03	CA made the following points: • It was clear on reviewing all of the discussions, the papers and submissions that the Trust needed to move forward with the redevelopment and the options recommended in order to deliver urgently needed improvements to the timelines that had been set out. • She understood the passionate views of the residents of west Hertfordshire and that some residents would be disappointed. • This was the opportunity to develop the facilities that patients and staff deserved. • She supported the proposal as presented.
06.04	**RESOLUTION:** Taking into consideration all of the information and analysis provided by the option appraisal report, emergency care high level risk assessment, the communications and stakeholder engagement report and the independent site feasibility report the WHHT Board: 1. Approved the proposed shortlist and preferred options for emergency and planned care 2. Noted the activities undertaken over the past four months to ensure that local people are informed of and engaged in planning for the redevelopment of WHHT hospital facilities. 3. Approved the recommended actions to address and mitigate the key concerns identified via the engagement activities summarised within the stakeholder engagement report.
07/83	**HVCCG Board Decision**
07.01	RE made the following points: • This was the time to make a decision to have excellent facilities for the future. • He fully supported the recommendations.
07.02	TF made the following points: • He thanked the Trust and members of the public for their well thought out submissions. • Within the time and financial constraints he emphasised the need to support the proposals laid out.
07.03	DCC made the following points: • COVID has shown how care may look in the future and this meant that the location of the hospital was less important with regards to emergency care. • The clinical models around planned care need to continue to be developed.
07.04	JW made the following points: • The view of the St Albans and Harpenden patient group was that the plan to develop all three sites was the best option for the whole area as it conformed to the principle of care nearer to patients' homes. • He was convinced that the recommendations represented the best way forward for residents.
07.05	DE made the following points: • It was important to note public feedback and to continue to engage with local

Agenda item	Discussion
	residents. • The clinical views from consultants and GPs had been well presented and agreed that the model was the right one to move forward with. • Now was the time to move forward with the plans and he endorsed the recommendations.
07.06	**RESOLUTION:** The HVCCG Board approved the recommendations as described in the papers and summarised in point 06.03 above.

TRUST BOARD MEETING IN PUBLIC
01 October 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 (virtual)
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) – to 02/84
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 (virtual)
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
Simon Vaughan	Director of IT (on behalf of Paul Bannister, Director of Information)	Yes (virtual)
Dr Anna Wood	Director of Governance	Yes (virtual)
Dr Simon West	Divisional Director, Surgery, Anaesthetics and Cancer	Yes (virtual)
In attendance		
Mark Cruise	Voluntary Services Lead	Yes (virtual)
Andrea Hone	Patient and Carer Experience Lead	Yes (virtual)
Monica Leitao	Volunteer	Yes
Rod While	Trust Secretary (notes)	Yes

3 members of the public were in virtual attendance

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/84	**Opening and welcome**		
01.01	The Chairman welcomed the Board and members of the public to the meeting.		
02/84	**Patient story**		
02.01	The Chief Nurse introduced the item which covered the volunteer service at WHHT and showed a picture of past and present and achievements.		
02.02	Andrea Hone introduced the item and made the following points: • The structure of the team was shown on a chart. • Pre-COVID there were 800 active volunteers covering a variety of duties across the Trust • Growth had been major over the past two years. • However with the pandemic in March, the number of volunteers dropped to 20. A new model was developed to meet the challenges Mark Cruise noted the following: • A COVID response volunteer role was developed and face to face training sessions held. • Accession was given to the MacMillan information centre, which became the volunteer hub. • A number of Trusts had decided to stand down their volunteer service. • Initially a large number of requests were received, largely from staff who had difficulty getting on to the wards. Monica Leitao an active response volunteer stated the following • She started in patient affairs supporting grieving families but a very rewarding experience • Currently much more focused on patients and feedback from patients was extremely positive. • One patient was so touched by being visited regularly and this changed her view of volunteering. Mark Cruise stated: • Six months into the COVID response role, volunteers had donated 5,000 hours of their time and 300 shifts took place each month via 120 response volunteers, half of whom were under 21. • Three volunteers have gone on to secure employment with the Trust. • Successes included being asked to speak to other Trusts to share the learning and volunteers have fed back that they are very happy in the response role as every shift is different. • For the next six months the response role would be continued with the intention that hours are increased. • Profile had been raised dramatically by being based in reception. • Co-production work would take place working with partners and members of the community. • Post COVID work was also being planned		
02.03	Paul Cartwright ask about all the volunteer's that were there pre-COVID. Mark Cruise noted that a large number of those volunteers had		

Agenda item	Discussion	Lead	Dead-line
	been over 70. They were being contacted regularly and many were keen to get back to being involved.		
02.04	Jonathan Rennison asked what the biggest opportunity was for the future. Mark Cruise noted that the team had managed to become much more impactful with a much smaller team and were much higher profile than previously. This needed to be maintained and momentum needed to be continued and opportunities to help actively sought.		
02.05	Ginny Edwards noted that a number of people had volunteered who did not actually go on site and this was an important resource.		
OPENING			
03/84	**Apologies for absence**		
03.01	Apologies were received from Paul Bannister and Ginny Edwards		
04/84	**Declarations of interests,**		
04.01	No changes were reported to the declarations of interest from those circulated prior to the meeting.		
05/84	**Minutes of previous meeting**		
05.01	**Resolution**: The Board approved the minutes of 3 September as a true and accurate record		
06/84	**Action log**		
06.01	It was noted that all actions were complete and should be closed.		
07/84	**Chair's and Chief Executive's report**		
07.01	The Chairman noted that a recruitment campaign for a new NED had concluded and the successful applicant would now be reviewed by an NHSI panel. The role was to replace John Brougham who would retire from the Trust around Christmas.		
07.02	The Chief Executive welcomed Joanna Bainbridge as the new Freedom to Speak Up Guardian, noting that Ginny Edwards would continue to support this in the future. She noted the re-launch of the connect BAME network which was chaired by Marsha Jones.		
08/84	**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 in future any changes in the BAF would be highlighted. There is also a need to reflect the Great Place Committee in the BAF.	RW	Oct 2020
08.03	**Resolution**: The Board approved the Board Assurance Framework		
PERFORMANCE			
09/84	**Activity Recovery Update & Access Standards Performance**		
09.01	The Chief Operating Officer introduced the report and informed the Board: • The report had been expanded to include recovery performance information. • All recovery priorities were set out in the paper and an activity recovery tracker was included. • Appendix 1 covered a full breakdown by service, each with a position statement.		

Agenda item	Discussion	Lead	Dead-line
	• The capacity offered by Spire had been reduced and other independent providers were being contacted, particularly in relation to diagnostics. • Attain had been commissioned to support recovery in surgery. • 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 was largely the result of a growing backlog of DEXA scans. • RTT performance had improved further, from 51% to 62.5% this month. However, there had 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 had all been achieved with the exception of the 31 day subsequent surgery standard where 2 breaches have resulted in non-compliance.		
09.02	John Brougham asked whether fixed recovery plans were now in place and set with NHSE. The Chief Operating Officer stated that the indicative plan had been submitted but would need to be refreshed in the light of new information, particularly on the availability of independent sector support.		
09.03	Paul Cartwright asked whether all departments were now open and whether the Minor Injury Unit (MIU) would be opening. The Chief Operating Officer informed the Board that every speciality had restarted services to varying degrees. The Chief Executive informed the Board that St Albans is the Trust's green site so the Trust is looking at options for the MIU with the CCG.		
10/84	**Integrated performance review**		
10.01	The Chief Operating Officer introduced the report and gave the following headlines: • A snapshot was provided on the COVID position (19 September). • The Trust was currently caring for 18 confirmed COVID patients, 16 were supported within the isolation area and two in ITU • There were 16 suspected COVID and 14 had had a negative swab. • The Trust continued to see an increase in A&E attendances. • The in-house testing solution for COVID had gone live. • The escalation surge plan was currently being reviewed.		
10.02	The Chief Nurse gave the following updates: • Audits were ongoing around protective equipment to maintain good oversight and infection prevention and control standards. • Monitoring of COVID training compliance had taken place to ensure that all staff were aware of infection prevention and control procedures. • Pop up isolation facilities had been trialled to manage wider infection control issues. • Maternity visiting guidance had been reviewed and changes to visiting arrangements would be implemented shortly.		
10.03	The Chief Medical Officer gave the following updates: • The V-SMART pilot had restarted to assess effectiveness. This would be expanded outside of medicine.		

Agenda item	Discussion	Lead	Dead-line
	• The clinical strategy workshops had commenced and were achieving good engagement from clinical staff. • Divisions were currently preparing for a second wave of COVID.		
10.04	The Deputy Chief People Officer gave the following updates: • A significant increase in absence was seen in September. In response a rapid testing programme had been set up to include family members. • The Flu campaign had commenced with 1,500 being vaccinated. The focus initially was on patient facing staff. • The staff survey would begin on 1 October, all on line rather than paper. • A programme was in place to support Black History month.		
10.05	The Chief Finance Officer gave the following updates: • The Trust had spent £173.7m with sufficient revenue to cover this amount. • Spend continued to be less than the original plan • The current financial regime would change for the second of the year with targeted activity levels and fixed financial allocations. This was projected to leave the Trust short by £12m and was being debated across the health system.		
10.06	The Deputy Director of IT gave the following updates: • After two challenging months, core performance was improving. • In the future application performance was being address through infrastructure improvements such as LAN improvements and Windows 10. • The Trust was completing a business case that would 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 enabled the Trust to start delivery of the digital strategy. • NHSX had 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. The Trust and system would need to work through how and to what extent the Trust could comply with this ambition given the improvement plans the Trust already had in place.		
10.07	Paul Cartwright asked the Chief Medical Officer to comment on the apparent increases in HSMR. The Chief Medical Officer stated that this was COVID related and the Trust was performing well in comparison to other Trusts.		
10.08	Jonathan Rennison asked whether services could be maintained in the case of a second wave and also how ongoing harm reviews would be managed. The Chief Operating Officer stated that services would be maintained on the St Albans site for as long as possible, though the limiting factor was workforce and harm reviews would be carried out with patients for whom procedures had been cancelled. The Chief Medical Officer noted than an electronic pre-op assessment tool had been launched and this sets a date for a harm review. He informed the Board that the regional ITU network had set thresholds for ITU patients and this was much less than the early stages of the pandemic. The Divisional Director, Medicine noted that the Trust's response was likely		

Agenda item	Discussion	Lead	Dead-line
	to be much more nuanced than previously. The Virtual Hospital also had an important role to play in the case of a second wave.		
10.09	Jonathan Rennison asked for further detail on the workforce challenge and how people were being retained, he also asked what was being done to support staff in the case of a second wave. The Chief People Officer stated that there was not a big turnover in staff and this was lower than it had been for a number of years, however there was a business case in preparation regarding providing psychological trauma support. A programme focused on compassionate leadership would also be implemented.		
11/84	**Annual Serious Incidents Report**		
11.01	The Chief Medical Officer informed the Board that 26 SIs were reported, though this had been reduced to 21 after investigation. There were three never events, though none of the patients came to harm. There was 100% compliance with duty of candour. The Trust achieved 93% compliance with reporting incidents against a target of 95% and the Serious Incident Group reviewed 45 action plans.		
11.02	John Brougham asked whether there was any benchmarking data to compare the Trust against. The Chief Medical Officer noted that the only benchmarking data available was never events and the Trust was low in comparison to that.		
11.03	Paul Cartwright asked how the Trust measured compliance on Duty of Candour. The Chief Medical Officer stated that there was a SI office with a responsibility to oversee this and this was confirmed by the SI Group		
12/84	**Quarterly Learning from Deaths Report**		
12.01	The Director of Governance informed the Board that the mortality indicators were within the expected range for 2019-20. Outlier diagnoses of SMR were due largely to COVID. She informed the Board that the Intensive Care National Audit and Research Centre Report (ICNARC) which was a specific COVID-19 mortality and outcome report submitted by trusts regarding patients admitted to ITU with COVID and was benchmarked nationally. Parameters in the report did not compare favourably with other Trusts but she wished to assure the Board that this was being investigated by the respiratory and ITU teams and by NHSE. She informed the Board that overall mortality was within the national figure of 35%.		
12.02	Paul Cartwright noted that COVID mortality was consistent across ethnicity and asked for comment on this. The Director of Governance noted that this reflected the local population and bespoke mortality reports confirm that the Trust is not significantly different from other Trusts in this respect.		
13/84	**Biannual establishment review – adult in-patient wards**		
13.01	The Chief Nurse informed the Board that the paper had been fully discussed at the People, Education and Research Committee and evidence of assurance sought. The report included September 2019 and February 2020 establishment reviews. She informed the Board that in her professional opinion safe staffing requirements were being met and the ward templates were being continuously reviewed.		
14/84	**Strategic Priorities Update**		
14.01	The Chairman asked for an update on the Mount Vernon clinical review. The Deputy Chief Executive noted that she had had conversations with the team responsible for the clinical review, the process was being led		

Agenda item	Discussion	Lead	Dead-line
	by the East of England Specialist Commissioning Team but discussions had taken place on options to relocate some elements of the service with the Trust.		
14.02	Paul Cartwright asked when the clinical strategy was coming to Board for discussion. The Deputy Chief Executive noted that this would be submitted to the December Board.		
14.03	Jonathan Rennison asked what work was being done with staff around leadership development alongside the development of the ICP. The Chief People Officer noted that there was an OD workstream which was looking at that piece of work.		
14.04	The Deputy Chief Executive introduced the update against strategic objectives and ambitions and informed the Board that a number of objectives are covered in the Integrated Performance Report, though standalone report would be submitted to the Board on a quarterly basis.		
15/84	**Office Relocation of HR and Finance**		
15.01	The Chief People Officer informed the Board that he was asking for approval to proceed with a business case to relocate support services to a new site adjacent to the Trust. The paper had already been discussed at Trust Management Committee and Finance and Performance Committee and both had supported, subject to further clarification on IT and dismantling costs. The reasons for the proposed move were firstly regarding location and cost and value for money. There was a significant capital cost requirement of £2m plus £500k for dismantling costs. He also informed the Board that the number of desks proposed was 70 fixed and 40 hot but due to home working there would be a massive increase in capacity. Planning permission had not yet been gained.		
15.02	Natalie Edwards asked how staff were feeling about the move. The Chief People Officer noted that staff were positive because the location was very close to the Watford site.		
15.03	John Brougham noted the strength of the case for change but noted that the £500k funding would be depreciated over time and the review was more than £84k per annum because utilities were excluded.		
15.04	Helen Davis asked whether it would be possible to extend the staff base beyond HR and finance. The Chief People Officer stated that this was the intention.		
15.05	**Resolution:** The Board approved the proposals for office relocation as set out in the business case.		
16/84	**Corporate Risk Register**		
16.01	The Chief Medical Officer noted that the Risk Review Group last met on 14 September and there were 20 risks listed currently. Two risks had been added relating to the lack of an interventional radiology suite. There was a new risk regarding a second wave of COVID and this replaced the previous risk which a corporate risk regarding COVID.		
16.02	**Resolution:** The Board approved the Corporate Risk Register.		
17/84	**Assurance Report from the Trust Management Committee**		
17.01	The Chief Executive noted that the report covered the two meetings that took place in August.		
18/84	**Assurance Report from the Finance and Performance Committee**		
19.01	The Board noted the report.		
19/84	**Assurance Report from the Quality Committee**		
19.01	Jonathan Rennison noted that the Committee had received an annual		

Agenda item	Discussion	Lead	Dead-line
	report from complaints and PALs which contained good assurance relating to an improving position. Two embrace reports had been received focused on clinical outcomes for mothers and babies. The Chief Nurse noted that there had been significant improvements in the outcomes of the maternity survey since 2017.		
20/84	**Assurance Report from the Great Place Committee**		
20.01	The Board noted the report		
21/84	**Assurance Report from the Charity Committee**		
21.01	Jonathan Rennison noted that there were two recommendations to the Corporate Trustee: • That the current investment strategy be continued. • That the Corporate Trustee supports the move to an outsourced finance function		
21.02	**Resolution:** The Corporate Trustee supported: • The current investment strategy be continued. • The move to an outsourced finance function.		
21.03	**Resolution:** The Corporate Trustee approved • A £10k contribution to an endoscopy simulator. • Up to £150k for staff wellbeing facilities at Watford, St Albans and Hemel Hempstead.		
22/84	**Questions from Hertfordshire Healthwatch**		
22.01	There were no questions from Healthwatch.		
23/84	**Questions from the patients and members of the public**		
23.01	There were no questions from members of the public.		
24/84	**Date of the next Board meeting**		
24.01	5 November 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
9/3/2020	08.03/82	Board Assurance Framework	The Board approved the Board Assurance Framework
9/3/2020	15.02/82	Corporate Risk Register	The Board approved the Corporate Risk Register
9/3/2020	16.03/82	Great Place Committee Terms of Reference	The Board approved the Terms of Reverence for the Great Place Committee
9/3/2020	10.04/86 (Part 2)	Phase 3 Recovery Letter	The Board approved the recommendation to delegate to the Executive team final sign off of the forecast submission to the ICS
10/1/2020	06.04/83	Redevelopment options shortlist	Taking into consideration all of the information and analysis provided by the option appraisal report, emergency care high level risk assessment, the communications and stakeholder engagement report and the independent site feasibility report the WHHT Board: 1. Approved the proposed shortlist and preferred options for emergency and planned care 2. Noted the activities undertaken over the past four months to ensure that local people are informed of and engaged in planning for the redevelopment of WHHT hospital facilities. 3. Approved the recommended actions to address and mitigate the key concerns identified via the engagement activities summarised within the stakeholder engagement report.*
10/1/2020	08.03/84	Board Assurance Framework	The Board approved the Board Assurance Framework
10/1/2020	15.05/84	Office relocation of HR and finance staff	The Board approved the proposals for office relocation as set out in the business case*
10/1/2020	16.02/84	Corporate Risk Register	The Board approved the Corporate Risk Register*
10/1/2020	21.02/84	The current charity investment strategy	The Corporate Trustee supported the current investment strategy be continued*
10/1/2020	21.02/84	Outsourced charity finance function	The Corporate Trustee supported the move to an outsourced finance function*
10/1/2020	21.03/84	£10k contribution to an endoscopy simulator	The Corporate Trustee approved a £10k contribution to an endoscopy simulator*
10/1/2020	21.03/84	Conribution to staff wellbeing facilities	The Corporate Trustee approved up to £150k for staff wellbeing facilities at Watford, St Albans and Hemel Hempstead*
10/1/2020	09.06/87	Full Business Case for Electronic Patient Record	The Board approved the Full Business Case for EPR*
10/1/2020	09.07/87	Electronic Patient Record	The Board delegated authority to the Chairman, The Chief Executive and two NEDS to approve the contract for the interim solution*

* Subject to final Approval of minutes

Agenda item: 08/84

Action log Part 1 – 05 November 2020

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	08.02/84	In future any changes in the BAF would be highlighted. There is also a need to reflect the Great Place Committee in the BAF.	RW	05 November 2020	Completed

Trust Board Meeting
05 November 2020

Title of the paper	**Chairman and Chief Executive report**
Agenda Item	**09/84**
Presenter	**Phil Townsend, Chairman and Christine Allen, Chief Executive**
Author(s)	**Rod While, Trust Secretary**
Purpose	**For approval**: **For discussion**: **For information**: ✓
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care *Objectives 1-5* ✓ Aim 2 Great place to work *Objectives 6-8* ✓ Aim 3 Improve our finances *Objective 9* ✓ Aim 4 Strategy for the future *Objective 10-12* ✓
Links to well-led key lines of enquiry	✓ Is there the leadership capacity and capability to deliver high quality, sustainable care? ✓Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ✓Is there a culture of high quality, sustainable care? ✓Are there clear responsibilities, roles and systems of accountability to support good governance and management? ✓Are there clear and effective processes for managing risks, issues and performance? ✓Is appropriate and accurate information being effectively processed, challenged and acted on? ✓Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ✓Are there robust systems and processes for learning, continuous improvement and innovation? ✓How well is the trust using its resources?
Previously considered by	Committee/Group: N/A Date:
Action required	The Board is asked to receive the report for information.

Agenda Item: 09/84

Trust Board Meeting – 05 November 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 November meeting is only open to members of the public via Zoom.

2. NEWS AND DEVELOPMENTS

Trust News

2.1. We are delighted to announce that chief nurse Tracey Carter and respiratory consultant Dr Matthew Knight have been appointed MBEs (Member of the Order of the British Empire) for services to the NHS in the Queen's Birthday 2020 Honours List. Dr Matthew Knight was one of many individuals nominated for an honour for their response to the pandemic. He led a frontline team of doctors, nurses, physiotherapists and admin staff to deliver a 'virtual hospital' to look after patients infected with COVID-19. A nurse for over 30 years, chief nurse Tracey Carter joined #TeamWestHerts in 2014 and is highly regarded from ward to board for her leadership, empathy and passion for the job. Her leadership has helped us to better recruit, retain and transform our nursing workforce helping to dramatically reduce the vacancy rate for junior nurses from over 23% to around 7%. Congratulations to Tracey and Matthew on their richly deserved appointments!

2.2. Throughout the month of October the Trust celebrated Black History Month, which provided a fantastic opportunity for us to recognise the outstanding contributions and achievements of black people.

2.3. #TeamWestHerts attended the virtual HPMA Awards ceremony on Thursday 1 October and scooped up two awards, including HR Team of the Year! The Healthcare People Management Association is the professional voice of HR in healthcare.We won the excellence in organisational development category for our Senior Medics' Assessment and Review Trial (SMART) Initiative. We also won HR Team of the Year and were shortlisted for best recruitment initiative (solving the crisis.)

2.4. The full business case for the Trust's Electronic Patient Record (EPR) was approved at October Trust Board which is great news as this moves us further forward in the programme. Over 100 staff also attended a kick-off session for the next phase and it was brilliant to see this number of staff engaged and participating in this way. An EPR will bring patient records and clinical applications together and will provide staff with all the information they need at their fingertips to make the best decisions for our patients.

2.5. #TeamWestHerts were delighted when Professor Jo Martin, president of the Royal College of Pathologists (RCPath), paid a visit to the microbiology department 14 October at Watford General Hospital to hear about all our recent microbiology developments.

In particular, Professor Martin heard about the rapid diagnostic testing for COVID-19 in response to the pandemic. She was very impressed with how the department has been able to implement local PCR testing (antibody tests for COVID-19) through identifying the required space and facilities, obtaining new analysers, setting up the right IT interface, recruiting the number of staff needed to provide a 24/7 service and ramping up COVID-19 testing capacity to about 250 samples per day. Professor Martin praised the department, saying that it has always had a fantastic reputation nationally and this was yet another example of how well the team has risen to COVID-19 challenges.

MP Updates

2.6. Daisy Cooper, MP for St Albans carried out the virtual opening of our new Orthopaedics centre at St Albans. Having a dedicated centre allows us to provide more treatments and services within the department, improving our patients' experience and freeing up capacity in other areas.

Other Meetings

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

- Consultant Interviews - Paediatrics - two appointments were made, with possible third.
- Attended the three day virtual provider conference
- Reviewed and signed the initial Cerner contract (EPR)
- Attended the regional and national event hear from Sir Simon Stevens
- Attended the virtual HSJ digital summit
- Reviewed progress with Ann Radmore, regional Director
- Chaired excellent Board Development on clinical strategy and meeting the architects
- Healthwatch Herts meeting
- Bike prize draw for staff
- The Chair and Chief Executive hosted Clay Van Doren the CEO of ATOS UK, to discuss with Paul Bannister and Helen Brown, our estate and digital roadmaps and how critical our ATOS partnership is.

- Attended committees
- Conducted interviews for Trust Secretary
- Met with Chair of Royal Free
- Chaired calls with ICP chairs

3. BOARD NEWS

Board Development Meeting

3.1. A Trust Board development meeting was held on 15 October September to consider the Trust's developing clinical strategy and an update regarding the acute redevelopment programme.

Board visit programme

3.2. As part of the monthly Board visit programme, the Board visited three areas at Watford hospital in October 2020, Antenatal Department, Endoscopy Department and the Special Care Baby Unit. Verbal feedback from the visits was received in the private session of the Board meeting in October 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
05 November 2020

Title of the paper	Board assurance framework report
Agenda Item	10/84
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. All changes to the BAF since the last Board Report are marked in red.
Trust strategic aims	Aim 1 Best quality care *Objectives 1-5* ✓ | Aim 2 Great place to work *Objectives 6-8* ✓ | Aim 3 Improve our finances *Objective 9* ✓ | Aim 4 Strategy for the future *Objective 10-12* ✓
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners

	engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	• Finance and Performance Committee • Quality Committee
Action required	The Board is asked to approve the Board Assurance Framework

Agenda Item: 10/84

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.

2.3 All changes to the BAF since the last Board Report are marked in red.

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	AJ/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		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 guidnace issued. To continue with current actions and reivew 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**	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	
		Performance against trajectories	2c	Failure to deliver UTCs in line with planned delivery dates	Deputy Chief Executive	Quality Committee			Medium	1. Programme Director in post 2. Programme Plan for July start for WGH UTC in place	3. Programme plan for procurement of HHGH and SACH UTCs to be finalised	1. Urgent Care Programme Board - joint with HVCCG 2. updates to Board via Strategy Update		1. finalise programme plan for procurement of HHGH and SACH UTCs	HB	Jul-20	
AMBITION 3 **Patient Experience: improve our scores on the Friends and Family Test and national patient survey result to better than national average.**	**Improving communications with our patients and carers**	**25 Selected questions from 9 of the 12 sections from inpatient survey**	3a	COVID-19 outbreak negatively impacts on patient experience	Chief Nurse	Quality Committee	4269 4287	CQC	High	1. Patient Experience Group 2. Family Liaison line introduced as an extension of PALS 3. Visitors helpline 4. Use of technology to face time 5. Letter to a loved one introduced 6. Additional staff within patient affairs 7. Increase in establishment within Spiritual & pastoral care	The national and local visiting policy has the potential to have negative impact with no or reduced visiting Reduced visiting for end of life, LD, MH and dementia patients	1. Divisional Governance meeting 2. Patient Experience Group 3. Quality Committee 4. national inpatient survey. 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 outcome 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	30/11/2020	Reimbursement mechanism moving to fixed payments, reinforcing the need for existing controls in order to avoid an increased risk of cost under-recovery. The plan for months 7-12 of FY21 have been submitted and signed off by the ICS / STP in the last week. The Trust deficit indicated by that plan is £5.6m (26/10/2020)
	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, sufficiently 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	Planning cycles well underway in relation to the remainder of 2020/21 and for the following financial year, both of which include appropriate assessments of Covid recovery actions. Efficiency savings of 1% have been included in planning assumptions. (26/10/2020)

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 WRES 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	Great Place Committee	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	The Local Area Network programme has been completed, a programme closure report is being produced. The HSCN upgrade has also been completed, meaning we are much more resilient from a network perspective. We are in the process of ascertaining the performance improvements that have come from these projects. We now have network diagrams and much more knowledge of how our network is structured. We are now turning to the hybrid model, the CIO is shortly to present a paper to the board describing a future operating model which should reduce the risk inherent in the hybrid model.
			6b	Failure to progress redevelopment OBC in line with the programme plan	Deputy Chief Executive	Great Place Committee			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 held 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.
	Redevelopment OBC approved	**Key milestones**	6c	Insufficient engagement of clinical staff and stakeholders in planning for the new hospital results in a sub-optimal solution	Deputy Chief Executive	Great Place Committee	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. Clinical Brief to be finalised - current focus on activity and capacity modelling and agreement of functional content.			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. Good clinical engagement via user groups. Offers made - 2 x new project managers to commence in November. 3rd candidate withdrew. New 'nurse lead' role to be developed. User groups now well established and meeting regularly.
	EPR secure funding and FBC mobilised	**Key milestones**	6d	Failure to secure funding for EPR	Chief Information Officer	Great Place Committee	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	Our EPR programme with RFL and Cerner has been launched with a programme team largely in place. An interim contract with Cerner to the end of Dec 20 has been signed. The Full Business Case (covering ten years of service) has been approved by the Trust Board. This Full Business Case is being reviewed by various regulators with the expectation that it will be formally reviewed (and hopefully approved) at the national Joint Investment Committee at the end of November. The plan then being that we would sign contracts with Cerner before the Christmas break. In the meantime the programme continues with the plan showing 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	Nov-20	Preparation of the Full Business Case is ongoing and is governed & progressed by weekly meetings with all relevant stakeholders. (26/10/2020)

Trust Board Meeting
5 November 2020

Title of the paper	Activity Recovery Update & Access Standards Performance (September 2020 data reporting period)
Agenda Item	
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	Activity recovery is progressing although September actuals are behind plan and target against a number of measures including some diagnostic modalities and elective inpatients/day cases. Performance data is provisional at the time of writing (30/10/2020) 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%	84.3%	↑
Diagnostic waits	99%	69.2%	↑
RTT incomplete pathways < 18 weeks	92%	69.7%	↑
52 week waits	0	855	↓
2 week wait referrals	93%	97.2%	↑
2 week wait breast symptomatic referrals	93%	97.1%	↑
28 day Faster Diagnosis standard	70%	78.5%	↔
31 day first definitive treatment	96%	97.0%	↔
31 day subsequent - surgery	94%	71.4%	↓
31 day subsequent - drug	98%	100.0%	↔
31 day subsequent - palliative	94%	100.0%	↔
62 day referral to first treatment	85%	83.7%	↓
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 better than the previous month (83.1%) at 84.3%

Diagnostics has improved slightly to 69.4%, previously 68.5%.

RTT performance has improved further, to 69.7% from 62.5% this month. However, there has been a further significant increase in 52 week waits, now at 855 (was 669).

All cancer waiting standards were achieved with the exception of the 31 day subsequent surgery standard (71.4%) where 2 breaches have resulted in non-compliance. The standard has not been met for either 62 day first pathways

<table>
<tr><td></td><td>(83,3%), where there are 19.5 breaches or 62 day screening pathways (66.7%) where there was 1 breach.</td></tr>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><th>Aim 1
Best care</th><th>Aim 2
Great team</th><th>Aim 3
Best value</th><th>Aim 4
Great place</th></tr>
<tr><td>Objectives 1-4</td><td>Objectives 5-8</td><td>Objective 9</td><td>Objective 10-12</td></tr>
<tr><td>✓</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td>
<table>
<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>Trust Management Committee</td><td>28 October 2020</td></tr>
<tr><td>Finance & Performance Committee</td><td>29 October 2020</td></tr>
</table>
</td></tr>
<tr><td>Action required</td><td>The Committee is asked to receive this report for information.</td></tr>
</table>

Trust Board Meeting
5 November 2020

Agenda Item:

Trust Board Meeting – 5 November 2020

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

Presented by: Sally Tucker, Chief Operating Officer

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.

ACTIVITY RECOVERY

2 Recovery to date (September 2020)

2.1 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.

2.2 Overall referrals received in September amounted to 81% of the September 2019 total. Within this, cancer referrals were at 96% of the previous year. New ways of working, including Advice & Guidance and Referral Assessment Services (RAS) mean that not all referrals progress and this is likely to result in a lower level of referrals than in previous years, but is a positive change. Work is underway to capture this new activity in a consistent way across all services.

2.3 Diagnostic recovery is progressing well, with CT scans above the phase 3 recovery target. There is a shortfall between plan and target in MRI scanning when compared with October 2019, largely due to less capacity being available in the independent sector.

2.4 Endoscopy recovery is influenced by a number of factors including patients declining appointments due to reluctance to self-isolate and capacity constraints due to IPC requirements. However, there has been a steady increase in activity, achieved through additional in house sessions. A locum consultant has been recruited who will deliver additional sessions from late October.

2.7 Discussions with other local independent sector providers (ISP) have progressed well and capacity has been secured for a range of CT investigations, MRI and ultrasound scans.

Additional Endoscopy capacity is dependent upon the ISP facilities meeting the required standards and discussions are progressing well.

2.8 Outpatient activity has not yet achieved plan or the phase 3 recovery target. Factors underpinning this shortfall includes some delayed re-starts, changes in service delivery eg changes in service delivery through Advice and Guidance etc.

2.9 Non-face to face outpatient targets have been achieved. Just under 40% of all activity was delivered virtually in September (target 25%) of which 63% was follow up (target 60%).

2.10 Elective inpatient admissions have continued to increase. Of the 87% of inpatient admissions, 20% were in the independent sector, where 10% of day case admissions (67% overall) were also undertaken. The plan to utilise all 6 theatres in mid-late September was not achieved due to a breakdown in the ventilation system followed by a significant leak in the roof. Both have now been addressed and the 6th theatre sessions were commenced in October.

2.11 Urgent and Emergency Care demand is near to pre-COVID levels, with attendances at WGH A&E at 98% of the September 2019 level, with inpatient admissions of 1 or more days at 94%. Same day admissions (0 LOS), at 76% of the September 2019 total, but this has continued to increase and the October 2020 activity is more than 100% of the 2019 total.

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%	84.3%	↑
Diagnostic waits	99%	69.2%	↑
RTT incomplete pathways < 18 weeks	92%	69.7%	↑
52 week waits	0	855	↓
31 day subsequent - surgery	94%	71.4%	↓
62 day screening referral to first treatment	90%	66.7%	↑
62 day referral to first treatment	85%	83.7%	↓

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

4 A&E 95% target

4.1 Performance against the 4 hour standard was better this month with 84.3% (previously 83%) of attendances at the trust's urgent or emergency care units. CED performance was lower than the previous month at 88.5% but this was underpinned by a 17.6% increase in attendances. Flow of Majors patients remains challenging (58% vs previous month 57.7%). There was an 11.8% increase in bed requests compared with the previous month

but a 24.5% reduction in patients waiting 8-12 hours for a bed. Non-admitted performance improved from 75.2% to 79.9% The Minor Injuries Unit at SACH remains closed but UTC at Hemel Hempstead achieved 99.9% compliance.

4.2 Watford UTC performance was just above 98.4%. When this activity is combined with the WGH type 1 activity performance was 78.8% (last month 77.1%).

4.3 Model Hospital benchmarking (September 2020 performance) shows the Trust (the black bar) position has improved from the bottom quartile to the third, with a national median of 86.2% and a regional median of 83.4% (regional peer trusts in grey).

5 Ambulance Handover Delays

5.1 The number of patients arriving at A&E in an East of England ambulance was similar to the previous month. There was a 7.6% improvement in delays between 30 and 60 minutes (327 from 354) and delays over 60 minutes improved by 57% (78 from 180).

5.2 Information shared by the regional EEAST team indicates a 5% increase in ambulance journeys to WGH, which places the trust as a significant outlier since all other trusts in the region have experienced a decrease. This has been raised with HVCCG and with NHSEI and further analysis is underway to better understand this. Early review of chief complaint details shows a large increase in patients conveyed to hospital as a result of self-harm. The other major growth was in patients experiencing falls. It is hoped that this information will be considered by commissioners when reviewing attendance avoidance initiatives.

6 RTT Incomplete pathways

6.1 Performance continues to improve and this month 69.7% of RTT pathways were less than 18 weeks (August 61.8%). This is due to the increasing number of referrals and actions to address the backlog.

6.2 Model Hospital benchmarking (August 2020 performance at 51%) shows the Trust (the black bar) position has improved significantly when compared with other trusts. It should be noted that no organisation achieved the standard, the highest performance being 79.9%. The regional and national medians improved, both at 53.9%.

7 52 week waits

7.1 The number of patients waiting more than 52 weeks continues to increase at a significant rate, now with 855 pathways waiting a year or more, and the highest number of these long waits remains in Oral Surgery.

Service	Sep-20
ORAL SURGERY	254
ENT	178
OPHTHALMOLOGY	137
UROLOGY	81
TRAUMA & ORTHOPAEDICS	93
GENERAL SURGERY	50
PAIN MANAGEMENT	24
VASCULAR SURGERY	20
ORTHODONTICS	10
COLORECTAL SURGERY	5
GASTROENTEROLOGY	2
GYNAECOLOGY	1
Total	855

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

7.2 Options to outsource the 3 specialties with the highest number of breaches are being explored. There is little or no capacity within the national ISP contract for these specialties at Spire Bushey, but other options including locally commissioned capacity are progressing and Oral Surgery activity is expected to commence in late October.

8 Cancer Waiting Times Performance

8.1 The 2 week wait and breast symptomatic standards were achieved, as were most of the 31 day standards.

8.2 There were 2 breaches (Urology, Lower GI) of the 31 day subsequent surgery standard, resulting in a failure to achieve the target. One of these breaches was due to the patient choosing to delay treatment beyond the target date. The other breach was due to capacity constraints.

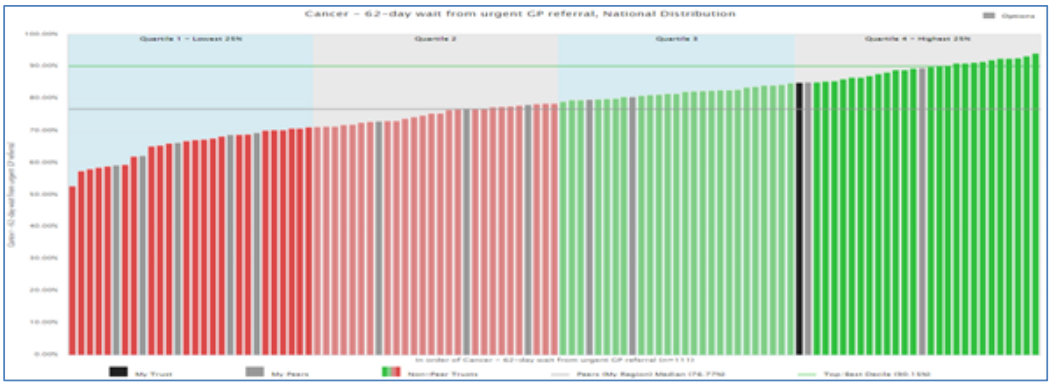
8.3 Performance against the 62 day referral to first treatment standard is currently just below the 85% target at 83.7% but the reporting period is still open and additional activity will be recorded which could affect performance either way. There are 19.5 breaches (5.5

Urology, 3 UGI, 2 LGI, 6 Haematology). There were 116.5 pathways in total, an increase of almost 60% on the previous month.

8.4 There has been no further improvement in performance against the 62 day screening referral standard. There was 1 breach (Lower GI) where there were significant delays to colonoscopy as a result of COVID constraints.

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 (August 2020 performance at 85.1%) shows WHHT has moved in to the top quartile (the black bar). Performance was better than the national median of 78.5% and the regional median of 76.7%.



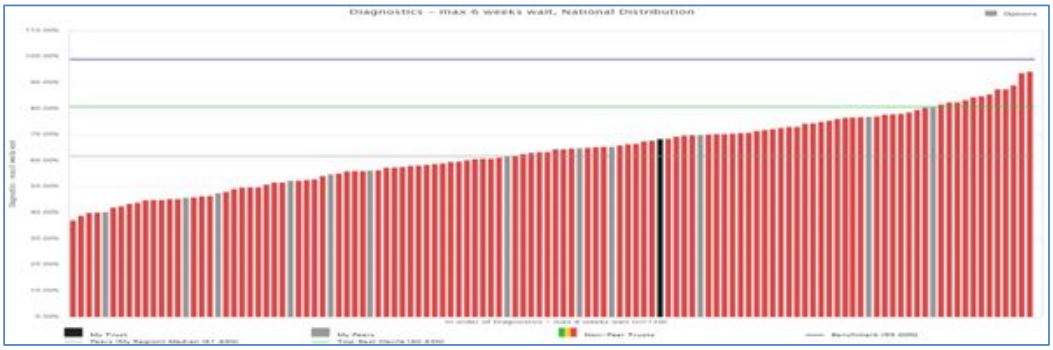
9 Diagnostic waiting times performance

9.1 The standard for diagnostic waiting times was not achieved, although performance has improved slightly on the previous month (68.5%) to 69.4%. Most modalities' performance remains below the standard.

Diagnostic Waiting Times Performance	April	May	June	July	Aug	Sept
W01: Imaging - Magnetic Resonance Imaging	52.8	55.2	75.6	72.9	75.8	82.4
W02: Imaging - Computed Tomography	53.3	90	83.3	91.3	83.5	78.3
W03: Imaging - Non-obstetric ultrasound	23.6	39.8	88.5	92	82.7	66.9
W04: Imaging - Barium Enema	80	100	100	100	100	100
W05: Imaging - DEXA Scan	7.5	39.3	73.6	84	35.1	38.8
W06: Physiological Measurement - Audiology - Audiology Assessments			100	57.2	54.8	55.8
W07: Physiological Measurement - Cardiology - echocardiography	2.2	5.7	40	36.8	70.3	86.1
W08: Physiological Measurement - Cardiology - electrophysiology						
W09: Physiological Measurement - Neurophysiology - peripheral neurophysiology	50		100	85.5	100	100
W10: Physiological Measurement - Respiratory physiology - sleep studies						
W11g: Physiological Measurement - Urodynamics - pressures & flows (Gynae)	100	100	100	100	100	100
W11s: Physiological Measurement - Urodynamics - pressures & flows (Surgical)			100	77.8	90.5	66.7
W12: Endoscopy - Colonoscopy	46.9	28	50.7	69.7	69.8	79.5
W13: Endoscopy - Flexi sigmoidoscopy	40.1	32.8	40.6	50.5	62.9	81.3
W14: Endoscopy - Cystoscopy	35.1	38.6	47.7	55.6	60.3	69.2
W15: Endoscopy - Gastroscopy	22	19.9	41.8	61.8	54	53.1
Total	26.5	39.6	64.8	73.4	68.5	69.4

9.2 There has been a small improvement for DEXA scanning which is subject to significant focus and recovery actions including outsourcing, recruitment to vacant posts and comprehensive validation, are ongoing.

9.3 Model Hospital benchmarking (August 2020 performance at 68.5%) shows the Trust's (the black bar) improving position, better than the national median, 64% and the regional position at 61.8%. No organisation achieved the 99% standard, the highest being 94.5%.



10 Harm Reviews

10.1 Tracking the completion of harm reviews is now conducted using the main waiting list. A paper was presented to the Quality Committee in October outlining the harm review process. Each division has a different trigger point; Surgery 48 weeks; WACS Gynaecology 40 weeks, Paediatrics 25 weeks; Medicine 40 weeks. Analysis of the PTL on 30/10/2020 is shown below.

Medicine (Trigger: 40 weeks)	Total > 40 weeks	Harm Reviews	
		Completed	In progress or outstanding
GASTROENTEROLOGY	6	33.3%	66.7%
CARDIOLOGY	20	60.0%	40.0%
DERMATOLOGY	1	100.0%	0.0%
RESPIRATORY MEDICINE	0		
NEUROLOGY	11	45.5%	54.5%
RHEUMATOLOGY	2	100.0%	0.0%
GERIATRIC MEDICINE	3	0.0%	100.0%
ENDOCRINOLOGY	2	0.0%	100.0%
CLINICAL HAEMATOLOGY	1	0.0%	100.0%
HEPATOLOGY	1	0.0%	100.0%
Total	47	46.8%	53.2%

WACS (Trigger: Gynae 40 weeks Paeds 25 weeks)	Total > 40/25 weeks	Harm Reviews	
		Completed	In progress or outstanding
GYNAECOLOGY	15	33.3%	66.7%
PAED ENDOCRINOLOGY	2	0.0%	100.0%
PAED CARDIOLOGY	3	0.0%	100.0%
PAEDIATRICS	2	0.0%	100.0%
Total	22	22.7%	77.3%

Surgery (Trigger: 48 weeks)	Total > 48 weeks	Harm Reviews	
		Completed	In progress or outstanding
GENERAL SURGERY	136	71.3%	28.7%
UROLOGY	123	80.5%	19.5%
TRAUMA & ORTHOPAEDICS	156	15.4%	84.6%
ENT	286	90.2%	9.8%
OPHTHALMOLOGY	251	94.0%	6.0%
ORAL SURGERY	364	98.9%	1.1%
COLORECTAL SURGERY	18	50.0%	50.0%
UPPER GI SURGERY	5	20.0%	80.0%
VASCULAR SURGERY	31	71.0%	29.0%
ORTHODONTICS	14	78.6%	21.4%
PAIN MANAGEMENT	78	29.5%	70.5%
PAEDIATRIC UROLOGY	14	28.6%	71.4%
PAEDIATRIC OPHTHALMOLOGY	9	88.9%	11.1%
Total	1485	77.6%	22.4%

10.2 Cancer 62 day harm reviews are tracked by the MDT Co-ordinator team. The latest available summary shows that 74% of August's breached pathways had a completed review. CWT guidance puts responsibility for completion of a harm review on the treating provider. Although WHHT have undertaken reviews for a number of pathways with onward tertiary referrals, input from the treating organisation is sometimes difficult to get but

HVCCG are supportive of the trust's position and are actively looking at ways of engaging other organisations in the process.

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

10.3 To date 9 low degree harms associated with delays on the RTT waiting list have been identified in Urology. These range from recurrent UTIs, urosepsis, condition progression requiring a change in treatment, or ongoing symptoms.

10.4 One low degree harm was recorded in Pain Management, as a result of the patient reporting increased levels of pain.

10.5 In the event of moderate or severe harm, duty of candour is applicable

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 A range of controls are in place with oversight and assurance not only through harm reviews, but also through regular review of performance and access to services in the weekly Access meetings, the monthly Elective Care Programme Board, and in reports to the Finance & Performance Committee and Trust Board

12 Recommendation

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

Jane Shentall
Director of Performance
30 October 2020

Appendix 1 - Elective Recovery – Actual vs Plan vs Target

Activity type			Sep	Oct	Nov	Dec	Jan	Feb	Mar	Update / Comment to w/commencing 26/10
Diagnostics	CT	Trust plan	103%	102%	102%	102%	102%	102%	102%	**The last week reported is not a final position** **Diagnostics** Additional capacity for MRI, CT and CT colon has been secured through local commissioning to supplement activity already outsourced. This commences on 26/10/20. The first patient went through CT in a box on 22/10/20. MRI in a box is not expected to go live until March/April 2021 **Endoscopy** New locum consultant commenced at the beginning of October and lists are scheduled. Additional locally commissioned ISP capacity is availabe but not until mid November and may be dependent on support from trust staff. Recent bid for capital has been successful for kit and estates works, and more recently also to support digital and IT requirements (Windows 10 replacement and reporting software and interface) **Outpatients** Referrals (all types) in September were at 80% of the previous year's September total, but within that Cancer referrals were at 96%. New pathways (Advice & Guidance, Referral assessment services and virtual consultations) are embedding and have influenced traditional outpatient activity, making benchmarking difficult. New consultations were at 75%, and in October (mtd) are currently 81%. The virtual consultation model works well for many follow up appointments. 40% of follow up activity in September was delivered virtuallythis year, and overall: 39% of all outpatient activity is non face to face **Elective Inpatient** SACH Theatre 5 came back in to service in early October. Some addtional weekend lists are planned. There are plans to run a WGH complex Orthopaedic admissions week in late October with other specialties coming on board in the following weeks. IS actiivity mainly Colorectal, Breast, Gynaecology, Urology continues. Paediatric bed capacity has been a constraint for some specialties but cross divisional working is progressing and paediatric lists are expected to start in the near future. **Indepdent Sector** The tender process for the second phase of the national ISP contract has commenced but there is not yet absolute clarity on the detail. In the meantime however, activity continues to be undertaken at Spire Bushey. Other IS providers within the national contract: (BMI, One Hatfield) activity picking up with Oral Surgery, Ophthalmology, Orthopaedic lists are confirmed and activity has commenced. Local commissioned IS capacity (One Stop Doctors) has been agreed and patients have been outsourced for imaging from 23/10/20 (MRI, CT Colon, US) Endoscopy capacity is progressing and the trust's lead nurse is working with the OSD team to take this forward with a possible start in mid to late November.
		Target	90%	100%	100%	100%	100%	100%	100%	
		Actual	93%	89%						
		Gap to plan	-10%	-13%						
		Actual vs target	3%	-11%						
	MRI	Trust plan	113%	102%	104%	104%	102%	108%	106%	
		Target	90%	100%	100%	100%	100%	100%	100%	
		Actual	75%	74%						
		Gap to plan	-38%	-28%						
		Actual vs target	-15%	-46%						
	Endoscopy	Trust plan	55%	81%	100%	100%	100%	100%	100%	
		Target	90%	100%	100%	100%	100%	100%	100%	
		Actual	60%	69%						
		Gap to plan	5%	-12%						
		Actual vs target	-30%	-31%						
Outpatients	All Outpatients	Trust plan	75%	90%	90%	90%	90%	90%	90%	
		Target	100%	100%	100%	100%	100%	100%	100%	
		Actual	77%	77%						
		Gap to plan	2%	-13%						
		Actual vs target	-23%	-23%						
Electives	Day Case	Trust plan	98%	94%	94%	95%	95%	94%	94%	
		Target	80%	90%	90%	90%	90%	90%	90%	
		Actual	56%	69%						
		Gap to plan	-42%	-25%						
		Actual vs target	-24%	-21%						
	Inpatient	Trust plan	79%	89%	89%	89%	89%	89%	89%	
		Target	80%	90%	90%	90%	90%	90%	90%	
		Actual	87%	74%						
		Gap to plan	8%	-15%						
		Actual vs target	7%	-16%						

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 29/10/20)

Standard	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 YTD (latest)
2ww	93.0%	94.1%	96.3%	96.8%	97.0%	97.6%	98.0%	95.1%	99.0%	97.7%	98.6%	96.5%	97.2%	97.4%
2ww 28 day FDS	75.0%	71.1%	75.2%	76.8%	75.8%	84.7%	77.0%	68.8%	85.6%	82.1%	80.9%	80.6%	78.4%	80.6%
2ww breast	93.0%	100.0%	96.3%	98.4%	94.2%	98.6%	98.5%	100.0%	87.9%	87.9%	98.1%	96.2%	97.1%	95.6%
31 day 1st	96.0%	94.3%	98.0%	99.4%	96.3%	97.2%	97.1%	98.5%	92.1%	97.2%	96.4%	96.6%	97.0%	96.4%
31 day surgery	94.0%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	87.5%	100.0%	94.4%	77.8%	71.4%	90.1%
31 day drug	98.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%	100.0%	100.0%	98.6%
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%
62 day	85.0%	79.4%	77.9%	82.9%	84.8%	80.1%	83.1%	70.3%	76.9%	86.4%	77.6%	86.0%	83.7%	79.9%
62 day screening	90%	66.7%	92.3%	100.0%	72.0%	80.0%	92.0%	85.7%	64.3%	100.0%	0.0%	66.7%	66.7%	59.4%

NB:

- Performance is provisional at the time of writing

Trust Management Committee Meeting
28 October 2020

Title of the paper	**Integrated Performance Report** ***(October 2020 reporting period – September 2020 data)***
Agenda Item	
Presenter	**Jane Shentall** **Director of Performance**
Author(s)	**Jane Shentall** **Director of Performance**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary	**Best Care / Great Team – COVID-19 snapshot** • Significant increase in COVID-19 positive inpatients to 34 (was 10), reduction in suspected at 8 (was 14), and 3 ITU COVID-19 positive patients (slide 3, 28-30) • Results awaited is higher at 108 is similar to previous months (slide 3, 28-30) • COVID-19 negative inpatients, is relatively unchanged now 465 (was 478) (slide 3, 28-30) • Staff absence indicators show a significant increase in COVID-19 sickness at 246 (up from 40), a significant increase in staff self-isolating at 174 (was 18) (slide 3) • 1 definite and 1 probable hospital 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: SHMI 100.6 (100.6 last period), HSMR 110 (117.5 last month) (slides 4, 25) • There were 6 hospital apportioned clostridium difficile cases (previous month 1) with a year to date total of 13 (slides 4, 26) • The overall C-section rate is higher at 34.3% (previously 31.2%) and is above (worse than) target (28%); the elective rate at 15.4% (was 16.1%) is above the local target (11%), as is the emergency rate (target 15%) at 18.9% (was 15.1%). The year to date rate for all C-sections is 33.4% (slides 4, 32). • Reporting for safe care, nursing shift fill, remains suspended as a result of the COVID-19 pandemic (slides 4, 34) • There were 2 serious incidents and patient safety incidents that are harmful is slightly higher than the previous month (7.9%) at 8.1% 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 96% and year to date the rate is 95.9% (slides 4, 37) • Stroke indicator performance deteriorated further to 15.9% (previously 18.5%) of patients admitted to the Stroke unit within 4 hours (target 90%, national average 54%), but 80% (was 84.1%) of patients spent 90% of their admission on the unit (target 80%, ytd 73.2%, national average 82.7%) (slides 4, 38) **Caring & Responsive Services** • Ambulance turnaround delays improved, with 327 (was 354) between 30 and 60 minutes and 78 (was 180) over 60 minutes (slides 5, 39) • ED 4 hour performance was better, at 84.3% (last month 83.1%) 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 are much improved and remain better than target (80%) at 85.7% with no reactivated complaints received in the month (slides 5, 44)

- RTT (incomplete) performance is better at 69.7% (from 62.5%) (ytd 56.9%). There were 855 x 52 week breaches (previously 669) (slides 5, 46)
- Diagnostic waiting times performance remains below the standard (99%) at 69% (was 68.4%) (slides 5, 46)
- 2 week wait (97.2%) is better (higher) than target (93%), 2 week wait breast symptomatic is compliant with the standard (93%) at 97.1% (slides 5, 47)
- 28 day faster diagnosis standard (2ww) performance is compliant at 79.8% (slides 5,47)
- 31 day subsequent surgery performance is currently below the standard (94%) at 71.4% (slides 5, 48)
- Performance against the 62 day urgent referral to first treatment is currently just below target (85%) at 83.7% (slide 5, 49)
- 62 day screening performance is unchanged and remains non-compliant at 66.7% (slides 5, 49)
- Short notice appointment cancellations remain above (worse than) target, and unchanged at 14.1% (slides 5, 50)
- Outpatient DNA rates have risen just above (worse than) target at 8.6% (previously 7.5%) (slides 5, 50)

Workforce & Finance

- 12 month turnover rate is similar to previous months at 13.6% (previously 13.3%) and is just above target (13%); the vacancy rate is higher at 10.4% and worse than target (10%) (slides 5, 51)
- Sickness absence rates have risen to just above (worse than) the target level at 3.9% (from 3.5%) (slides 6, 51)
- All staff appraisals rates are temporarily suspended (slides 5, 52)
- Mandatory training is compliant at 90.5% (slides 5, 52)
- Bank pay is better (lower) than the target (12%) at 11.1% (ytd 10.5%) and agency pay has remains better than target (4.7%) at 4.2% (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 £0.07m better 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 £1.2m. The YTD CIP ask of £4.0m 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 – 28/10/2020

Trust strategic aims

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

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

Links to well-led 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?

<table>
<tr><td></td><td>☒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>28 October 2020</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Committee is asked to receive this report for information, assurance and discussion.</td></tr>
</table>

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

October 2020

Reporting Period: September 2020

Trust Board: 5th November 2020

Performance data updated on: 28th October 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** 85.7% Target 80%	**Mandatory Training** 90.5% **Appraisal Rates** 87.0% Target 90%
Clostrioides Difficile cases 7 Target 2	**ED 4 hour standard** 84.3% Target 95%	**Agency pay** 4.2% Target 4.7%
VTE assessment 96.0% Target 95%	**RTT 52 week waits** 855 Target 0	**Vacancy rate** 10.4% Target 10%
Inpatient Friends & Family positive scores Suspended Target 95%	**CWT - 62 day referral to first treatment** 83.7% Target 85%	**I&E forecast** (Full year) £0 **I&E actual** (YTD actual & YTD plan) £0 Target -£ 1,999

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

COVID-19 SNAPSHOT – 15th October 2020

BEST CARE

GREAT TEAM

INPATIENTS

C-19 positive **34**	C-19 suspected **8**	ITU C-19 positive **3**
C-19 result awaited **108**	C-19 negative **465**	ITU C-19 negative **7**

STAFF TESTING

C-19 positive **0**	C-19 negative **15**
Antibody test positive **4**	Antibody test negative **9**

PATIENT TESTING

Non-elective C-19 positive **3**	Non-elective C-19 negative **66**
Elective C-19 positive **0**	Elective C-19 negative **1**

STAFF ABSENCE

C-19 sickness absence **246**	C-19 self isolating **174**
C-19 shielding **TBC**	

NOSOCOMIAL INFECTIONS

Hospital definite **1**	Hospital probable **1**
Hospital indeterminate **0**	Community **1**

PPE ESTIMATED STOCK DURATION (DAYS)

Fluid resistant face masks **25 (Green)**	FFP3 face masks **31 (Green)**
Gloves **18 (Green)**	Gowns **21 (Green)**

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Essential Measures – Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Lower than previous month and within the "as expected" range	SHMI 100.6 HSMR 111.0	**Complaints response times** Above target (80%) and better than previous month	85.7% YTD 74.7%	**All staff appraisal** Unchanged from previous month Below target (90%)	Suspended
Infection Control – clostrioides Difficile (hospital & healthcare) 6 Cat1 and 1 Cat2 case this month	7 (Cat1: 6 Cat 2:1) YTD 20	**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 – 2 SIs in reporting period	SI 2 YTD 10 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	13.6% YTD 13.8%
Patient safety incidents which are harmful Higher than previous month	8.1% YTD 8.3%	**Outpatient DNA rates** Above (worse than) target (8%) and higher than previous month	8.6% YTD 6.8%	**Income & Expenditure** Breakeven position for September	£0.00m YTD £0.00m
Combined Caesarean Section Standard (28%) not achieved and worse (higher) than previous month	34.3% YTD 33.4%	**ED waiting times** Better than previous month Target (95%)	84.3% YTD 84.2%	**Capital Spend** £0.51m Capital spend in September against a target of £2m	(£0.51)m YTD (£6.09)m
VTE assessments Better (above) than target (95%) Similar to previous month	96.0% YTD 95.9%	**RTT waiting times** Lower than the target (92%) Increase in 52 week waits	69.4% YTD 60.3% 855	**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%) achieved	4 hr 15.9% YTD 29.1% Adm 80.0% YTD 73.2%	**Cancer waiting times** 2ww achieved consistently 62 day below target (85%) Worse than previous month	2ww 97.2% YTD 97.5% 62 day 83.7% YTD 80.1%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 0 Elec 2070 vs 4148.37 Non-Elec 3901 vs 4925.79
Reporting Sub-Committee **Quality Committee**		**Reporting Sub-Committees** **People, Education & Research Committee** **Finance & Performance Committee**		**Reporting Sub-Committees** **People, Education & Research Committee** **Finance & Performance Committee**	

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

COVID19 – SNAPSHOT - Indicator Summary

Domain	Theme	Trend Month on Month	Aug-20	Sep-20	Oct-20
COVID 19 Snapshot	**Inpatients**				
	C-19 positive	Worsening	25	10	34
	C-19 suspected	Improving	16	14	8
	C-19 result awaited	Improving	128	111	108
	C-19 negative	Worsening	480	478	465
	ITU C-19 positive	Worsening	2	0	3
	ITU C-19 negative	Worsening	10	13	7
	Staff Testing				
	C-19 positive	Stable	0	0	0
	C-19 negative		31	3	15
	Antibody test postive	Improving	1	1	4
	Antibody test negative		2	16	9
	Patient Testing				
	Non-elective C-19 positive	Worsening	0	2	3
	Non-elective C-19 negative	Improving	30	50	66
	Elective C-19 positive	Stable	0	0	0
	Elective C-19 negative	Stable	0	0	1
	Staff Absence				
	C-19 sickness absence	Worsening	93	40	246
	C-19 self isolating	Worsening	60	18	174
	C-19 shielding		N/A	N/A	N/A
	Nosocomial Infections				
	Hospital definite	Worsening	0	0	1
	Hospital probable	Worsening	0	0	1
	Hospital indeterminate	Stable	0	0	0
	Community	Worsening	0	0	1
	Estimated duration of PPE stock (days)				
	Fluid resistant face masks	Worsening	33	39	25
	FFP3 face masks	Improving	9	17	31
	Gloves	Improving	5	15	18
	Aprons		11	N/A	N/A
	Gowns	Improving	11	16	21

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Jul-20	Aug-20	Sep-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	99.1	100.6	100.6			Apr-20	National	100	Apr-20
		HSMR - Total (Rolling three months)	26	100	Performance improved but worse than target	109.0	117.5	111.0			Jun-20	National	100	Jun-20
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	28	n/a		1	1	6	13		Sep-20	National	n/a	
		Clostridioides Difficile - Healthcare associated (Cat 2)	28	n/a		5	1	1	7		Sep-20	National	n/a	
		Clostridioides Difficile - Hospital and Healthcare associated Total	28	3	Performance stable but worse than target	6	2	7	20	16	Sep-20	National	n/a	
		Hand Hygiene Compliance	29	95%	Performance stable and better than target	97.4%	97.3%	98.4%	97.6%	95%	Sep-20	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	33	3.5%	Performance improved and better than target	4.0%	3.3%	2.5%	3.6%	3.5%	Mar-20	National	3.5%	Mar-20
		30 Day Emergency Readmissions - Emerg *	33	11.1%	Performance stable but worse than target	14.9%	12.7%	12.2%	13.7%	11.1%	Mar-20	National	11.1%	Mar-20
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	34	28.0%	Performance stable but worse than target	35.8%	31.2%	34.3%	33.4%	28.0%	Sep-20	Local	28.0%	2017/18
		Caesarean Section rate - Emergency*	34	15.0%	Performance stable but worse than target	15.9%	15.1%	18.9%	16.6%	15.0%	Sep-20	Local	16.0%	2017/18
		Caesarean Section rate - Elective*	34	11.0%	Performance stable but worse than target	19.9%	16.1%	15.4%	16.8%	11.0%	Sep-20	Local	12.0%	2017/18
		Patient Safety												
		% nursing hours (shift fill rate)	36	95.0%	Performance stable and better than target	suspended		101.3%	100.1%	95.0%	Sep-20	National	n/a	
		Serious incidents - number*	37	0	Performance stable but worse than target	1	1	2	10	0	Sep-20	National	n/a	
		Serious incidents - % that are harmful*	37	0.0%	Performance stable but worse than target	100.0%	100.0%	100.0%	60.0%	0%	Sep-20	National	n/a	
		% of patients safety incidents which are harmful*	37	0.0%	Performance stable but worse than target	7.2%	7.9%	8.1%	8.3%	0%	Sep-20	National	n/a	
		Never events	37	0	Performance stable and better than target	0	0	0	1	0	Sep-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%	Sep-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%	Sep-20	National	97.8%	Mar-20
		Category 4 pressure ulcers - New (Hospital acquired)	39	0	Performance stable and better than target	0	0	0	0	0	Sep-20	Local	n/a	
		Category 3 pressure ulcers - New (Hospital acquired)	39	0	Performance stable and better than target	0	0	0	1	0	Sep-20	Local	n/a	
		VTE risk assessment*	42	95.0%	Performance stable and better than target	96.3%	95.8%	96.0%	95.9%	95.0%	Sep-20	National	95.3%	Q3 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	43	90.0%	Performance deteriorated and worse than target	26.1%	18.5%	15.9%	29.1%	90.0%	Sep-20	National	54.0%	Mar-20
		Stroke patients spending 90% of their time on stroke unit	43	80.0%	Performance stable and better than target	78.9%	84.1%	80.0%	73.2%	80.0%	Sep-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

West Hertfordshire Hospitals NHS

Domain		Theme	Page	Target	Trend	Jul-20	Aug-20	Sep-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	268	354	327	1716	0	Sep-20	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	89	180	78	433	0	Sep-20	National	n/a	
		% Patients admitted through A&E - 0 day LOS		n/a		27.5%	28.3%	28.6%	27.7%		Sep-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	15.1%	17.8%	16.6%	15.0%	33.0%	Sep-20	National	n/a	
		Mixed sex accommodation breaches	45	0	Performance stable and better than target	suspended				0	Sep-20	National	59 Trusts breaching	Feb-20
		LOS > 21 days	46	65	Performance stable but worse than target	52	58	69	69	65	Sep-20	National	n/a	
		Delayed Tranfers of Care (DToC) beddays used in month	46	n/a		Suspended				n/a	Sep-20	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	46	n/a						n/a	Sep-20	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	-	95%	Performance improved but worse than target	suspended				95%	Sep-20	National	85.0%	Feb-20
		Inpatient Scores FFT % positive	-	95%	Performance improved but worse than target					95%	Sep-20	National	95.9%	Feb-20
		Daycase FFT % positive	-	95%	Performance improved but worse than target					95%	Sep-20	National	n/a	
		Maternity FFT % positive	-	95%	Performance improved but worse than target					95%	Sep-20	National	96.9%	Feb-20
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	47	80%	Performance stable and better than target	92.3%	80.6%	85.7%	74.7%	80%	Sep-20	National	n/a	
		Reactivated complaints	47	0	Performance stable and better than target	0	5	0	8	0	Sep-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)	44	95.0%	Performance stable but worse than target	85.9%	83.1%	84.3%	84.2%	95.0%	Sep-20	National	87.3%	Sep-20
		Referral to Treatment - Incomplete*	49	92.0%	Performance stable but worse than target	51.0%	61.8%	69.4%	60.3%	92.0%	Sep-20	National	53.6%	Aug-20
		Referral to Treatment - 52 week waits - Incompletes	49	0	Performance deteriorated and worse than target	484	669	855	2498	0	Sep-20	National	111026 (all Trusts)	Aug-20
		Diagnostic (DM01) <6 weeks		99.0%	Performance stable but worse than target	73.4%	68.5%	69.4%	59.9%	99.0%	Sep-20	National	62.0%	Aug-20
		Cancer												
		Cancer - Two week wait *	50	93.0%	Performance stable and better than target	98.6%	96.5%	97.2%	97.5%	93.0%	Sep-20	National	92.0%	Q1 20/21
		Cancer - Breast Symptomatic two week wait *	50	93.0%	Performance stable and better than target	98.1%	96.2%	97.1%	95.2%	93.0%	Sep-20	National	89.5%	Q1 20/21
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	50	75.0%	Performance stable and better than target	82.3%	83.1%	79.8%	81.3%	73.3%	Sep-20	National	n/a	
		Cancer - 31 day *	51	96.0%	Performance stable and better than target	96.5%	96.6%	97.0%	96.4%	96.0%	Sep-20	National	94.7%	Q1 20/21
		Cancer - 31 day subsequent drug *	51	98.0%	Performance stable and better than target	100.0%	100.0%	100.0%	99.2%	98.0%	Sep-20	National	98.9%	Q1 20/21
		Cancer - 31 day subsequent surgery *	51	94.0%	Performance deteriorated and worse than target	94.4%	77.8%	71.4%	90.1%	94.0%	Sep-20	National	88.6%	Q1 20/21
		Cancer - 31 day subsequent radiology *	51	94.0%		-	-	-	100.0%	94.0%	Sep-20	National	95.5%	Q1 20/21
		Cancer - 62 day *	52	85.0%	Performance stable but worse than target	76.6%	86.0%	83.7%	80.1%	85.0%	Sep-20	National	73.3%	Q1 20/21
		Cancer - 62 day screening *	52	90.0%	Performance stable but worse than target	0.0%	66.7%	66.7%	60.9%	90.0%	Sep-20	National	62.0%	Q1 20/21
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	53	5.0%	Performance stable but worse than target	16.1%	14.1%	14.1%	20.3%	5.0%	Sep-20	Local	n/a	
		DNA rate	53	8.0%	Performance stable but worse than target	6.6%	7.5%	8.6%	6.8%	8.0%	Sep-20	National	n/a	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Jul-20	Aug-20	Sep-20	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Workforce and finance	Well led	**Recruitment & Retention**												
		Staff turnover rate (rolling 12 months)	54	13.0%	Performance deteriorated and worse than target	13.6%	13.3%	13.6%	13.8%	13.0%	Sep-20	National	15.0% (Beds and Herts orgs)	Q1 19/20
		% staff leaving within first year (excluding medics and fixed term contracts)	54	n/a		15.7%	16.0%	16.6%	16.3%	n/a	Sep-20	National	n/a	
		Vacancy rate	54	10.0%	Performance stable but worse than target	9.1%	9.7%	10.4%	9.6%	10.0%	Sep-20	National	11.1% (local survey)	Q1 19/20
		Sickness rate	54	3.5%	Performance stable but worse than target	4.0%	3.5%	3.9%	5.5%	3.5%	Sep-20	National	3.7% (EoE orgs)	Q1 19/20
		Developing Staff												
		Appraisal rate (Total)	55	90.0%	Performance improved but worse than target	87.0%	87.0%	87.0%	87.0%	90.0%	Sep-20	National	n/a	
		Mandatory Training	55	90.0%	Performance deteriorated but better than target	93.9%	93.9%	90.5%	93.1%	90.0%	Sep-20	Local	91.0% (local survey)	Q1 19/20
		Essential Training	55	90.0%	Performance deteriorated and worse than target	90.8%	90.8%	0.0%	90.8%	90.0%	Sep-20	Local	n/a	
		Finance overview												
		Financial Risk Rating	14-24	3	Performance improved but worse than target	0.00	0.00	0.00			Sep-20	Local	n/a	
		Income & Expenditure Actual	14-24	-£74	Performance stable and better than target	£0	£0	£0	£0	-£1,999	Sep-20	Local	n/a	
		Income & Expenditure forecast	14-24	£0	Performance improved and better than target	£0	£0	£0	£0	£0	Sep-20	Local	n/a	
		Cash balance at the end of the month	14-24	£3,310	Performance deteriorated but better than target	£49,140	£52,789	£50,383	£50,383	£3,310	Sep-20	Local	n/a	
		Capital expenditure	14-24	-£2,008	Performance stable but worse than target	-£710	-£1,400	-£506	-£6,093	-£12,042	Sep-20	Local	n/a	
		CIP delivery against plan	14-24	£1,153	Performance improved but worse than target	suspended				£6,916	Sep-20	Local	n/a	
		% Bank Pay**	14-24	12.0%	Performance stable and better than target	10.8%	11.4%	11.1%	10.5%	12.0%	Sep-20	Local	n/a	
		% Agency Pay**	14-24	4.7%	Performance stable and better than target	4.9%	4.2%	4.2%	3.8%	4.7%	Sep-20	Local	7.3% (local survey)	Q1 19/20
		Activity (chargeable)												
		GP referrals		8,027	Performance stable and better than target	5,253	5,008	6,375	24,481	48,162	Sep-20	National	n/a	
		A&E attendances		15,092	Performance stable and better than target	11,559	11,892	11,933	60,458	85,516	Sep-20	National	n/a	
		Elective spells (overnight)		492	Performance stable but worse than target	253	345	410	1,476	2,820	Sep-20	National	n/a	
		Elective daycase		3,656	Performance stable but worse than target	1,628	1,660	2,031	7,226	20,939	Sep-20	National	n/a	
		Total elective spells		4,148	Performance stable but worse than target	1,881	2,005	2,070	8,331	23,759	Sep-20	National	n/a	
		Non-elective spells		4,926	Performance stable and better than target	3,732	3,708	3,901	20,446	30,048	Sep-20	National	n/a	
		Births		322	Performance stable but worse than target	389	381	360	2,203	1,965	Sep-20	National	n/a	
		Outpatient attendances		21,481	Performance stable but worse than target	11,357	9,500	11,185	55,953	123,029	Sep-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

With increasing numbers of patients presenting with COVID, the Division of Medicine has made extensive plans to redeploy staff if required. To date, this has not been required, but it is being evaluated on a daily basis.

The hospital redevelopment strategy continues to attract significant engagement from the consultant workforce, with proposed schedules of accommodation providing for lively debate and future strategy! I am obviously delighted that Tracey Carter and Matthew Knight were awarded MBE's in recognition of their outstanding contribution to the trust, and our patients, both before and during the COVID-19 pandemic.

Appraisals for medical staff are due to restart this month, albeit in a different, more supportive format, as recommended by NHSE and the GMC.

Chief Nurse

Nosocomial infections has been a focus for the trust working with PHE, the CCG and the regional infection control team. We have continued to take a number of actions to manage any outbreaks and a full investigation and learning taking place. This has been incorporated into the IPC BAF which is reported to quality committee (sub-committee of the trust board). The IPR COVID slides have also been reviewed again to update the oversight for the trust board.

Safe staffing continues to be an area of focus across nursing and midwifery working closely with HR around recruitment and health and wellbeing, also ensuring a clear plan of communication as we move into winter. Staffing for the winter surge escalation plan has been reviewed and is now being finalised for professional sign off .

Continuity of carer – this model of midwifery led care improves maternity outcomes. The national interim ambition is 35% by 31 March 2021 and was paused during the peak of the pandemic earlier this year. The implementation has now been resumed to meet this ambition by the 31 March 2021. A slide to give oversight to the Board has been added to the IPR which will continue to be developed. Evidence of assurance will be reviewed at the quality committee to provide assurance to the board of the progress.

Interviews have taken place for the Associate Chief Nurse Quality and Michelle Hope has been appointed and will commence in November.

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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 agreed across the local Maternity & Neonatal System (LMNS). 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. As from the 5th October partners can accompany women to the dating scan. We continue to risk assess women with other health requirements to ensure we meet their individual needs.

I am pleased to announce that we have appointed Michelle Creese to the Lead Nurse Information Officer post for NMAHP and she has commenced in post to support the implementation of the EPR.

We continue to expand the roles of our volunteers and are investigating expanding the coordination to support 7 day cover.

The second co-production board took place chaired by Healthwatch with a number of projects agreed.

Chief Operating Officer

Based upon ED attendances continuing to rise to pre-COVID levels the Trust has found itself under pressure with regards to bed capacity, this is compounded by the segregation of beds for those patients awaiting swab results on admission and also the carve out of a COVID bed base within Granger suite. As a result of this since the last Trust Board two business continuity incidents due to capacity constraints were declared during October.

The Trust has been very successful with various capital bid initiatives which include Phase 2 of EAU, funding to support the conversion of an existing cystoscopy room to an Endoscopy procedure room, Endoscopy equipment – 2 colonoscopes, 2 gastroscopes and 1 colon capsule equipment set, CT 'in a box' and MRI at SACH. The first patient was scanned in the CT scanner at SACH on 21.10.20. In addition to this the new Orthopaedic department was formally opened at SACH offering a range of services for our patients.

Work continues with recovery arrangements in the delivery of outpatient, diagnostics and inpatient elective activity. Progress has been made in relation to mobilising additional capacity within the independent sector with contractual terms and specialty activity levels being agreed.

Solomon Brown commenced in the organisation as Head of Emergency Planning and Resilience on 26th October and Aimee Venner will commence on 1st December as the new Divisional Manager for Surgery, Anaesthetics & Cancer.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief People Officer

Valuing you week – Working is underway on weeklong activities aimed at recognising and thanking staff for their the efforts during the pandemic. This will include a number of videos which allow colleagues to 'tell' their stories , as well as sign posting them to psychological services as required. Other activities during the week will include this year's Long Service Awards and 'walk abouts' by executives handing out wellbeing pack.

System working – We have been successful in working with system partners on a financial bid to help support our approach to health and wellbeing. This will see the formalisation of a psychological helpline run by HPFT, creation of a new health and wellbeing app and the introduction of on-site clinical psychologist support services. In addition we have also had approval of a bid to pilot a new service which will offer our staff 'mini health checks' as part of our Occupational health Support services.

Flu and staff survey – Flu vaccination rates stand at 56% and staff survey completion rates at 31%. These rates are significant improvements on both project as compared to the same point in 2019.

Teaching Hospital – Work continues on this project with the appointment of additional communications support to help support this work. The anticipated time line for this change to occur is April 2021.

Staff redeployment service – Learning from our experience during the pandemic we are creating a new re-deployment service which will see the formalisation of the re-deployment of staff unable to work within their original roles as a result of COVID.

Inclusion Charter – We are working with our BAME and Disability networks to launch an inclusion charter which will comprise of a number of commitments made by the organisation. This charter is due to be launched on March 24th by Yvonne Coghill who formerly ran the NHS's national Workplace Race Equality Scheme.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief Finance Officer

Month 6 is the last month where the temporary system assures organisations of sufficient funds to minimise the risk that any NHS organisation fails to respond to the COVID-19 pandemic, due to money constraints. From October NHS organisations will work to a largely fixed funding allocation which includes funds expected to be needed to support COVID related activities. Revenue flows from Commissioners will therefore be fixed regardless of patient numbers. The Trust continues to follow internal processes to ensure all costs incurred in relation to the pandemic are accurately captured. These processes follow national guidance despite funding being fixed.

For month 6, in line with this last month of the temporary system, the Trust reports that accrued income matches the £36.3m of expenditure incurred in the month. Within the £36.3m, the COVID-19 pandemic created an extra £2.2m 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 £0.1m. in September. The 'full reimbursement' meant that the Trust was £0.1m 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 September. For the year to date total costs and revenues totalled £210.1m including £13.2m of COVID related costs.

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 61% of the original plan in month, compared to an average of 31% for previous months.
- Outpatient attendances were 74% of the original plan in month, compared to a 58% YTD average.
- A&E attendances 83% of plan compared to a 69% average trend for previous months.

The Trust spent £0.5m on buildings and equipment assets in September. The year to date capital spend stands at £5.4m. 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 total capital expenditure programme for 2020/21 now exceeds over £50m including starting construction on a new multi-story car park, the development of a new electronic patient record, new complex imaging equipment including replacing our cardiac catheter labs, fire safety and critical infrastructure improvements and the business case for the major redevelopment of Watford General Hospital.

The update to the financial plan is now in the process of being approved by NHSEI which currently indicates that the Trust requires an extra £5.6m 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

September saw a continuation of the improved metrics reported last month:

Metric	Jun	Jul	Aug	Sep
Priority 1 incidents	4	7	2	3
Priority 2 incidents	17	20	21	10
Incident backlog	350	415	416	417
First time fix rate	87%	91%	92%	91%
Customer satisfaction score	7.2	6.6	6.8	6.9
Network availability	100%	100%	100%	100%

Of the three priority 1 incidents, the most significant occurred on the 20th when the interface between PACS, ICE and Patient Centre stopped working properly. This was resolved on the same day. The other two issues related to some users having some difficulty logging in, this was caused by an imprivata upgrade and a short deterioration in the performance of a winpath scanner.

In more strategic news, the EPR programme continues to progress well. Recruitment to key programme posts has been very successful, clinical and operational engagement in programme workshops has been strong and the clinicals programme was officially launched on the 7th October with an introductory presentation by our Chief Medical Officer. The external approvals process continues alongside the contract negotiations with Cerner. The Full Business Case is currently scheduled to be presented at the Joint Investment Committee in November which would enable the ten year contract to be signed before Christmas.

Since the last board meeting we have completed the business case that will enable the full roll-out of windows 10 across the organisation, this is being considered at the next Capital planning meeting. We have issued the tender documentation for our new printing service, we have completed the digital strategy and we have prepared an exploratory paper which describes our aspirations to restructure our relationship and contract with Atos and how this ties in with the longer term aspirations of the organisation.

We are also making progress, albeit a bit more slowly than hoped on the Medical records Outsourcing programme building on the OBC which was approved earlier this year. We are proceeding with caution so we can ensure that we bring a Full Business Case to the board that is financially viable.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Income and Expenditure September 2020

Trust Definition	Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance		YTD Budget	Actual	Variance	
Income	Divisional Income	81,014	6,764	9,178	2,414	Bii	40,482	46,405	5,923	Fii
	NHS Revenue	336,416	28,327	27,102	(1,225)	Bi	167,988	163,662	(4,325)	Fi
	Income Unallocated CIPs									
Income Total		**417,431**	**35,092**	**36,280**	**1,189**	**B**	**208,470**	**210,067**	**1,597**	**F**
Pay	Medical Pay	(81,832)	(7,210)	(7,291)	(81)		(41,223)	(40,862)	361	
	Non-Clinical Pay	(61,737)	(4,811)	(4,249)	562		(29,223)	(25,273)	3,950	
	Nursing Pay	(80,052)	(6,701)	(6,710)	(9)		(40,028)	(38,846)	1,182	
	Other Clinical Pay	(30,913)	(2,833)	(2,662)	171		(15,457)	(15,800)	(343)	
	Scientific, Technical & Profes	(27,348)	(2,281)	(2,328)	(48)		(13,661)	(13,813)	(152)	
	Pay Unallocated CIPs	9,386	722		(722)		2,527		(2,527)	
Pay Total		**(272,496)**	**(23,114)**	**(23,240)**	**(127)**	**C**	**(137,065)**	**(134,594)**	**2,470**	**G**
Non Pay	Clin Supp Serv	(31,262)	(2,722)	(2,256)	466		(15,569)	(13,070)	2,499	
	Drugs	(21,424)	(1,863)	(1,902)	(40)		(10,669)	(9,482)	1,188	
	OTHER (NON CLIN)	(81,359)	(6,286)	(7,489)	(1,203)		(40,292)	(44,695)	(4,403)	
	Non Pay Unallocated CIPS	5,654	198		(198)		1,401		(1,401)	
Non Pay Total		**(128,390)**	**(10,673)**	**(11,647)**	**(974)**	**D**	**(65,129)**	**(67,247)**	**(2,118)**	**H**
Recharges	Recharges				()		()			
Recharges Total					**()**		**()**			
Financing Charges	Depreciation	(10,948)	(912)	(930)	(18)		(5,471)	(5,453)	18	
	Trust Debt Redemption	(5,570)	(464)	(464)	()		(2,793)	(2,783)	10	
	Unwinding Discount	(27)	(2)	2	4		(13)	10	23	
Financing Charges Total		**(16,545)**	**(1,379)**	**(1,393)**	**(14)**	**E**	**(8,277)**	**(8,226)**	**51**	**I**
Total		**()**	**(74)**		**74**	**A**	**(2,001)**		**2,001**	**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 September. The performance to plan was better by £74k. 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 £1,189k.
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 £27,102kin 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 September. The underperformance was £1,225k in month. 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 £23,240k which was £127k overspent. Within the pay position, an additional £1,055k was spent in relation to covid-19 and is offset by income. After allowing for these items, the residual underspend is due to reduced activity levels in month .

D – The non pay position reported an overspend of £974k. This includes an additional £1,142k 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 £14k.

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Workforce & Finance: Finance overview dashboard

Financial Overview 30 September 2020

Month 6 Income & Expenditure

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

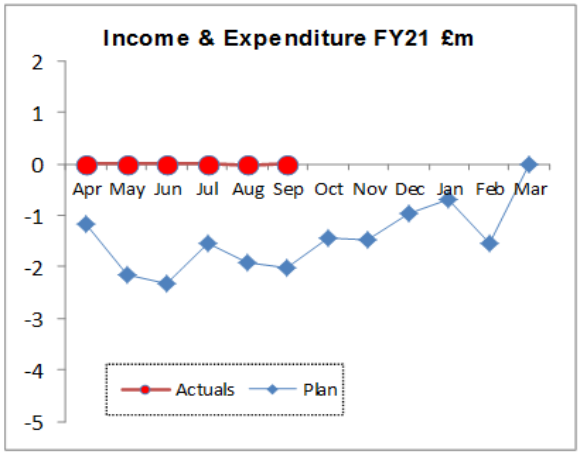
£m	YTD M6 20/21		
Surplus / (Deficit)	(2.0)	(0.0)	2.0

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 30/9/20 equated to 50.3 days' spend.	G
BPPC	Month 6 performance - 86.9% on number, 87.3% on value (95% target)	A

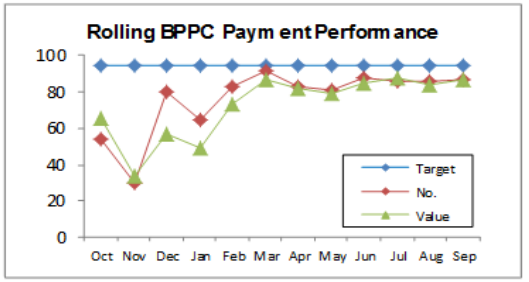
Financial Risk Rating	FY21	2

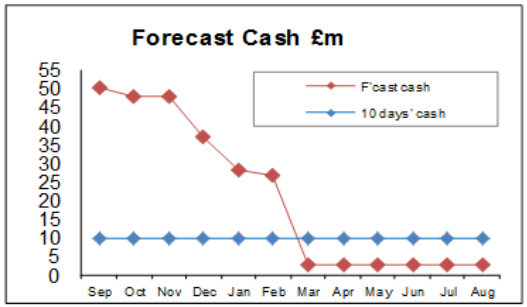
Risk rating on a scale of 1 to 4, with 1 being best and 4 being worst.

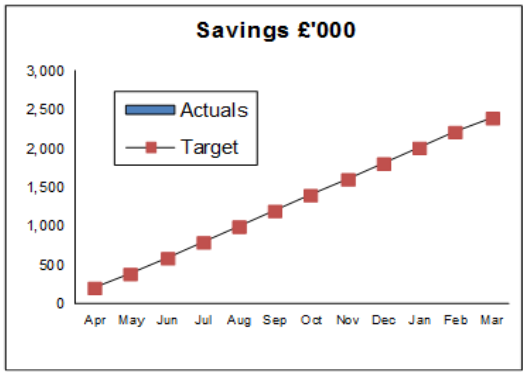


YTD Variance by Division £m

Medicine	(10.1)
Unscheduled Care	(6.4)
Surgery	(16.1)
Women's	(3.9)
Clinical Support	(3.7)
Estates & Facilities	(0.8)
Corporate	(0.1)
Other	43.2
Total	**2.0**







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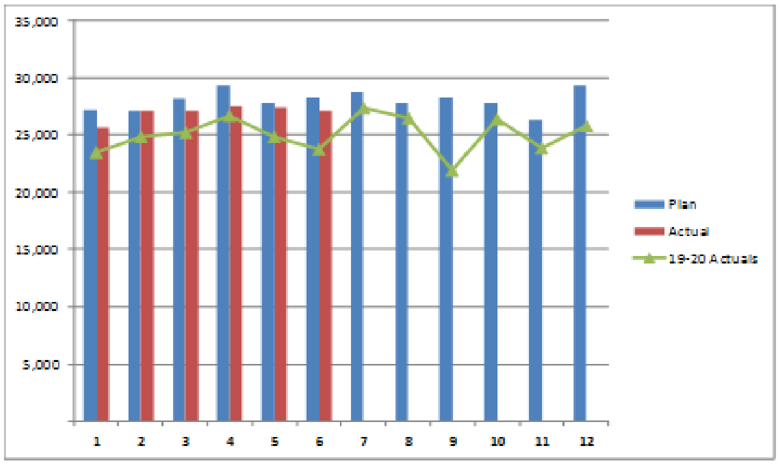
Workforce & Finance: Trust Income – September 2020

NHS Revenue: Performance by Month (£s)

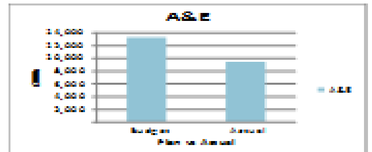


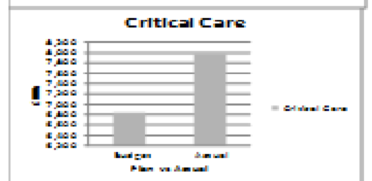
In line with national guidelines, NHS revenue continues to be set at a block amount of £27.1m for the month of September. This resulted in an underperformance against the business as usual plan.

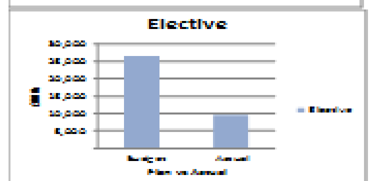
All points of delivery showed underperformances as a result of the Covid-19 outbreak:

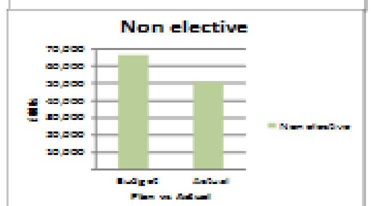
Despite increases in activity from previous months, A&E continues to underperform against plan by £0.4m
In September, Critical care achieved a break even position. This was linked to the number of covid patients requiring critical care facilities.
The reduction in Elective cases continues to drive a monthly underperformance of £1.8m. This is predominately within the Surgery division.
For Non Elective the in month position showed under performance of £0.7m.
Despite an increase in virtual interactions, the overall fall in Outpatient attendances meant performance was £1.8m away from plan.

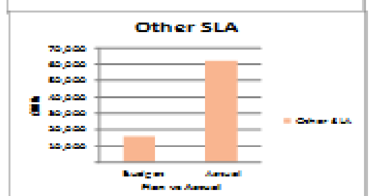
The adverse variances above were offset by other SLA income being favourable to plan by £3.5m. This reflects the interim block reimbursement arrangements.

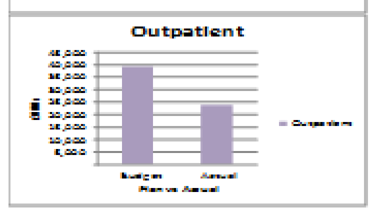












In Month Performance (£s)

			In Month (£000's)		
Expense Type	POD	Annual Budget	Budget	Actual	Variance
NHS Revenue	A&E	26,486	2,181	1,816	(365)
	Critical Care	13,664	1,128	1,166	38
	Elective	53,207	4,627	2,801	(1,826)
	Non elective	132,024	10,851	10,102	(749)
	Other SLA	32,316	2,772	6,232	3,460
	Outpatient	78,721	6,768	4,985	(1,783)
	NHS Rev Unallocated CP's				
NHS Revenue Total	Total	336,418	28,327	27,102	(1,226)

In Month Performance (spells)

			In Month (Activity)		
Expense Type	POD	Annual Budget	Budget	Actual	Variance
NHS Revenue	A&E	[illegible]	[illegible]	[illegible]	[illegible]
	Critical Care	[illegible]	[illegible]	[illegible]	-71
	Elective	[illegible]	[illegible]	[illegible]	[illegible]
	Non elective	[illegible]	[illegible]	[illegible]	[illegible]
	Other SLA	[illegible]	[illegible]	[illegible]	[illegible]
	Outpatient	[illegible]	[illegible]	[illegible]	[illegible]
NHS Revenue Total	Total	[illegible]	[illegible]	[illegible]	[illegible]

Divisional Income

Divisional income delivered a £2.4m surplus in month. Reduced MRET, PSF and car parking income was mitigated by the national covid top up payment. In addition to this the Trust submitted £2.2m worth of claims for additional covid related expenditure. This is included within the position.

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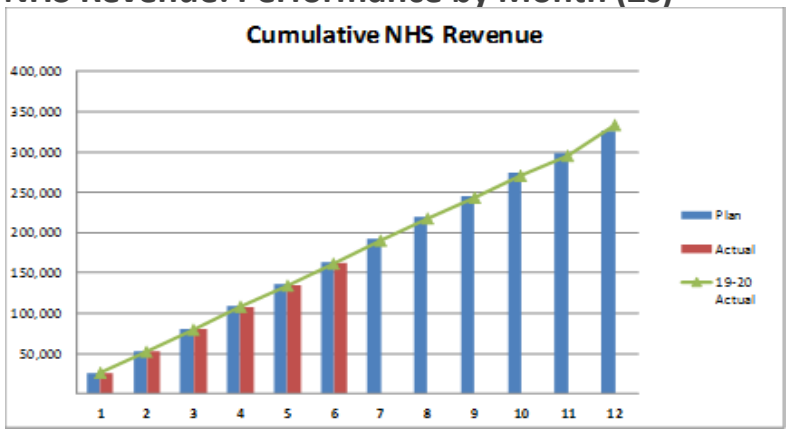
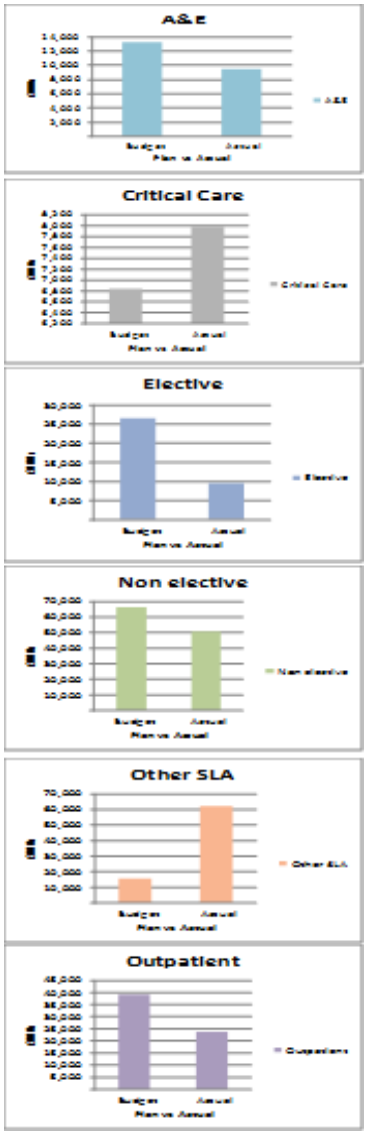
Workforce & Finance : Year To Date (YTD) – Trust Income

NHS Revenue: Performance by Month (£s)



Month6 YTD shows Income under performance of £4.3m. £163.7m has been generated against plan of £168m.

A&E has a YTD under performance of £3.7m 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 £16.9m 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 £15.6m. This is predominately centred around the Emergency division and is linked to a reduction in emergencies throughout the pandemic.
YTD Outpatient performance shows £15.4m worth of under performance.
Other SLA income is £46.21m 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	13,275	9,498	(3,776)
Critical Care	6,844	7,980	1,136
Elective	25,498	9,581	(16,917)
Non elective	66,193	50,573	(15,620)
Other SLA	15,921	62,135	46,214
Outpatient	39,257	23,895	(15,362)
NHS Rev Unallocated CIPs			
Total	**167,988**	**163,662**	**(4,325)**

YTD Performance (spells)

	YTD (Activity)		
POD	Budget	Actual	Variance
A&E	93,674	64,412	-29,262
Critical Care	7,309	7,719	409
Elective	23,759	8,968	-14,791
Non elective	32,267	22,592	-9,675
Other SLA			
Outpatient	239,029	134,927	-104,102
Total	**396,038**	**238,617**	**-157,421**

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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Workforce & Finance: Trust Pay September 2020

Trust Pay Performance

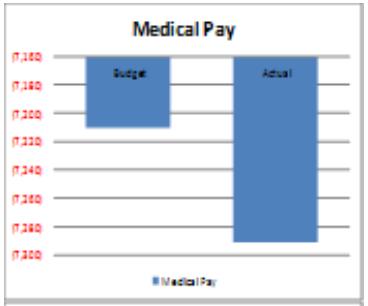
Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	WTE Budget	Actual	Variance
Medical Pay	(81,832)	(7,210)	(7,291)	(81)	713.37	754.07	-41
Non-Clinical Pay	(61,737)	(4,811)	(4,249)	562	1,273.15	1,207.26	66
Nursing Pay	(80,052)	(6,701)	(6,710)	(9)	1,638.72	1,601.26	37
Other Clinical Pay	(30,913)	(2,833)	(2,662)	171	1,046.19	1,065.21	-19
Scientific, Technical & Profes	(27,348)	(2,281)	(2,328)	(48)	512.90	526.53	-14
Pay Unidentified CIPs	9,386	722		(722)	0.00	0.00	0
Total	**(272,496)**	**(23,114)**	**(23,240)**	**(127)**	**5,184.33**	**5,154.33**	**30**

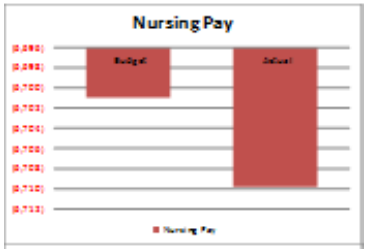
The Trust reported an in month overspend of £0.12m This is linked to reduced activity levels performed in month. There was also £1,055k worth of cost captured in relation to Covid-19.

Key areas to note include;

- Medical pay was £0.08m overspent, this is linked to operational changes in dealing with the COVID-19 outbreak.
- Non Clinical Pay was underspent by £0.6m. This represents unspent growth reserves across divisions.
- Nursing and other clinical pay showed a combined underspend against plan of £0.16m. 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 resulting in the £0.04m overspend in month.
- Expected pay efficiencies in month were not achieved and this caused a £0.7m adverse movement against plan.

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





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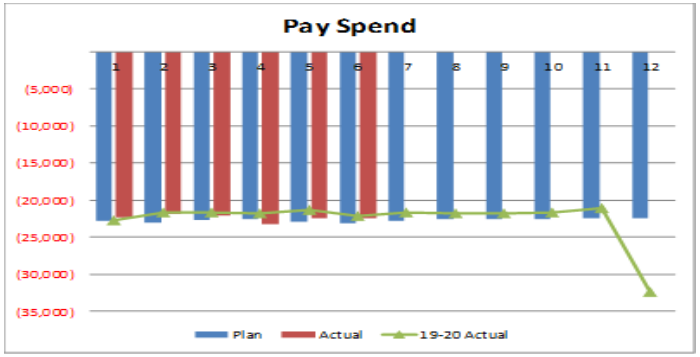
Workforce & Finance: Trust Pay September 2020



The year to date reported position shows an underspend of £2.5m.

Key year to date themes to note are:
Medical pay – is showing an underspend of £0.4m. This reflects operational changes made during the covid-19 pandemic.

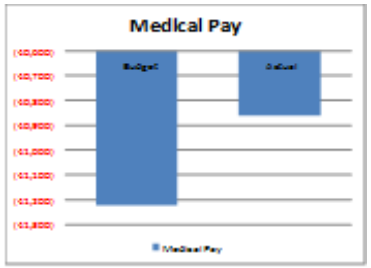
Nursing and other clinical pay has a combined underspend of £0.84m YTD. This is driven by a lower bank and agency fill rate and operational changes made to deal with COVID-19 (zonal deployment).

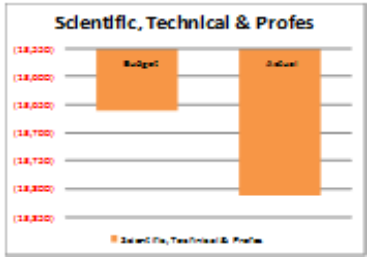
Scientific & therapeutic agency premium to cover vacancies across clinical support, theatres and cardiology are causing £0.15m YTD overspend.

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

Unachieved CIPs due to the temporary suspension of the efficiency programme account from a £2.52m overspend.

Total Pay costs which have been spent in relation to the COVID-19 pandemic total £4.8m.





YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(81,832)	(41,223)	(40,862)	361
Non-Clinical Pay	(61,737)	(29,223)	(25,273)	3,950
Nursing Pay	(80,052)	(40,028)	(38,846)	1,182
Other Clinical Pay	(30,913)	(15,457)	(15,800)	(343)
Scientific, Technical & Profes	(27,348)	(13,661)	(13,813)	(152)
Pay Unallocated CIPs	9,386	2,527		(2,527)
	(272,496)	(137,065)	(134,594)	2,470

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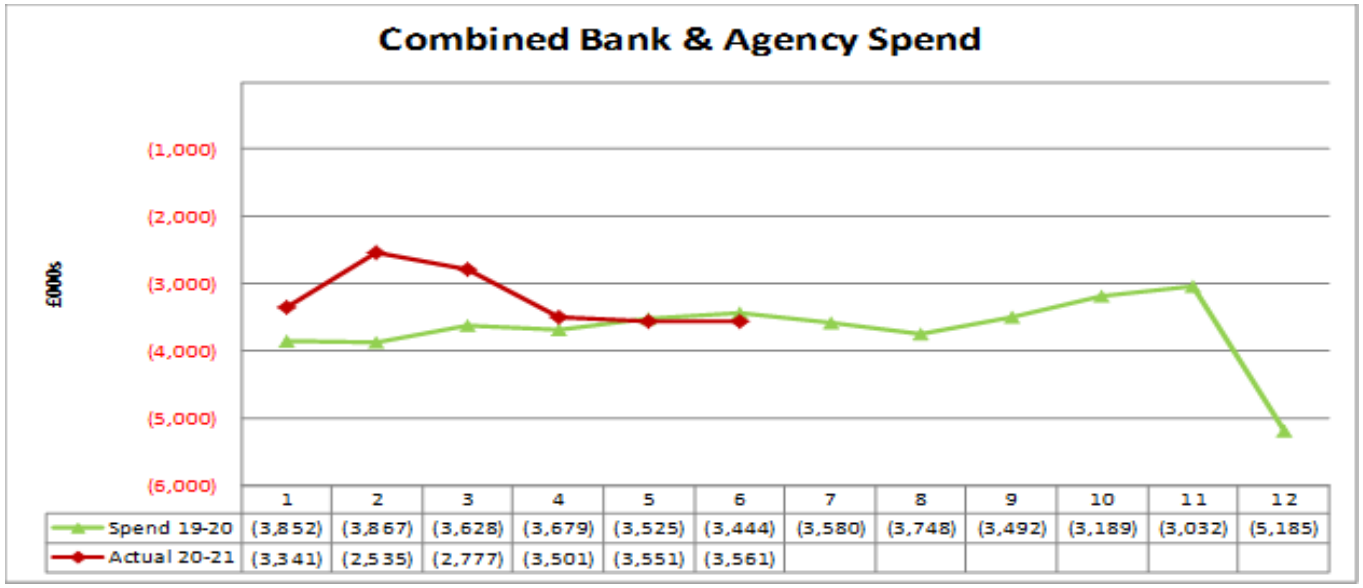
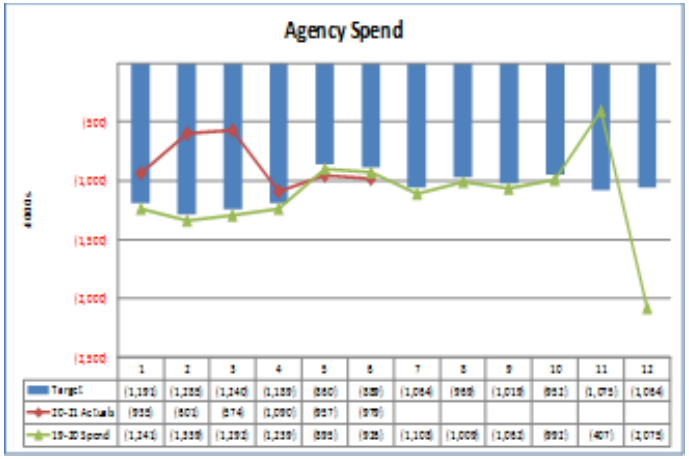
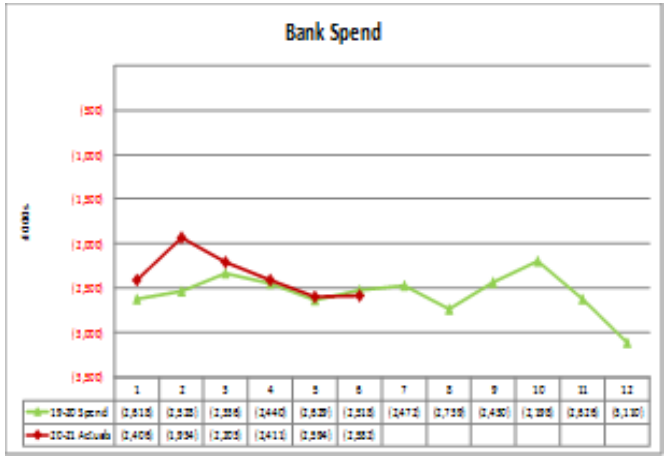
Workforce & Finance: Bank & Agency Spend September 2020



	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)	(3,561)						





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

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

Agency expenditure in the month totalled £1m. This is in line with previous month's spend.

Of the £1m in-month spend, £0.41m was spent in relation to COVID.

Bank
Bank spend for August was £2.6m. This is slightly higher than the patterns of spend seen in previous months.

Of the £2.6m spend, £0.42m was spent in relation to COVID.

When comparing to the same month last year, the Trust has spent £0.17m more on temporary staffing.

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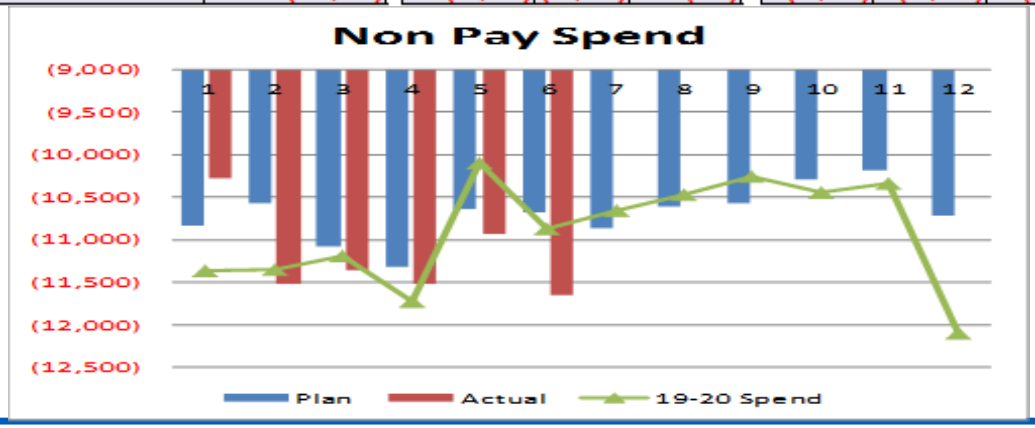
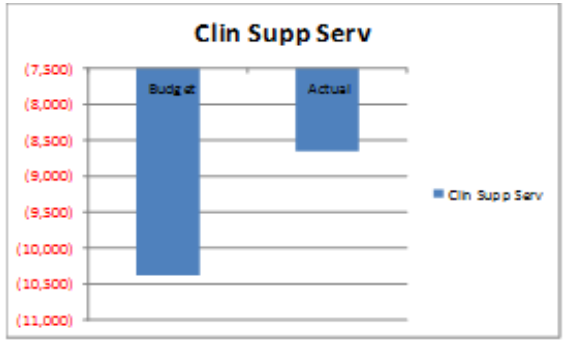
Workforce & Finance: Non Pay September 2020

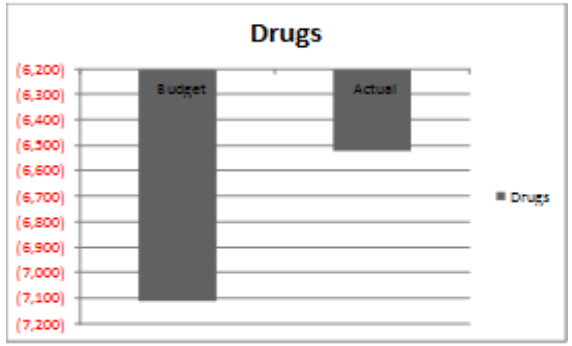
Non Pay Performance

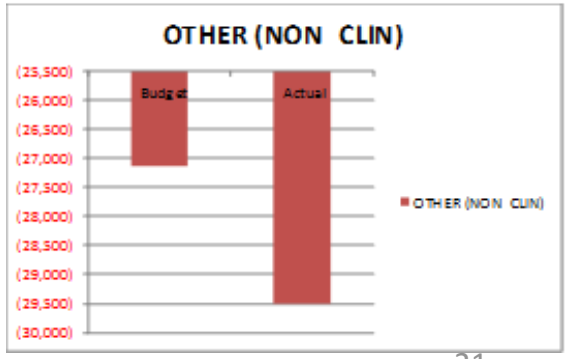
Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	YTD Budget	Actual	Variance
Clin Supp Serv	(31,262)	(2,722)	(2,256)	466	(15,569)	(13,070)	2,499
Drugs	(21,424)	(1,863)	(1,902)	(40)	(10,669)	(9,482)	1,188
OTHER (NON CLIN)	(81,359)	(6,286)	(7,489)	(1,203)	(40,292)	(44,695)	(4,403)
Non Pay Unallocated CIPS	5,654	198		(198)	1,401		(1,401)
Total	**(128,390)**	**(10,673)**	**(11,647)**	**(974)**	**(65,129)**	**(67,247)**	**(2,118)**



YTD Performance







The in month non pay position reported an overspend of £0.97m. Actual spend was £11.65m against a budget of £10.67m.

The main drivers of the position include:
Clinical supplies were £0.47m 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 £0.04m. This is in line with the activity profile for the month.
Other non clinical supplies were overspent by £1.2m. The majority of this relates to COVID related infrastructure costs.

The position includes a total spend of £1.14m in relation to COVID-19 in month.

YTD the position is £0.97m overspent. This includes total YTD COVID non pay costs of £8.4m.

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Workforce & Finance: Covid-19 Cost Capture September 2020

Principles

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

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

Month 6

In month 6 the following costs have been captured:

- £1,05k pay
- £1,15k non-pay

This has been offset with £2,17k 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	312	1353
	Non-Clinical Pay	236	1004
	Nursing Pay	213	1097
	Other Clinical Pay	147	540
	Scientific, Technical & Profes	147	785
Pay Total		**1,055**	**4,780**

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Non Pay	Bedding & Linen	-	1
	Cleaning supplies & materials	126	353
	Computer expenditure	3	57
	Consultancy	14	169
	Drugs		202
	Estates expenditure	129	1087
	Fuel & power	24	24
	Furniture & office equipment	-1	12
	Healthcare from other NHS Bod	20	84
	Laboratory expenses	307	1510
	Medical & Surgical Equipment		1126
	Other non-pay	328	3207
	Printing & stationery	10	31
	Provisions	-31	116
	Rates	35	35
	Staff Uniforms	150	382
	Travel & subsistence		3
Non Pay Total		**1,115**	**8,400**
Grand Total		**2,170**	**13,180**

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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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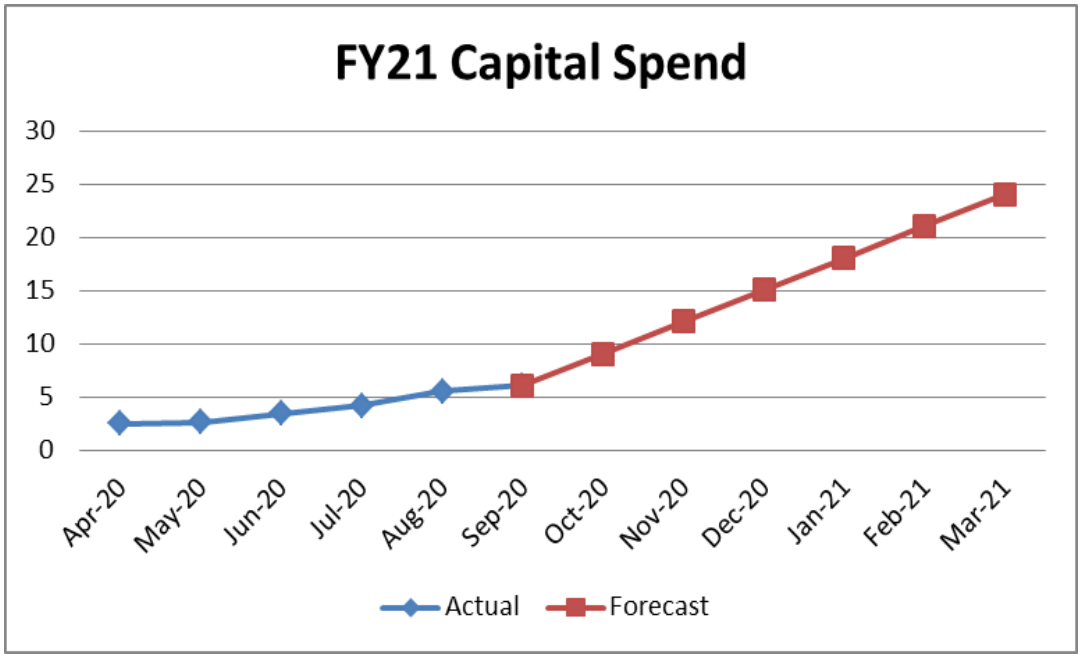
Workforce & Finance: Capital Expenditure September 2020



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	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**
6	Fire Safety	0.04
6	Your Care Your Future	0.14
6	Medical Assessment Unit	0.04
6	Security Improvements	0.03
6	IT LAN Remediation	0.06
6	Cardiac Catheter Lab	0.16
6	Sundry Estates	0.03
6	Covid-19 related projects	0.01
	Month 6 Total Spend	**0.51**

West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

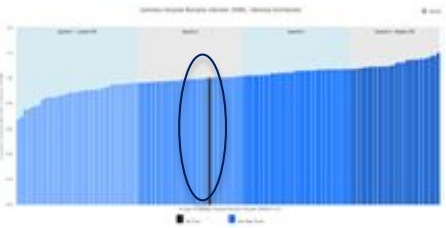
In this reporting period:
The latest available (April 2019 to March 2020) Summary Hospital Mortality Indicator (SHMI) was 100.56 and within the 'as expected' range (band 2). For the 12 month period (Jun 2019 to May 2020), the Trust's overall HSMR of 105.1 was within the 'as expected' range. The COVID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

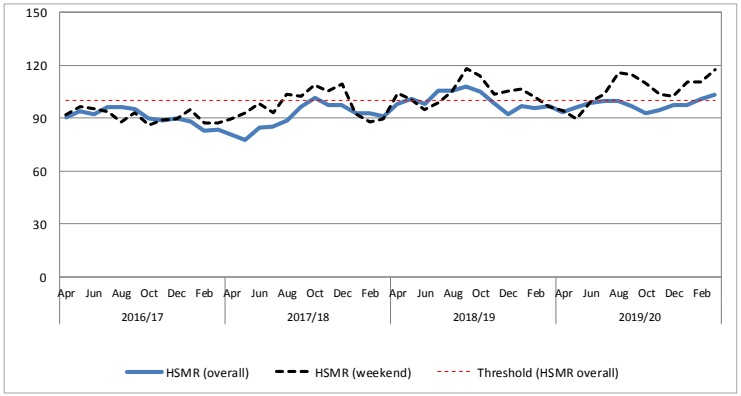
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



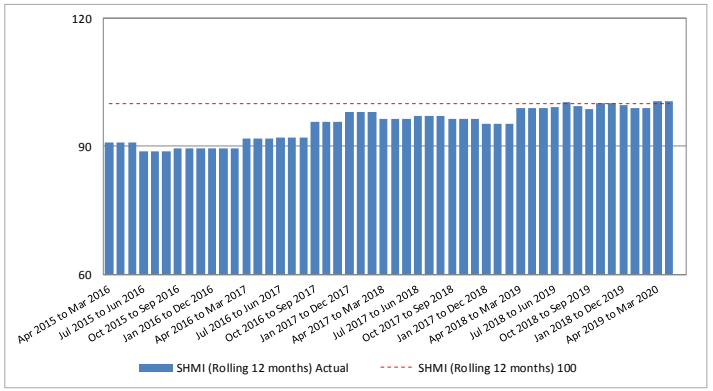
Period: Apr 2020

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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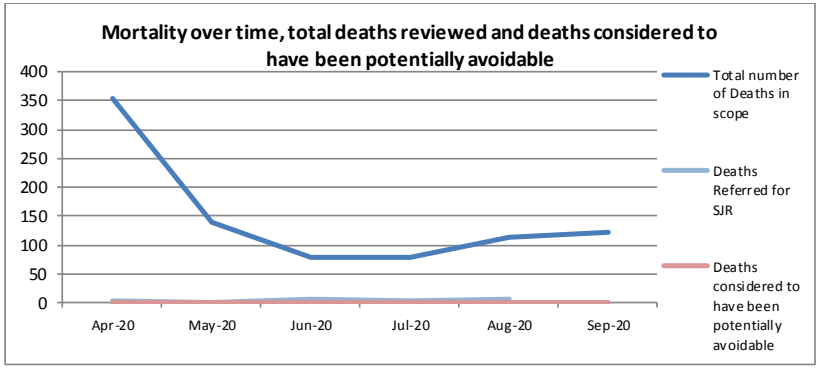
Safe Care & Improving Outcomes: Learning from deaths dashboard

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
122	114	0	7	0	6	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
315	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
890	1652	23	137	9	32	1	2



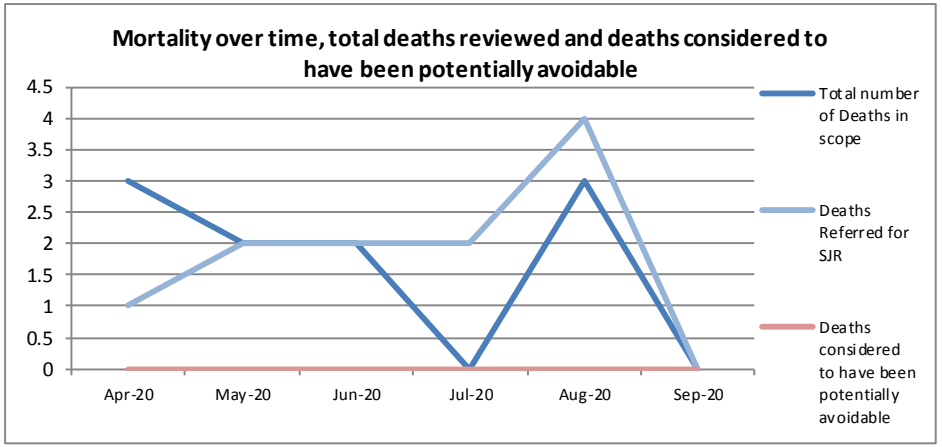
Total Deaths Reviewed by RCP Methodology Score

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	0	This Month	0	This Month	0	This Month	0	This Month	0
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
0	3	0	4	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)

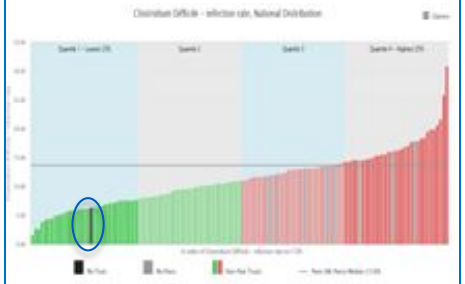
In this reporting period:
Clostrioides difficile Infection (CDI) objectives for 2020/21 are based on criteria commenced on 1 April 2019: Hospital onset healthcare associated – cases detected 2 days or more after admission (CAT1). Community onset healthcare associated – cases that occur in the community 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 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 trajectory of no more than 34 cases with identified lapses in care for the full year continues in 20/21. In Sept 2020 7 cases of C diff infection were attributed to the Trust (6 cat 1 and 1 cat 2) . Total number of Trust apportioned cases April to Sept is 20 (cat 1 x13 and cat 2 x7). RCA's have been completed in all cases up to end of July, and August/Sept cases RCAs have been commenced. No links have been identified with any of the cases during Sept or any cases earlier in the year. 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 Sept 2020. With over a year since the last post 48 hour (trust) cases .

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

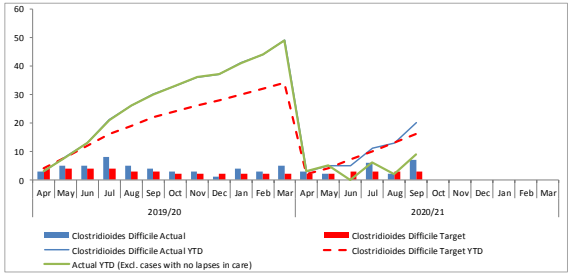


Period: to March 2019

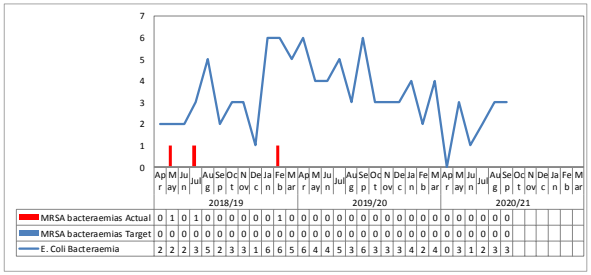
WHHT 6.42 Peer 13.68
National 11.11

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

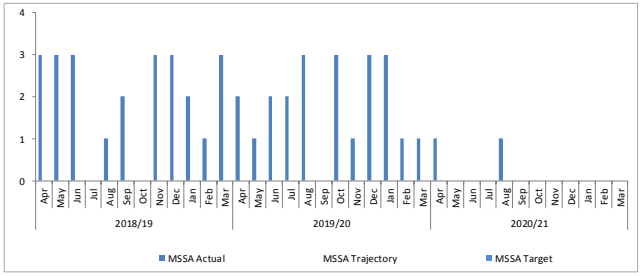
Clostrioides Difficile Infection (CDI)



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 22 pre-48 hour cases (non-trust) reported in Sept 2020. There is no externally set target for the trust but the national target is to deliver a 25% reduction by 2021 and 50% by 2024; this is reflected in the quality indicator which is monitored by the CCG. Thematic data is gathered for post-48 hour cases and reviewed alongside microbiology review of the pre-48 hour cases. Work around this is to be recommenced as part the recovery plan.

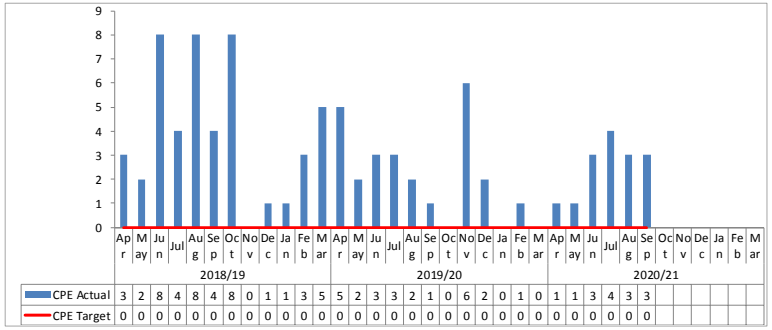
Methicillin-sensitive Staphylococcus aureus (MSSAb):
There was 0 post-48 hour case and 3 pre-48 hour cases of MSSAb in Sept 2020. Each case is usually reviewed by a microbiologist using an RCA tool to identify and share learning and is to be picked up as part of the Covid19 work.

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. A cluster of x3 cases were identified on one ward, and genetic typing identified the same strain. An outbreak meeting was convened and learning identified has been fed back to division and clinical area.

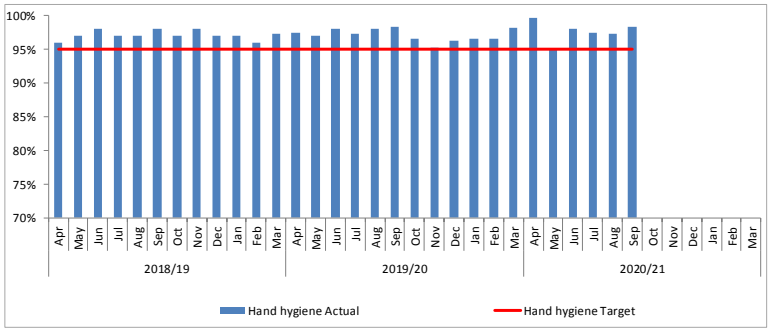
IPC Progress Update: The IPC Code of Practice (CoP) audits have been reviewed to incorporate Covid19 IPC guidance & the BAF. Divisions and wards have recommenced their CoPs audits in their departments, and IPC Team are supporting. During Sept work on the use of PPE continues for Covid19. The IPCT have 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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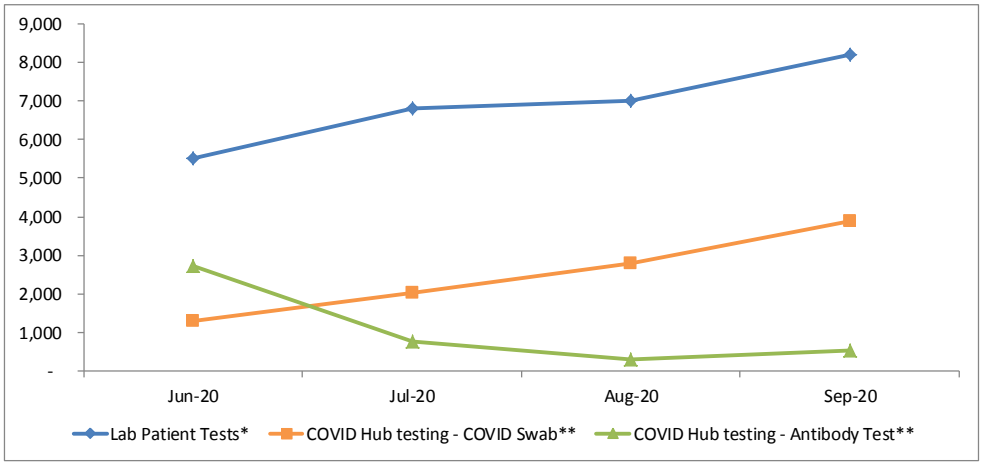
Safe care & Improving Outcomes: COVID-19 (Slide 1 of 3)

Laboratory and COVID Hub testing – Staff and patient volumes

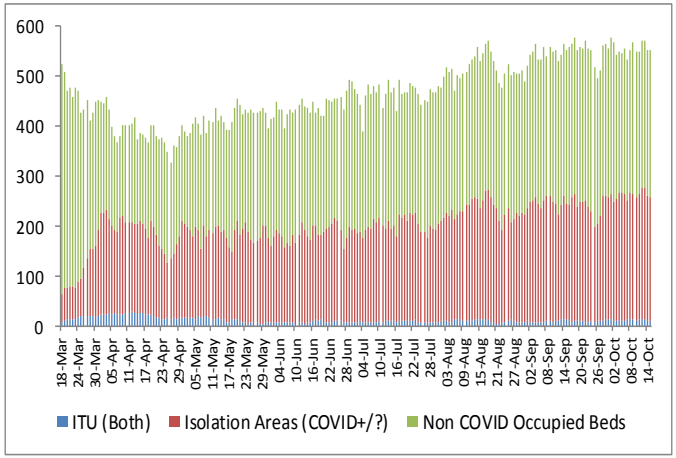
Tests/Month	Jun-20	Jul-20	Aug-20	Sep-20
Lab Patient Tests*	5,516	6,816	7,022	8,195
COVID Hub testing - COVID Swab**	1,282	2,009	2,797	3,894
COVID Hub testing - Antibody Test**	2,734	746	281	539

*(all specialties incl A&E - based on validated date)

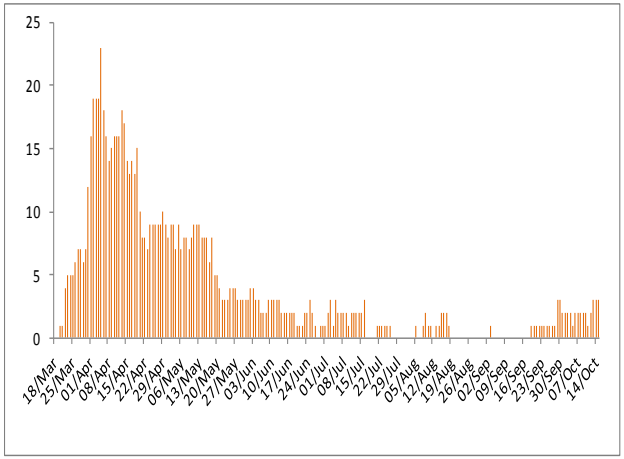
**(includes WHHT/bank/agency/mitie/household - based on appt date)



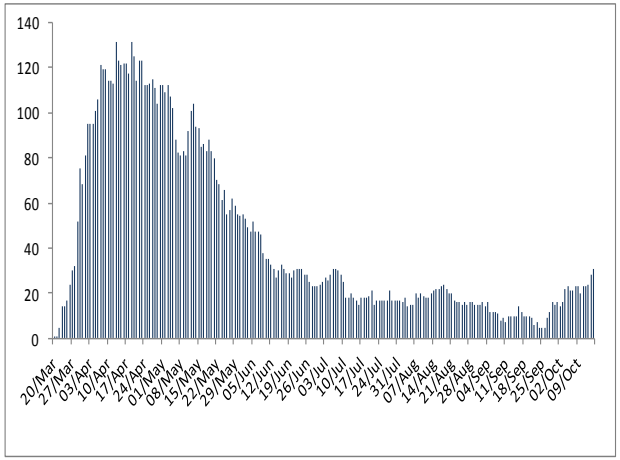
Occupied beds all areas at 0800



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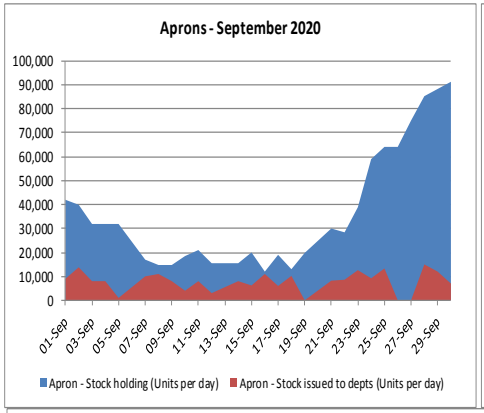
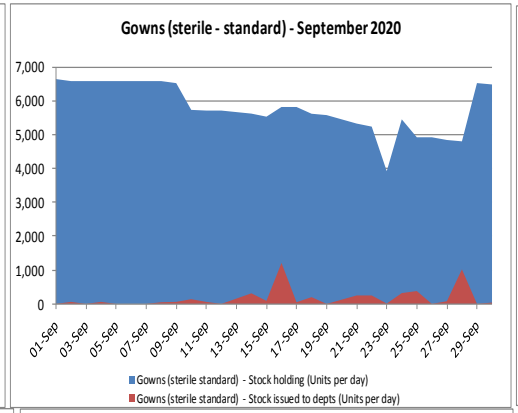
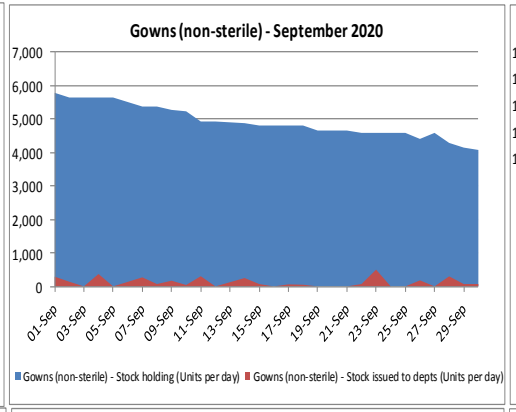
Safe care & Improving Outcomes: COVID-19 (Slide 2 of 3)

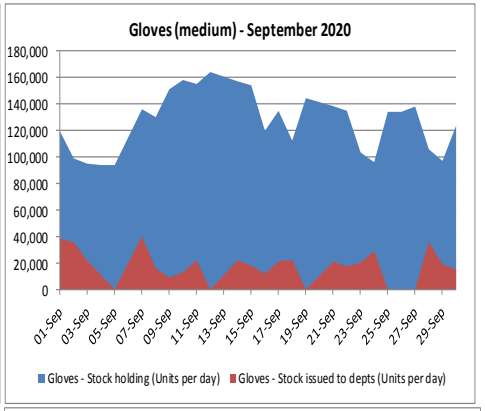
PPE

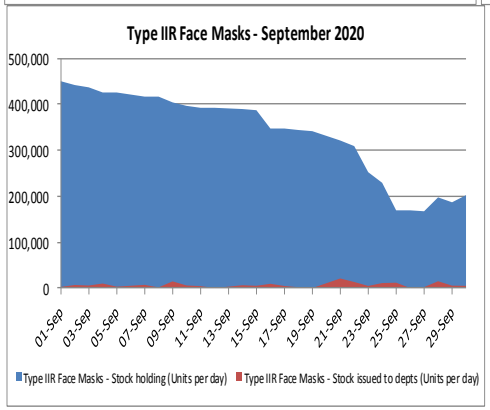
- Central DHSC control of supply and delivery of items from the National Pandemic stock continues.
- The graphs below show at a summary level usage (red block) has remained below stock level although during May stock levels for gowns were under pressure.
- The main current concern remains that National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

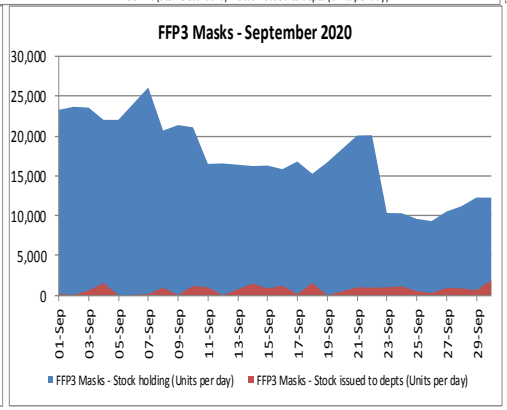


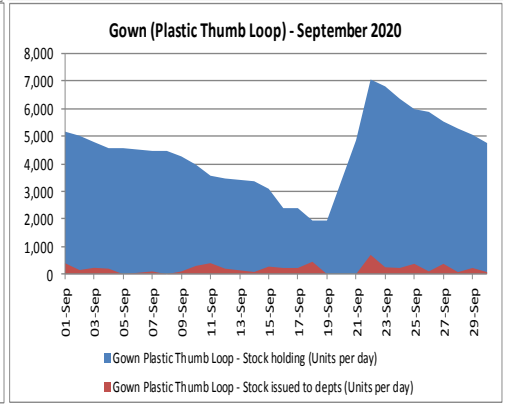


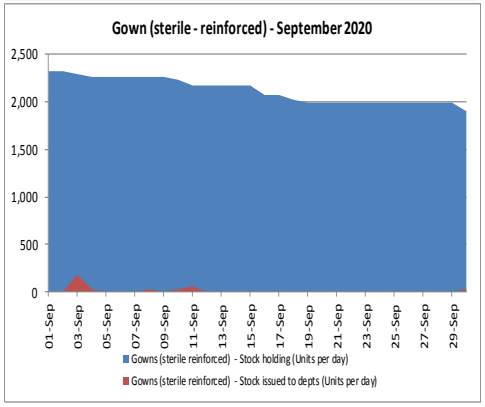












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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

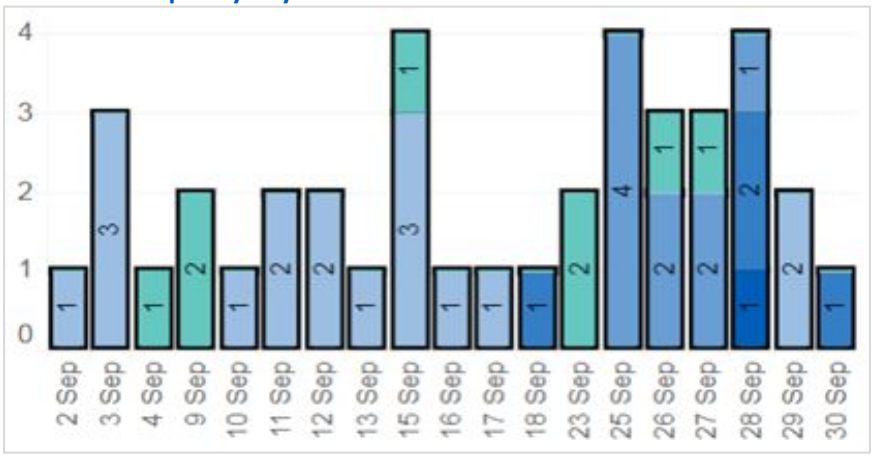
Nosocomial infection cases

COVID19 positive inpatient cases are reviewed each day at a joint IPC meeting. The 4 categories of Nosocomial Infection are based on date of patient's 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 are reported to NHSE and RCAs undertaken. During Sept 2 outbreaks were identified with 18 cases (patients) from on ward and 11 cases (patients) in a second area. Outbreak meetings and protocols were implemented (including PHE and NHSE representation).

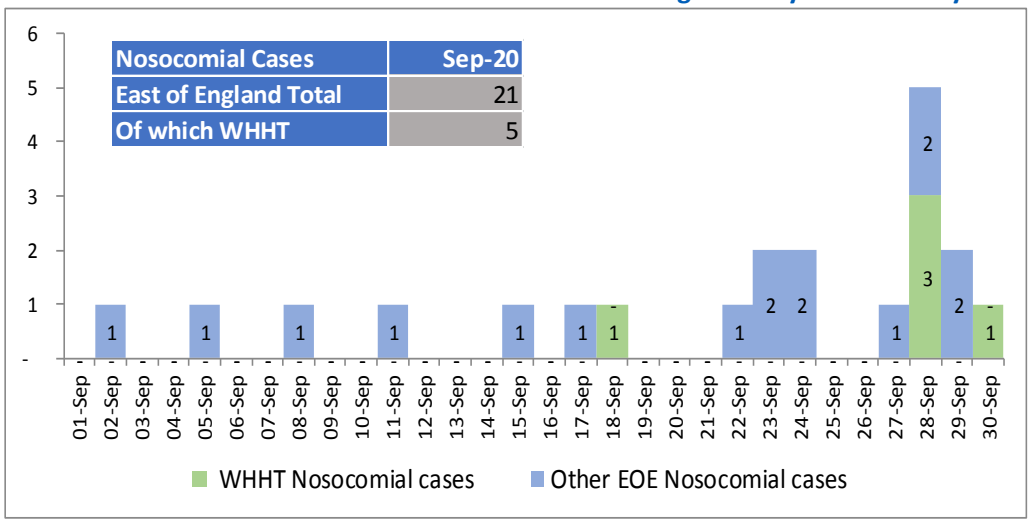
Actions undertaken included ward restrictions, staff screening, improvements in standards of cleaning and continued monitoring of remaining in the areas. RCAs are being completed for the cases falling into probable and definite categories. Initial investigations have not highlighted any significant lapses in care, but a differing presentation of COVID has been evident from that seen in the first phase.

The IPC team supports the management of the COVID-19 Pandemic through daily clinical visits and reviews, PPE training in clinical areas. Advice and support regarding management of COVID-19 in both clinical and non clinical areas. Work is undertaken in the analysis of positive test results, for managing any Hospital Acquired cases (in line with NHSE definitions) . All patients are now tested on admission and screened on day 5 -6 of their admission. A review of commencing testing at day 12 is also being undertaken for inpatients. Screens for open bays are being trialed and plastic curtains to support separation and segregation of the bed spaces in isolation areas and children's ED have been trialed and await delivery.

All cases – split by days admission to swab - WHHT



Nosocomial infection cases – WHHT and EOE - including 8-14 days and 15+ days.



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

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Safe care & Improving Outcomes: Emergency Readmissions

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

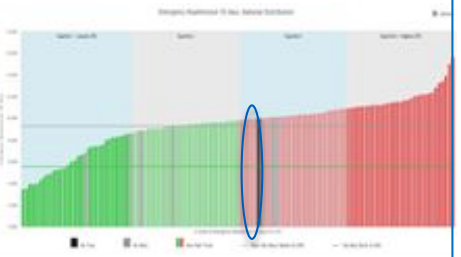
There has been a decrease in emergency readmissions to 12.2%, which is 1.1% higher than the national average of 11.1%.

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 Mar 2020

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Readmission 30 days

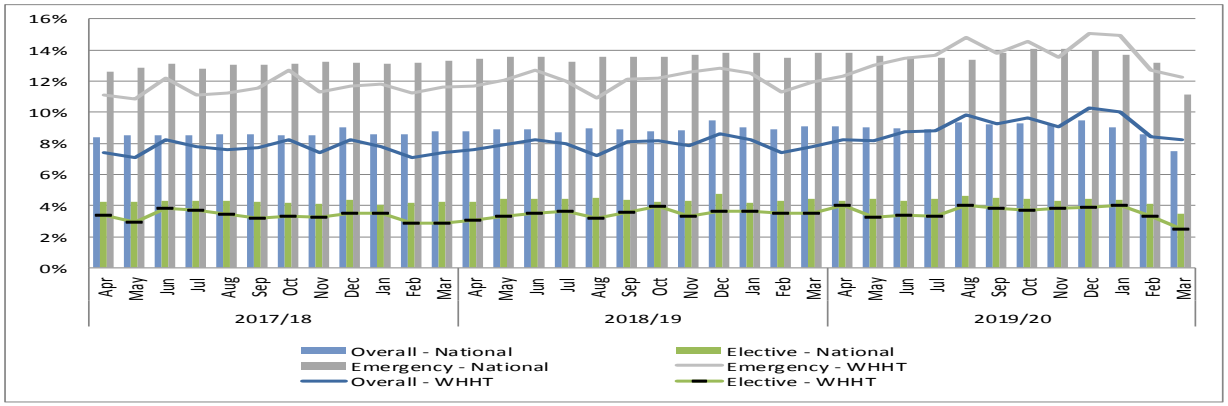


Period: Q1 2020/21

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 34.3% (Emergency 18.9%, Elective15.4%).

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

There is a C Section summit planned for November with focus on normality, decision making and operative skills.

Performance stable
Better than target/threshold

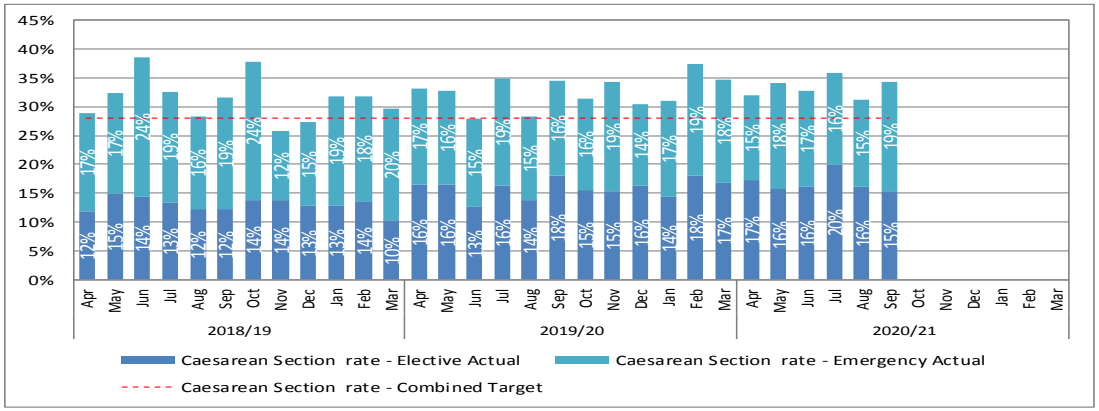
Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate

Period: July 2020

WHHT 13.88% Peer: 13.49%
National: 16.88%

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

Caesarean section rates



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

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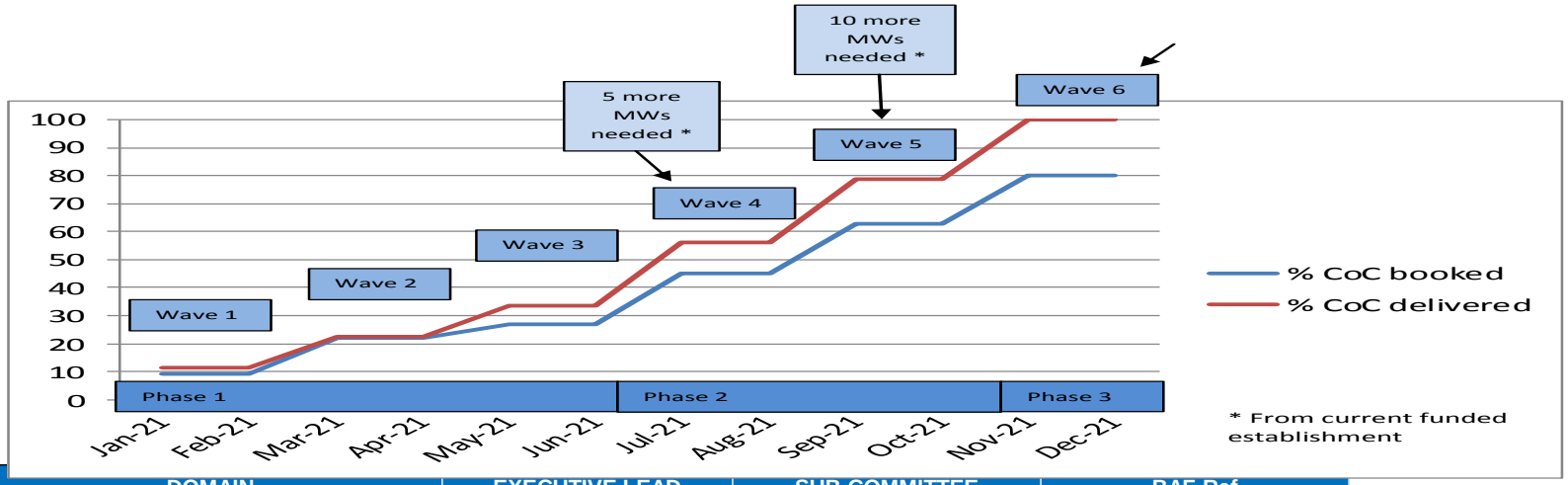
Safe care & Improving Outcomes: Maternity – Continuity of Carer

The key recommendation of Better Births (2016), the report of the National Maternity Review is for most women to receive Continuity of Carer (CoC), to ensure safe care based on a relationship of mutual trust and respect in line with the woman's choices and decisions.

In October it has been requested nationally that we resume implementation and the expectation of recovering the **35%** ambition as quickly as possible and at least by 31 March 2021 has been set. At the same time, we will be specifically looking at the proportion of Black and Asian women and those from the most deprived neighborhoods are placed onto a continuity of carer pathway meets and preferably exceeds the proportion in the population as a whole.

Summary progress, in particular how we are planning to target BAME women for CoC

- To review CoC staffing template based on funded establishment. Building recruitment plan for midwives.
- One continuity of carer (CoC) pilot team in place – Lotus Team.
- One year evaluation of Lotus team completed. Action plan in place.
- Lotus Team currently experiencing staff shortages due to team leavers. Action plan for recruitment in progress.
- Current % CoC (new bookings) = 20/417 = 4.8% September 2020.
- Local risk register updated
- Local BAME, age, BMI and deprivation data collected for targeted CoC
- Local Maternity Neonatal System (LMNS) BAME working group – action plan in place
- Work through action plan for Lotus Team to be realigned to BAME women
- CoC working party monthly meetings recommenced September 2020
- Further HEE training sessions planned across the LMNS January 2021
- 3 LMNS funded midwives to be recruited and deployed – unable to recruit
- Engagement with key stakeholders to ensure co-production e.g. senior leaders, staff, student midwives/universities, service users
- Letter to staff drafted and to be circulated in 1/11/2020
- Training needs analysis of all staff, PDM support & supernumerary time for up-skilling
- Recruitment of staff to Trust & CoC teams
- CoC communications and development of supporting materials



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

35

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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 September the fill rate was 101.3 % (92.2% registered and 102.6% unregistered). ITU overall fill rate was 100.8%. Zone A – Granger: overall staffing was 88.2% 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.

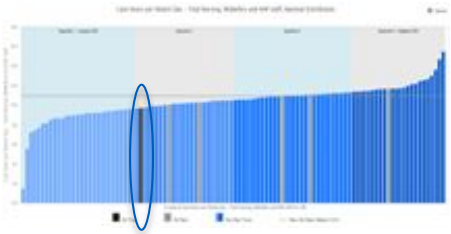
Overall 67.9% shifts were RAG rated green, down 12% from last month. 31.9% were rated amber, an increase of 11.8% from last month and 0.2% (3 shifts) red shifts were reported. These were in SCBU x 2 and Delivery Suite x 1. No safety incidents were observed or recorded.. Ward leaders' supervisory time was 77.7% an increase of 1.9% compared to previous month.

There continues to be an increased demand for temporary staff. A total of 79255 hours were requested (4,963 more than last month). Fill rate is 66.7% NHSP, 14.1% agency & 19.2% unfilled) At the workforce meetings chaired by the Deputy Chief Nurse, KPIs indicated good management of e-rostering. From March, i.e. during COVID the realignment of medicine beds had resulted in there being no designated patients with dementia unit. However, this has now changed and Oxhey ward now caters for dementia patients. 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 September enhanced care usage was 4192.75 hours a further decease of 906.33 from last month.

CHPPD rate is 8.87, an decrease of 1,.29 from last month (Model Hospital data has not been updated since February 2020). Band 5 nursing turnover is currently at 14.9% (down 3.7% in the year). Overseas recruitment continues to be successful with the pipeline of 78 nurses arriving before the end of December 2020 and another 21 in January 2021.

Performance stable
Better than target/threshold

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



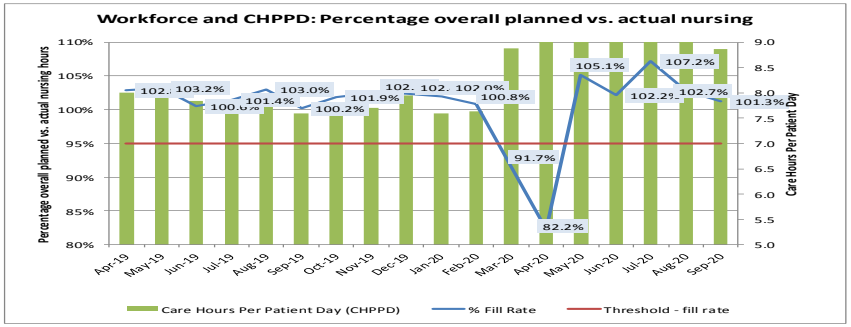
Period: July 2020

WHHT: 9.7 **Peer: 10.9**
National: 10.5

(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.
- 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



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 – September 2020:
Never events
There were no Never Events reported in September 2020.

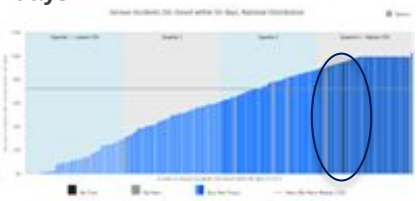
Serious Incidents
Two serious incidents were declared in September 2020. At the end of September 2020 the Trust had 11 ongoing SIs. Of these, 7 were in date, 3 were overdue, and 1 investigation was being undertaken by HSIB.

% of patient safety incidents which are harmful
20% (20) of incidents reported in September 2020 were recorded as having caused moderate or above level of harm to patients, compared with 13% (13) in August 2020. This demonstrates an increase in the percentage of incidents reported which were harmful. Although the % of harmful incidents was higher in September compared with August, the number of incidents rated as "death/catastrophic and severe" was lower in September (3 incidents) than in August 2020 (8 incidents).

There were two incidents reported in September 2020 with a harm level rated as "death/Catastrophic":

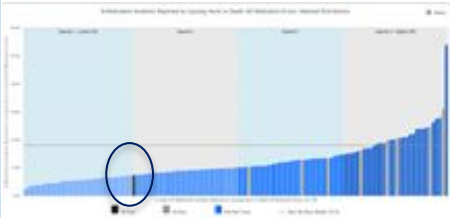
Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



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

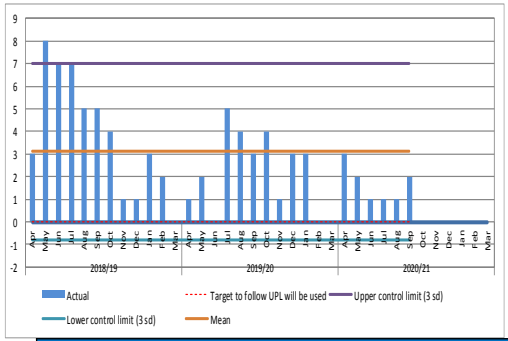
Benchmarking: MODEL HOSPITAL
% medication incidents reported as causing harm or death/all medication errors



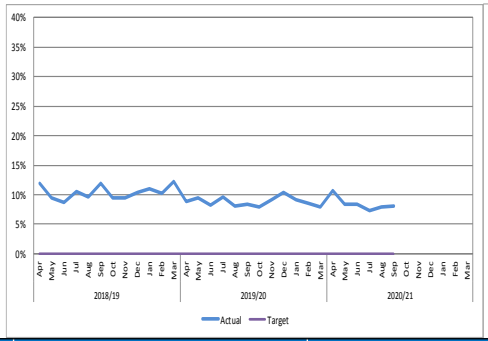
Period: 31/09/2019
WHHT 7.5% **Peer: 18.1%**
National: 10.2%

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

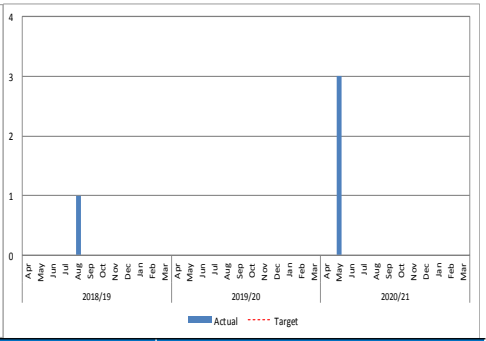
Serious Incidents



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 September there were 119 inpatient falls in total. 22 falls with low harm. 1 fall with moderate harm and 1 fall – level of harm to be confirmed by medicine division. For falls with harm analysis shows that 21 (87.5%) were not witnessed, 3 (12.5%) falls were witnessed,14 incidents occurred during the day shift and 10 during the night shift, 12 (50%) incidents with harm involved patients with cognitive impairment. Of these 2 patients were reported as having dementia.

Of the 119 falls reported in September, 15 patients were recurrent fallers accounting for 35 (29.3%) incidents. Additionally 80 (67.2%) were around the bed area.

The clinical area reporting the highest number of falls was Tudor/Castle – 17 (themes include; 5 patients were recurrent fallers accounting for 11 incidents, 14 (82.45%) were not witnessed and the majority occurred during the day shift). Elizabeth, Oxhey and Sarratt ward reported 8 falls each.

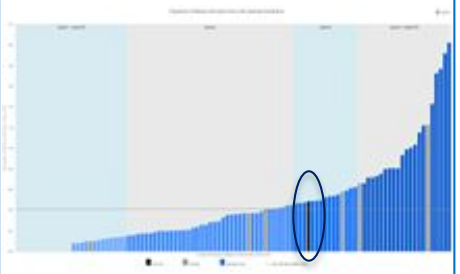
Croxley ward is using a QI approach to reduce falls. There was 26 days between falls in September. This is an improvement.

Actions:

- Increase focus in Tudor/Castle on managing high risk fallers – falls service to support
- Senior sister on Tudor ward to review day shift clinical activities – incidents to be discussed in ward meetings and huddles
- Ongoing falls awareness, prevention and management sessions on clinical staff development
- Falls service to do spot checks to provide assurance that areas reporting higher number of falls are using safety huddles to highlight issues to help improve the falls prevention management
- 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

Performance stable
Better than target/threshold

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

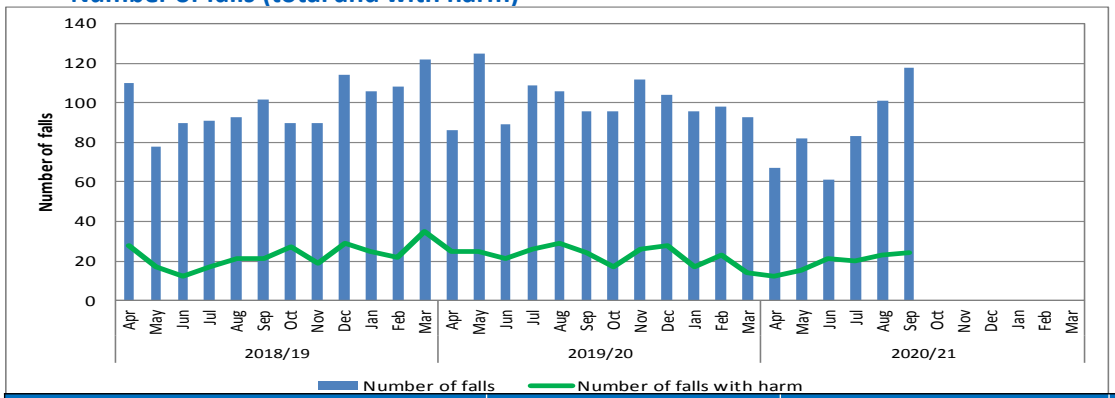


Period: December 2019

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

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

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

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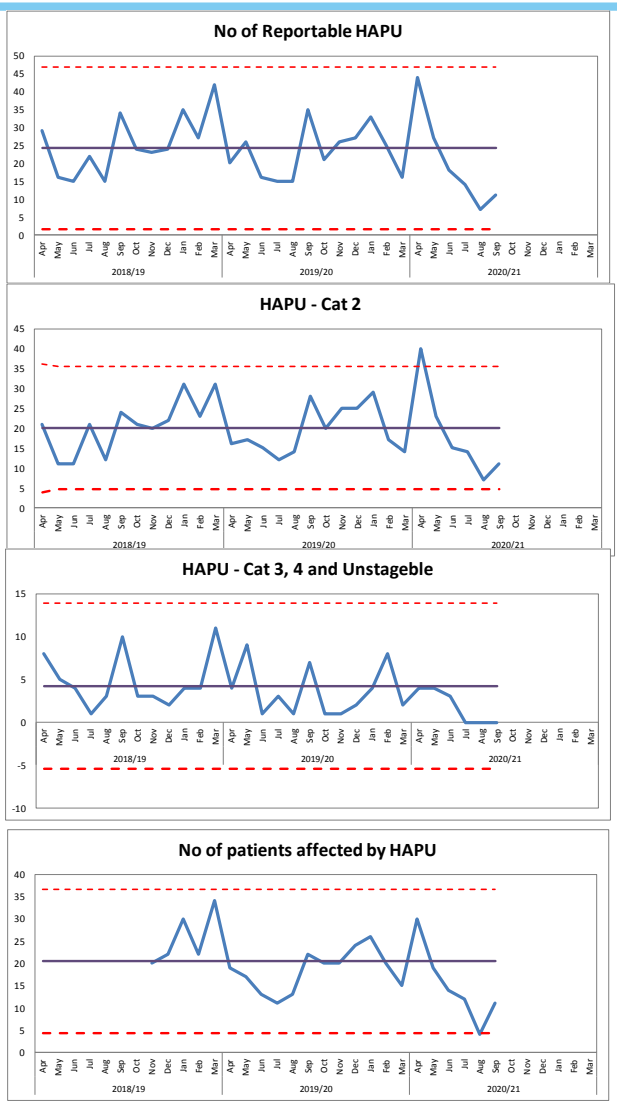
Safe Care & Improving Outcomes: Pressure ulcers (HAPUs)

September 2020 monthly report indicated a small increase in the reportable HAPUs, from (7) reportable HAPUs in August to (11) reportable HAPUs in September.
Medical device related pressure ulcers remains low
Due to widespread differentiation in location of pressure damage and anatomical location , no noticeable trends identified.
The reduction in category 2 HAPU is in part due to re-categorisation of reported HAPU to moisture lesions (ML). There were 16 ML which were originally reported as a category 2 HAPU.

Reportable HAPU (September 2020)			
	HAPU Non-medical Device related	HAPU Medical Device Related Pressure Ulcer	Total HAPU
	9	2	11
Categories	0	0	0
Category 2 (affecting 4 patients)	0	0	0
Unstageable (possibly category 3 or 4)	0	0	0
Total reportable (affecting 11 patients)	9	2	11
Non-Reportable HAPU			
Category 1 (affecting 3 patients)	2	1	3
Suspected deep tissue injury (SDTI) (affecting 6 patients)	10	0	10
Total non- reportable (affecting 8 patients)	12	3	12



Actions/developments for Pressure Ulcer management

1.At the ward based level, awareness needs to be maintained and evidenced by continued implementation of 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. Robust and effective repositioning as required for the identified patients as indicated by timely risk assessment and evidenced by the relevant documentation.

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

5. Considerations to be made regarding setting up of virtual training for all staff including senior nursing staff .

6. Review and re-introduce updated versions of the Tissue Viability Resource Folders on all clinical areas. Planning and discussions ongoing

7. Working with Continence CNS to address moisture lesions .

Training started with the Skin Champions , to be extended throughout the Trust.

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	**21**
AAU Y1	10
UCC	5
A&E	3
AAU B1	2
AAU P1	1
AAU G1	0
MIU	0
Medicine	**70**
Red	10
Aldenham	8
Oxhey	7
Winter	7
Sarratt	6
AAU B/Y 3	6
Tudor	5
Cassio	5
Winyard	4
Stroke	4
CCU/ P/G 3	3
Bluebell	3
Heronsgate & Gade	2
Frailty	0
Croxley	0
Simpson	0
Surgery	**37**
Flaunden	12
Letchmore	6
Elizabeth	5
Ridge	4
Cleves	4
ICU	4
Langley	2
DLM	0
Grand Total	**128**

Three Months

Emergency Medicine	**70**
AAU Y1	30
A&E	14
AAU P1	8
UCC	7
AAU B1	6
AAU G1	5
MIU	0
Medicine	**195**
Heronsgate & Gade	26
Winter	24
Red	21
Oxhey	20
Aldenham	16
Cassio	13
Sarratt	13
AAU B/Y 3	12
Tudor	10
Winyard	10
Stroke	9
Bluebell	8
Croxley	7
CCU/ P/G 3	6
Simpson	0
Frailty	0
Surgery	**88**
Flaunden	22
Letchmore	15
Elizabeth	14
Cleves	11
ICU	9
Ridge	8
Langley	7
DLM	2
Grand Total	**353**

Six Months

Emergency Medicine	**195**
AAU Y1	62
AAU P1	40
AAU G1	32
AAU B1	28
A&E	23
UCC	10
MIU	0
Medicine	**470**
Heronsgate & Gade	51
AAU B/Y 3	39
Winter	39
Red	38
Tudor	37
Winyard	34
Stroke	33
Aldenham	32
Bluebell	30
Sarratt	29
Oxhey	26
Cassio	25
Croxley	21
Simpson	19
CCU/ P/G 3	16
Frailty	1
Surgery	**209**
Flaunden	41
Letchmore	37
Ridge	34
Cleves	34
ICU	21
Langley	20
Elizabeth	20
DLM	2
Grand Total	**874**

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Safe care & Improving Outcomes: VTE risk assessment

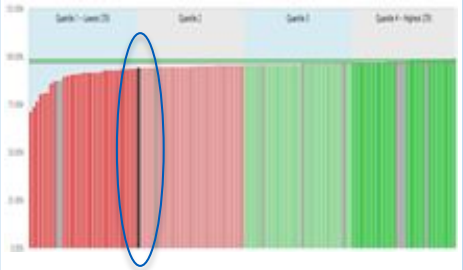
In this reporting period:
The target was achieved this month.

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

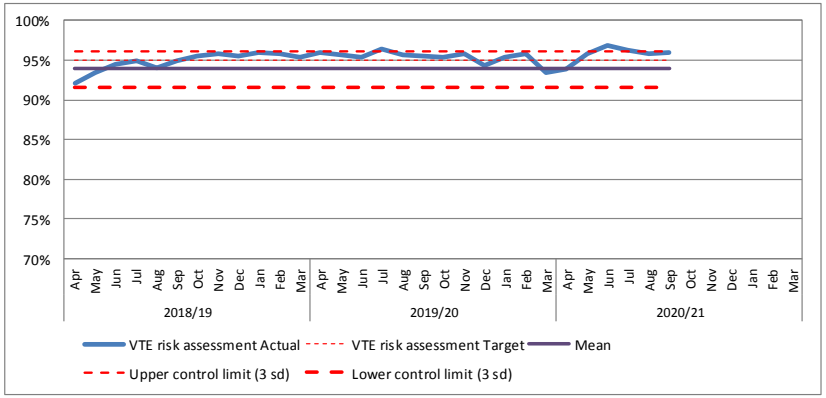


Period: Q3 2019/20

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 – 15.9%

Since the beginning of the COVID pandemic performance has deteriorated as patients admitted to the Trust require COVID swabs prior to any planned ward transfers and therefore wait in a holding ward until the swab results are available, which can take up to 5 hours resulting in the inability to standard of admission to the Stroke unit within 4 hours. During the time in the holding areas, patients are reviewed by the Stroke team and continue to receive 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 80.0% (target 80%)

Despite the constraints described above, this target was achieved.

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

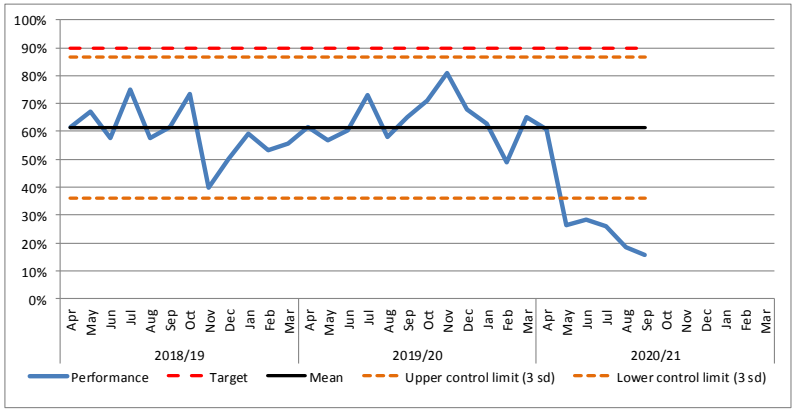
Benchmarking: SSNAP

Period: October to March 2020

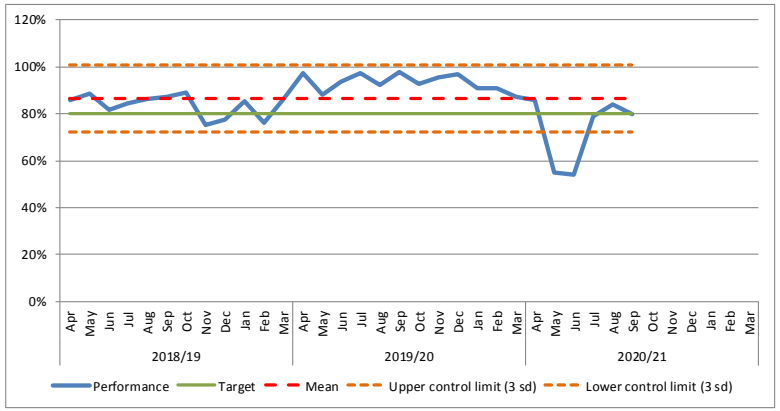
Admission within 4 hours: 54.0%

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

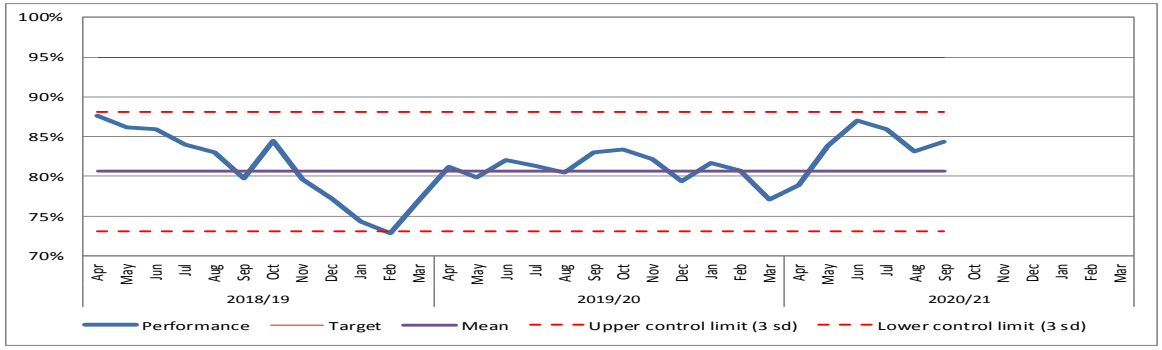
In this reporting period:
At 84.3%, overall Trust performance improved on the previous month's performance of 83%. Compliance with the 95% standard was maintained at HH UTC (99.9%). Performance at the WGH UTC was 99%. Processes for COVID pathways hinder established pathways mainly due to capacity constraints in ED and staff are challenged with working in isolation environments in PPE. Hemel UTC attendances fell by 2% on the previous month but still remained higher than the previous 4 months. MIU remains closed. Total Trust attendances including attendances at the UTC were 2.6% lower that the previous month but higher than the previous 4 months .

In September the average handover time was 23 minutes an improvement from 27 minutes in August. Conveyances are up 5% from the previous year in comparison to a decreasing trend 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.

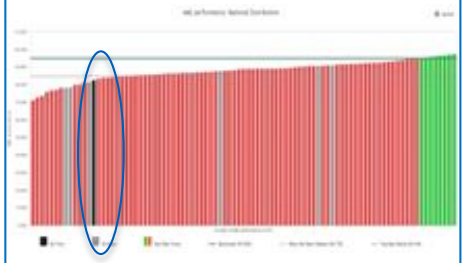
Next Steps:
- The regular check in meetings between the service team and Executive colleagues have restarted.
- The monthly programme board meetings oversee the ambulance work stream with a joint action plan between EEAST and the Trust restarted in May.
- Consultant recruitment has not been successful but a paper to TMC on 23rd Sept outlining a recruitment and retention package was approved.
- SMART has been limited due to the new COVID pathway, a Virtual SMART commenced 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: August 2020

WHHT: 82.73% Peer: 84.73%
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

Submission suspended

Performance stable
Better than target/threshold

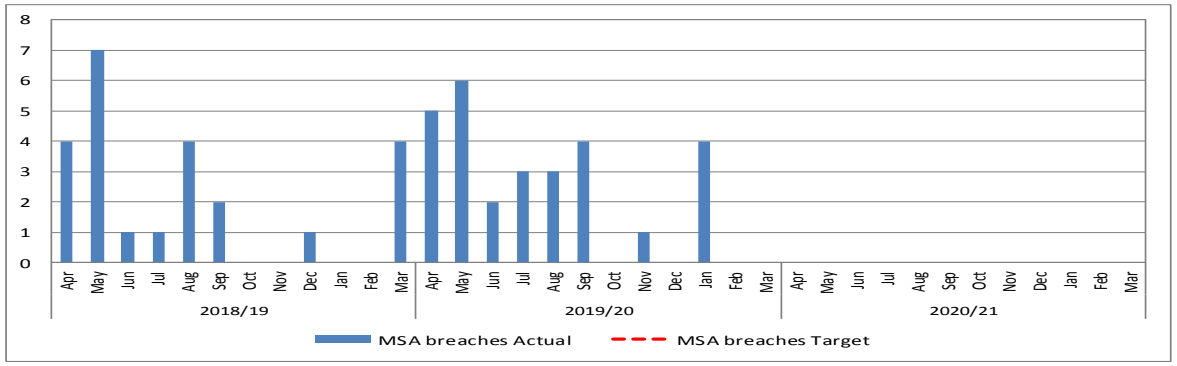
Benchmarking:

Not currently available

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.

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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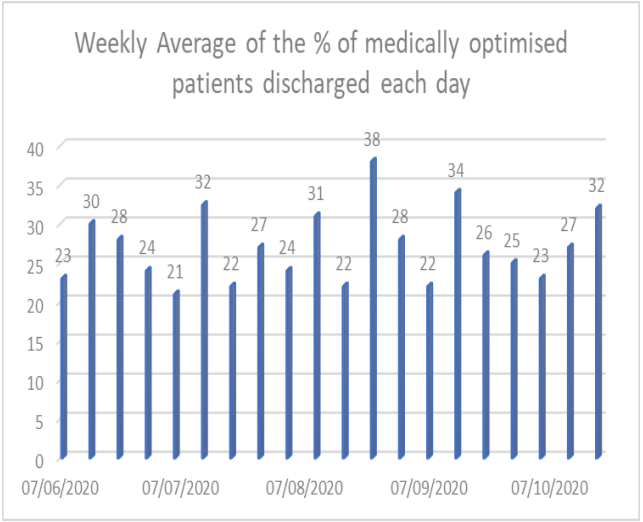
Caring & Responsive Services: Delayed Transfers of Care

In this reporting period:
The below table shows 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). Discharge numbers were significantly depressed during August although improvements have been observed since.

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

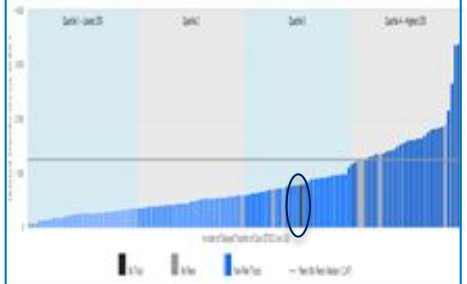
The main external issues impacting on flow are:
Care Capacity, mostly this relates to Home Care and in some cases specialist placements sourced by the CCG.
Flow in CLCH beds remain good and capacity is good.
There is also evidence that nursing and nursing dementia DTA beds is delaying movement. Although not reflected in August data the availability of COVID beds outside of the acute will become an increasing risk.

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

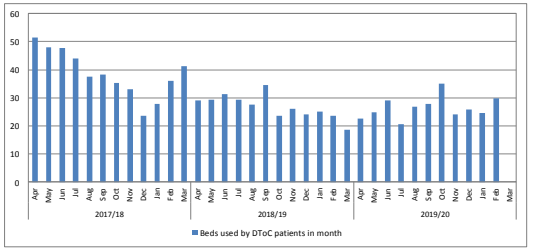


Period: December 2019

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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Caring & Responsive Services: Complaints

In this reporting period:
The Trust's monthly target of 80% was achieved - 86% in September.
44 new complaints were received as follows:

- 30% (13) relate to Surgery, Anaesthetics and Cancer (SAC)
- 27% (12) Medicine
- 18% (8) Women's & Children's (WACs)
- 14% (6) Emergency Medicine
- 7% (3) Corporate
- 2% (1) CSS
- 2% (1) Finance

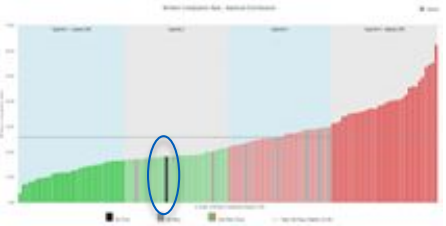
At month end there were a total of 49 live complaints (same as at end of previous month).
43 complaints were closed in the month. 4 complaints were re-opened in September 2020 (2 Medicine and 2 SAC)

Improvement plan:
No complaints are older than 2 1/2 months and of 49 open complaints, 3 were overdue at the end of the month. Medicine and SAC continue to receive the most complaints. 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 55% (24); attitude of staff and communication at 11% (5), appointments 14% (6) Admissions/Discharge 11% (5) and 9% (4) other. No specific themes or trends have been identified although communication remains a consistent factor throughout all complaints received.

Performance improved
Better than target/threshold

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

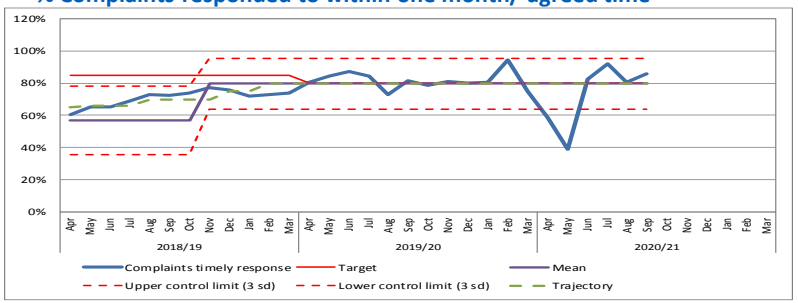


Period: December 2019

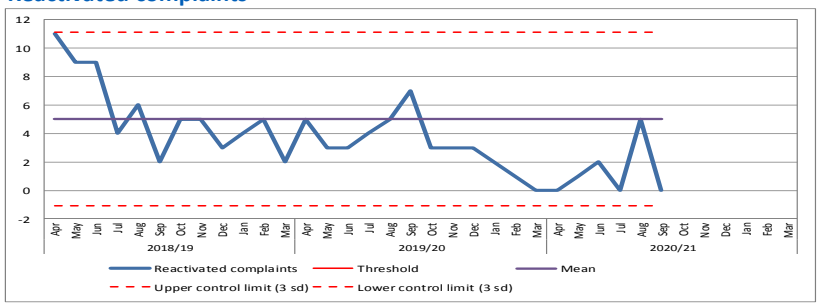
WHHT 18.36 Peer 25.90
National 21.95

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

% Complaints responded to within one month/ agreed time



Reactivated complaints



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

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Caring & Responsive Services: End of life care

In this reporting period:

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

Referrals to Specialist Palliative Care

The strategy identified that people weren't supported to die in their place of choice; and although progress has been made, this has been evidenced in many other reports. There continues to be a national focus on reducing the numbers of patients dying in hospital and offering everyone who is approaching the end of their life the opportunity to express and share their preference for where they want to die as well as any goals that are important to them (National Palliative and End of Life Care Partnership, 2015).

In September 2020 90 referrals were made to the Trust Specialist Palliative Care Team. Of the patients with capacity to make decisions about PPD and where it was appropriate, 100% had an identified PPD.

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

There were 12 patients in September 2020 who died in a setting that was not their preferred place of death (PPD). For the 6 patients wishing to be at home ,all of them had physical symptoms that did not permit their transfer home. There were 5 patients who wished to die in a hospice. In 3 cases there were no hospice beds available and 2 patients became too unwell to transfer. 1 patient wished to die in a Nursing Home but there was a delay in the CHC funding process.

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

Of the 12 patients whose deaths were reviewed in September, 9 patients were on the IPCD. There were 3 patients who **did not** have an IPCD but it was deemed that it was appropriate for these patients. 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.

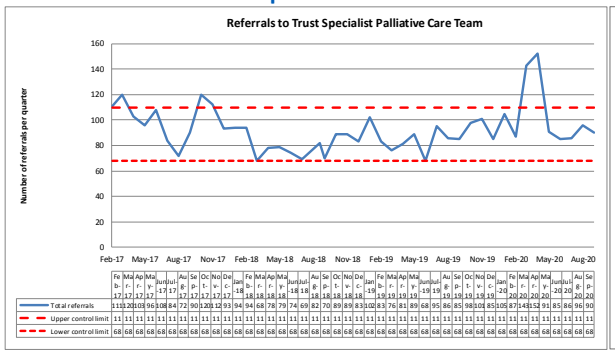
Of the 12 patients whose notes were reviewed, who died in September 2020, **all** patients had a TEP in place; however only 4 of those patients had had their TEP reviewed as needed and they were appropriate.

Stable

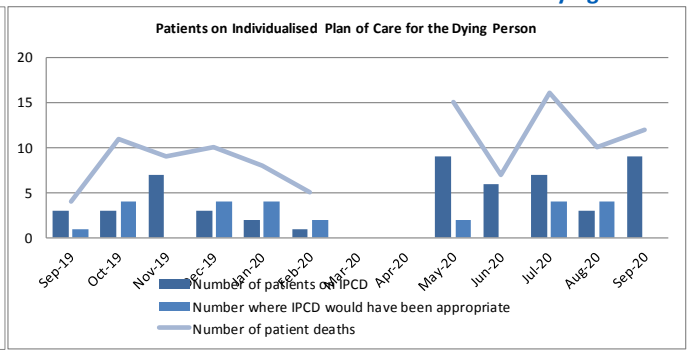
Benchmarking:

Not currently available

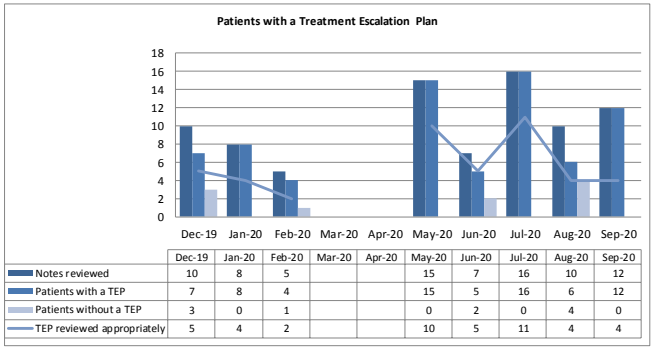
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Notes reviewed	10	8	5			15	7	16	10	12
Patients with a TEP	7	8	4			15	5	16	6	12
Patients without a TEP	3	0	1			0	2	0	4	0
TEP reviewed appropriately	5	4	2			10	5	11	4	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:
Performance improvement has continued as a result of a reduction in backlog and an increase in referrals, combining to deliver a better position against the 92% target, with 69.7% of pathways under 18 weeks (previous month 61.8%),

The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was better than the national position (8.5 vs 14.8 weeks) but the 92nd percentile wait time was worse (44.4 vs 42.1 weeks).

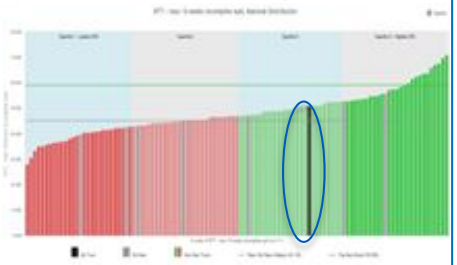
The increase in 52 week waits continues however, and at the end of the month there were 855 patients whose waiting time exceeded 52 weeks wait, the majority being in Oral Surgery 30%, ENT 20%, Ophthalmology 16%.

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 the backlog in DEXA scanning continues to impact overall performance has improved slightly to 69% (from 68.4%).

Performance improved
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

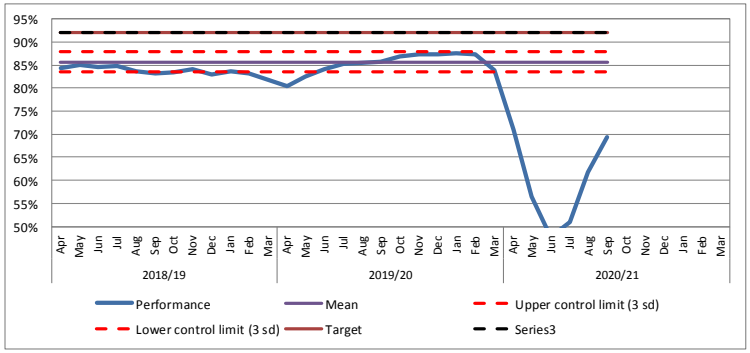


Period: July 2020

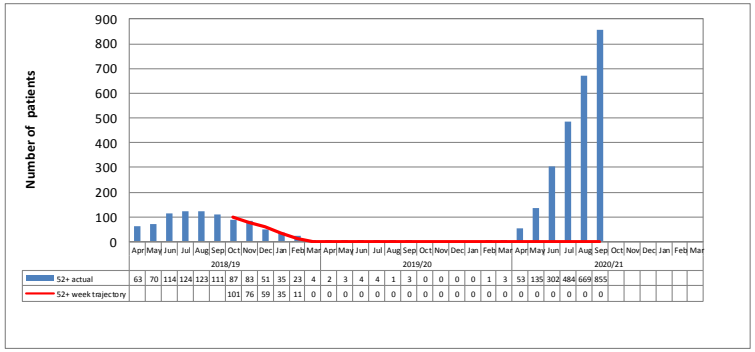
WHHT: 51.03% Peer: 45.12%
National: 47.10%

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

RTT - % within 18 weeks



Number of 52 week waits



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

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

2 week waits:
The provisional position for September is compliant at 97.2% with 1361 referrals of which 38 were seen beyond 14 days. Of the 38 breaches the specialty breakdown is as follows: 4 skin, 5 breast, 7 UGI, 3 urology, 1 Head & Neck, 11 LGI, 1 Haematology and 6 Gynaecology.

In September 96% of the 'normal average' referrals were received, compared to September 2019.

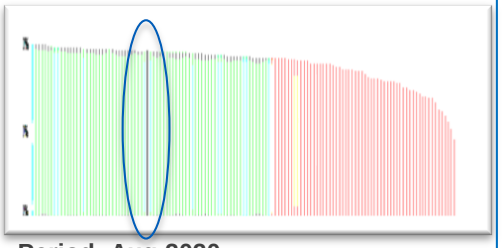
The Trust are monitoring the referral numbers and the numbers of patients diagnosed with cancer. Currently the conversion rate is lower than usual at 4.0% in September compared with a baseline figure of 6.7%.

2 week wait breast symptomatic:
The provisional position for September is compliant at 97.1 %.
There were 109 referrals, a drop on the previous month of 21. Of these 3 patients were seen beyond 14 days.

28 day Faster Diagnosis Standard : September's FDS activity is
- 2ww - 78.4%
- Breast Symptomatic – 97.2%
- Screening –80% - 3 patients: All Gynaecology

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

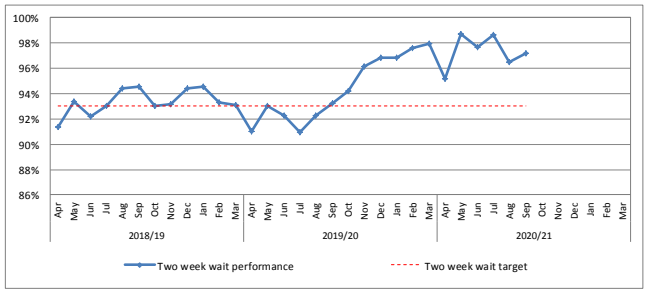


Period: Aug 2020

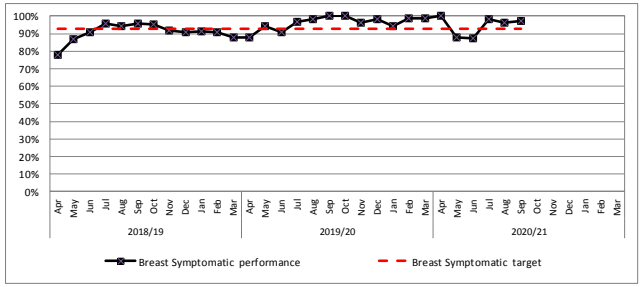
WHHT: 96.5% Peer: 87.3%
National: 87.8%

(Peers = East of England region)

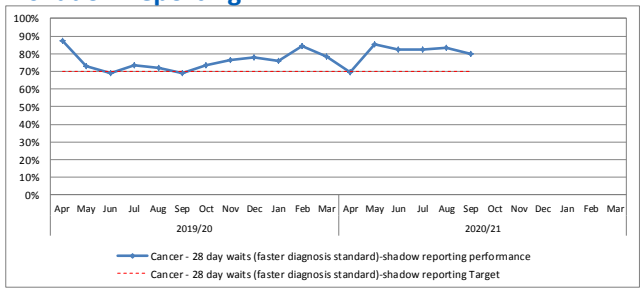
Two week waits: % within target time



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 September is compliant at 97% with 168 pathways and 5 breaches (2 Urology, 2 Breast and 1 LGI).

31 day subsequent surgery
The provisional position for September is non- compliant at 71.4%, with 7 pathways and 2 breaches (1 Urology and 1 LGI)

31 day subsequent Drug
The provisional position for September is compliant with 100%. There were 18 pathways

31 day subsequent palliative and other
The provisional position for September is compliant at 100 % with 18 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

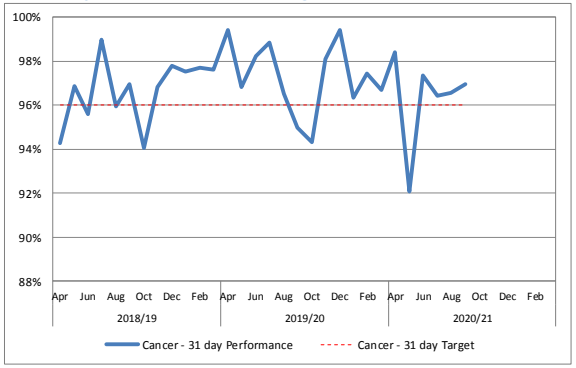
Benchmarking: NHSI Analytics Hub

Period: August 2020
31 day first:

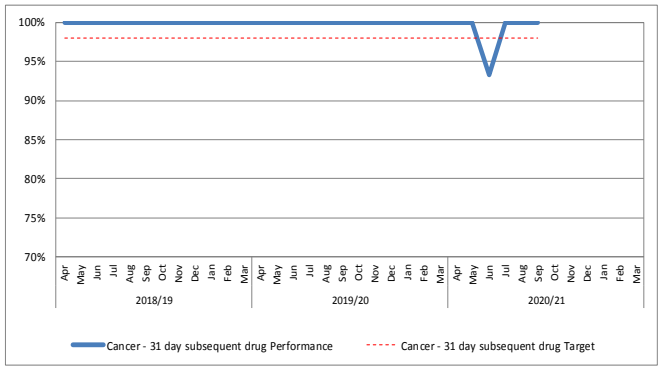
WHHT: 96.5% **Region: 91.6%**
National: 94.5%

31 day surgery:
WHHT: 77.8% **Region: 73.0%**
National: 86.3%

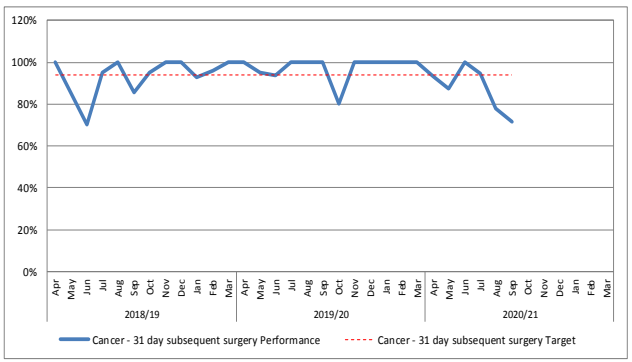
31 day first: % within target time



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 September is non-compliant at 83.7%
Provisionally there are 116.5 treatments (128 patients) with 19 breaches (23 patients). This includes 1 Breast , 3 Gynaecology, 6 Haematology, 2 LGI, 1 Lung, 1 Skin, 4 UGI, 6 Urology.
The number of people treated on a 62 day pathway is progressing towards pre-COVID levels. The average for 2019/20 was 105 patients and recent months are as follows: July 98, August 82 and September 127.

A provisional review of the breaches indicates that there were fewer breaches associated with COVID and specifically endoscopy. There were more complex pathways this month for a variety of reasons, particularly within Haematology. It was notable that there have been changes to the prostate pathway - patients are no longer having a TRUS and a template biopsy, now all patients who need a biopsy have a template. However there are a limited number of slots in which the template can be done under LA and therefore many of the Urology breaches we associated with requiring theatre time for templates.

62 day screening referral to first definitive treatment –Performance for September is provisionally non- compliant at 66.7 % with 1x LGI breach.
62 day consultant upgrade The provisional September position is 57.1% with 10.5 pathways (14 Patients) with 4.5 breaches (5 patients) – All were lung
104 day breaches open pathways: In September submission of open pathways over 104 days, there were 30 patients of which 22 were LGI, 1 Brain 1 Breast 1 Haematology 2 head & neck 1 UGI and 2 Urology. These long pathways are being actively managed with clinical input where necessary
Closed – In September the Trust closed 9 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

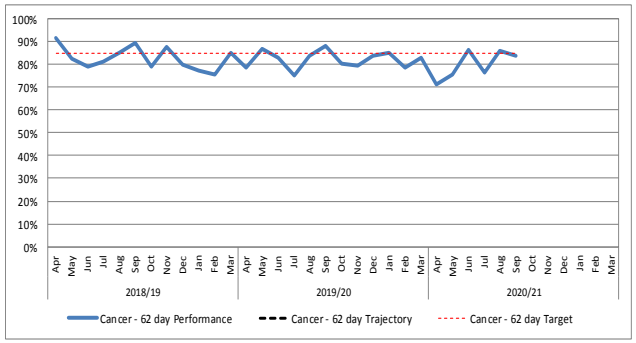
Period: July 2020
WHHT: 76.58% Peer: 85.34%
National: 78.08%

Peers = Nightingale Group – acute multi-site trusts

Benchmarking: NHS Analytics Hub
Period: August 2020
WHHT: 85.1% Peer: 73.6%
National: 77.9%

Peers = East of England Region

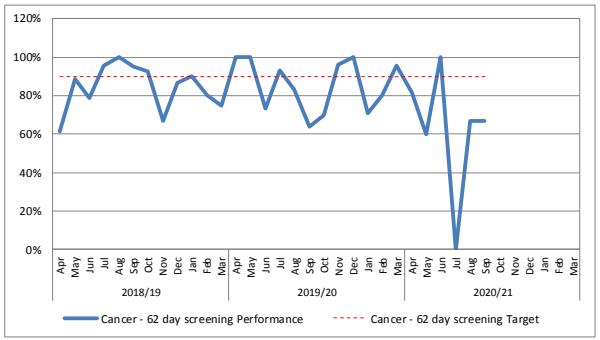
62 day GP: % within target time



62 day GP: Tumour Site

Tumour type	July	August	September	Q2 (provisional)
Breast	100	100	95.7	97.7
Gynaecological	75	100	93.3	91.7
Haematological	66.7	75	40	52.9
Head and Neck	0	100	100	62.5
Lower Gastrointestinal	52.2	76	73.3	66.7
Lung	66.7	0	0	28.6
Skin	100	100	100	100
Upper Gastrointestinal	80	100	62.5	69.6
Urological	37.5	66.7	60.6	56
Testicular	100		100	100
Other	0			0
Childrens		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:

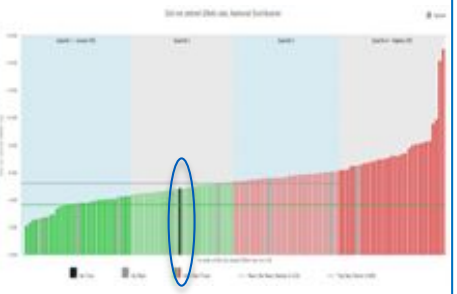
Referral management: Work with the information team and finance is underway to ensure the Trust appropriately records referrals that are 'returned to referrer with advice', extracting the data from e-RS. This development was part of the new approach to referral management within the recovery plans and is supporting good capacity management as these referrals do not convert to an outpatient appointment but have had consultant review.

The Attend Any Where Reception function is to be piloted and resource identified within the OPD reception team to support this element of virtual activity.

WHHT's DNA Rate continues to be below the national level but there are some significant hot spots within services and these will be discussed at the Outpatient Users Group and in divisional performance reviews going forward.

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Did not attend rate



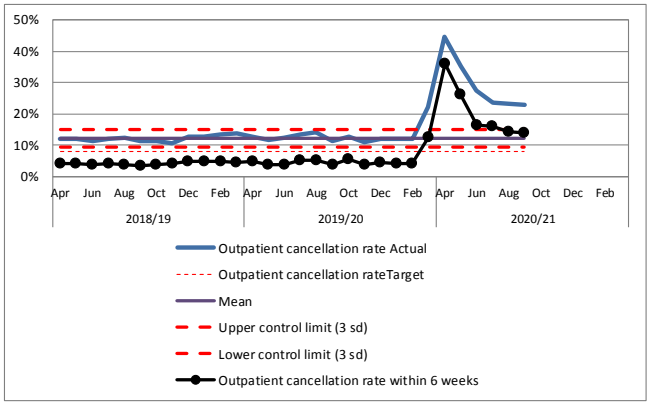
Period: Q1 2020/21

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

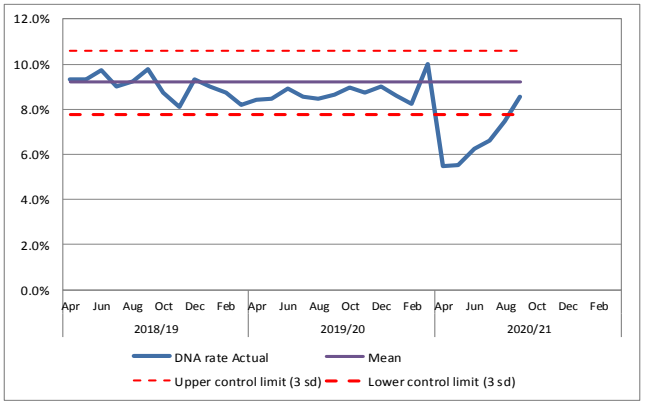
(Peers = Nightingale Group – acute multi-site trusts

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

Outpatient cancellation rate



DNA rate



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

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Workforce & Finance: Recruitment & Retention

In this reporting period:

Contracted wte and Vacancies - staff in post is 4,626 (4,655) wte last month (+114wte over the last 12 months). NB – some of this increase is due to COVID staffing arrangements such as employing aspirant student nurses. The Trusts workforce establishment is now 5164wte (excl external staff working on rotation). This is an increase of approx. 100wte over the last 12 months, recent increases are for A&E Medical staff, Acute Care Physicians, Enhanced Care Needs Team, and Tudor Ward. **The number of vacancies** is currently 537 wte, in percentage terms this is 10.4%. This compares to 531wte in Sept 2019. For Band 5 nurses the vacancy rate is currently 10.6%, an increase from previously lower rates achieved before COVID which have disrupted planned overseas recruitment. However, vacancy rates for Nurse Band 6 and 7 staff have decreased to under 2%, as staff have been promoted. The B5 reduction is also a significant decrease from 123wte or 17.2% in March 2018 and 32% in 2015. There are plans to recruit both in the UK and abroad to reduce these vacancies over 20/21 to reduce the vacancy rate, with approx. 100 nurses planned to start between now and January 2021.

Sickness – absence is currently 3.9%, above the 3.5% target. The Trust is ranked 4 / 12 in terms of the lowest sickness scores as at Q3 for local NHS benchmarking organisations. The 12 monthly NHSI sickness rate is 4.7%, reflecting the high point of COVID in April when rates were 11%. There are currently over 60 staff off sick who are COVID symptomatic. There are also over 120 staff absent due to COVID household contact and over 60 absent due to test and trace contact.

Labour Turnover and Number of staff leaving within first year

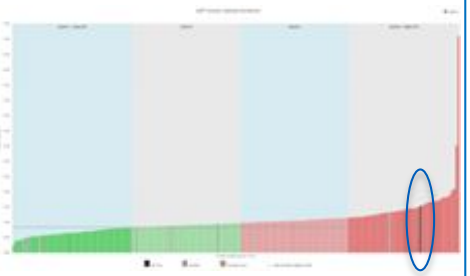
Based on a rolling 12 month period is currently 13.6%, a small increase from last month, but reduced from a year ago when it was 14.7%. The Trust also measures 3 monthly turnover rates which help identify more immediate changes in trends, and the rate is currently approx. 11%, meaning there are no short term pressures to show that turnover will increase. The percentage of staff who leave their post before serving 1 year is currently 16.5%. This rate is significantly less than 22.6% where it was just over a year ago. Nursing Band 5 turnover is slightly under the 16% target, at 14.9%, but has remained stable at 17.0% or under for the last year, much reduced from the 29% rate 2 years ago.

Next steps – recruitment :

- Since mid-august we have increase our deployment of overseas nurses and we have planned group of 24 arriving each month. From 19th August to date, 32 overseas nurses have started in post with a further 24 planned for 21st October and 12th November.
- We have reviewed our OSCE training timeline, we are now able to fast track a nurse through 3 weeks of continued OSCE training with an exam within 2 weeks of completing their training, shortening the time it takes to receive registration.
- Our cohort of OET students due to take their exam in March / April were delay due to Covid. These have now been rebooked over September, October and November. 3 have already passed their OET.

Performance stable
Worse than target/threshold

Model Hospital benchmarking:
Proportion of staff leaving each month

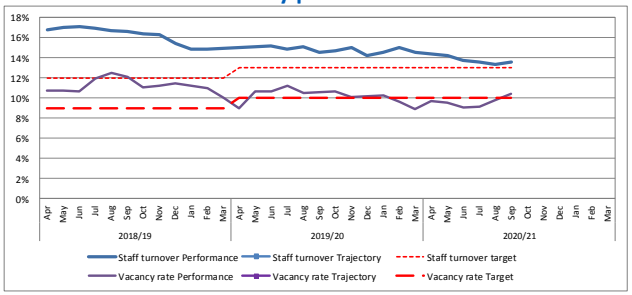


Period: October 2019

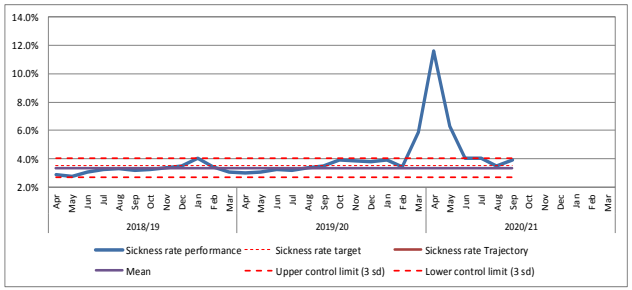
WHHT: 1.54% Peer: 0.83%
National: 0.98%

Peers = Nightingale Group – acute multi-site trusts)

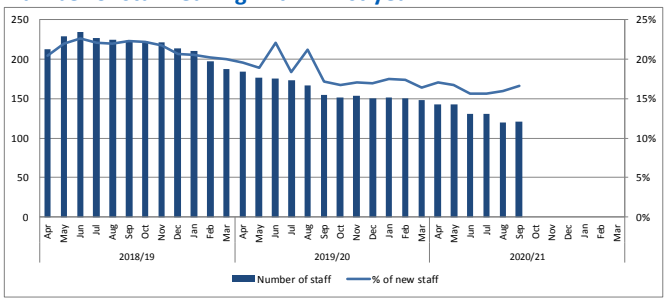
Staff turnover and vacancy performance



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
The current reported appraisal rate is 87%, this rate was set at the end of March, slightly below compliance. This includes medical staff (apart from Deanery training grade medical staff). Due to COVID, this rate was maintained for reporting purposes, while appraisals were undertaken where possible and there would be no disruption to services. Over the last 2 months, the Divisions have been working to a recovery plan in order to achieve compliance.

Divisional HR Business Partners are continuing to work closely with Divisions on maintaining and improving appraisal rates. Currently, incremental grade progression is applied automatically, however a successful appraisal will be required from November.

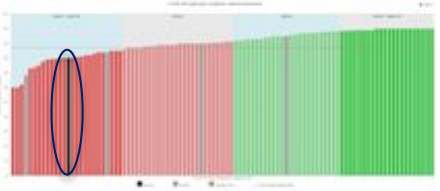
For local benchmarking for appraisals, within Herts Beds and Essex Trusts, the Trust ranks equal 4/13 local Trusts (Q4, 19/20)

Mandatory / Essential training
The all Trust mandatory training rate remains above target at 91%, for September. Compliance is now measured for one single set if mandatory training, rather than separating into mandatory and essential.

With the all-Trust targets met, attention is now focussed on any subject, department or staff group where specific help to reach compliance is still required, and the Education Service will continue to liaise with the HR Business Partners, Divisional Performance Reviews and Trust management as necessary to ensure that any outstanding areas receive appropriate support.

Performance improved
Better than target/threshold

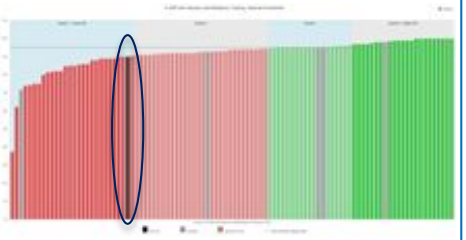
Benchmarking: Model Hospital
Trust staff with appraisal completed by the required date



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

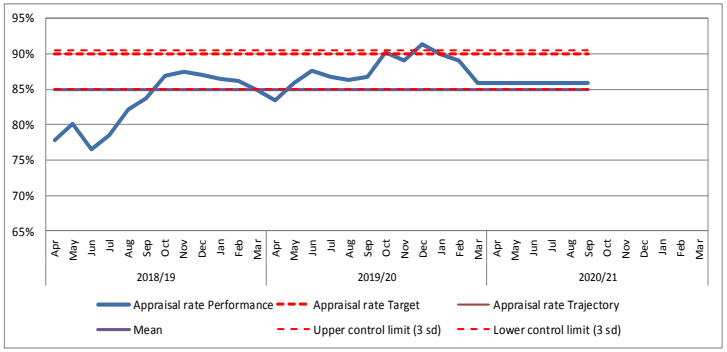
Performance stable
Better than target/threshold

Benchmarking: Model Hospital
Statutory & Mandatory training compliance rate

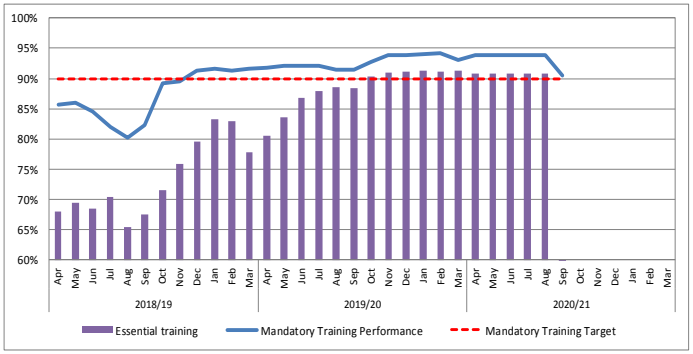


Period: 2018/19
WHHT 90% **Region 95%**
National 94%
Peers = Nightingale Group – acute multi-site trusts)

Appraisal performance



Essential training and mandatory training performance



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 we are monitoring. These include B5 nurse vacancies and turnover, reflecting the focus on recruitment and retention of these staff in conjunction with NHSI. These areas are identified as the Trust's highest workforce risk factors. B5 Nurse Turnover rates are 14.9% currently, about half their rates 3 years ago. The Trust is now below its 16% target. For B5 Nurse vacancies, the rate is currently 10.6% overall and means the Trust is higher than its forecasted position. This is because of the impact of COVID on international recruitment plans. However approx. 100 B5 nurses are planned to start between now and the end of January 2021 - since mid-August we have increased our deployment of overseas nurses and we have planned group of 24 arriving each month. From 19th August to date, 32 overseas nurses have started in post with a further 24 planned for 21st October and 12th November.

Combined appraisals rates have been held at their pre-covid rates of 87%m just below the compliance requirement of 90%. The overall rate for medical staff (97%) includes all medics apart from Deanery posts. Mandatory training compliance is 91%, and is now consistently above the 90% target. The divisions are working with HRBPs in recovery plans to increase the appraisal rates to compliance levels by November.

The Sept monthly Trust sickness rate is 3.9% against a 3.5% target, and so is above target. The 12 month sickness figure is 4.7%, above the 3.5% target and reflecting high COVID related sickness over Spring 2020. It is anticipated that sickness will rise over Winter months, particularly if COVID cases rise in the general population.

The current agency pay bill percentage is 4.2%. The overall target rate for 2019/20 is 4.7%, reflecting the reduced agency cost target envelope.

The 12 month turnover rate is 13.6%, amongst the lowest rates we have recorded. The Trust is ranked 9 / 16 nearby NHS organisations.

FFT scores have been suspended during COVID. The 2020 staff survey is currently being undertaken, response rates are 13%, which is 484 more returns than at the same stage last year.

Workforce Indictors - Progress Table

Progress against target - Sep 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	11.1%	10.5%	9.5%	10.4%	10.0%	0.4%	↗	4%
Band 5 Nurse Vacancy		0.0%	7.0%	10.6%	9.0%	1.6%	↗	18%
Headline Turnover	13.7%	14.6%	13.6%	13.6%	13.0%	0.6%	→	5%
Band 5 Nurse Turnover	16.3%	17.0%	16.0%	14.9%	16.0%	-1.1%	↘	-7%
Total Sickness	3.6%	3.5%	4.3%	3.9%	3.5%	0.4%	↘	11%
Non-Medical Appraisal	54%	87.0%	87.0%	87.0%	90.0%	-3.0%	→	3%
Medical Appraisal		97.0%	97.0%	97.0%	90.0%	7.0%	→	-8%
Core Skills Framework	89%	91.0%	94.0%	90.5%	90.0%	0.5%	↘	-1%
Agency as a % of Paybill	7.1%	4.2%	2.6%	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
5 November 2020

Title of the paper	**Annual Complaints and Patient Advice and Liaison Service (PALs) Report**
Agenda Item	13/84
Presenter	**Tracey Carter, Chief Nurse, Director of Infection Control and Prevention**
Author(s)	**Brian Haig, Complaints Manager; Jackie Dick, Senior Nurse for Resolution & PALS**
Purpose	*Please tick the appropriate box* *For approval* ✓ | *For discussion* | *For information* ✓
Executive Summary	In accordance with the NHS complaints Regulations 2017 this report sets out an analysis of the number and nature of complaints received by the Trust. The annual Complaints and Patient Advice and Liaison Service (PALS) report is presented to the Quality Committee for discussion and assurance. This report provides a summary of patient complaints, concerns and compliments received in 2019/2020. It includes details of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman's investigations and actions taken by the Trust in response to complaints. **Complaints key points to note:** • In 2019/20 352 complaints were received as compared to 432 complaints during the same period in 2018/19 giving an average of 29 complaints per month. • Acknowledgments were made within the national target of 3 working days 100% of the time. • The Trust responded to 81% of all complaints within the time agreed with the complainant an improvement from 71% in 2018/19 and 56.4% in 2017/2018. • At the time of writing this report there was only one complaint over 6 months old, a significant drop from the same period last year. **PALS Key points to note** • Continuation of a weekly tracker to monitor all concerns at a Divisional level using a RAG rating system (RED for breach, AMBER for nearing breach and GREEN for under investigation). • Standard Operating Procedure (SOP) developed in 2019 is embedded within the PALS team with robust monitoring. • Quality of data collection has improved due to robust management of individual members of staff recording concerns accurately. • Daily monitoring of all concerns raised (either by email, letter or phone contact), which has improved the strategy of who is the best contact to resolve concern. • Ongoing discussions with Herts Interpreting Service (HITs) to establish

<table>
<tr><td></td><td>usage of interpreters and review of costings.
• The WEB page has been updated.</td></tr>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><th>Aim 1
Best care</th><th>Aim 2
Great team</th><th>Aim 3
Best value</th><th>Aim 4
Great place</th></tr>
<tr><td>Objectives 1-4</td><td>Objectives 5-8</td><td>Objective 9</td><td>Objective 10-12</td></tr>
<tr><td>X</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td>
<table>
<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>Quality & Safety Group
Quality Committee</td><td>16/05/2020
24//09/2020</td></tr>
</table>
</td></tr>
<tr><td>Action required</td><td>The Trust Board is asked to receive this report for information and assurance that the Trust is compliant with NHS England Complaints Policy.</td></tr>
</table>

Agenda Item: 13/84

Trust Board – 5 November 2020

Annual Complaints and Patient Advice & Liaison Service Report

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

1. Introduction

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

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

2. Purpose

2.1 This report provides assurance that complaints handling and management is compliant with our Trust Policy. It presents the findings on complaints and PALS activity, and identifies the trends and learning from 1 April 2019 to 31 March 2020.

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

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

3. Background

3.1 The Department of Health published the Local Authority Social Services and NHS Complaint Regulations, which was updated in 2017. The policy contains up to date information relating to safeguarding in terms of patients, complainants and staff. Further minor amendments have been made, with the aim to improve the service provided to complainants. These include making specific regulatory requirements more clear within the

policy and also improving the quality of communication with complainants. This document outlines NHS England's commitment to dealing with complaints about the service provided by them and the services they commission. In doing so, it meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) updated June 2017, conforms to the NHS Constitution and reflects the recommendations from the Francis report (2013).

3.2 The Trust's Complaints Handling Policy outlines the process the Trust undertakes to manage complaints, which are received in writing, email, verbally, or in person. Information for patients and their families about how to raise a concern or make a complaint and who to contact is outlined on the Trust's website and through posters and leaflets. All complaints received are reviewed by the Chief Nurse or designated deputy and formally signed off by the Chief Executive or their deputy.

4. Summary

4.1 In 2019/20, 352 complaints were received at West Hertfordshire NHS Trust compared to 432 in 2017/2018. In total 373 complaints were responded to. The additional responses were as a result of outstanding complaints from 2018/2019.

4.2 The Trust responded to 81% of all complaints within the timeframe agreed with the complainant; 71% in the previous year. Of the complaints responded to, 54% of complaints were upheld or partially upheld, comparable to the number in the preceding year.

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

4.4 The volume of complaints referred and considered for formal investigation to the Parliamentary and Health Service Ombudsman (PHSO) reduced significantly from 17 in 2018/19 to 2 in 2019/20. This has in part been attributed to the improved standard of the responses provided by the Trust and the willingness to review those complaints further where the complainant is dissatisfied with the outcome.

4.5 All lessons learnt are captured by being recorded onto Datix. Specific learning throughout the Trust are highlighted in section 20 'Learning and Improvement from Complaints' of this report.

4.6 The End of Life Compassionate Care Group continues to scrutinise and review complaints relating to End of Life Care within their bi-monthly meeting. Themes and learning are shared within the meeting and used to improve and shape processes and policy.

4.7 The Complaints team attend and provide reports for the Patient Experience Group (PEG) meeting. The aim of the report is to provide an update to the PEG on the delivery of four priorities within the Patient Experience and Care Strategy at a divisional department's level and to provide evidence of achievement against key performance indicators agreed for 2019/20.

4.8 The last year has seen challenges in maintaining and improving complaint responses due to the reduced staffing levels within the complaints team since August 2019, there was a 50% (2 of 4) complaints advisor vacancy. Although recruitment took place, various factors meant

that the team were working with 2 full time advisors and 1 complaints manager to cover the workload. Additionally performance within SAC with regard to complaint responses was challenging and as a result SAC complaints reached a backlog of 38 open complaints, however this was reduced to 18 by the end of March 2020. However performance was able to be maintained throughout this period.

4.9 The complaints team now have a staffing level of 3 Complaints Advisors/Investigators, 1 Administrator and 1 Complaints Manager with recruitment for a further Complaints Advisor imminent.

4.10 In line with the continued development of staff and to improve service delivery/performance around complaints, the Trust has invested in developing members of staff from the Complaints advisor role (Band 5) to Complaints Investigator (Band 6) and there are now 2 in post. The role of a Complaints Investigator has enhanced responsibilities in the investigation of managing and investigating complaints, which further supports the Divisions in investigating and resolving complaints. Staff were recruited into the role in January 2020, however due to various factors there was a delay in getting staff into post. Filling all vacant posts remains a priority and this is being progressed into 2020/21 and will be continually reviewed to see how this impacts upon complaints handling and management.

5. Risks

5.1 There are no specific risks identified at this time.

6. Overview of compliance with Complaints Policy

6.1 Complaints performance, themes and trends are monitored through the Patient Experience Group (PEG). Complaints performance is also monitored monthly by the Trust Board and discussed bi-monthly at the Quality Committee, a subcommittee of the Board, through the Divisions Performance Review Meetings and at Quality and Safety Group.

6.2 Themes and trends are monitored and shared at the Quality Committee and complaints performance is monitored in Divisional Governance Meetings and the Divisional Performance Meetings. The Trust process is compliant with the Complaints and Concerns Handling Policy.

7. Analysis of Complaints Received in 2019/20
(Extracted from Datix Database)

7.1 The chart below records complaints per 10,000 bed days. This is reported monthly via the Integrated Performance report and bi monthly to the Quality Committee. The Complaints Team continue to work with the divisions and to support the reduction of overdue complaints. As is apparent from the graph below the number of complaints the Trust received has again reduced, although it is anticipated that it is likely to remain at a similar level for 2020/21.

7.2 **Fig 1**: Number of complaints – rate per 10,000 bed days 2018 to 2020.

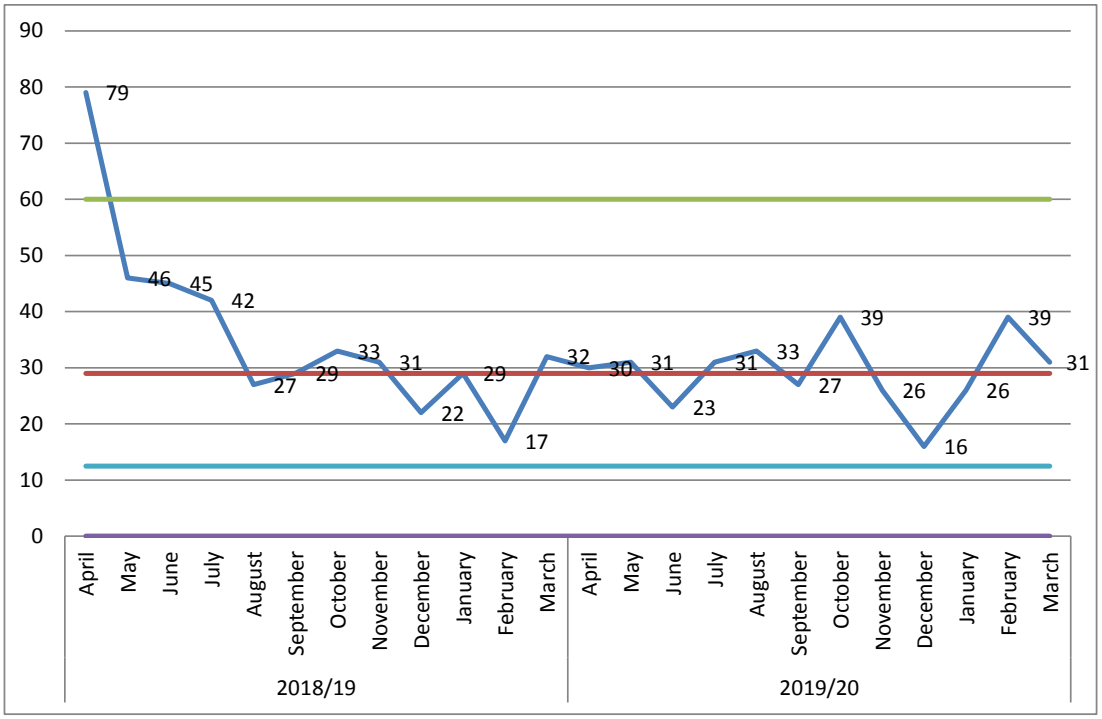


Fig 1

In 2017/18 complaints averaged 73 per month. In August 2018 onwards complaints reduced due to more concerns being managed through the wards and PALS earlier and more effectively. Since August 2018 complaints have therefore averaged 29 per month. February 2019 and December 2019 saw significant reductions in the number of complaints received with 17 and 16 respectively. October 2019 and February 2020 had above average number of complaints with 39. No trend or specific reason has been identified for these fluctuations.

7.3 The Trust received a total of 352 complaints in 2019/20 (down from 432 the previous year) a decrease of 80 complaints from 2018/19.

7.4 There continue to be a number of factors impacting on why the numbers of complaints the Trust receive have decreased, including:

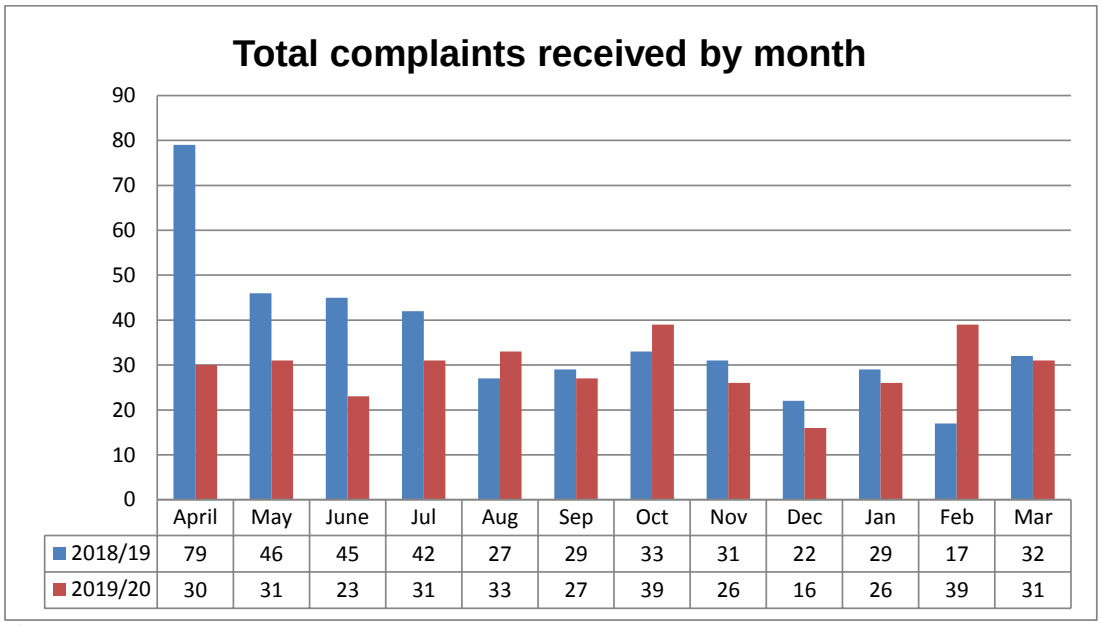
- Complaints continue to be triaged on a daily basis by the Complaints team and the Senior Nurse for Resolution and PALS and at this point a decision is made as to whether the concern can be dealt with by the PALS team or Complaints team. This ensures the concern is appropriately registered on Datix and managed by the most appropriate department.

- Divisions continue to capture learning/actions from complaints and these are put into place to avoid reoccurrences and improve care and service provided.

- Ward staff continue to be proactive in resolving concerns before they escalate to become formal complaints, although this can vary significantly across wards and divisions and is often dependent on staff being confident in stepping forward to deal with matters quickly and effectively, rather than pass them onto PALS or Complaints.

8. Number of new complaints opened per month

8.1 **Fig 2:** breakdown of the complaints received by month.



	April	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	79	46	45	42	27	29	33	31	22	29	17	32
2019/20	30	31	23	31	33	27	39	26	16	26	39	31

Fig 2

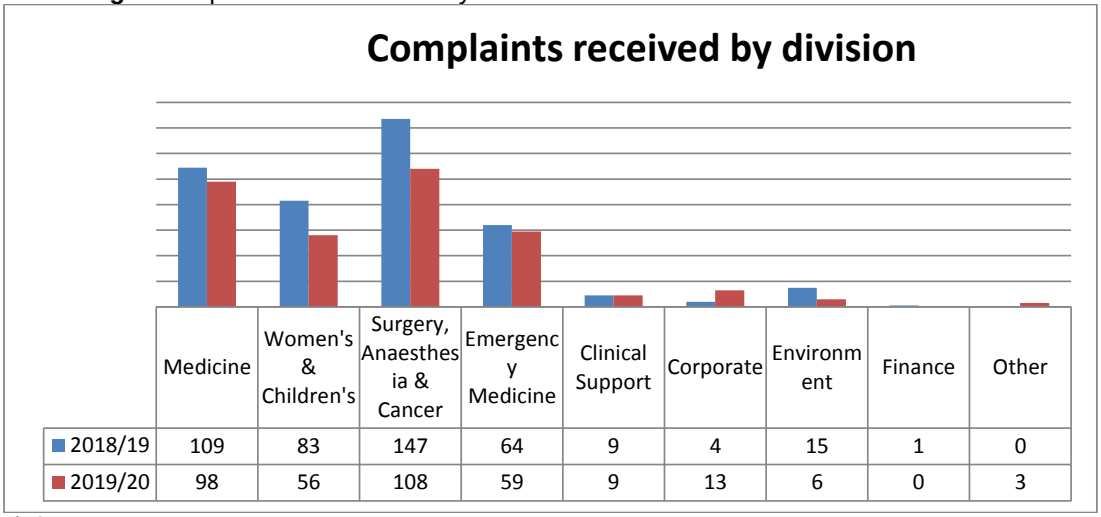
8.2 Since August 2018 the Trust has seen a reduced number of complaints and averages slightly less than 1 per day at present.

9. Complaints acknowledged within 3 working days

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

10. Complaints received by Division by year

Fig 3: complaints broken down by division FY 2018/19 and 2019/20



	Medicine	Women's & Children's	Surgery, Anaesthesia & Cancer	Emergency Medicine	Clinical Support	Corporate	Environment	Finance	Other
2018/19	109	83	147	64	9	4	15	1	0
2019/20	98	56	108	59	9	13	6	0	3

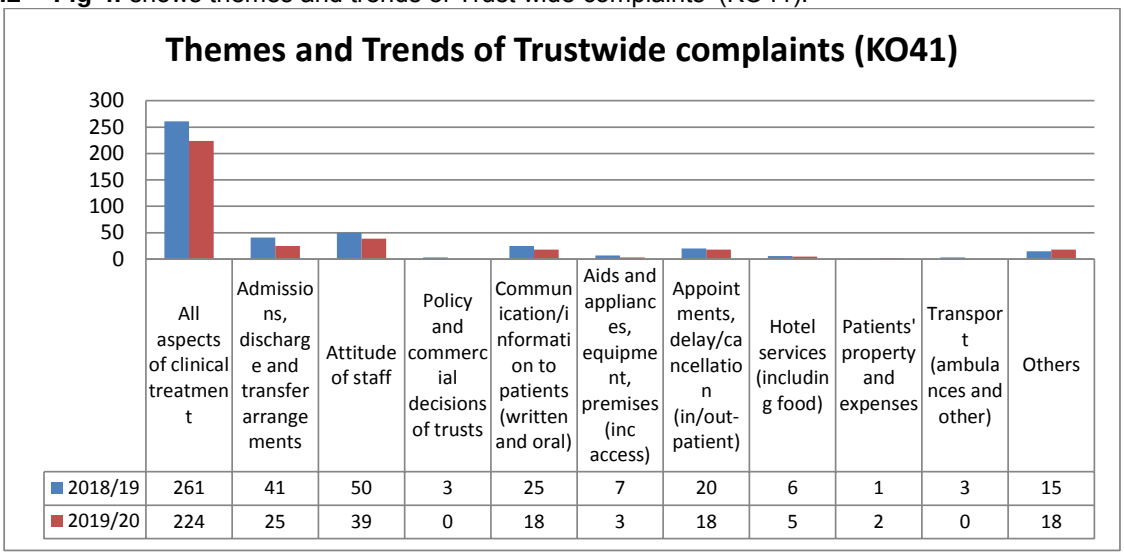
Fig 3

All Divisions have seen a decrease in complaints. Surgery, Anaesthetics and Cancer (SAC) in both 2018/19 and 2019/2020 had the largest number of complaints however this has consistently reduced from **254** in 2017/18 to **108** in 2019/20. The division of Women's and Children's Services (WACS) have also decreased by 27 in the past year, while Medicine and EM have seen small decreases. Corporate complaints showed an increase primarily due to complaints relating to Medical Certificate Certifying Death (MCCD) delays and loss of property, partly due to the onset of the Pandemic.

11. Breakdown of complaints – Themes and Trends (KO41)

11.1 The Trust uses nationally reported subjects (KO41's) to analyse the main reasons for patients complaining. The Trust also uses a separate subject matter list of reasons to provide clarity in understanding the themes from the concerns raised. Each complaint the Trust receive can have a number of issues raised in each complaint received this can be from the cleanliness of the ward to concerns over care. The issues identified below are not an exhaustive list and are not broken down further; therefore all aspects of clinical treatment can encompass a wide range of issues.

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

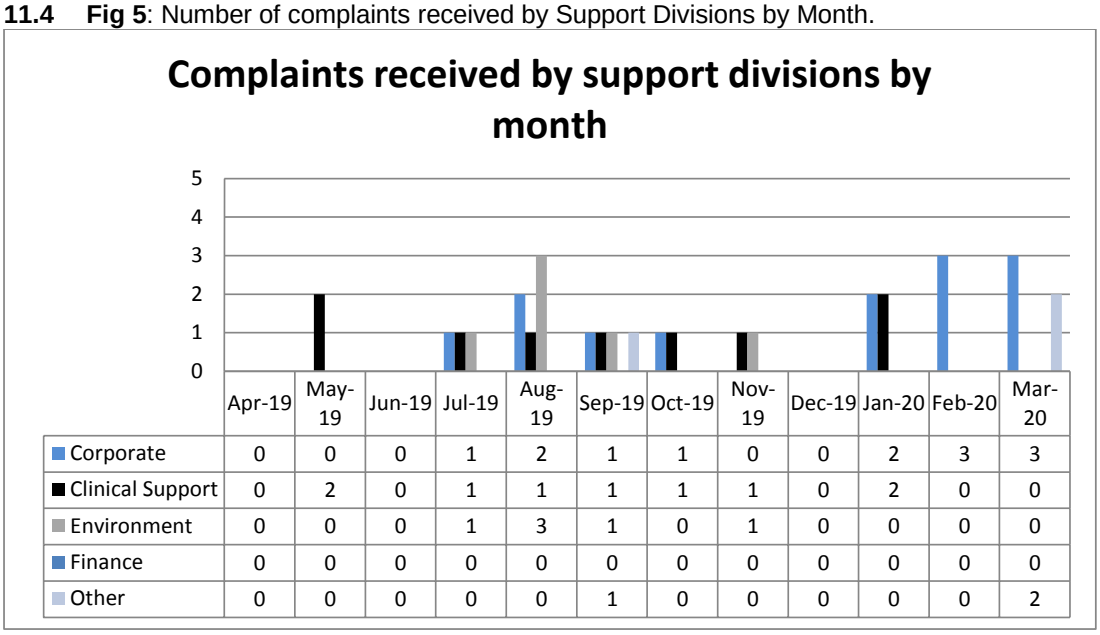


	All aspects of clinical treatment	Admissions, discharge and transfer arrangements	Attitude of staff	Policy and commercial decisions of trusts	Communication/information to patients (written and oral)	Aids and appliances, equipment, premises (inc access)	Appointments, delay/cancellation (in/out-patient)	Hotel services (including food)	Patients' property and expenses	Transport (ambulances and other)	Others
2018/19	261	41	50	3	25	7	20	6	1	3	15
2019/20	224	25	39	0	18	3	18	5	2	0	18

Fig 4

11.3 **Complaints received by Support Divisions by month**

11.4 **Fig 5**: Number of complaints received by Support Divisions by Month.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Corporate	0	0	0	1	2	1	1	0	0	2	3	3
Clinical Support	0	2	0	1	1	1	1	1	0	2	0	0
Environment	0	0	0	1	3	1	0	1	0	0	0	0
Finance	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	1	0	0	0	0	0	2

Fig 5

11.5 **Themes of complaints received by the Environment Division**
Complaints received were very few and primarily around the cost and difficulties around car parking.

Particular issues raised: Costs and use of payment machines for car parking.

11.6 **Themes of complaints received by Clinical Support Services**
There were no themes identified due to the few complaints received.

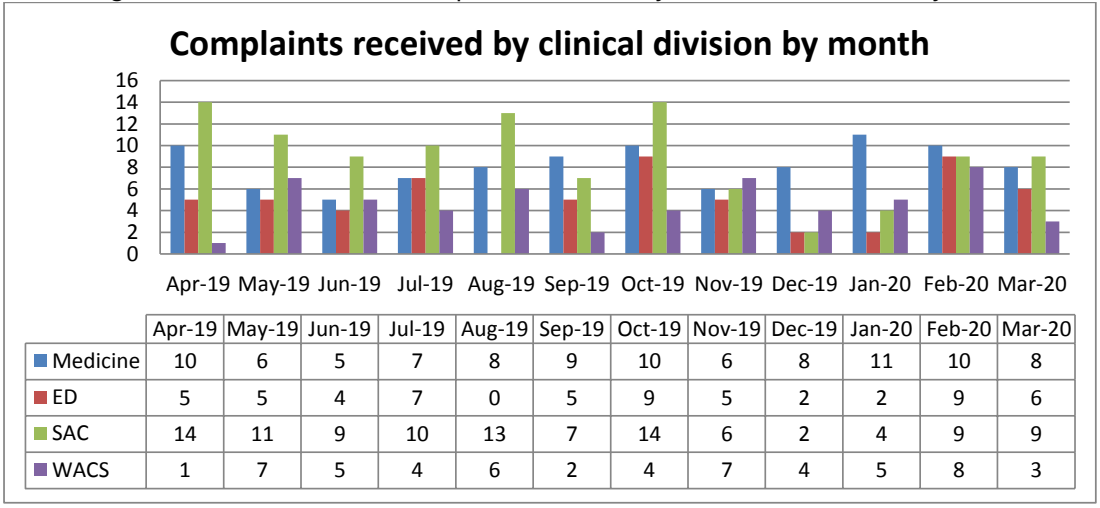
11.7 Themes of complaints received by the Corporate Division

Complaints were around discharge planning, delays in Medical Certificates Certifying Death (MCCD) and the loss of a deceased patient property.

Particular issues raised: lost property, MCCD issues.

11.8 Complaints received by Clinical Divisions by Month

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



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Medicine	10	6	5	7	8	9	10	6	8	11	10	8
ED	5	5	4	7	0	5	9	5	2	2	9	6
SAC	14	11	9	10	13	7	14	6	2	4	9	9
WACS	1	7	5	4	6	2	4	7	4	5	8	3

Fig 6

11.9 Themes of complaints received by the Division of Surgery Anaesthetics and Cancer

Trauma and Orthopaedics received the highest number of complaints, 40 (41%) followed by General Surgery, 26 (24%). Complaints were related to all aspects of clinical care, including: lack of pain relief, poor treatment, incorrect diagnosis, failure to diagnose, missed fractures and delays in treatment and care, cancellations of operations, continuity of care and attitude/communication from staff.

The Division acknowledge that Trauma and orthopaedics have received the highest number of complaints for the past two years. Complaints are reviewed each month as part of each directorate's monthly departmental governance. Through this learning is achieved from each complaint by means of a case review process, so that learning can be disseminated throughout the surgical team.

11.10 Themes of complaints received by the Division of Medicine.

Care of the Elderly received the highest number of complaints, 32 (33%) followed by general Medicine 23 (23%). Complaints related to poor care and treatment, missed diagnosis, communication and attitude of staff, missed appointments, end of life care (EOLC) and lack of nursing care.

There are no major themes with regard to EOLC complaints specifically in relation to Medicine, however as Care of the elderly falls within Medicine and will have a disproportionate number of complaints whereby EOLC is mentioned as a factor in their overall complaint. All learning is captured by the division through their governance processes to aid improvements in service.

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

11.12 Themes of complaints received by the Division of Women's and Children's
Midwifery received the highest number of complaints 18 (32%) followed by Gynaecology 16 (29%) and Paediatrics 11 (20%). The complaints related to retained products, not being informed of the risks of surgery, lack of post-operative care, lack of empathy, not being kept fully informed about the procedure, experience in the delivery suite and staff attitude.

12. Complaint Outcomes

12.1 A complaint is recorded as being fully upheld if the care or service provided to a patient or visitor fell below the standard expected in relation to all or a majority of the primary aspects of the complaint issues raised, due to a failing on the part of the trust. A complaint is partially upheld if there were some failings, however these related to minor aspects of the complaint. A complaint is not upheld if the issues raised were found not to be substantiated as a result of the Trust investigation. Sub categories exist to include where complaints resulted in actions to be undertaken to ensure failings do not reoccur or learning is disseminated.

12.2 **Fig 7:** shows the number of complaint outcomes.

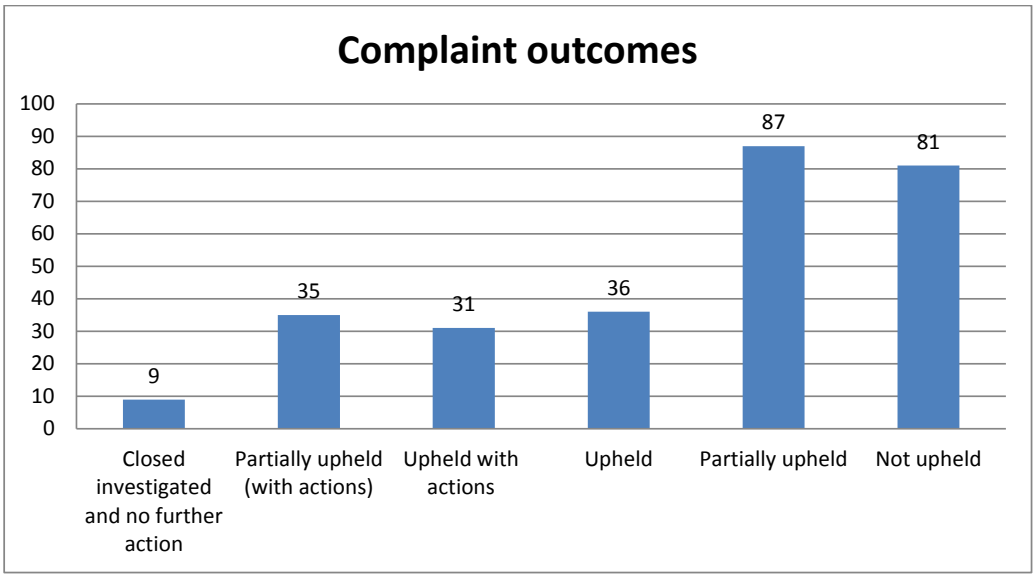


Fig 7

Not all complaints which are upheld or partially require further actions to be completed. For example this could be if changes have already been implemented prior to the complaint being received or there were minor issues requiring no further specific action. Where these are shown as partially upheld or upheld with actions this is where a formal action plan has been completed or initiated and the Division has captured specific areas that need to be addressed.

As part of an ongoing review of processes and procedures the Complaints team are currently identifying how it would be possible to more effectively capture learning/actions

during the complaints investigation. This is part of the 2020/21 work plan.

12.3 Divisional breakdown of upheld (incl. partially upheld) complaints

Surgery, Anaesthetics and Cancer – 60
Medicine – 56
Emergency Department – 34
Women's and Children's – 27
Environment – 3
CSS – 4
Other - 5

13. Reopened/Reactivated complaints

13.1 A complaint is categorised as re-opened or reactivated if the complainant is not satisfied with the Trust's first response and requests a further response to the issues raised. A total of 30 (10%) of the 352 complaints received in 2019/20 were returned for further investigation/response, a reduction against 65 (15% of all complaints received) in 2018/19.

13.2 The Trust is committed to understanding why complaints are returned for further local resolution and is constantly seeking to improve the way complaints are investigated and handled to improve complainant satisfaction. As with the period 2018/19 complainants request that their complaint be reopened as they consider that not all of their questions have been responded to fully; they raise additional issues having received the response to the original complaint and/or they do not accept the information or findings in the complaint response.

13.3 The reduction in the number of reactivated complaints continues to be attributed to improved investigation, comprehensive complaint responses, compliance with agreed timeframes and the allocation and the correct recording of concerns received on Datix.

13.4 During the twelve month period from April 2019 to March 2020, 36 complaints were reopened in total - this figure includes complaints which may have been received in 2018/19 and cases where the complaint has been reopened more than once.

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

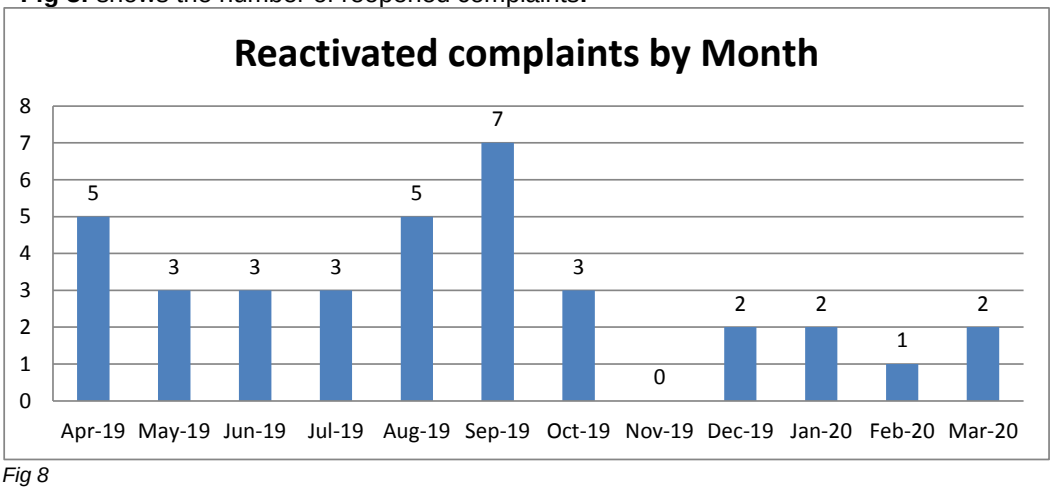


Fig 8

14. Local Resolution Meetings

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

14.2 During 2019/20 the Trust dealt with 24 complaints by way of local resolution meetings (LRM). Face to face resolution of concerns is considered the most effective way to resolve concerns and with the most positive outcome. A majority of the issues were fully resolved at this stage.

14.3 Of the LRM's which took place, 19 were resolved by the end of the meeting. 2 were not considered resolved and the complainants approached the PHSO, both of which are still being considered by the PHSO as to whether a formal investigation will take place. 1 is still ongoing with the complainants wishing for a second LRM and 1 has indicated they were not satisfied, however have not raised the matter further either with the Trust or the PHSO.

14.4 WACS in particular utilised early communication with the complainants in a number of cases to allow for speedy resolution of complaints where the complainant was dissatisfied that their concerns had not been resolved to their satisfaction.

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

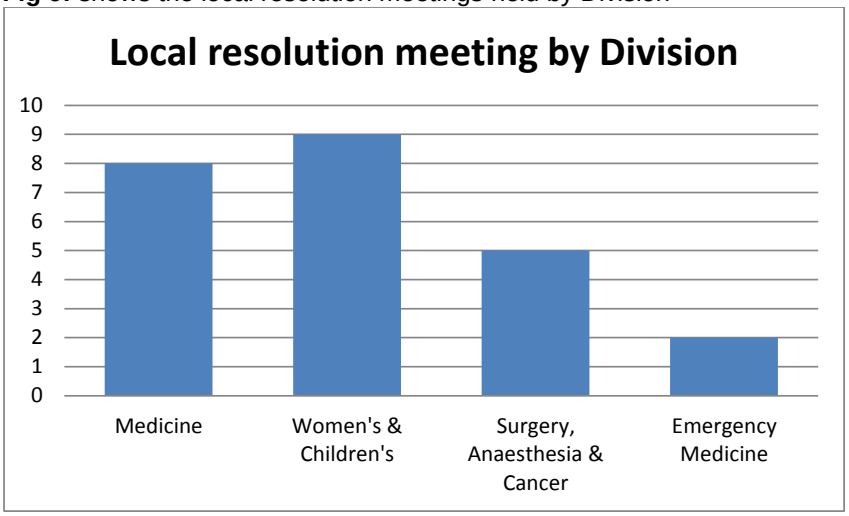


Fig 9

15. Complaints Performance

15.1 The Trust is committed to providing timely responses to complaints received and all complaints are managed in accordance with the Trust complaint policy. The Trust sets timeframes of 30 working days for standard complaints, 40 working days for complex complaints and 60 working days for local resolution meetings to be organised and held. However the Trust can set timeframes for periods outside of these if the complaint is more involved or requires information which may take longer to obtain. In those cases the complainant is consulted and may agree to an extended timeframe.

15.2 The Trust's target is to respond to 80% of all complaints within agreed timescales. Over the course of the year the number of complaints responded to within the agreed timescale steadily improved and was sustained at the overall level 81% over the 12 month period, although with the onset of the impact of the Covid-19 Pandemic, performance started to decline in March 2020 and dipped below the 80% target for that month.

Fig 10: Complaint response compliance over the past 2 years 2018 through to 2020

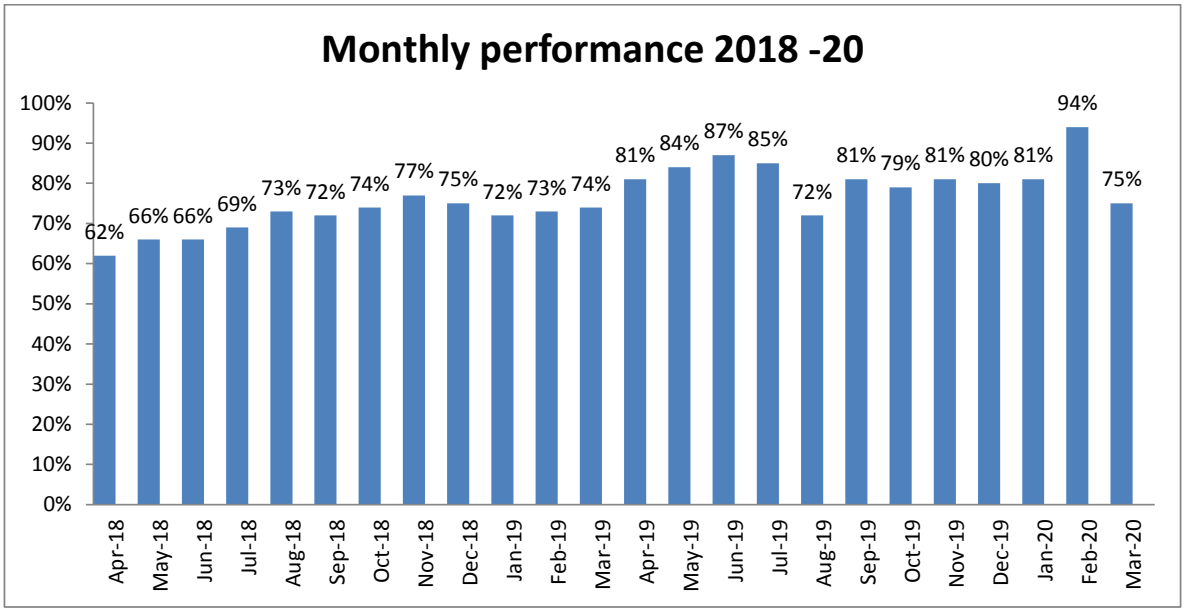


Fig 10

15.3 Divisional complaints performance is monitored weekly using a RAG tracker. The tracker is sent throughout the Trust to the Divisional Managers, Assistant Divisional Managers, Heads of Nursing, Matrons and other key staff within the organisation. The document provides the Divisional leads with an ongoing overview of all open complaints within the organisation. It indicates performance by way of 'Red' to highlight complaints which have breached the agreed response timeframe, 'Amber' for those complaints which are due within 7 days of the tracker being generated and 'Green' for complaints which are under investigation but still in time.

15.4 Corporate Complaint Investigators/Advisors, who are each assigned responsibility over specific divisions, meet on a weekly basis with their divisional colleagues to address the performance of complaint investigations. The Corporate Complaints team provide continued support to those divisions who have a backlog of delayed responses.

15.5 The Corporate Complaints team triage all complaints and decide the timeframe for completion of these, standard being 30 working days or complex 40 working days. In more involved cases this can be extended beyond the period. The complainant is contacted by their preferred communication preference, email, letter or telephone to discuss their concerns and identify what questions they wish the trust to answer. The Complaint Investigator/Advisor will log the complaint and a mutually agreed date. Should the divisions require a longer period of time the dates are adjusted if possible, with agreement of the complainant.

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

16.1 There were a total of 37 complaints in which the complainant involved any of the above group. A majority of these cases, the complainant copied one or more of the MP, CQC or CCG into their complaint and if the complainant consented a copy was sent to the appropriate person.

16.2 11 of the complainants contacted their local MP to support them and 7 complaints were subsequently received directly from the MP. The other 4 mentioned contacting their MP; however no correspondence was received from the MP or their offices. Furthermore there were 2 letters received from MP's which contained no detail of complainants but raised general issues of concern. The complaints covered areas such as clinical treatment, delay and cancellation of operations, and lack of care provided to the patient. A response to these complaints were sent directly to the MP.

16.3 7 of the complaints were copied to the Care Quality Commission (CQC) and in 4 complaints the Clinical Commissioning Group (CCG) was copied in. The types of complaints related to all aspect of clinical care, such as delays and errors in diagnosis, concerns regarding general treatment and care and issues around pain relief.

16.4 We received 2 complaints in which the media had been contacted, one in January 2020 relating to a Homeless male and their travel back to Hemel Hempstead and one relating to the death of a patient during the Covid-19 Pandemic in March 2020. Neither had any media contact with the Trust as a result of the complainant contacting the press.

17. Complaints that are Serious Incidents/RCA

17.1 There were 4 complaints investigated as part of the serious incidents framework. Any complaints considered to fall under the criteria as possible SI's, will be notified to the Division for consideration to be taken to panel. If confirmed as a SI investigation or Divisional RCA the complaint will be closed pending the outcome of the report. If there are any outstanding issues, not addressed by the report, the complaint will be re-opened to address these.

18. Parliamentary and Health Service Ombudsman (PHSO)

18.1 There were 2 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) relating to the period 2019 to 2020.

18.2 One request was received in July 2019 and the other in January 2020.

18.3 Both of the complaints are still currently being assessed by PHSO and a decision has not been made at the time of writing this report as to whether they are going to formally investigate the complaints.

19. Improvements to Managing Complaints and Organisational Learning

19.1 Where the complaint investigation identifies learning and scope for improvement, especially in circumstances where there have been specific failings, an action plan will be completed by the relevant division. This is undertaken so that accurate records of the issues and steps taken to improve/prevent reoccurrence are maintained. A designated individual is assigned

responsibility to oversee the action and the timeframe within which the action is expected to be completed.

19.2 The action plans are reviewed at the divisional monthly quality and governance meeting and actions are tracked and monitored. Divisions are responsible for ensuring that the learning from complaints and incidents is shared widely with all relevant staff. All Divisions have implemented local communication approaches, which have included the review of how shared learning can be achieved across the organisation utilising good practice for established areas. In addition to circulation within the Division, action plans are presented monthly to the Quality and Safety Group.

19.3 Complaint learning events were held twice during this reporting period and although it had been intended to hold these quarterly, staffing reductions and the increased workload meant this could not be maintained. At these events, divisions were invited to share examples where direct learning has originated from a complaint.

19.4 The family of a patient recently presented their experience directly at a Trust Board meeting, which was beneficial in allowing the Trust to better understand how complainants felt regarding care and service provided and how to draw learning from these to improve our processes. At Local Resolution Meetings patients and families have been actively encouraged to share their experiences with staff. This remains a valuable engagement opportunity for staff to discuss concerns with patients and to understand how they experienced their care and treatment.

19.5 The Complaints Manager also provides training at the Band 7 development programme around the effective management and resolution of complaints. This is undertaken in order to allow those attending to gain a better understanding of the process of complaints handling and the importance of early resolution. The training also covers the importance of good record keeping and the need to ensure that lessons are learned from complaints to ensure that service quality is improved.

19.6 Figure 11 provides a number of examples of organisational learning set

Fig. 11 Organisational learning from complaints

Although learning from complaints is recorded on Datix, the capture of how learning is implemented is reliant on Divisional input and although Divisional Governance processes are in place, there is scope for improvement . An ongoing review of the way that the Trust record and capture learning is being undertaken in conjunction with the 4 main Divisions. This is to ascertain how we can more effectively capture learning and demonstrate implementation of actions taken to improve services and care, as part of governance processes.

Of note, all Complaints relating to end of life care and treatment are discussed through the Patient Experience Group and presented to the End of Life Compassionate Care Panel. The complaints are reviewed and discussed at the meetings and learning is shared with the wider team and used to inform policy and practice as appropriate

Complainant raised concerns around the interaction their mother had with staff, believing there to have been a lack of kindness and consideration shown towards them,	Lead Nurse for Emergency Medicine took responsibility to speak with family and convey apologies and capture learning. Staff involved had opportunity to reflect on interactions and had family feedback presented to them. Patient's experience was used in departmental training to improve care/service. Learning captured and presented at Divisional

despite the patient being in pain, The doctor and HCA did not offer assistance and there was a lack of compassion and communication was poor. The patient was moved which did not allow the family the opportunity to be with their mother at the point she died.	Governance meeting with action plan to ensure improvements captured and implemented.
Patient had symptoms suggestive of viral illness and it would have been appropriate as part of clinical assessment to have had a chest x-ray due to patient being immuno suppressed and having a fever. Antibiotics should have been considered but were not given.	Doctor was given opportunity to reflect on the care and treatment given and to review what should have been considered. Training was provided to junior doctors as part of the training cycle to address 'fever in immuno suppressed patients'
Administrative error when booking interpreter (gender) Eligibility for NHS treatment should have been established earlier in the booking process and therefore not discussed on the day of the procedure.	Discussions were held to provide training and learning around the need for improved checking when booking interpreter and the eligibility of overseas visitors regarding treatment.
Lack of communication between triage and MDAU and lack of midwife escort when transferring patient from MDAU to triage, Missing drug chart and drug errors. Patient feeling alone - while lots of staff at desk	All midwives in MDAU were reminded of the correct processes relating to patients needing triage, including calling ahead and escorting the patient personally. Ward Manager to relaunch the 6 hourly comfort rounds to improve interactions with patients. A drug round has now been implemented with the drug charts in a folder in room and bay order.
Patient diagnosed with viral illness on initial attendance to A&E. Missed diagnosis of appendicitis. Appendix had ruptured requiring emergency surgery when patient re-attended. Parents felt doctor did not appreciate how much pain their daughter had been in, prior to the administration of pain relief and that her condition was something more serious than a viral illness.	All staff were reminded of the need to review a patient's score with Senior Sister, and the CED reinforced with nursing staff that they should request prompt review by a clinician if a child is in severe pain. Reinforced with junior medical staff the importance of listening to history provided by parents when a child is in pain (based on the findings of this case) - this was included in teaching sessions to improve care.

Poor quality strapping manufacture. Delay with production/issue of gaiters	A full review of the items was undertaken and third party supplier was replaced by in-house manufacture of strapping as it was identified that the standard of the product was not of the required level.

20. Complaints Key Achievements of 2019 – 2020

20.1 Divisional roll out of actions module

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

20.2 Response time improvements

The Complaints team continued to work with the divisions to consolidate the response time improvements and to achieve the Trusts 85% target, reaching 81% for the 12 month period.

20.3 Develop Local Resolution Checklist

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

20.4 Healthwatch and Herts Valley CCG recommendations.

WHHT was to consider the introduction of an initial template which allows complainants to complete in order to make the process of making a complaint easier. This may provide WHHT with more detail during first contact which may mitigate any misinterpretation of issues raised. The template was created and is now available on the Trust website.

20.5 New Complaints Investigator role

In line with the continued development of staff and to improve service delivery/performance around complaints, the Trust has invested in developing members of staff from the Complaints advisor role (Band 5) to Complaints Investigator (Band 6). This now means that 2 of the complaints team are now in role and taking on additional responsibilities with regard to working closely with the medical divisions to resolve complaints.

The Complaints team work plan for 2020/21 can be found in Appendix 1.

21. Patient Advice and Liaison Service (PALS) and Interpreting Service

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

21.2 PALS team instigated the use of local resolution meetings (LRM) to help patients, families and staff understand the implications of concerns raised, which has proven to be a valuable means of communication. The PALS team did not historically write to complainants following a local resolution meeting (LRM), outlining any action's, however this has been reviewed and is now a standard procedure.

21.3 Following development of the weekly tracker, this has been embedded in the Divisions and the team. The tracker is an invaluable tool for focusing on each concern raised and ensuring resolution in a timely manner.

22.4 The Standard Operating Procedure (SOP) has provided awareness of the need to close concerns within 5 working days.

22.5 Quality of data collection has improved due to robust management of individual members of staff recording concerns accurately. A small number of concerns are escalated to the formal complaints team or forwarded to the SI team for investigation and discussion as appropriate.

22.6 The graph below demonstrates the % of concerns closed within the 5 working day time frame.

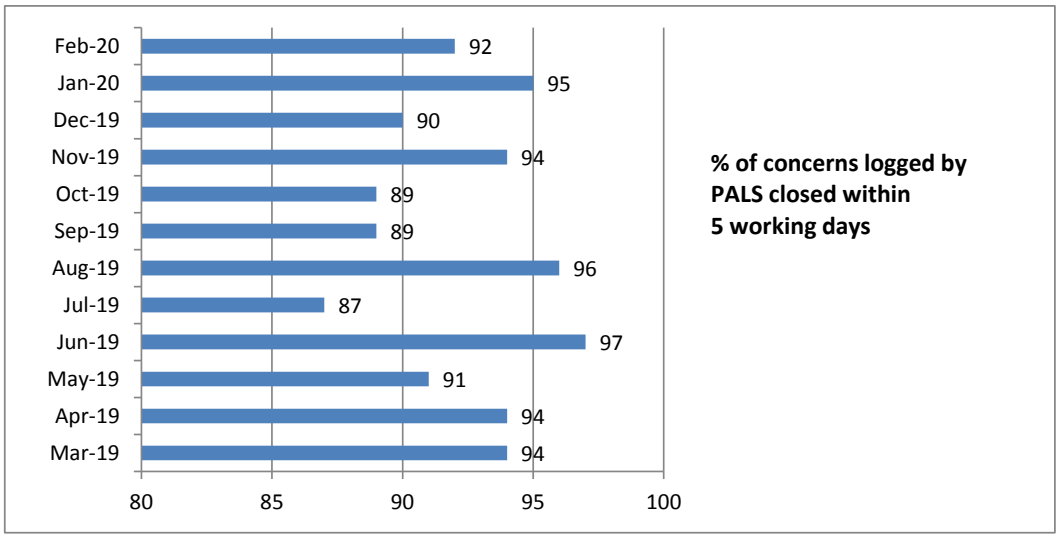


Fig 12

23 PALS activity Trust wide

23.1 For the period year ending 31 March 2020 the number of contacts/concerns received was 3232; a decrease of 39 when compared to 2018/19.

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23.2 The following graphs detail the PALS activity for 2019/20 compared to 2018/19 followed by a breakdown of the concerns by division and subject and the conversion of PALS concerns to formal complaints.

PALS Activity graph Trust wide 2018/19 & 2019/20

3232 concerns were recorded by PALS from April 2019-March 2020

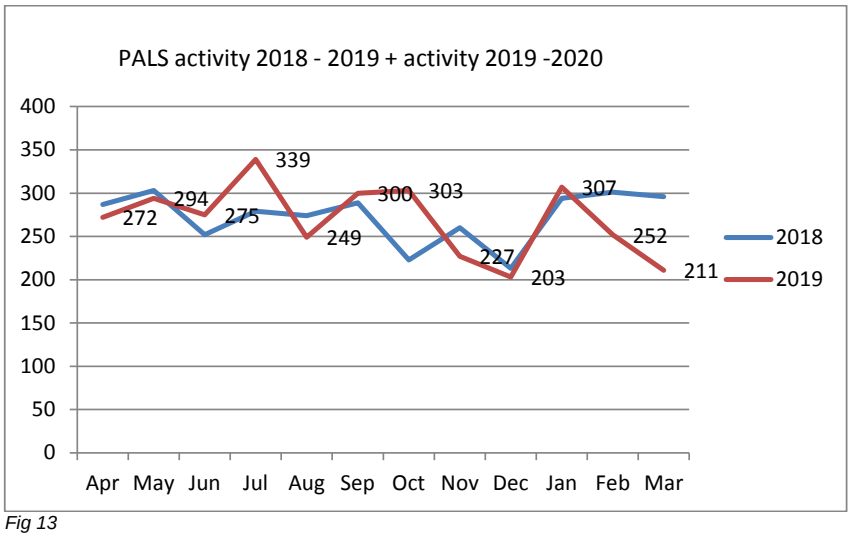


Fig 13

23.3 PALS concerns recorded by Division

The below graph demonstrates the concerns recorded by each Division, which shows the Surgery division received the most concerns followed by medicine.

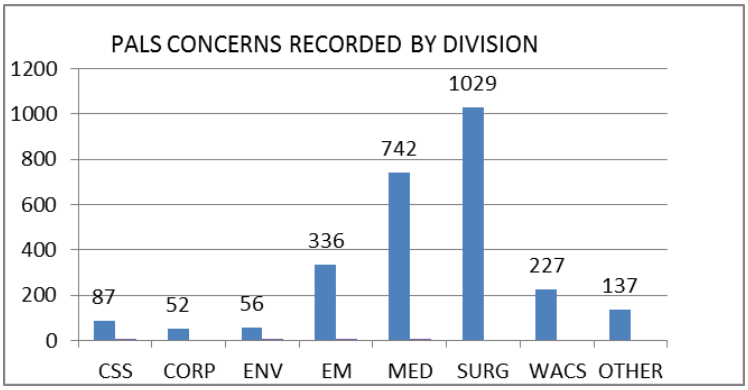


Fig 14

23.4 PALS top 5 concerns recorded by Division and subject

The main concerns were regarding appointments in surgery and medicine, followed by care and treatment in all divisions.

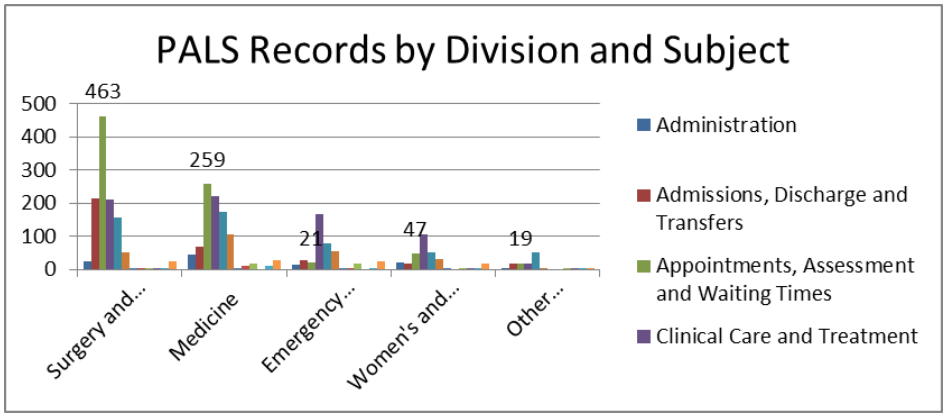


Fig 15

Themes by Division update

In surgery complaints were related to delay in outpatients appointments or delay in surgery dates. All aspects of clinical care, including: lack of pain relief, poor treatment, delays in treatment and care, cancellations of operations and communication from staff.

General medicine received the concerns related to lack of appointments, cancelation of procedures, poor communication and attitude of staff and lack of nursing care.

Emergency medicine concerns were related to clinical care and treatment, following by some administration concerns regarding poor communication.

Women's and Children's concerns were regarding poor clinical care and treatment**,** lack of empathy from Consultant, staff attitude and general lack of care.

The complaints and concerns themes dealt with through the formal complaints process and by PALS are very similar and are often dependent on the complainant how they wish these to be dealt with, with many being satisfied with an early resolution of the concern through PALS and others requiring more formal responses. All complaints and concerns are reviewed through the Divisional Governance processes and common themes are identified.

24 PALS concerns to formal complaints department

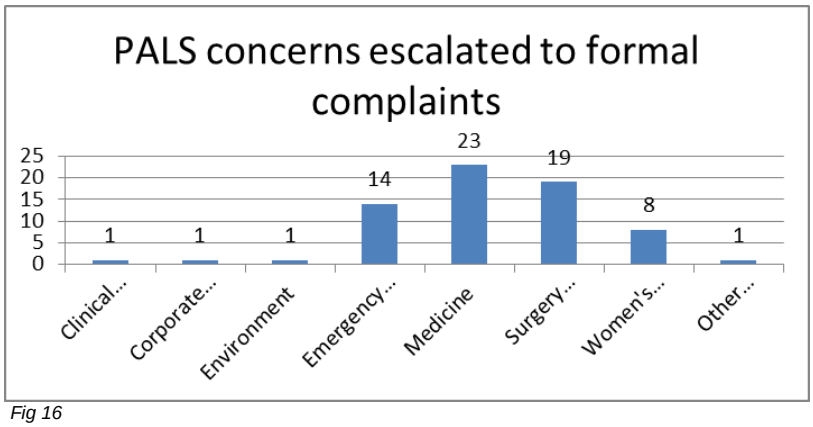


Fig 16

24.1 Reasons and themes of PALS concerns sent to formal complaints

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

25 Learning from PALS concerns

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

25.2 A report is presented at the bi monthly Patient Experience Group meetings; highlighting achievements and progress against the Patient Experience & Carer Strategy priorities.

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

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

26 Compliments received

26.1 Compliments are received in the Trust by the various wards and departments through a variety of means including electronically, letters, cards and verbally. Although these are recorded on Datix, the collation of these relies on staff within the wards and departments recording, scanning and forwarding them to the Complaints or PALS teams so that these can be recorded.

26.2 This does mean that not all compliments are effectively captured as it relies on staff forwarding these. As part of the 2020/21 work plan a new email address for compliments will be created, as currently these are submitted to the complaints email address.

Communication will be sent out to all wards/departments and Matrons to reinvigorate the process, with the aim of compliments also being collated through Friends and Families.

There were 349 PALS compliments logged for 2019-2020.

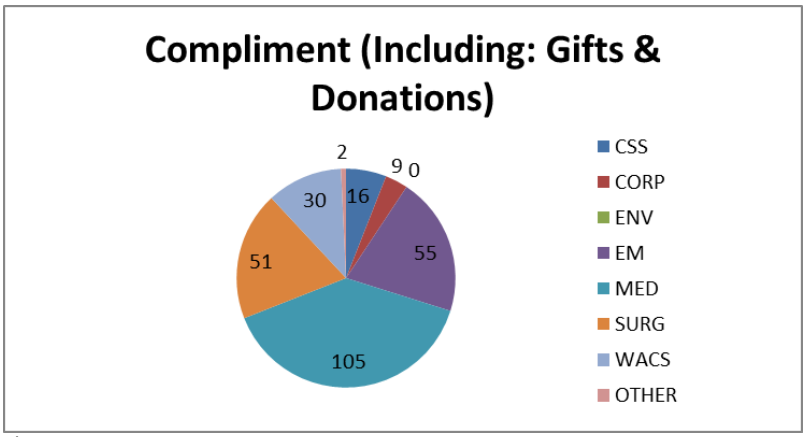


Fig 17

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

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

27 Interpreting & Translation

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

27.2 A total of 4463 requests for interpreters was received in 2019-2020. The volume of requests has increased year on year since the data was recorded in 2016 as per table below.

27.3 The budget for the interpreting service comes from PALS and this amount has been increasing year on year due to the vast amount of requests and new languages due to the diversity of the local population

27.4 PALS are looking to improve the process for requesting interpreters as this is a high priority for the Trust in attempting to reduce spending in this area. The team are working with Herts Interpreting service. (HITs) We are planning to review the service next year with an aim to automate bookings and extend service options.

27.5 Ongoing discussions continue with the interpreting service regarding how to improve the system for both parties and staff who have to request the service.

27.6 The below graph demonstrates the monthly amount of requests for the interpreting service over the year. The grand total of requests for the Trust for the years is; **4463**

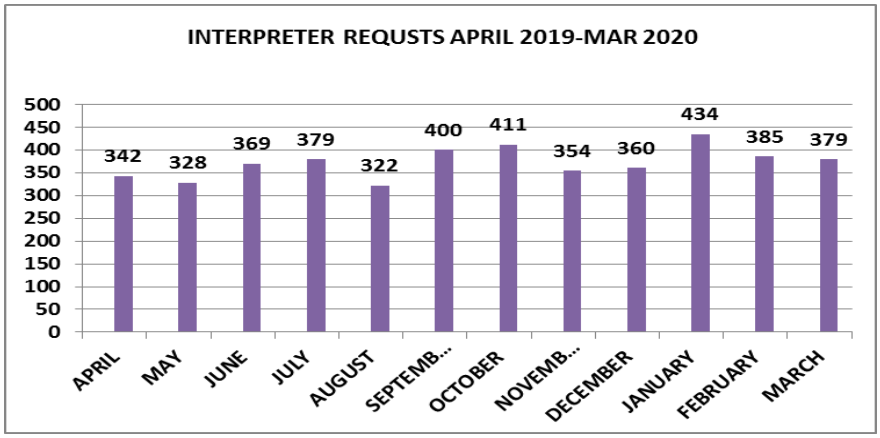


Fig 18

28 PALS Key Achievements for 2019-2020

- Development of the weekly Tracker for Divisions
- Development of the PALS Standard Operating Policy
- In the absence of the Senior Nurse for Resolution the PALS tracker is provided by the PALS staff
- PALS information and details added to the WHHT Patient Experience website
- Development of Family Liaison and Visitors Line Services during the Covid-19 pandemic to enable communication during patient and families due to restricted visiting

The PALS team work plan for 2020/21 can be found in Appendix 2.

29 RECOMMENDATION

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

Tracey Carter- Chief Nurse, Director of Infection, Prevention and Control

November 2020

Appendix 1

Further developments / Complaints team work plan for 2020 – 2021

Objective	Reasons for objective	Actions to deliver objective	Target date	Date objective completed
Development of an informal guide to 'Writing Complaint Responses'	In order to improve the quality and content of our written complaint responses, it has been identified that an informal guide to writing these would be benefit to those providing comments or who may be involved in the complaint investigation. It is intended to create a short guidance document, which would be available for distribution across the Trust in order to enhance complaint responses. The aim of this guide is to provide a simple series of guidelines around the purpose of the response, provide an understanding of why complaints occur, identifying how to use opportunities for feedback	The guide will be compiled by the Complaints team, with input from other departments to capture best practice and address specific points. This is intended to improve the overall quality of complaint responses, allow for identification of learning opportunities and increase understanding of what an effective response should include.	It is anticipated that completion of the guide will be completed by Q3 of 2020/21.	

	and learning and the useful do's and don'ts.			
Develop a Satisfaction Survey	It is intended to develop a short Satisfaction Survey to capture feedback from complainants. The aim is to identify opportunities for improvement within the current complaints process through capturing feedback from complainants who have experienced the process. The Trust is committed to supporting people to raise their concerns and we strive to make the complaints process as user friendly as possible. The complaints service place great importance on understanding and learning from the user experience and a feedback survey will be developed, introduced and issued with every complaint response to gain and learn from customer insights. This survey is to be about	The survey will be compiled by the Complaints team, with input from other departments and a sample section of complainants.	This will be developed during Q2 of 2020-2021	

	the service received from the complaints team not the outcome of the complaint and will be based on a short online survey or a written one sent out with each response.			
Complaints training to be part of the induction process	All new staff should receive training on complaints handling in line with the 'Complaints Handling Policy' Training around complaints is an important first step in reducing complaints. As such it is intended that Training is delivered at the Induction stage and throughout other ongoing training sessions for staff.	The complaints team will seek to offer regular training on advice for front line staff on how to deal with complaints. The process regarding complaints will be highlighted to new staff at Trust Induction and should ensure that all staff are made aware of the procedure for dealing with complaints and receive appropriate training to ensure that they are able to deal speedily and appropriately with complaints at the point of contact and are aware of the procedure to be followed for more complex complaints handling.	The aim for the training will be for this to commence during Q3 of 2020-2021 as currently no induction is taking place due to the Covid-19 Pandemic.	
Review of Current Complaints Policy	It is intended to review the current Complaints Policy to ensure that it is fit for	The review process will include a series of discussions with	This has been commenced and the aim is for this to be completed	

	purpose. A complaint raised by the family of a patient raised concerns around certain aspects of the current complaints policy. It was therefore identified that a review was appropriate to consider whether the complaints policy required updating. The Covid-19 Pandemic also meant that changes implemented throughout the Trust impacted upon the complaints process and should be taken as an opportunity to review current procedures as we move forward to ensure our processes are robust and fit for purpose.	stakeholders and key contributors to identify best practice and obtain feedback around the practical application of the processes and procedures. This will be augmented by a SOP around specific aspects of complaint investigations	by end of Q2 2020-21.	
Enhanced capture of learning	A vital part of the complaints process is the ability to effectively capture learning in a format which shows what we as a Trust have identified as requiring improvement, the changes we need to make and how we record when these	It is intended to develop a standard template which can be populated with themes and learning for all complaints and which is easy to utilise to ensure that learning is captured and disseminated to aide improvements in care and service.	This will be started during Q2 of 2020-2021 with the aim of completing this by end of Q3, although this will remain an ongoing process.	

	have been completed. As such the plan is to develop a process whereby every complaint has the main themes and areas for improvement clearly identified and captured. Although this is in part already recorded within action plans, these are generally only completed when failings have been identified and concerns such as miscommunication, staff attitude or minor matters are not subject of any recording process if for example a general apology is provided. This would then allow for better capture of these and permit the Trust to share learning within all Divisions.			
New Band 6 Complaints Investigator role – Improved handling and management of Complaints	In line with the continued development of staff and to improve service delivery/performance around complaints, the Trust has invested in developing members of	Complaints Investigators are now in role and this will be continually monitored and reviewed to ascertain how this impacts upon complaints handling and management with a	Implemented Q1 and ongoing with improved handling and management of complaints being undertaken throughout the year.	

	staff from the Complaints advisor role (Band 5) to Complaints Investigator (Band 6) and there are now 2 in post. The role of a Complaints Investigator has enhanced responsibilities in the investigation of managing and investigating complaints, which further supports the Divisions in investigating and resolving complaints.	view to improving the standards around complaint management.		
Improved capture of Compliments	Not all compliments received are being effectively captured as a number are received by wards/departments but are not forwarded to PALS and Complaints for recording. It is necessary to reinvigorate the process to ensure robust systems and processes are in place to allow for the capture of compliments.	This is intended to ensure that we have bespoke systems in place to improve capture of compliments throughout the Trust. New email address and process to be reviewed.	To be commenced Q2 and will be an ongoing process.	
Improving response for complex cases	Current performance in relation to complex complaints being responded to in a timely manner could be improved with the aim of reducing delays.	Aim to reduce time taken to reduce complex complaints responses to achieve 40 deadline consistently.	To be commenced Q2 and ongoing process	

Appendix 2

Further developments / PALS team work plan for 2020 – 2021

Objective	Reasons for objective	Actions to deliver objective	Target date	Date objective completed
To enable an Open day for PALS	To raise awareness of the service to staff and patients and families	Link with manager to discuss and arrange suitable date plus make plans of how to implement open day	October/November 2020	
To develop an information leaflet for staff about the PALS & Interpreting service and upload onto the intranet	It is intended to create a short guidance document, which would be available for distribution across the Trust in order to enhance information regarding the service	The guide will be compiled by the PALS team. This is intended to improve and increase understanding of what the PALS and interpreting service is about.	September 2020	
To design and develop a flow chart for staff to request interpreters	It is intended to create a flow chart guide for staff on how to request an interpreter and how to access information	The guide will be compiled by the PALS team.	April 2020	
Enable shadowing opportunities for staff to join PALS Team as part of 'whose shoes' initiative	Linking with ward managers, matrons and staff	Link with Matrons and ward managers to establish the available opportunity for staff to be released from ward areas	October/November 2020	
Improve learning from concerns	Collaborate with Complaints and SI team in organising learning events	Link with Matrons and ward managers to establish improvements in	December 2020	

	related to common themes of concerns raised. Recommend areas of improvement as potential coproduction projects for divisions to be considered by the coproduction board.	care and service from themes around concerns.		
To expand and update the PALS & Interpreting information on intranet and internet	To improve the request system for the interpreting service Updating the web page will provide up to date information on the service available	Collaborate with the interpreting service to improve the request system	January/February 2021	
Link with Heads of Patient Experience Network bimonthly to ensure the service is developing in line with National Guidance	To improve and enhance the PALS service already available, capturing new initiatives from other Trusts.	Collaborate with the HOPE network	June 2020	Ongoing
To undertake review of current process for requesting interpreters with aim of implementing an online system	To decrease calls and emails required to request interpreters, reduce errors in submission of interpreting request forms and simplify overall system by implementing an existing web based process.	Discussions with Hertfordshire Interpreting Service ongoing to identify training needs of staff and implementation date of new process.	November 2020	

Trust Board
5 November 2020

Title of the paper	IP&C Annual Report – April 2019 to March 2020
Agenda Item	14/84
Presenter	Tracey Carter, Chief Nurse and Directors of Infection Prevention & Control
Author(s)	Glynis Bennett, Deputy Director of Infection Prevention & Control Dr Prema Singh, Infection Control Doctor, Consultant Microbiologist
Purpose	*Please tick the appropriate box* *For approval* | *For discussion* | *For information* | | *X*
Executive Summary	The annual report is a summary of the Trust's performance in relation to Infection Prevention and Control (IP&C) for April 2019 to March 2020. The information provided is evidence and assurance on the Trusts compliance with the Hygiene code. It also includes information on incidents and actions undertaken to address these. This demonstrates that the Trust is providing a clean and safe environment and infection prevention and control is everybody's business. The following summary outlines the achievements and continued work: There were 48 cases of Trust apportioned CDI from April 2019 to March 2020 against a trajectory of 34 for the year, however following review with CCG only 5 of these cases were identified to have any lapses in care (17 cases remain outstanding for review due to the constraints of the pandemic). The Clostridioides difficile infection (CDI) objectives for 2019/20 are based on new criteria (4 categories) for apportioning of cases; this system commenced on 1 April 2019. 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. There were 0 cases of MRSAB identified post-48 hours, a reduction from the previous year. There has been an increased focus on Escherichia coli bacteraemia (E. coli) and joint work undertaken across the Integrated care system has focused on UTI reduction. A significant response to the COVID-19 pandemic has challenged the Trust since Feb 2020, with high numbers of admissions that begun in the latter part of March 20 and continued into 20-21. Work to improve compliance with key interventions such as hand hygiene and compliance with Personal Protective Equipment (PPE) continues and a focus

<table>
<tr><td></td><td>on PPE usage has been driven by COVID-19.

The limited numbers of single rooms (isolation facilities) continues to be an operational challenge for patient flow in the trust, as a response to COVID-19 the Trust has made cohort isolation areas to manage these patients.

The IP&C Team currently do not have an electronic surveillance system but use a paper-based system working closely with Microbiology colleagues to ensure systems are in place to identify infectious patients as well as identifying any transmission.

Compliance with the Hygiene Code is underpinned by ten compliance criteria, this is monitored by the IPC Panel, which ensures that the Trust continues to maintain and strengthen its compliance and has mitigation in place to manage the risks to compliance.</td></tr>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><td>Aim 1

Best care

Objectives 1-4</td><td>Aim 2

Great team

Objectives 5-8</td><td>Aim 3

Best value

Objective 9</td><td>Aim 4

Great place

Objective 10-12</td></tr>
<tr><td>X</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?

☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

☒Is there a culture of high quality, sustainable care?

☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?

☒Are there clear and effective processes for managing risks, issues and performance?

☒Is appropriate and accurate information being effectively processed, challenged and acted on?

☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

☒Are there robust systems and processes for learning, continuous improvement and innovation?

☒How well is the trust using its resources?</td></tr>
</table>

Previously considered by	Committee/Group	Date
	IPC Panel	September 2020
	Quality Committee	October 2020
Action required	The Trust Board is asked to receive this report for information and assurance of the compliance with the Health & Social Care Act which contains the 'Hygiene Code'.	

Agenda Item: 14/84

Trust Board – 5 November 2020

Title of paper: IP&C Annual Report – April 2019 to March 2020

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

1.0 INTRODUCTION

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

Criteria 1 – Management and Structure for Infection Prevention and Control

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

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

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

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

IP&C Nurses (IPCN) are responsible for new results of alert organisms, providing advice and support in the management of identified patients when received from the microbiology laboratory.

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

Additionally, the IPCN's provides support and advice to clinical staff in the identification and management of infections, liaising with both operational and management teams coordinating individual patients and outbreaks of infections within wards and clinical areas.

Currently the Trust has no dedicated electronic infection control surveillance software in place. The IPCT use a manual system which is resource intensive. The need for an electronic surveillance system would allow the IPCT to identify and assess all the infected patients within the hospital immediately. A business case for an electronic surveillance system has been under development and will be a priority to complete for consideration by the IP&C panel and Trust Management Committee in 20-21.

2.0 MANDATORY SURVEILLANCE REPORTING OF Health Care Associated Infection (HCAI)

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

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

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

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

2.1 Trust Assigned *Methicillin Resistant Staphylococcus Aureus* Bacteraemia

Trajectory = none set

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

For the year 2019/20, the Trust reported 0 post 48-hour and 0 pre-48 hours' cases of MRSAb being one of only two East of England Trust to achieve this (Figure 1b). An improvement on the previous year's performance from 12 cases (Figure 1a).

During Apr 2019 to Mar 2020 WHHT MRSA bacteraemia rate remained at zero, which means that we performed well compared to the regional and national figures

Figure 1a: This illustrates the MRSA bacteraemia from April 2001 to March 2020, identifying the number of WHHT cases per year since 2001.

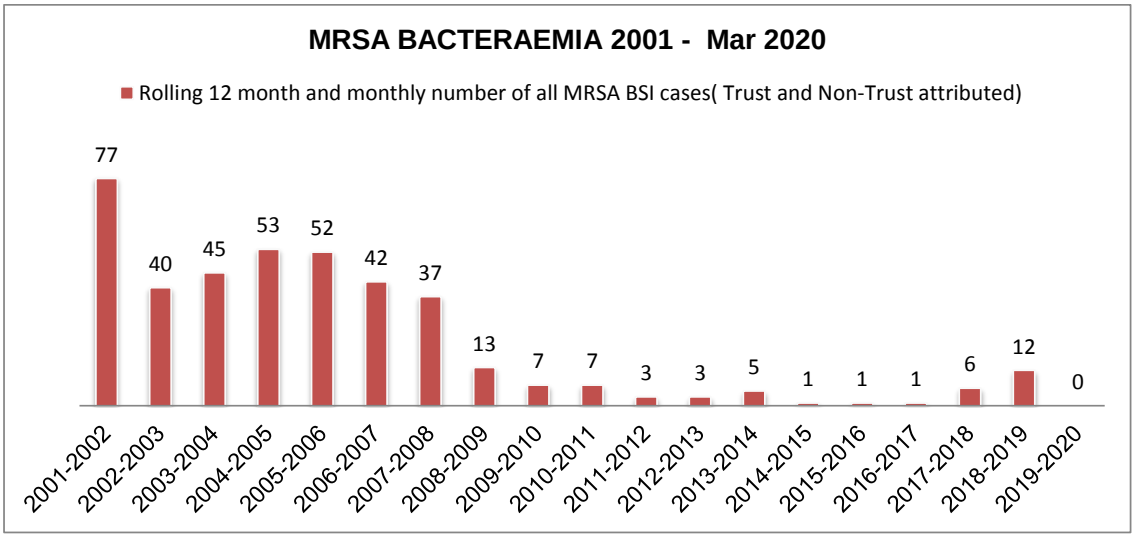
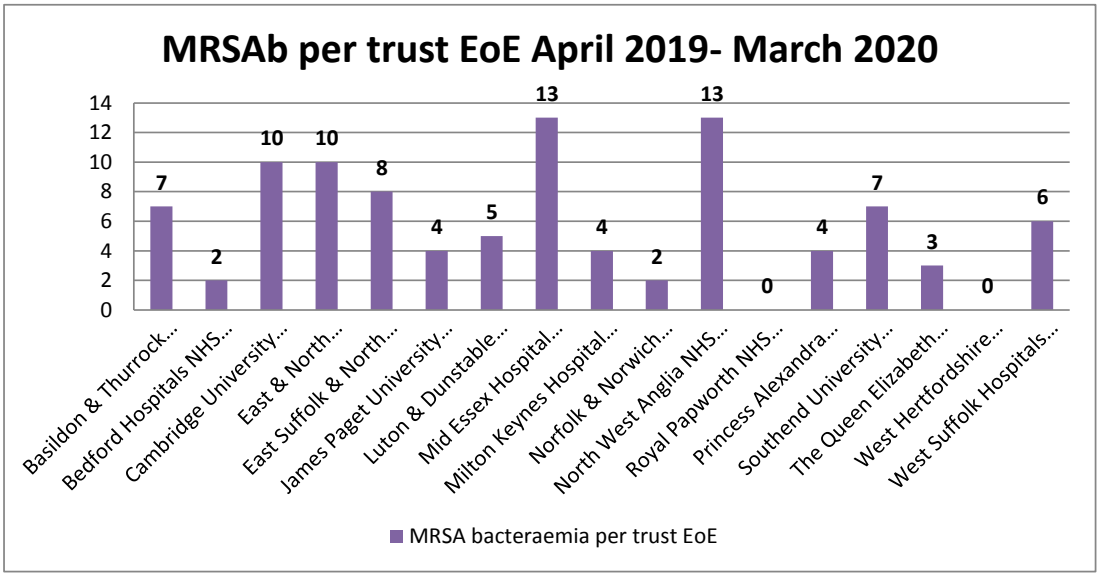


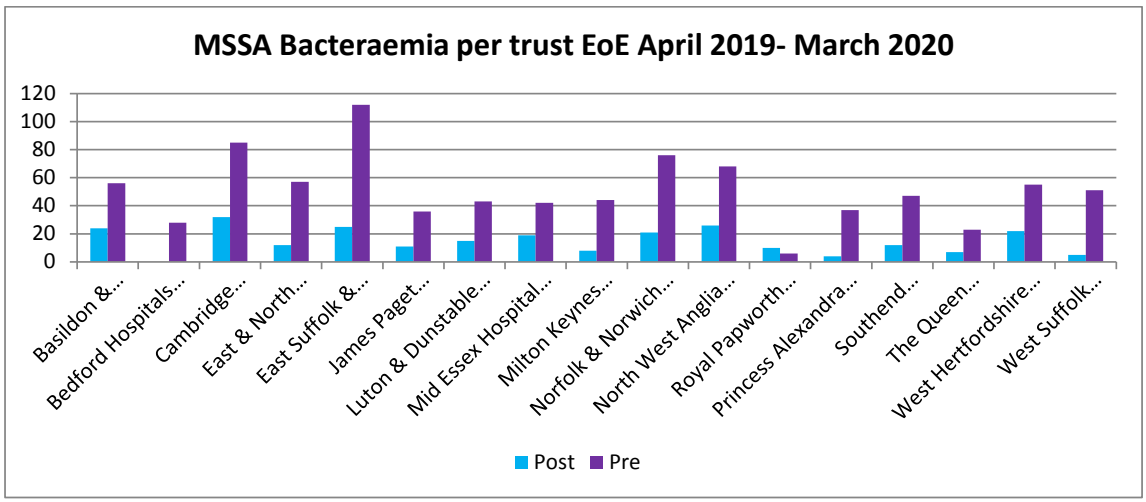
Figure 1b: This illustrates the number of MRSAb per trust in East of England



2.2 *Methicillin Sensitive Staphylococcus Aureus Bacteraemia* (MSSAb)

Reporting of MSSAb has been mandatory since January 2011. As with MRSAb, no trajectory is set for MSSAb. For the year 2019/20 there were 22 post-48 hours' cases of MSSAb and 55 pre 48-hours cases (Figure 2). Each case of MSSA is reviewed and findings from thematic analysis such as the presence of an invasive device were addressed.

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



The graph above illustrates the number of MSSAb per Trust in Midlands & East of England, 2019/20.

2.3 *Escherichia Coli* Bacteraemia (E. colib)

The reporting of E. colib became mandatory in June 2011. For the year 2019/20 no targets were set, however the Clinical Commissioning Group (CCG), - set a reduction target of 20%for both Hospital and the Community.

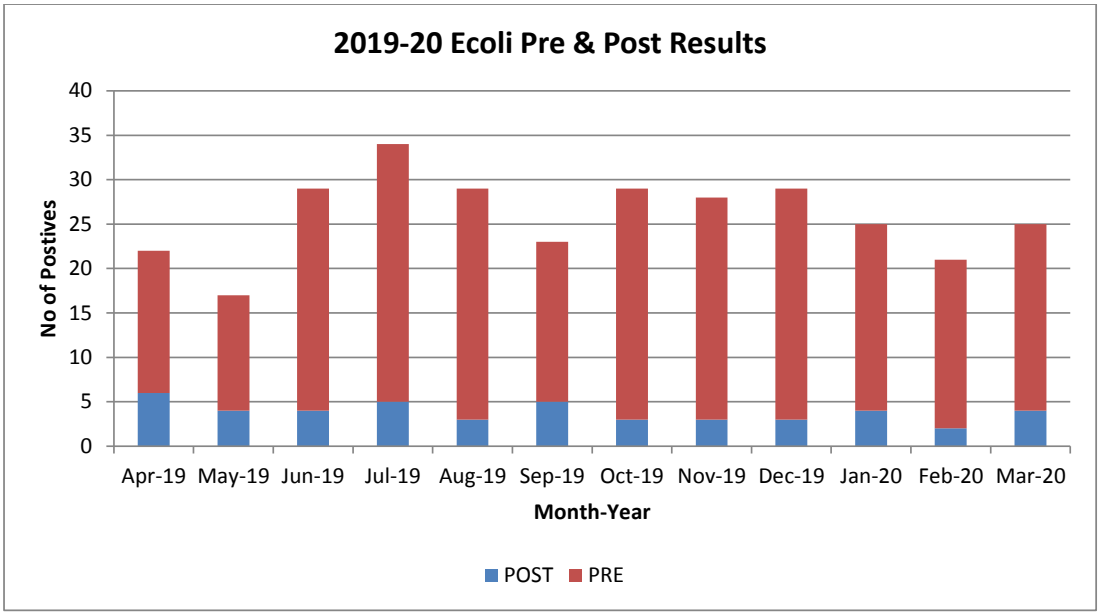
The majority of cases reported were within the community with 47 E. colib post-48 hours' cases and 263 pre 48 hours cases. (Fig. 3)

A 50% reduction target has been set for March 2024 involving all Gram Negative Bloodstream Infections across health care settings.

The common theme for E. colib is urinary tract infections (UTIs). A collaborative Quality Improvement (QI) project across the local healthcare system has been undertaken, focusing on hydration of patients to avoid the risks of UTI. Development of ideas alongside both community and other healthcare providers to increase the fluid intake of vulnerable patients included offering alternative drink choices, reviewing the number of drinks offered during a shift, picture cards to help with choice of drinks and highlighting those patients that require assistance to drink. Further work to roll out the successful interventions across the trust was planned for 20-21 but has been delayed by the pandemic so this will go over into 21-22 as well.

Collaborative work with partner organisations regarding Anti-Microbial Resistance (AMR), 'To Dip and Not To Dip' and diagnosis and management of UTIs has also been undertaken. The Trust's antimicrobial pharmacist is supporting this programme to contribute to improving antimicrobial stewardship, which aims to reduce gram-negative resistance.

Figure 3:



2.4 WHHT apportioned CDI cases 2019/20

The *Clostridioides* difficile Infection (CDI) objectives for 2019/20 are based on new criteria (4 categories) for apportioning of cases; this system commenced on 1 April 2019.

The trust trajectory for this financial year was 34, and Root Cause Analysis (RCA) are required to be completed for all cases.

All cases of CDI that fall in to the first two categories:

- Hospital onset healthcare associated (HOHA) – cases detected 2 days or more after admission (category 1).
- Community onset healthcare associated (COHA) – cases that occur in the community that have had a hospital admission/inpatient in the previous 4 weeks (category 2).

Currently the CCG IPCT undertake a full review of all RCA's on a monthly basis involving HOHA and COHA cat 1&2 cases, which are presented by the clinical teams. This includes identifying key learning and the development of action plans. All identified actions are then reviewed as part of the following month's meeting and reported back via the IPC Panel for assurance. Those cases with no identification of lapses in care within the trust remain on the Trust figures but are not subject to financial sanctions.

Of the 48 cases reviewed, 5 were identified with lapses in care, 26 identified as unavoidable with no identified learning and a further 17 reviews were postponed due to the COVID–19 pandemic. These cases have been discussed internally and any learning identified.

In the first 6 months of the year April – Oct 2019 higher numbers of cases were seen in comparison to the previous year using the same criteria (Fig 4.). As a result a CCG review was undertaken and feedback received, general themes were around cleaning standards/oversight. Many of these cases were successfully appealed with no lapses in care identified.

Following an increase in the number of cases in the first half of the year, a full review was undertaken with the CCG IPC and quality team. Actions undertaken were reviewed and included work in a number of areas:

- Epidemiological review of all cases and identification of any links
- Review of standards and process for domestic (contactor cleaning)
- Use of chlorine products in all areas including clinical equipment
- Deep clean of identified high risk areas
- Auditing and review of IPC practice
- Review of all RCA cases for identification of any themes in data
- Review of antibiotic usage in all cases

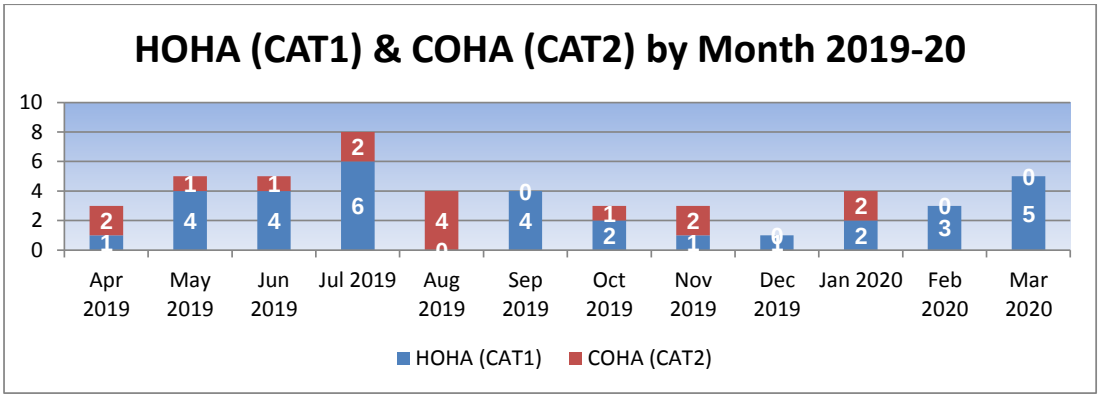
The IPC and facilities teams have been working with cleaning contractors to improve standards and assurance, including a review of cleaning schedules, training of cleaning staff and a review of overall standards. This has included a focus on high touch areas and IPC training supported by the IPCT for cleaning staff.

In addition, for cleaning of clinical equipment the Trust adopted the use of a chlorine realising solution for all items while C.*difficile* numbers were higher than the usual rate.

The IPCT developed a targeted education program based on concise IPC approaches and key messages 'Power training', for all clinical areas.

Within the latter two quarters of 2019/20 the numbers of cases declined, with many cases identified with no lapses in care.

Figure 4:



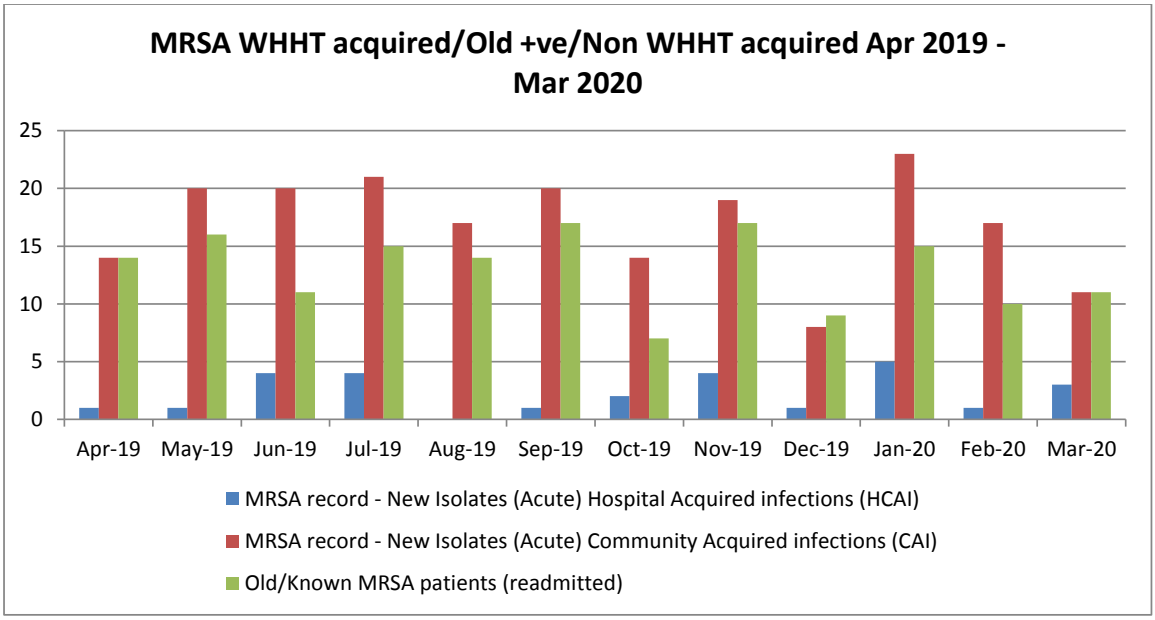
MRSA Isolates

2.7.1 MRSA isolates for April 2019 – March 2020

Patients identified MRSA positive were promptly isolated and the MRSA decolonisation protocol initiated. All patients who are admitted undergo an IPC risk assessment as per the patient risk alert system.

Rates of MRSA are significantly higher within the community compared to Healthcare Associated Infections (HCAI), suggesting low transmission rates with the hospital setting (fig. 5).

Figure 5:



2.8 Carbapenemase-Producing Enterobacteriaceae (CPE)

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

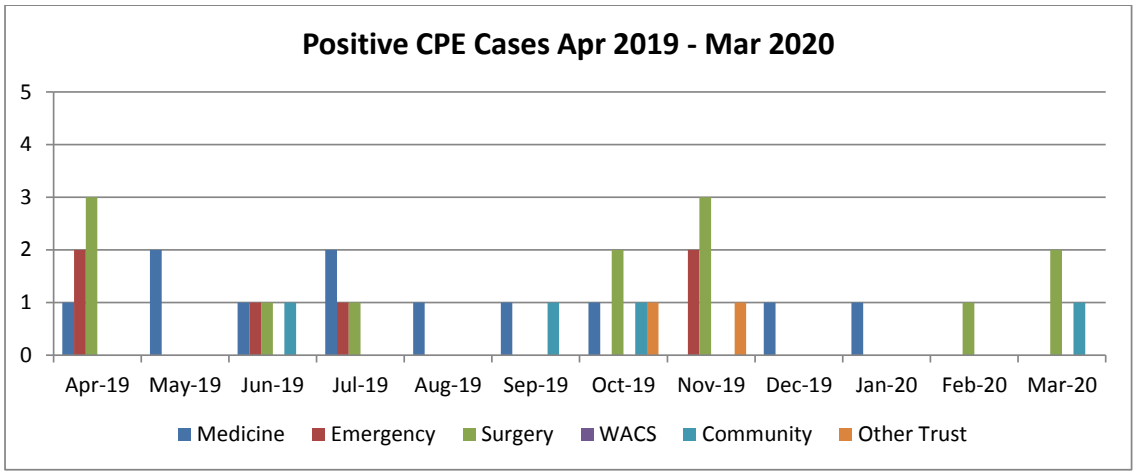
A review of the management and learning from previous cases and clusters has resulted in the following actions been undertaken to reduce incidence.

Actions undertaken to reduce the incidence of CPE in the trust:

- Full deep clean of bays/side room where patients are found to be CPE positive
- Screening of all contacts
- Training for ward staff regarding CPE management
- CPE management meetings including outside agencies
- Enhanced cleaning of area including drain decontamination
- Risk assessment of sinks and upgrading to the compliant model of sinks in areas which are seen as high risk for CPE.

The above action plan has led to a reduction of incidents of CPE across the Trust (fig 6)

Figure 6:



2.9 COVID – 19

Since March 2020 the Trust has been challenged along with the rest of the NHS with the COVID-19 pandemic. The Trust's response over a short period required a significant change in the management of infectious patients and the following interventions and actions were undertaken.

Assessment and Emergency Dept:

Following the outbreak, a national system was implemented whereby Acute Hospitals had to manage the screening and assessment of patients. COVID-19 assessment pods for screening were initiated at both Watford and Hemel Hempstead sites.

As the numbers of patients with symptoms increased separate ED departments were implemented to facilitate those patients presenting with Covid-19 symptoms and those for non COVID-19 conditions. This included cohorting of staff and equipment to protect those patients attending for non COVID-19 reasons from contact with symptomatic patients and the environment

During this time the IPCT supported along with Emergency Planning and Resilience (EPR) Team with training for PPE donning/doffing and management/ placement of patients on a daily basis.

Fit testing on respirators (FFP3) masks, was undertaken by the Health and Safety Team, this was and remains an ongoing process with the changes to masks available from the national supply chain with each different type/manufacturer requiring re testing.

Admissions and cohort areas:

Reconfiguration of the environment at the Watford site to facilitate, cohort areas for both COVID-19 positive patients and those suspected (awaiting confirmation of results) was undertaken, staff dedicated to these areas were supported with IPC advice including PPE

training in line with PHE guidance at that time. Support and training on the correct swabbing techniques to ensure reliable results was also provided.

In addition to onsite training, a communication strategy including daily email updates, posters and on line demonstrations supported staff with changing guidance.

Incident management Team (IMT):

With the emergence of the pandemic the IMT was developed to provide oversight and governance of the Trusts strategy and management. The purpose of the IMT:

- Meet daily
- Review / disseminate the latest national guidance
- Oversight of PPE
- Management of case and reporting.

Representation from IPC, EPR, Microbiology and Clinical Areas lead by members of the Executive Team, including the DIPC.

Inpatient management:

As numbers of cases requiring admission increased the Trust responded by allocating areas of the Hospital as Covid-19 zones. Cohorting positive patients on wards together with dedicated staff. This included using facilities at the Hemel site for those patient requiring palliative care. Defined areas of ITU and specified ward areas for those patients requiring enhanced care such as Non Invasive Ventilation (NIV), were also allocated for patients with positive COVID-19 results.

The IPC team supported with training and guidance along with ensuring standards of practice, management of patients and environmental decontamination were maintained.

Improvements to environment:

To support and facilitate the inpatient and emergency management response at this time, improvement work was undertaken in many areas. This included the installation of hand wash facilities; purpose built donning and doffing areas and the instillation of new doors within many areas. The estates team worked with IPC and EPR teams to expedite the process of works facilitating a timely response to the rising numbers of cases.

In addition to building works the estates team have also undertook a review of the ventilation systems, this has included increasing the numbers of air changes and sourcing extra cleaning of ventilation ducts on Covid-19 specified areas.

Cleaning and decontamination:

As the numbers of patients requiring inpatient care increased the standards of cleaning and decontamination across the organisation were reviewed. Extra cleaning of all areas including corridor and other public areas was implemented.

Enhanced cleaning which included high touch areas, across the organisation (not just in defined COVID-19 cohort areas) was implemented. With extra cleaning staff recruited to achieve the standards required.

Enhanced cleaning methods including the use of Hydrogen Peroxide Vapour (HPV) has been used throughout the pandemic to provide extra assurance of standards.

2.10 Influenza

In January 2020 a higher incidence of Influenza was identified on Bluebell Ward. 5 cases of Influenza A strain H3 were identified from samples sent between 7 and 15 January 2020. A full investigation and outbreak process was undertaken and outside regulators informed. The investigation concluded likely transmission of Influenza had taken place and interventions including strict IPC practices, enhanced cleaning and review and treatment of patients were effective. A Serious Incident (SI) investigation was also undertaken as Influenza was noted as cause of death on 2 patients.

3.0 CRITERIA 2 ENVIRONMENTAL CLEANING AND DECONTAMINATION

3.1 Environmental Cleanliness Joint Monitoring

Since April 2018, the cleaning service is provided by Mitie and the contract is monitored by the Facilities team. The Standards are audited monthly by Mitie and are monitored through the Trust monitoring officers.

Input from clinical staff including Ward Managers, Matrons and Housekeeping staff is encouraged throughout the audit process. Scores are divided into responsibilities including estates, domestic and clinical issues to identify the areas where the improvement required.

The cleaning audit scores are reported on the IPC dashboard and shared with ward managers on a monthly basis and are further discussed at the IPCP on a bi-monthly basis.

3.2 Informal Monitoring of Cleaning

The Trust has a programme of regular ‘walk-about’ including the Director of Infection Control (DIPC), Deputy DIPC/IPC, Lead Nurses and the environment and facilities teams. These visits include assessing; cleaning standards, reporting back to clinical areas and ensuring actions are taken to address the findings. The IPCT ensure that oversight of findings is raised at the time of the review and risk assessments are in place for any outstanding works and actions identified / resolved immediately.

3.3 Clinical Cleaning Responsibilities

Cleaning of clinical items and patient equipment is undertaken by both the nursing and housekeeping staff with oversight by the matrons. Compliance with policy is monitored through the environmental and IPC audits which are reported on the IPC Dashboard. IPC audit themes have included the cleaning of equipment and in particular the cleaning of chairs, clinical equipment and estates items. Action plans are completed and progress reported via the IPCP.

3.4 Estates

The Estates team report to the Director of Environment. The aging estate presents challenges for IPC and a continuous maintenance programme is required. Findings regarding the infrastructure are escalated through the auditing process and Senior Team 'Walk-about', and risk assessments are undertaken to prioritise the work. Much work was completed prior to and during COVID-19 pandemic to provide effective and safe working practices.

3.4.1 Water safety

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

A full review of the Trust's Water safety plan has been commenced to provide a comprehensive plan of work. This includes further role out of an Electronic system to monitor the flushing of all outlets, updating of many hand wash sinks and water outlets in higher risk areas and a long term maintenance programme to improve the current systems.

In accordance with HTM 04-01, the Trust is required to check for the presence of pseudomonas aeruginosa in augmented clinical care areas, including Women's and Children's services.

The Trust has a statutory responsibility to take appropriate measures for the control of all water-borne microorganisms including Legionella and pseudomonas. Regular temperature checks and surveillance is in place to monitor the water systems. This is reported via the Water Safety Group and IPCP.

3.4.2 Ventilation.

The ventilation is managed by the estates team with oversight from an authorising engineer, the Trust Ventilation group aims to meets quarterly and includes multi-disciplinary members. A programme of maintenance and checking is undertaken in all high-risk areas including the Theatres and ITU. Vents in all areas are cleaned as part of the deep cleaning schedule undertaken by Mitie as part of the cleaning contract.

3.4.3 Decontamination

The Trust decontamination committee reports to IPCP, an Authorising engineer for decontamination oversees practices.

Outcome Endoscopy Investigation:

Investigations in Endoscopy were undertaken following the identification of Serratia and pseudomonas in some clinical samples from March to Sept 2019. An investigation and

incident review was undertaken resulting in an external oversight from Prof Peter Hoffman from Public Health England.

Finding suggested that there was possible contamination from one scope (number 17) and a review of the decontamination processes for this scope were reviewed. The scope was taken out of use and a full examination by the manufacturer undertaken, no further cases have been identified.

4.0 ANTIBIOTIC USAGE

Antimicrobial Stewardship April 2019 - March 2020

4. ANTIMICROBIAL STEWARDSHIP ACTIVITIES (April 2019- April 2020)

Establishing antimicrobial stewardship programme is crucial to reduce healthcare associated infections (HCAI) and contributes to slowing the development of antimicrobial resistance. Antimicrobial stewardship team focused on the delivery of the national CQUINs and AMR (antibiotic review and reduction in total consumption). Members of the antimicrobial committee meet bi-monthly to discuss the Trust antimicrobial strategy and stewardship programme. Minutes of these meetings are submitted to IPCP.

WHHT antimicrobial strategy document has an antimicrobial stewardship audit plan for each year. This includes monthly antibiotic report, monthly antimicrobial stewardship CQUIN audits and annual point prevalence survey of antimicrobials. Junior doctors participate in antimicrobial stewardship audits as part of junior engagement plan.

Several interventions were put in place to achieve the National CQUIN target including education and training of medical and nursing staff regarding “To Dip or Not to Dip” in an effort to improve the Trust’s performance in diagnosing and treatment of lower urinary tract infections in 65+ patients. Antibiotic consumption and other relevant data have been submitted to CCG and PHE for part 1a and 1b for the year 2019/20 (see below).

Indicator 1a: Lower Urinary Tract Infections in Older people

Date	Diagnosis of lower UTI based on documented clinical signs or symptoms	Diagnosis excludes use of urine dip stick	Empirical antibiotic prescribed following Guideline	Urine sample sent to microbiology	Overall compliance	Number compliedd/ total audited	Target
QTR 1	71%	49%	73%	88%	24%	24/100	90%
QTR 2	76%	77%	89%	87%	50%	50/100	90%
QTR 3	87%	91%	95%	90%	71%	71/100	90%
QTR 4	88%	97%	86%	83%	66%	66/100	90%

Indicator 1b: Antibiotic prophylaxis in colorectal surgery

Month	Number of antibiotic doses given for surgical prophylaxis	Antibiotic Choice Compliant with Guidelines	Overall compliance	Number complied/ total audited	Target
QTR 1	96%	96%	96%	54/56	90%
QTR 2	96%	94%	94%	50/53	90%
QTR 3	100%	100%	100%	60/60	90%
QTR 4	100%	97.5%	97.5%	39/40	90%

Reduction in antibiotic consumption per 1,000 admissions
Reduction of 1% or more in total antibiotic consumption against 2018/19 target:

Date	Baseline 2018/19 DDD/1000 admission	DDD/1000 admission	Variation % from baseline 2018/19	YTD %
QTR 1	3837	3449	-10.1	-10.1
QTR 2	3837	3271	-14.8	-12.5
QTR 3	3837	3360	-12.4	-12.5
QTR 4	3837	3737	-2.6	-10.2

Weekly MDT C.diff, orthopaedic and diabetic foot infections MDT ward rounds and TB MDT rounds are conducted to ensure high quality of care and safe prescribing of antimicrobials.

Publications and awards:

The antimicrobial stewardship team received the national highly commended antibiotic guardian award in 2018 and this year the team was recognised for their innovative approach in tackling antibiotic resistance and implementing a robust antimicrobial programme and they were finalist at a very prestigious and competitive award, Acute sector innovation of the year HSJ award 2019

The team have engaged junior doctors and microbiology laboratory staff in antimicrobial stewardship activities and published their studies in national and international conferences:

- Use of alternative diagnostic tests to guide antibiotic stewardship in critically ill patients with pneumonia, State of the art conference December 2019 Birmingham, UK
- Appropriateness of Meropenem prescriptions at a local district general hospital, East of England, UK, November 2019, Edinburgh, UK

- Characteristics of patients admitted to Intensive care units with severe Influenza and management outcome at a large district general hospital in East of England, UK, November 2019, Edinburgh, UK
- Evaluation of molecular rapid diagnosis of enteric bacterial infection in patients with diarrhoeal disease and its clinical and infection control impact at a large district hospital, UK, November 2019, Edinburgh, UK

4.1 Actions (completed) and Recommendations for 2019/20:

- Assess appropriateness of antimicrobial prescribing for treatment and prophylaxis.
- Complete the annual point prevalence audit in November 2019
- Plan, organise and carry out EAAD activities on 16 November 2019
- Continue to engage junior doctors in antimicrobial stewardship audits
- Continue to deliver educational teaching sessions to medical, nursing and pharmacy staff and to re-enforce AMR agenda
- Introduction of innovation to improve antibiotic prescribing and ensure appropriate antibiotic use for example rapid diagnostics
- Roll out of new drug chart with antimicrobial review tool (ART) section to improve prescribing and timely review of antibiotics

5.0 CRITERIA 4 – PROVIDING INFORMATION TO SERVICE USERS

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

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

In addition, the Trust responds to rises in cases of communicable disease and seasonal peaks of viruses such as Influenza and Norovirus, providing advice on visiting the Trust and measures to reduce spread. In the final quarter of 2019/20 it has included COVID–19 and continued updates and communication with both the general public and media.

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

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

6.1 Identification of patients with infections

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

6.2 Assessment of patients with risk factors for infections

6.2.1 Diarrhoea & Vomiting (D&V) risk assessment

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

6.2.2 Admission IPC assessment

In response to the COVID–19 pandemic an assessment process in to ED was adopted to identify patients presenting with symptoms. As a response to increased numbers a separate ED department was implemented to ensure patient safety and reduce any risk of transmission. Patients were triaged by clinical indication and by questions regarding contact and risk. Patients requiring admission were then cohorted according to status, those awaiting test results, those to be confirmed with the virus. Those requiring a higher level of care were also allocated in to cohort areas with a separate ITU area for those with known infection.

6.3 **WHHT Surgical Site Infection Surveillance Programme 2019-2020.**

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

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

- Repair of neck of femur

6.3.1 SSIS Results 2019/20 (published data)

In 2019/20 WHHT has continued to participate in continuous THR + TKR SSI surveillance across both Watford General Hospital (WGH) and St Albans City Hospital (SACH), in line with the mandatory requirement. In accordance with 'Get It Right First Time' recommendations, continuous SSI surveillance on spinal surgery at SACH was also commenced in July 2019. Additional SSI surveillance has also been undertaken on breast surgery at SACH during Oct-Dec 2019, and Fracture Neck of Femur surgery at WGH during Jan-Mar 2020.

Tabled below are WHHT's SSI results for the year 2019/20.

SSIS results:

Q2. April-June 2019

SACH Total Hip Replacement (THR)	**Apr-Jun 19**	**Last 4 periods**
Study population (number of operations)	81	295
Number of inpatient/readmission SSIs	0	1
% infected	0%	0.3%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
SACH Total Knee Replacement (TKR)	**Apr-Jun 19**	**Last 4 periods**
Study population (number of operations)	67	344
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%
WGH Total Hip Replacement (THR)	**Apr-Jun 19**	**Last 4 periods**
Study population (number of operations)	16	106
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Knee Replacement (TKR)	**Apr-Jun 19**	**Last 4 periods**
Study population (number of operations)	16	106
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%

Q3. July-September 2019

SACH Total Hip Replacement (THR)	**Jul-Sep 19**	**Last 4 periods**
Study population (number of operations)	60	278
Number of inpatient/readmission SSIs	0	1
% infected	0%	0.4%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
SACH Total Knee Replacement (TKR)	**Jul-Sep 19**	**Last 4 periods**
Study population (number of operations)	74	341

Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%
SACH Spinal Surgery	**Jul-Sep 19**	**Last 4 periods**
Study population (number of operations)	31	123
Number of inpatient/readmission SSIs	0	1
% infected	0%	0.8%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		1.2%
WGH Total Hip Replacement (THR)	**Jul-Sep 19**	**Last 4 periods**
Study population (number of operations)	35	131
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Knee Replacement (TKR)	**Jul-Sep 19**	**Last 4 periods**
Study population (number of operations)	15	89
Number of inpatient/readmission SSIs	1	1
% infected	6.7%	1.1%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%

SSI details:

- **Operation:** Left Total Knee Replacement
- **Date of operation**: 17/07/2019
- **Date of SSI:** 11/03/2020
- **Detection**: Readmission
- **Depth:** Organ/Space
- **Organism 1:** Staphylococcus Epidermidis

Q4. October-December 2019

SACH Total Hip Replacement (THR)	**Oct-Dec 19**	**Last 4 periods**
Study population (number of operations)	78	293
Number of inpatient/readmission SSIs	0	1
% infected	0%	0.3%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
SACH Total Knee Replacement (TKR)	**Oct-Dec 19**	**Last 4 periods**
Study population (number of operations)	70	308
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%
SACH Spinal Surgery	**Oct-Dec 19**	**Last 4 periods**
Study population (number of operations)	44	167
Number of inpatient/readmission SSIs	0	1
% infected	0%	0.6%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		1.2%
SACH Breast Surgery	**Oct-Dec 19**	**Last 4 periods**
Study population (number of operations)	105	201

Number of inpatient/readmission SSIs	0	1
% infected	0%	0.5%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		
WGH Total Hip Replacement (THR)	**Oct-Dec 19**	**Last 4 periods**
Study population (number of operations)	28	130
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Knee Replacement (TKR)	**Oct-Dec 19**	**Last 4 periods**
Study population (number of operations)	13	66
Number of inpatient/readmission SSIs	0	1
% infected	0%	1.5%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%

Q4. January-March 2020

SACH Total Hip Replacement (THR)	**Jan-Mar 20**	**Last 4 periods**
Study population (number of operations)	66	285
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
SACH Total Knee Replacement (TKR)	**Jan-Mar 20**	**Last 4 periods**
Study population (number of operations)	77	288
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%
SACH Spinal Surgery	**Jan-Mar 20**	**Last 4 periods**
Study population (number of operations)	40	163
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		1.2%
WGH Total Hip Replacement (THR)	**Jan-Mar 20**	**Last 4 periods**
Study population (number of operations)	19	115
Number of inpatient/readmission SSIs	0	0
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.6%
WGH Total Knee Replacement (TKR)	**Jan-Mar 20**	**Last 4 periods**
Study population (number of operations)	13	57
Number of inpatient/readmission SSIs	0	1
% infected	0%	1.8%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		0.5%
WGH Repair of NOF (#NOF)	**Jan-Mar 20**	**Last 4 periods**
Study population (number of operations)	94	348
Number of inpatient/readmission SSIs	0 (1 SSI investigation	0

	pending)	
% infected	0%	0%
National baseline: results from all hospitals from the previous 5 yrs *(Inpatient + Readmission without PQ)*		1.1%

West Hertfordshire NHS Trust SSI Surveillance data April 2018 - March 2019:

	Category	Year	Number of operations	No of Inpatient + Readmission SSI's	Inpatient + Readmission SSI Rate
West Hertfordshire Hospitals NHS Trust	THR	2018/19	400	1	0.3%
	TKR	2018/19	491	0	0%
	#NOF	2018/19	80	0	0%

Comparative SSI Surveillance data from participating local NHS Trusts:

	Category	Year	Number of operations	No of Inpatient + Readmission SSI's	Inpatients + Readmission SSI Rate
Luton and Dunstable University Hospital NHS Foundation Trust	THR	2018/19	300	2	0.7%
	TKR	2018/19	309	5	1.6%
East and North Hertfordshire NHS Trust	THR	2018/19	105	1	1%
	TKR	2018/19	98	3	3%
	#NOF	2018/19	56	0	0%
Royal National Orthopaedic NHS Trust	THR	2018/19	469	4	0.9%
	TKR	2018/19	520	6	1.2%

6.4 Vascular Access

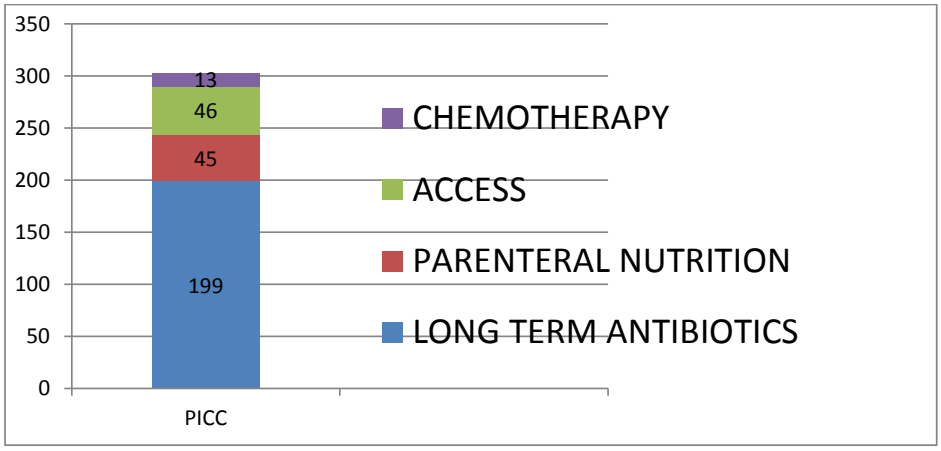
Vascular Access April 2019 – March 2020

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

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

6.4.1 PICC/ Midline insertions

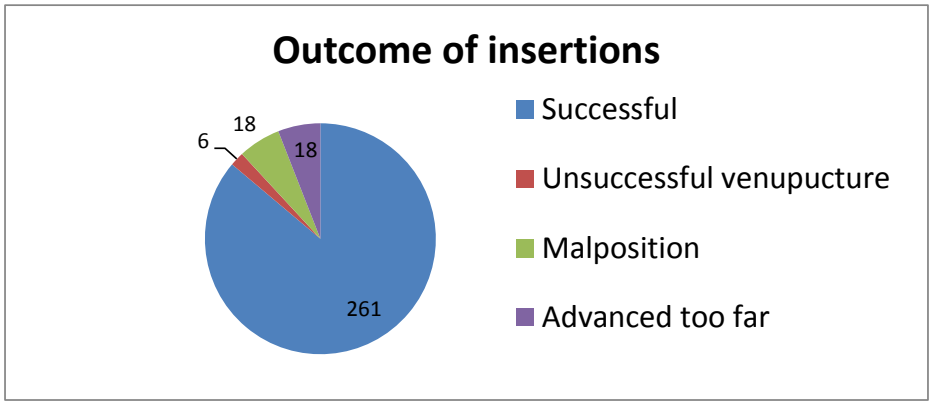
Figure 7: Total insertions of PICCs/ Midlines (n= 303)



Comparison with previous years:

PICC/Midline	**Apr 19 – Mar 20**	**Apr 18 – Mar 19**	**Apr 17 – Mar 2018**	**Apr 2016 – Mar 17**
Numbers (n):	303	253	218	260

Figure 8: Outcome of insertions:



6.4.2 PICC/ Midline removal

Notification of line removal is vital in providing safe care to the patients especially once the patient is discharged into the community. According to NICE policies and EPIC 3 guidelines, all CVADs that are no longer required must be removed, so as to prevent unnecessary complications.

There were 193 known removed PICC/ midlines during April 2019 – March 2020 (figure 9).

Total catheter dwell time **5606 catheter days.**

PICC dwell time range: 1-133 days	Mean average dwell time: 28 days
PICC/ midline in situ **up to 1 week:** 20	PICC/ midline **in situ 1 to 3 months**: 57
PICC/ midline in **situ 1 week - 1 month**: 107	PICC/ midline in situ **> 3 months:** 3

It is recommended that the incidence of CR-BSI is expressed as per 1000 catheter days as this allows for more meaningful estimate of risk (Loveday, 2014).

Figure 9: Indication of known removals (n=193)

Reason of removal:	Number:	Comments:
Treatment completed	95	
Not indicated	22	
Suspected Intraluminal infection	**12 (3 positive)**	**13.2 per 1000 catheter days***
CLABSI	**0**	
Occlusion	15	
Migration	10	
Suspected UEDVT	3 (1 positive)	**0.33% ****
RIP	14	
Other	22	

Three out of twelve patients displaying signs of infection had the tip of the PICC positive (all three colonised with **Staphylococcus epidermidis). None had positive blood cultures which indicate the bacteria was localised within the PICC lumen and did not progress to the bloodstream, due to swift recognition and action.*

***Incidence rate of **4 – 8%** reported in the literature for cancer patients and 2.7% for other patients (Chopra, 2013).*

6.4.3 Care and Management audit

The audit reviews on a weekly basis all inpatient PICC and midlines provided by the Vascular access service and all other Central Venous Access Catheters (CVADs) referred for review.

Main themes:

1. **Phlebitis rates:** There has been a significant decrease of microbial and mechanical phlebitis. Weekly reviews showcase 10 suspected phlebitis cases – 0 growths from swabs.

a. Tegaderm Chlorhexidine 2% infused dressing is routinely used to prevent colonization. Out of 312 review, 47 times protective dressings were not according to policy → 75% compliance.

2. Occlusions

2.a Persistent Withdrawal Occlusion (PWO): 4 PICCs/ none premature removal.

2.b Total Occlusion (TO):

TO is a preventable complication of CVADs, normally caused by poor flushing and allowing medication/ blood comportments/ other to pool within the catheter lumen.

30 PICCs became TO with 15 leading to premature removal.

RISK: Occlusion of devices can lead to premature removal of device/ reinsertions, infections, pulmonary embolisms and fracture of lumens.

ACTION:

There has been a focus around ward based training accessing devices, as well as creating a Vascular Access Champion that will have enhanced vascular access training in troubleshooting .

6.4.4 Reduction of PICC migrations due to SecurAcath

SecurAcath is a device to secure PICCs and is associated with low incidents of catheter-associated complications (such as dislodgements and phlebitis), improved stability and reduced infection risk.

The device has the potential for cost savings from a reduction in time taken during correct dressing changes and is recommended by NICE.

It was chosen as a NHS Innovation Technology Payments (ITP) and is available for free until June 2020. At WHHT, SecurAcath was introduced in December 2018, and a reduction of 35% of PICC migrations was noted.

6.4.5 Training

New workshops were initiated: CVC IV Update administration, Midline training (incorporated with peripheral IV training) and Vascular Access Champions

6.4.6 PICC Passport

A PICC passport is being drafted to replace the patient leaflet provided to patients. Therefore all information needed for the patient, nurse/ service providing the therapy, other healthcare providers will be in one booklet.

Up to date, all interesting parties have reviewing the passport and comments/ feedback has been received.

6.4.7 Vascular Access – Plans for coming year

Expansion of the PICC team:

- ✓ Senior radiographer to be trained in insertion and troubleshooting of PICCs.
- ✓ Develop a business case for a further specialist nurse to provide cross-cover of service.
- ✓ Consider future expansion to include a paediatric division. Currently there is no paediatric PICC service. Currently Patients younger than 16 need to be transported to GOSH and St Mary's hospitals for these procedures leading to cost implications for the trust, as well as impacting on the patient experience.

CVAD occlusion

Continue and increase the drive for CVAD related occlusion reduction. A big drive will be medical staff training involving blood sampling from devices.

Trial of "positive" needle free devices for PICC lines and correlate findings with occlusion rates.

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

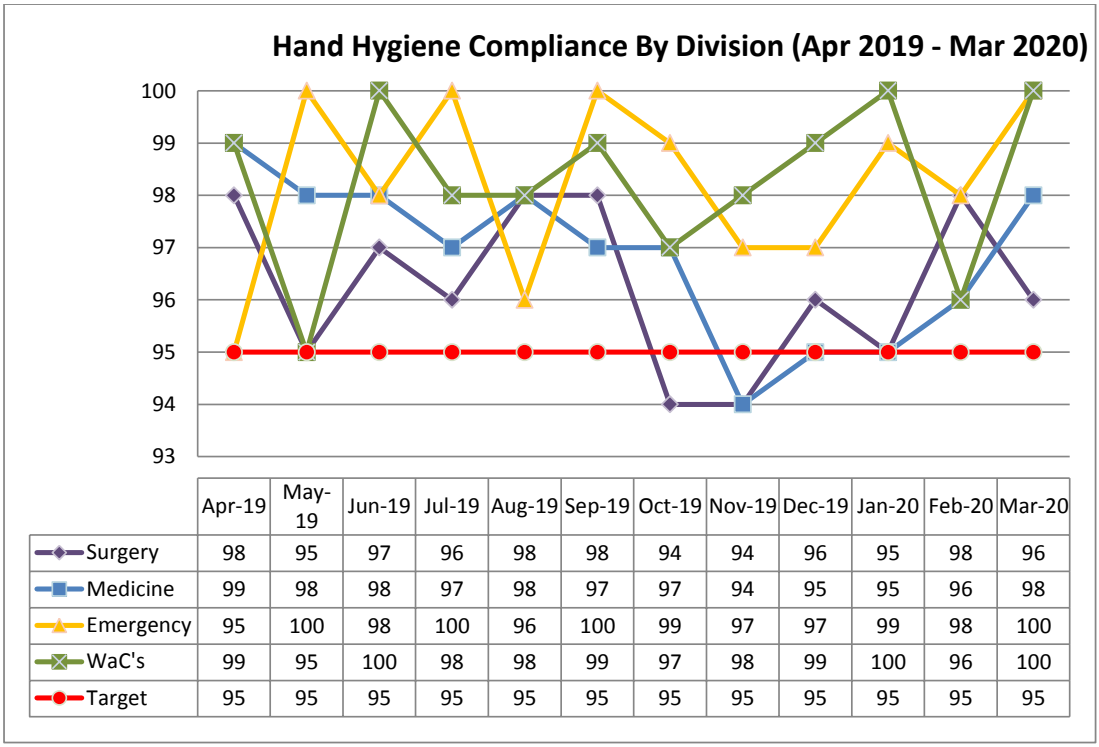
7.1. Hand Hygiene Audits Compliance

Effective hand hygiene remains the single most important intervention in the reduction of HCAI. All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates continue to be calculated and individual tables for each area within the divisions are produced by the IPCT. The trust Hand hygiene compliance target is 95%. Compliance with hand hygiene is monitored in the bi-monthly IPCP meetings, through the IPC dashboard. Where scores are indicated below the Trust benchmark an action plan is developed / implemented and subsequently re-audited (Fig 10a and 10b).

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

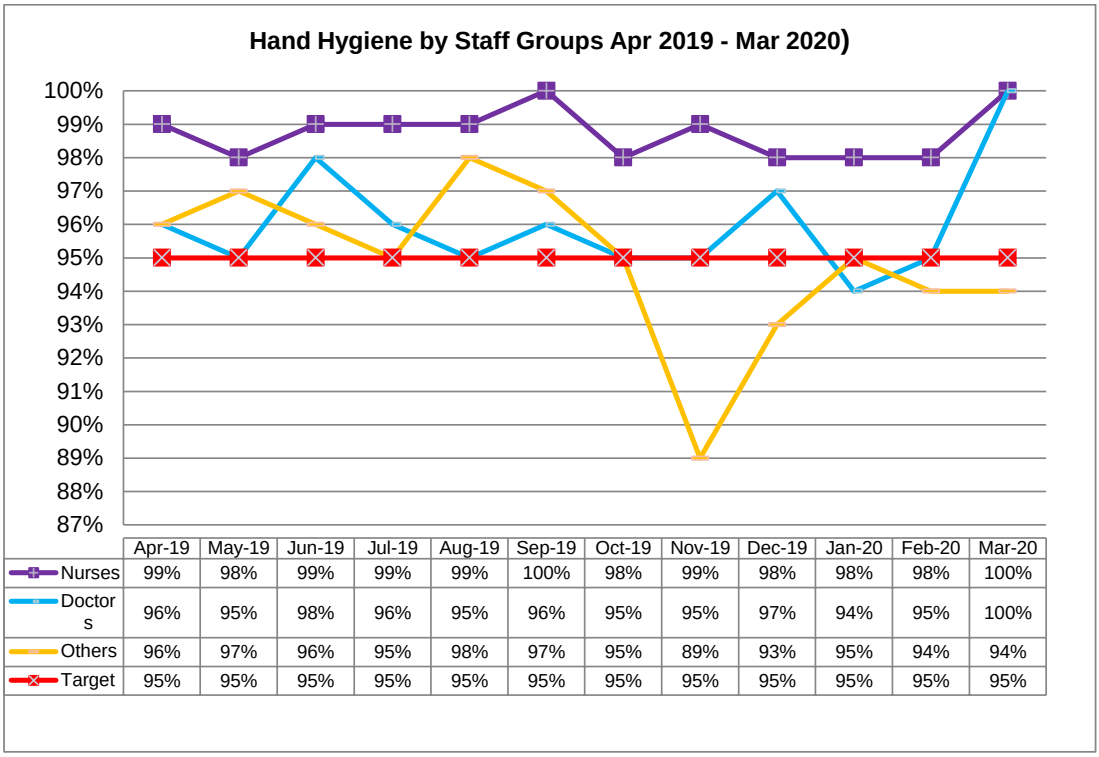
Several IPC “Campaigns” have been undertaken throughout the year to encourage and promote best practice. These have included national IPC awareness week and global hand hygiene day. Other campaigns have included “Bush Tucker Trials” and “I am a coronavirus get me out of here” which focused on the correct use of PPE, safe “donning” /“doffing” practice and hand hygiene. These campaigns have provided a “fun” promotion of IPC practice and a drive to improve practice. Audits undertaken alongside these campaigns have illustrated improvements in practice and provided support/education for clinical staff.

Figure 10a:



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Surgery	98	95	97	96	98	98	94	94	96	95	98	96
Medicine	99	98	98	97	98	97	97	94	95	95	96	98
Emergency	95	100	98	100	96	100	99	97	97	99	98	100
WaC's	99	95	100	98	98	99	97	98	99	100	96	100
Target	95	95	95	95	95	95	95	95	95	95	95	95

Figure 10b:



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Nurses	99%	98%	99%	99%	99%	100%	98%	99%	98%	98%	98%	100%
Doctors	96%	95%	98%	96%	95%	96%	95%	95%	97%	94%	95%	100%
Others	96%	97%	96%	95%	98%	97%	95%	89%	93%	95%	94%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

7.2 IPC Audits

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

7.2.1 Code of Practice (CoP) audits

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

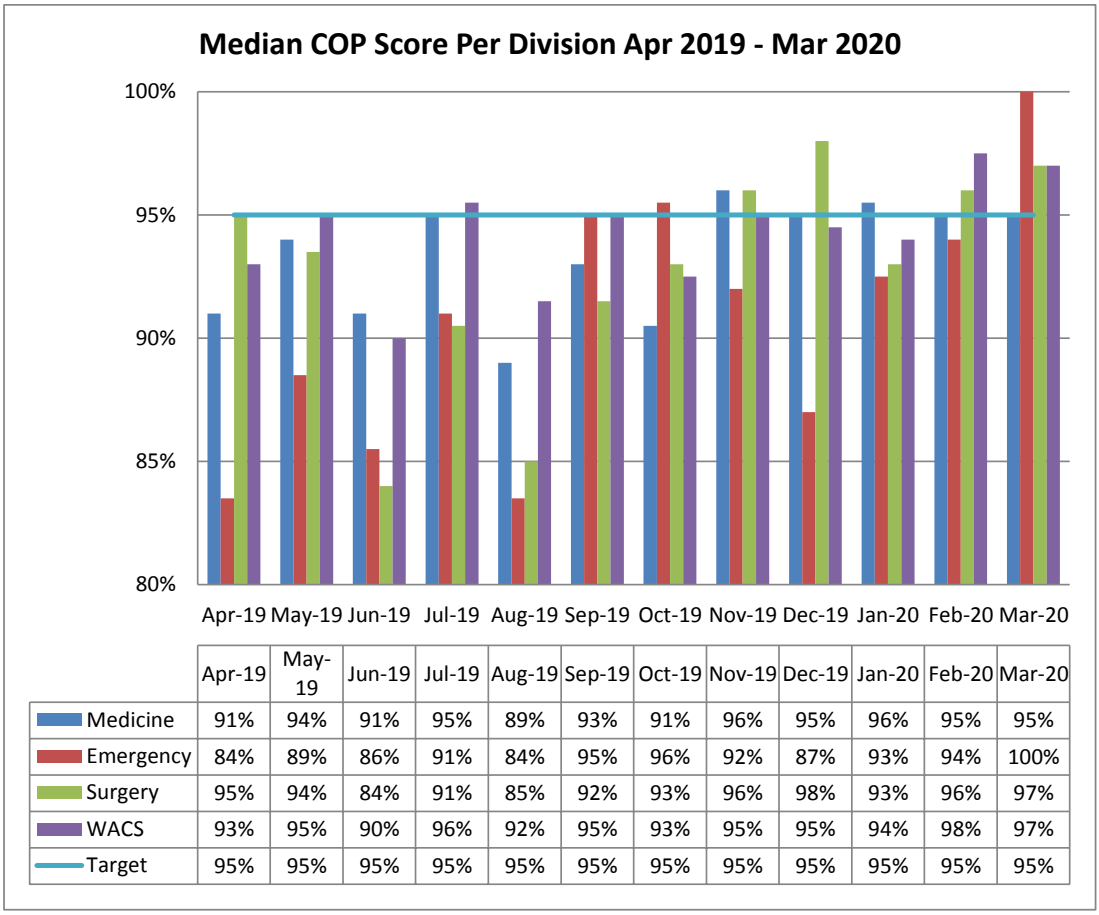
The key themes are:

- Cleanliness of equipment
- PPE usage and compliance with policy
- Cleaning of the environment to remove high- and low-level dust

The audits are then followed up with the facilities, Mitie and clinical leads. Feedback is provided at the matrons meeting, where actions for improvement are agreed and taken forward. This data is also reported to trust board as part of the Integrated Performance Report.

The COP audit is regularly reviewed and updated as IPC priorities change. Themes from the data along with Infection data are used to focus on the areas requiring focus and improvements.

Table 11:



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Medicine	91%	94%	91%	95%	89%	93%	91%	96%	95%	96%	95%	95%
Emergency	84%	89%	86%	91%	84%	95%	96%	92%	87%	93%	94%	100%
Surgery	95%	94%	84%	91%	85%	92%	93%	96%	98%	93%	96%	97%
WACS	93%	95%	90%	96%	92%	95%	93%	95%	95%	94%	98%	97%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Action plans are completed by clinical areas for any identified areas of concern, the IPCT support with Power training on areas such as PPE usage, hand hygiene. C.*difficile awareness* and other identified needs, there has been a consistent improvement within quarter 4 2019/20 with all areas achieving minimum standards in March 2020.

7.3 IPC ACTIVITIES

The IPCT also offer education in the form of formal study days, awareness days and ad-hoc ward power training. This has been particularly useful in promoting good practice around PPE usage, Donning/Doffing and education around the management of COVID.

7.4 IP&C Dashboard Data

The IPC monthly dashboard is updated at the start of each month and the data forms part of the monthly board report and is shared with all managers. Each ward area has its own separate dashboard with information to share with ward staff. This data is reviewed at IPCP, and divisional reports received. Infection data along with IPC practice and cleaning audit data is collated in the dashboard. Themes from the data are used formulate divisional plans for IPC these are reviewed at IPC panel and divisional governance meetings.

8.0 Criteria 7 - Provide adequate isolation facilities

There are challenges in isolating patients with the limited availability of side rooms within the Trust as well as competing priorities. There is no side room availability in the Granger Suite (Red Suite, Winyard & Bluebell); this is identified on the Trust Risk Register: Risk number 3436 with a risk score of 10.

Patients that require isolation in a side room are transferred either to the Isolation Unit or to another ward where a side room is available. Out of hours and at weekends there is a senior nurse to support ward staff in prioritising the side rooms, during week days the IPCNs support this. IPC and the site team review the use of the side rooms regularly and allocate them to patient who requires isolation. A review of single rooms in admission areas assists in the management of those patients admitted with suspected infection or who are flagged on electric system as having infection risks or compromised immunity. The IPC team work with operation colleagues assist with the management of this resource.

The COVID–19 pandemic has required isolation facilities to be used differently, and the use of Cohort areas for patients with positive results have been implemented. Single room facilities have been used as a protective facility to protect those patients at a higher risk from infection for example those with compromised immunity.

9.0 Criteria 8 – Microbiology Laboratory Support

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

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

10.0 Criteria 9 - IPC Polices

There has been a delay in the updating of some of the IPC policies due to COVID-19 response in quarter 4. A review of the policies has been undertaken to ensure that advice and guidance remains in line with national guidance/policies and practices are evidenced based.

Plans for the 20 – 21 include a review and update of all IPC policies.

11. Criteria 10 – Occupational Health 2019/20

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

12. RECOMMENDATION

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

Tracey Carter, Chief Nurse and Director of Infection Prevention & Control
Date: October 2020

APPENDIX 1

The Hygiene Code: Health and Social Care Act 2008 (2015): Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

Compliance Criteria	What the registered provider is required to demonstrate	Compliant Yes/ No
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Yes
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.	Yes
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse effects and antimicrobial resistance.	Yes
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Yes
5	Ensure prompt identification of people who have, or are at risk of developing, an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Yes
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Yes
7	Provide or secure adequate isolation facilities.	Yes
8	Secure adequate access to laboratory support as appropriate.	Yes
9	Have and adhere to policies, designed for individual's care and provider organisations that will help control infections.	Yes
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Yes

Appendix 2:

PRIORITIES FOR COMING YEAR

- Strengthen IPCT infrastructure to undertake surveillance and analysis through the development of a business case for ICNET.
- Sustain standards, methods and assurance around all aspects of cleaning working, through partnership with cleaning contractors to provide assurance on standards in all three sites.
- Continue work to improve and sustain clinical standards of IPC across the Trust to ensure consistency in all areas.
- Manage current estate including plans for refurbishment and updating. Continue with risk assessment for management of water, ventilation and decontamination.
- Undertake collaborative work with the CCG to reduce numbers of gram-negative BSIs across the region, including a collaborative QI programme across the whole region to improve patient hydration.
- Active role in the recovery planning post COVID-19 and planning for further management of possible further rise in cases.
- Monitor and manage Health Care transmission of COVID-19.
- Contribute to the design and planning of the proposed newly refurbished hospital to design out infections.
- Review IPC policies and update.

Board Meeting
5 November 2020

Title of the paper	Workforce Disability Equality Standard Report 2019-2020
Agenda Item	15/84
Presenter	Paul Da Gama, Chief People Officer
Author(s)	Arfan Bhatti, Inclusion & Diversity Manager
Purpose	*For approval*: √ ; *For discussion*: ; *For information*:
Executive Summary	This document reports on the Trust's data and activity from April 2019 – March 2020. We are reporting this information to Board in November following the reporting deadline extension from NHS England due to Covid-19. The reporting period therefore demonstrates we have made progress in relation to disabled staff in the following metrics: • experiencing discrimination from colleagues • feeling valued The data shows we have not made progress in relation to disabled staff in the following metrics: • experiencing harassment and abuse from patients/public • experience of equal opportunities for development and promotion • feeling pressured to come into work despite note feeling well enough to perform their duties The above metrics are taken from the 2019 staff survey, which received almost 300 responses from disabled colleagues; around 6% of all employees. The below metrics remain neutral and are influenced considerably by our low declaration rate on ESR, where only 1% of staff share the fact they have a disability: • Representation • Appointment from shortlisting • Formal disciplinary • Board diversity

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*
	√		

<table>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☐Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Diversability</td><td>3 September 2020</td></tr><tr><td>Diversability</td><td>17 September 2020</td></tr><tr><td>Diversability</td><td>12 October 2020</td></tr><tr><td>People, Education and Research Committee</td><td>22 October 20202</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to approve the report and action plan prior to publication on our website.</td></tr>
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Agenda item: 15/84

TRUST BOARD – 05 November 2020

Workforce Disability Equality Standard Report 2019/20

Presented by: Paul Da Gama Chief People Officer

1. Purpose

This paper seeks to:

- provide a breakdown and analysis of the 2019-2020 Workforce Disability Equality Standard (WDES) findings.
- compare workplace and career experiences of Disabled and non-disabled staff
- raise awareness of disability within the Trust and outline some of the challenges that Disabled staff experience
- recommend next steps in Appendix 1. This plan has been developed in partnership with the Trust's disabled staff network Diversability.

2. Background

The WDES was introduced in April 2019 and is mandated as part of the NHS Standard Contract. It is designed to improve workplace experience and career opportunities for disabled people working, or seeking employment, in the NHS.

The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change. It forms part of future CQC inspections under the 'well led' domain.

The WDES data for 2019-2020 was submitted to NHS England via the Strategic Data Collection Service on 25 August 2020. We are now required to publish an annual report for WDES with planned action to address the gaps.

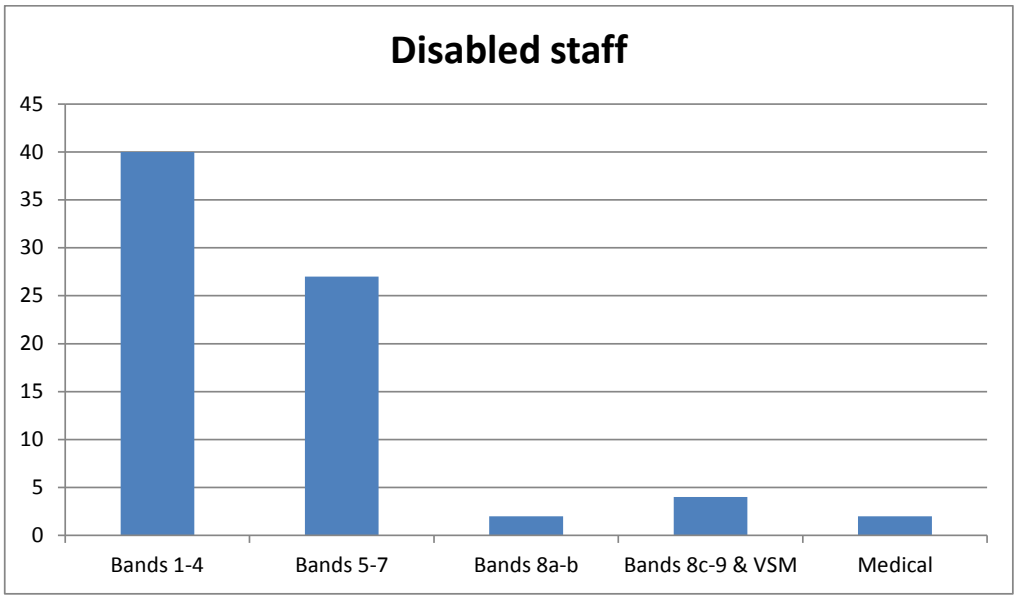
Indicators 1 - 3 and 10 are produced via the Electronic Staff Record (ESR) from the reporting period of April 2019-March 2020. All other indicators are from the 2019 staff survey and therefore do not take into account actions taken during the pandemic (which caused this year's reporting deadline to be extended).

3. WDES performance for April 2019 – March 20

Indicator		Direction of travel	
1	Disabled staff in each of the Agenda for Change (AfC) Bands	→	Neutral
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	↑	**Positive**
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	↓	**Negative**
4a	Disabled staff experiencing harassment, bullying or abuse from patients and colleagues	↑	**Positive**
4b	Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	↑	**Positive**
5	Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	↓	**Negative**
6	Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	↑	**Positive**
7	Disabled staff saying that they are satisfied with the extent to which their organisation values their work	↑	**Positive**
8	Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	↓	**Negative**
9	Staff engagement score for Disabled staff, compared to non-disabled staff	→	Neutral
10	Difference between the organisation's Board and its overall workforce	↑	**Positive**

3.1 **Indicator one:**
Disabled staff in each of the Agenda for Change (AfC) Bands

*Notes:
- VSM includes executive Board members and senior medical staff
- Includes all staff on permanent and fixed term contracts only (thereby excluding bank and locum staff).



Narrative:

Only 1% of staff have shared the fact they have a disability on ESR yet 19% of the working age population have a disability according to the House of Commons 2020 report Disabled People in Employment . Overall, 3% of the NHS workforce nationally have declared a disability through ESR.

The majority of disabilities are acquired during an individuals employment and most ESR input is completed at the start of employment.

Anecdotally there is evidence to suggest many colleagues are unaware they have a disability and/or are not comfortable sharing information on ESR from a confidentially as well as functionality perspective.

Actions taken (April 2019-March 2020)**:**

Launch of Diversability, a network for staff with disabilities and long-term health conditions. The network established a terms of reference with four key objectives, which include:

1. Be a support network for employees who consider themselves as having a Disability or Long Term Health Condition, working for West Hertfordshire Hospitals NHS Trust

2. Raise awareness within the Group of different disabilities

3. Raise awareness within the Trust of different disabilities

4. Improve the experience of staff who have a Disability/Long Term Health Condition

Further plans to implement these objectives are afoot and are included in the action plan, Appendix 1.

Prior to the networks launch, our Disability Champion spent time across our three sites engaging with other disabled staff prior.

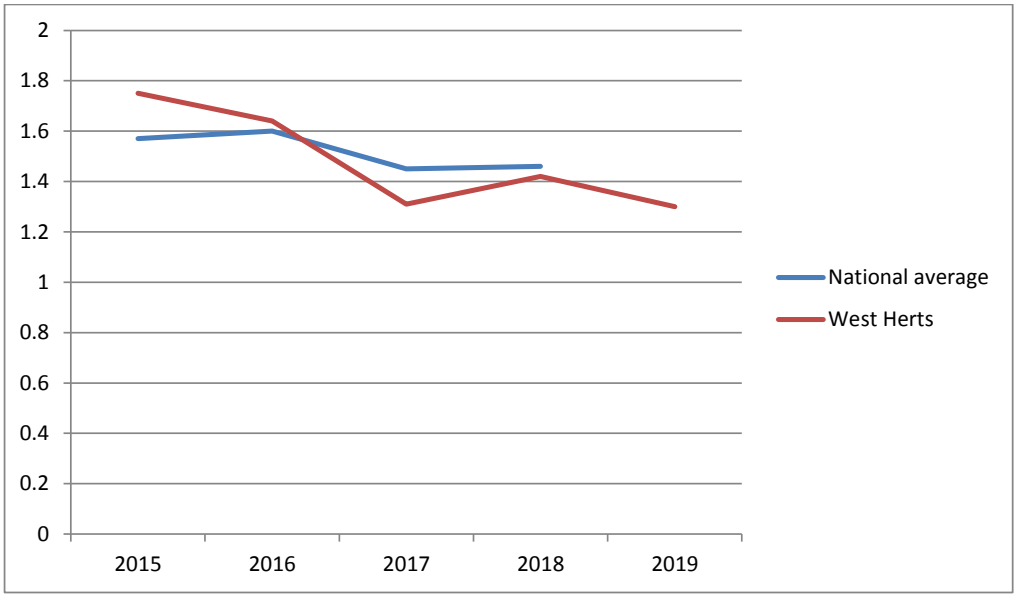
Our Disability Champion also delivered 17 awareness raising sessions to a number of meetings ranging from Matron's, Clinical Support and Student Induction. These sessions included a clear call to action for colleagues to update their ESR

The Trust's new appraisal process includes a section where line managers are required to follow-through disability and wellbeing issues and to provide appropriate support to staff and to their teams.

From a communications perspective we have been able to:

- mark and raise awareness on a number of disability related calendar dates
- publish a guide that instructs as well as empowers colleagues to update their ESR
- highlight the benefits of sharing diversity details on ESR in line with the WDES metrics

3.2 <u>Indicator two</u>:
Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.



Narrative:

The data demonstrates non-disabled staff are less likely to be appointed from shortlisting and is just outside the non-adverse range of 0.8 - 1.2.

This includes internal as well as external posts and is taken from 22 disabled, 719 non-disabled and 65 not declared successful appointments.

3% of successful appointments and therefore identify as Disabled applicants, with a further 8% not sharing their details with us.

Actions taken (April 2019-March 2020)**:**

The Trust operates a guaranteed interview scheme as part of our commitment to inclusion; whereby if applicants meet the essential criteria, they are guaranteed an interview.

Our recruitment & selection guide “Choosing the best talent” promotes fairness and inclusion and is embedded in panel preparation material

Our Recruitment Team participate in a number of interview panels to help ensure inclusive processes and also offer recruitment and selection training twice a year

3.3 Indicator three:
Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

	Disabled staff	Non-disabled staff	Unknown
Entered formal capability process no.	3	43	7
Entered formal capability process %	6%	81%	13%
All staff	75	3845	1223
All staff %	1%	75%	24%

Narrative:

- Refers to staff who have entered a formal investigation as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation are also included in this definition.

- Staff who have been subject to an investigation, but for whom no further action was taken are also counted.

- Cases where mediation has taken place rather than any kind of formal investigation or disciplinary are not counted.

- In July 2019 NHS England/NHS Improvement published “A fair experience for all: closing the ethnicity gap in rates of disciplinary action across the NHS Workforce” which set a target for 51% of NHS organisations to be within the non-adverse range of WRES reporting, between 0.8 and 1.25, by 2020. We have also applied this in principle to our disabled colleagues and are pleased to fall within this range.

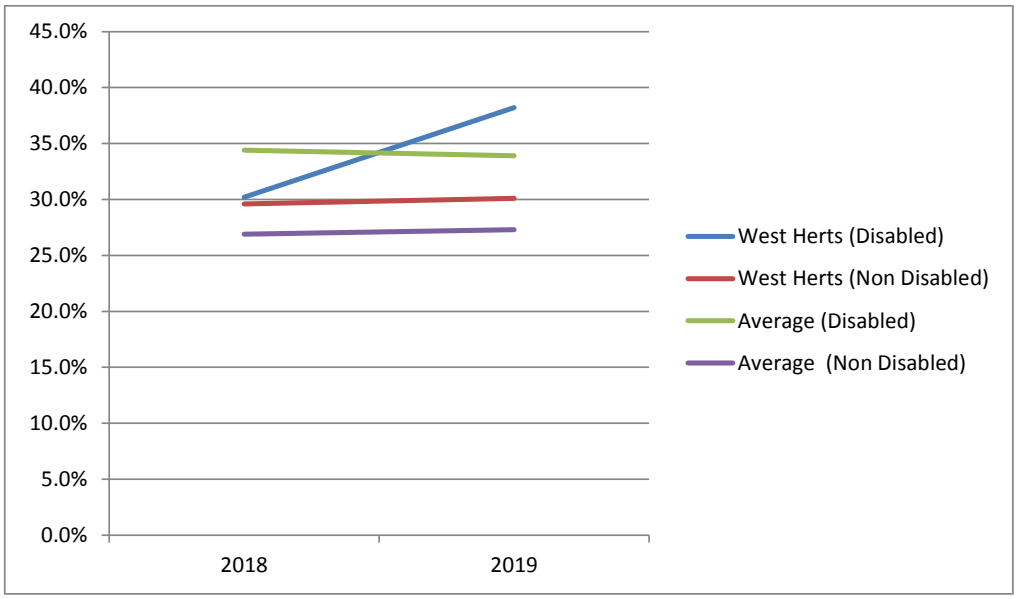
- NHS England also state disabled staff were more likely to enter formal capability processes in trusts that did not have separate processes for managing capability on the grounds of performance and ill health; reasonable adjustments policies; or champions for disability equality.

Actions taken (April 2019-March 2020)**::**

- updating our Disciplinary Policy against GMC and NMC guidance to improve the running of investigations
- inclusion embedded into investigating managers training
- investigators appointed internally chosen from outside the area where the investigation is to be carried out to ensure impartiality. We never allow a grandparent manager to carry out the investigation
- the panel chair will have had no prior involvement with the case and where appropriate work in another division
- robust preliminary process overseen by senior managers prior to any disciplinary investigation being commissioned
- further tightening the preliminary process to ensure that where possible cases are resolved and managed informally with only the most serious cases progressing formally – this means collating all evidence in advance of an investigation to determine whether it is necessary to proceed in this way.
- outcome given on the day in majority of disciplinary cases. Only where time does not allow for this will we communicate the decision in writing and only with their consent
- if a challenge to a particular panel member or case investigator is received, the person can be changed

3.4 Indicator 4a (staff survey)

Disabled staff experiencing harassment, bullying or abuse (BHA) from patients, relatives or public



Narrative:

285 Disabled colleagues responded to this question in the 2019 staff survey, exactly the same that did so in 2018.

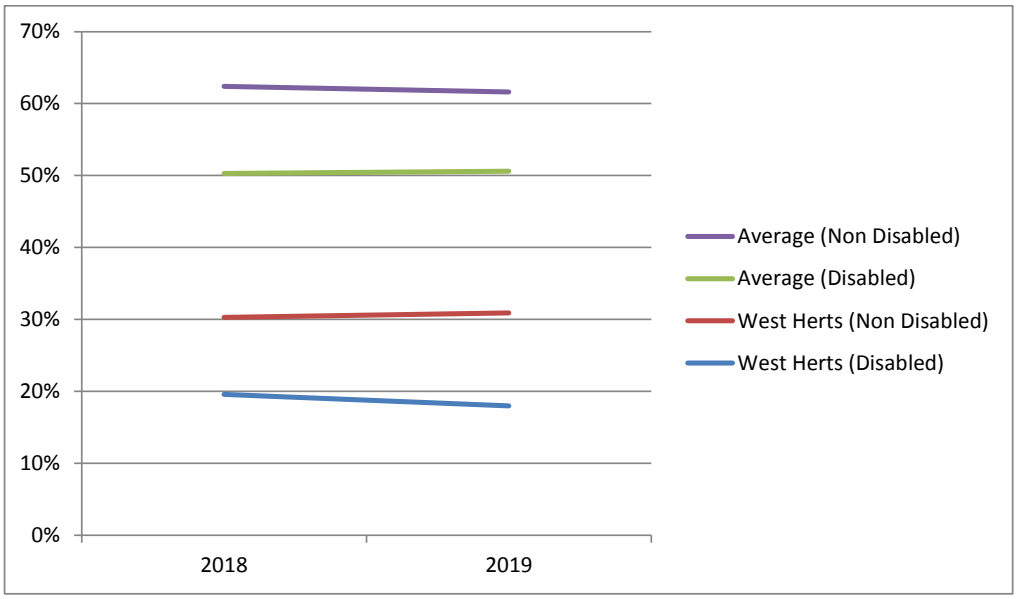
Actions taken (April 2019-March 2020)**:**

Running a campaign called the “Big 5” which focused on 5 key themes from the staff survey. The month of May was themed as “Protecting you” which included: (1) implementation of zero tolerance to violence/threatening behaviour posters (2) encouraging staff to report issues or concerns (which are taken up via Datix and investigated) (3) promoting our Speak Up Champions

Our Security Team drafted a Memorandum of Understanding (MOU) between the Trust and Hertfordshire Constabulary in relation to requests for emergency police assistance during incidents involving a threat of harm to person(s) and at other times of exceptional crises where NHS staff cannot manage the incident alone. The Team also updated our Clinical Staff- Security Support Strategy as well as Violence & Aggression Policy.

3.5 **Indicator 4b (staff survey)**

Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



Narrative:

132 Disabled colleagues responded to this question in the 2019 staff survey, 21 more than did so in 2018.

Actions taken (April 2019-March 2020)**:**

As part of the Trust's commitment to eradicating bullying and harassment, and encouraging staff to raise concerns as part of the Freedom to Speak Up campaign the Trust has more than 20 Speak Up Champions with whom staff can discuss and raise concerns that they may have.

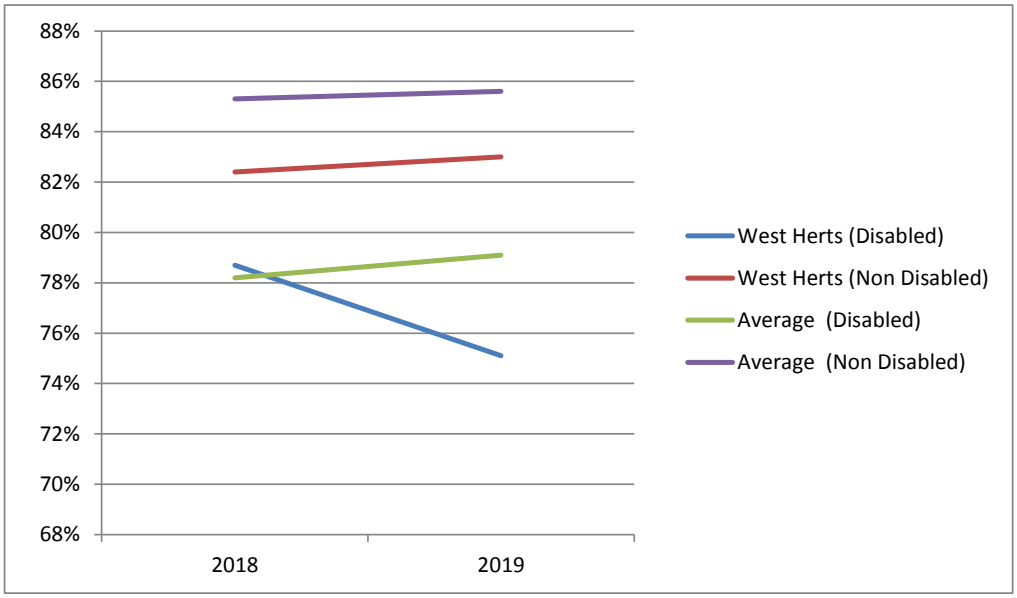
Providing staff with psychological safety as well as standing in order to better understand the kinds of BHA taking place and implementing interventions accordingly

Continuing to implement a number of wellbeing events and initiatives, such as the Employee Assistance Programme

Creating a new equality impact assessment which includes a comprehensive toolkit to equip staff with knowledge of discrimination and how to combat it.

3.5 Indicator five (staff survey)

Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.



Narrative:

201 Disabled colleagues responded to this question in the 2019 staff survey, 15 fewer than did so in 2018.

Actions taken (April 2019-March 2020)**:**

Advertising acting up as well as vacancies in our bi-weekly Trust newsletter to promote transparency.

Cultural competence of recruitment companies adhering to our inclusive procurement guidelines.

Integration of training data records and ESR in order to monitor diversity in relation to continuous personal development

Embedding a comprehensive annual appraisals process with a focus on behaviours, objectives and career aspirations.

Running a campaign called the “Big 5” which focused on 5 key themes from the staff survey. June was themed as “Race for Equality” which called for staff to:

- make sure staff know that it’s okay to talk about any equality issues and who to speak to should they have any concerns
- break down barriers by showcasing the various career progression options available for staff from different background

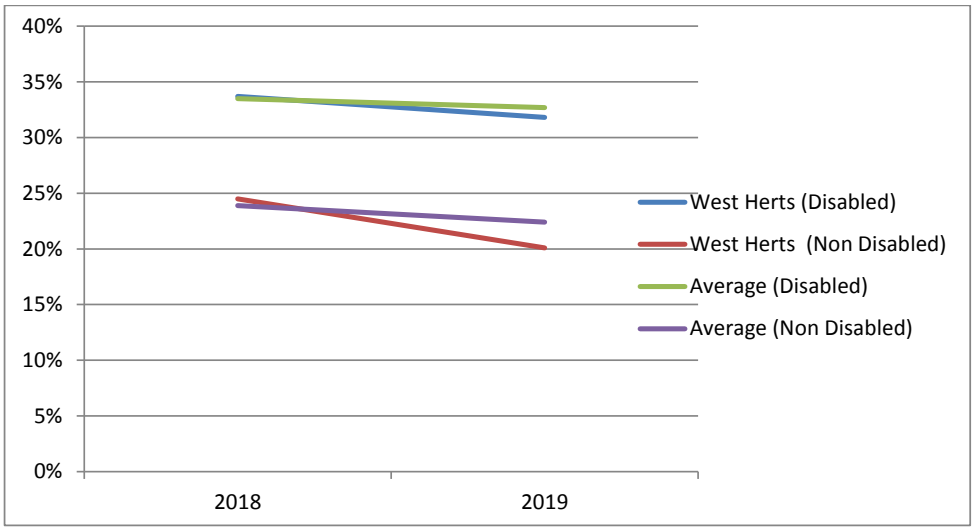
April marked “Keep talking” in the “Big 5” campaign which enabled:

- staff to communicate to senior leaders in the organisation to highlight what they need to support the best quality care via “Back to the floor” as well as “Night walk” events

We also created and launched our new workforce 2020-2023 People Strategy which includes plans to:

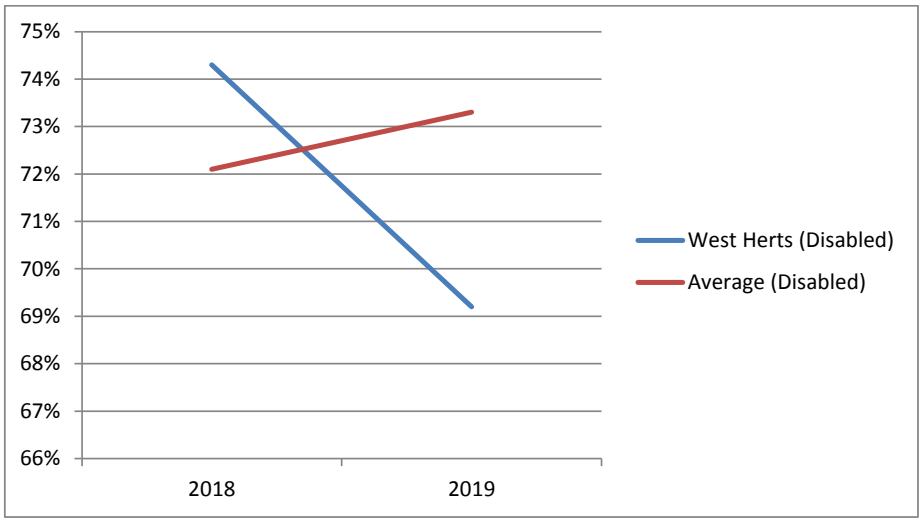
- Become a recognised Teaching Hospital
- Provide a comprehensive careers development service encompassing advice, coaching, mentoring, networking and talent management
- Developing our staff to work differently; supporting, training and developing our existing workforce to work in new ways or perform new roles within the system
- Adapting some training courses to be deliverable on line; thus negating issues caused by accessibility to classrooms.
- Creating a coaching culture of distributed leadership where everyone can lead
- A new talent management framework setting out how we will attract and develop future leaders
- Providing quality improvement training at all levels to enable a culture of continuous improvement
- Give people the opportunity to develop outside of their specialism

3.6 **Indicator six (staff survey)**
Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



211 Disabled colleagues responded to this question in the 2019 staff survey, 12 more than did so in 2018

3.7 **Indicator eight (staff survey)**
Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work



182 Disabled colleagues responded to this question in the 2019 staff survey, 7 more than did so in 2018

Actions taken (for Indicators 6 + 8) (April 2019-March 2020)**:**

Our Managing Attendance Policy was updated in March 2019 and sets out a number of responsibilities in relation to disability in accordance with the Equality Act 2010.

Line managers:

- To be proactive in supporting employee wellbeing to prevent sickness absence
- Ensure employees are informed of attendance procedures, certification and local reporting procedures at their local induction
- Maintain appropriate contact with employees during their absence
- Notify employees of support available to them including Occupational Health and Employee Assistance Programme (EAP)
- Identify stress triggers that relate to their employees and take actions to mitigate these through regular Stress Risk Assessments
- Sustain healthy workplace conditions, appropriate roster arrangements and rest times to support in maintaining good health

The Policy also states for disability-related short term absence, it is appropriate for the stage 1 and subsequent meetings to go ahead; however the Trust will delay issuing sanctions where absences have been caused by the employee's disability.

Advice on specific cases must be sought from OH and the Employee Relations Team if they have a disability or long-term health condition.

Phased returns

Phased returns are also embedded into the policy and involve Occupational Health undertaking a clinical assessment to facilitate a successful return to work for employees, which may comprise of a temporary review of work activities or alteration in hours where appropriate. It is linked to medical appropriateness and not to length of absence.

Phased returns are limited up to four weeks for all employees and up to an additional 2 weeks where the absence is related to a disability/long-term health condition.

During a phased return, employees will receive full pay. Where an employee is unable to return to their full hours after the phased return, there will be a permanent contractual reduction in hours and pay.

Reasonable adjustments

For employees with a disability or long term health condition, an episode of sickness absence may be unrelated to their disability or condition. Where it is related, the Trust has a duty under the Equality Act 2010 to make reasonable adjustments, which may include:

- Delaying the stage 1 meeting
- Adapted equipment
- Physical changes to the environment
- Changes to working hours, patterns, location or
- Time off for treatment or appointments which would normally be managed around current work commitments where possible
- Disability-related absences will be recorded as sickness absence but flagged as disability related in order that disability and non-disability related absences can be identified separately.

Training & events

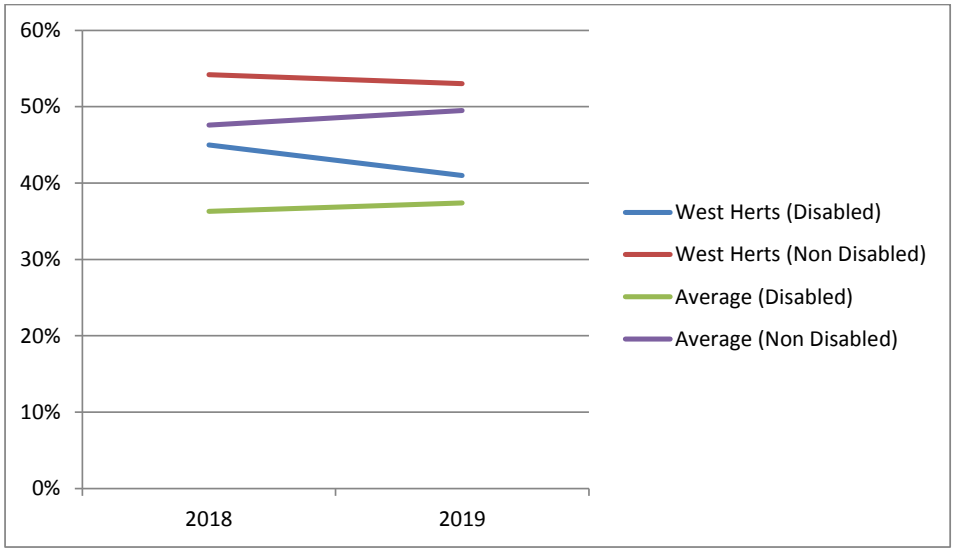
An event marking International Day for People with Disabilities which included a speaker who gave an insight into living with an invisible disability and the workplace adjustments that can be made to accommodate

Surbhi Shah from Mills and Reeve Solicitors led a training session for all H.R staff on Disability Discrimination, covering:

- understand when a member of staff would be considered disabled
- describe the basic principles of disability discrimination
- understand the duty to make reasonable adjustments
- managing a disabled employee under the capability process – using a case study

3.8 Indicator seven (staff survey)

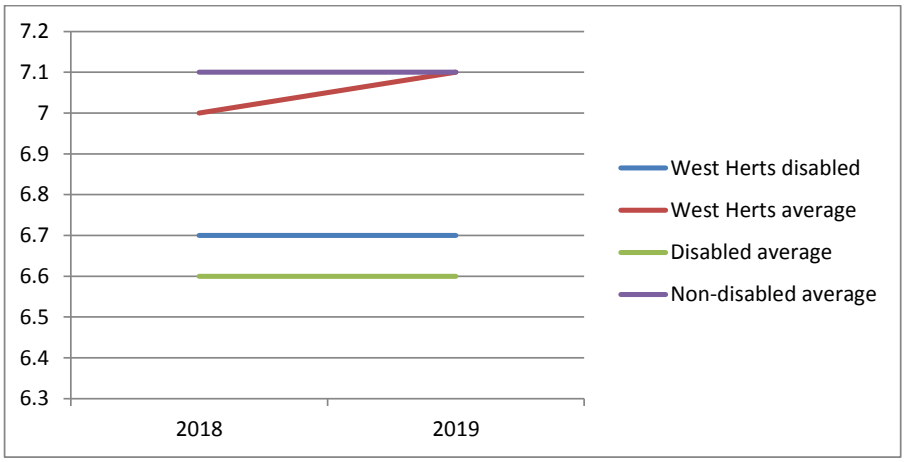
Disabled staff saying that they are satisfied with the extent to which their organisation values their work



288 Disabled colleagues responded to this question in the 2019 staff survey, 1 fewer than did so in 201

3.9 Indicator nine (staff survey)

Staff engagement score for Disabled staff, compared to non-disabled staff



289 Disabled colleagues responded to this question in the 2019 staff survey, 2 fewer than did so in 2018.

Actions taken (for indicators 7 & 9) (April 2019-March 2020)**:**

Launching our staff network Diversability (terms of reference are set out in 3.1 of this report)

Our “Big 5” campaign in July was themed as “We value you” which included our very first Star of Herts awards ceremony.

Another “Big 5” campaign was themed as “Looking after you” which focused on health and wellbeing as well as career development. Activities included a Wellbeing Café, promotion of a “Going home checklist” to help colleagues achieve a work/life balance as well as promoting our wellbeing offering which not all staff are fully aware of.

Prior to the pandemic breaking out we also ran monthly “Birthday breakfasts” for all colleagues to attend with one of the senior leaders. During the breakfast a conversation regarding ideas were initiated enabling visible and compassionate leadership to be strengthened.

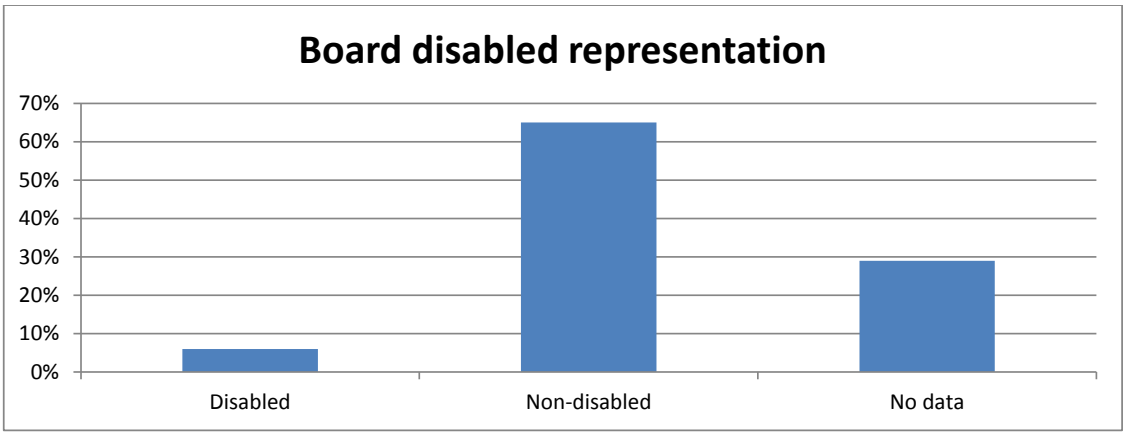
During Christmas “We value you cards” rewarding all staff for going the extra mile and showing staff that we value them which can be exchanged for a drink and a muffin.

Our Long Service Awards are also held annually for all those that have worked for WHHT for longer than 15 years, as they reach each five year threshold.

Appendix 2 also details a number of broader health and wellbeing related activities which are particularly applicable for colleagues with long term health conditions and mental health conditions.

3.9 <u>Indicator ten</u>:

Percentage difference between the Board voting and our overall Disabled representation



Narrative:

- Our disabled board representation (6%) is higher than our overall disabled representation (1%).
- Nationally 2.1% of board members are Disabled; 1 percentage point lower than the percentage of Disabled staff in the wider workforce

Actions taken:

- Our Chief People Officer emailing all Board members asking them to share their diversity details on ESR to help inform the above metric
- addressing the lack of diversity in very senior management through developing a Trust reverse mentoring programme. The first year of implementation is with BAME mentees, with 2021/2022 earmarked for disabled mentees

- Chief Executive ensuring all Executive Directors meet equality, diversity and inclusion objectives as part of the appraisal process
- Disability inclusion is championed by our Chief People Officer, who is the executive lead for diversity and inclusion
- Increasing our Inclusion & Diversity Manager from a part-time to full-time post to increase inclusion of our Disabled staff (who works closely with our Chief People Officer)

4. WDES action plan

The WDES action plan can be found in the Appendix and sets out how the Trust seeks to improve its performance in relation to each of the indicators.

Some of the “big ticket” items in relation to the action plan include: a review of our Occupational Health provision, recruiting a new Wellbeing Co-Coordinator and Apprentice as well as a co-produced WDES action plan and report.

5. Governance

Overall accountability for our equality and diversity agenda is held with our People, Education and Research Committee (PERC) which is a sub-committee of the Board and chaired by a non-executive Director. It meets and reviews this work every two months.

Diversability, the Trust’s disabled staff network are also a crucial stakeholder in relation to formulating the plan in Appendix 1 and monitoring its implementation.

Our Great Place to Work meetings are also aligned against the Trust’s People Strategy implementation plan.

6. Risks

Non-compliance with WDES would lead to a breach of the standard NHS contract.

Implementation of planned action, as outlined in Appendix 1 could be impacted if there is a second spike in Covid-19 infections.

7. Recommendations

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

Paul Da Gama
Chief People Officer

12 October 2020

Appendix 1 – WDES Action Plan 2020-2021

WDES Metric	Action	Measure	Date	Lead
1) Representation	Increase disability data via ESR	Targeted communication to shielders to include action to update ESR Videos with disabled colleagues sharing they have updated ESR Decrease "Unknowns" from 27% to 22% (around 250 staff members) Rolling out ESR self-service and supporting all staff to use it with complete coverage of ESR, including increased data on the demographic and diversity of our people.	May 2021	Disability Champion Deputy Director for Human Resources
	Increase + diversify Diversability membership	Increase emails list to 100 Ensure representation in each Division and across all 3 sites	May 2021	Diversability
	Increase awareness, representation and inclusion of People Directorate	Annual D&I training for all H.R staff	May 2021	Inclusion & Diversity Manager
2. Shortlisting	Overhaul recruitment and promotion practices to ensure staffing reflects the diversity of the community as well as regional and national labour markets *(People Plan action)*	Review (a) Approval to Recruit (b) Secondment & Acting Up (c) Redeployment (d) Recruitment & Selection policies; and clearly communicate any changes	Oct 2020	Recruitment Manager
	Ensure recruitment materials are accessible	Audit recruitment web pages in line with governments new Accessibility regulations	Feb 2021	Disability Champion
	Recruit and train more diverse	Training sessions commencing targeting disabled	Jan 2021	Inclusion & Diversity

	representatives to interviewing panels	colleagues		Manager
3. Disciplinary	Monitor the level of disciplinary action taken against disabled staff throughout the year	Quarterly figures included in Integrated Performance Report/diversity dashboard	Sept 2020	Head of Employee Relations
	Eliminate the disability gap when entering into a formal disciplinary process	Ensure non-adverse range of reporting between 0.8 - 1.25	January 2021	Head of Employee Relations
	Audit legalistic and retributive language with language that promotes a just culture and explore embedding a decision tree checklist to help managers decide whether formal action is essential	Updated Disciplinary Policy	May 2021	Head of Employee Relations
4a. Bullying, harassment and abuse from patients, relatives and public	Undertake further analysis of hot spot areas	Include incidents from Datix and other sources in 2021 WDES report	Ongoing	Datix Team
	Update the Management of Violence & Aggression policy	Produce: (a) information on unacceptable behaviour; (b) guidance for staff experiencing abuse from patients with cognitive impairments	Dec 2020	Head of Security
	Increase security staff	Hire: (1) a dedicated Security Officer (SO) in A&E/ AAU; and (2) an additional Supervisor SO to cover nightshifts and weekends	Dec 2020	Head of Security
4b. Bullying, harassment and abuse	Increase awareness and accessibility of Freedom to Speak Up (FTSU)	Hire a Freedom to Speak Up Guardian Launch FTSU post boxes to allow a method of additional access for staff, particularly for staff	April 2021	Freedom to Speak Up Guardian

from staff		who do not have access to computers/IT Drop in sessions set up for all 3 sites from September- December 2020 Trust bullying and harassment zero tolerance campaign led by CEO Review and then communicate behavioral boundaries as well as appraisal and performance management process, speaking up conversations to be encouraged between manager and staff members Commission a quarterly West Herts staff bullying and harassment Increase FTSU Champions disabled representation and include diversity and inclusion training during onboarding process Provide bullying and harassment training to line managers		
	Increase staff wellbeing initiatives	Recruit and onboard a new Wellbeing Co-Coordinator and Apprentice Discuss equality, diversity and inclusion as part of health and wellbeing conversations on topics such as: appropriate PPE, home working and access to psychological support (People Plan action)	March 2021	Wellbeing Team
	Increase staff awareness of bullying, harassment or abuse and where they	Create a guide on "How to react, act and report" bullying, harassment and abuse	March 2021	Wellbeing Team

	can access support	Increase staff wellbeing initiatives via new Wellbeing Strategy, including a new prayer room Discuss equality, diversity and inclusion as part of health and wellbeing conversations on topics such as: appropriate PPE, home working and access to psychological support (People Plan action)		
5. Equal opportunities	Increase opportunities for disabled staff to have a direct line of communication with individuals working in roles they are aspiring to	Quarterly opportunities through channels such as: "Career Lounges" with speakers hosting a Q&A		Disability Champion
	Extend capacity for coaching across the Trust	Introduction of more in-depth coach training programmes to provide more available coaches within the organisation If capacity is increased sufficiently, allowing the Trust's coaching service to be available on demand to all staff	Dec 2021	Head of Education, Learning and Developmentb
	Explore sponsorship programme	Explore: application criteria and costing	Feb 2020	Inclusion & Diversity Manager
	Explore possibility of integrating disability data into the Trust's Learning Management Systems for the provision of better disability data.	Review to take place in Spring 2021 after tender for LMS is complete	June 2021	Head of Education, Learning and Development
	Review more non-mandatory training provision in respect of the possibility of remote delivery (or the option of this)	Review to take place in Q3 and Q4 20/21 Remote options to be made available as appropriate	March 2021	Head of Education, Learning and Development
6 & 8 Presenteeism & Reasonable	Ensure colleagues who have to shield are integrated back into the workplace safely and/or supported to work remotely	Regular calls from Absence Hub Half day training sessions for shielders returning to work	Sep 2020	Absence Support Hub / Training Team / Occupational Health

adjustments		Shielders completing additional risk assessment on their return to work Thank you's to staff, including shielders with planned week dedicated to staff recognition		
	Explore infrastructure and produce resources to empower and support colleagues working remotely	Upload guide on conducting inclusive meetings on intranet Explore interactive platforms to support meeting engagement	Sep 2020	Disability Champion
	Create awareness of social model of disability (which WDES is underpinned by)	Ensure EIA's are completed at start of new policy formation rather than at end via updated template Embed disability and accessibility requirements in the design process	Ongoing	Inclusion & Diversity Manager & Director for Environment
	Ensure a safe working environment for our disabled staff	Improving uptake of the flu vaccination in underrepresented 'at risk' groups Procure clear face masks and establish application criteria Produce "Please communicate clearly" badges to mitigate hearing challenges due to face masks	Jan 2021	Occupational Health
	Produce training sessions as well as resources to increase awareness of discrimination	Update mandatory training module on Acorn Annual (online) refresher training Targeted training for line managers	April 2021	Inclusion & Diversity Manager
	Produce a Disability Passport	Finalise design, promote through comms and embed into policies and processes	May 2021	Disability Champion

	Complete a detailed review of Occupational Health	Optimise the service Present to the Senior Leadership Team later this year		Dr Lucy Wright, Occupational Health
7 & 9 Feeling valued & engaged	Create targeted interventions following the COVID19 specific staff survey with an emphasis on well-being support and boosting morale	Direct mail to all staff thanking them for their efforts during Covid. Socially distanced thank you events with feedback from staff. National Staff survey in October/November 2020 in addition to Covid Staff Survey undertaken in June 2020. Long service awards of which some will be in person and some virtual planned for the middle of November 2020	Dec 2020	Deputy Director for Human Resources
	Provide staff with psychologically safe environments to raise concerns	Safe space sessions to understand experience and perceptions and develop appropriate actions accordingly Promote Speak Up Champions	Ongoing	Diversability/ Freedom to Speak Up Guardian
	Mitigate effect if stressful environment and improve mental wellbeing caused by pandemic	Creating a comprehensive wellbeing, engagement and recognition plan Specific interventions for colleagues with mental health as well as long term health conditions Developing new guidance on agile working to accommodate better flexibility with the workforce	Jan 2021	Wellbeing Team

		while making them feel valued System wide business case supporting psychological support, staff benefits and compassionate leadership training Re-engaging with well-being champions in order to support better levels of engagement particularly during the pandemic period Re-engaging with Mental Health First Aid Trainers with new training planned		
10. Board diversity	Continue a direct line of communication between executive members and Diversability	Minutes of the meeting sent for inclusion in PERC paper	Ongoing	Disability Champion
All indicators	Explore targeted interventions at Divisional level	Produce Disability data from WDES metrics specifically for Divisions	Dec 2020	Inclusion & Diversity Manager
	Continue to work with other organisations to review and provide fresh perspective on our work	Conduct an audit and assurance service through BDO Participate in the NHS Diversity & Inclusion Partners Progamme 2020/2021 Contribute and influence a system wide approach at ICS level	Ongoing	BDO
	Review governance to ensure staff networks contribute and inform decision-	Establish renewed sponsorship monetary amount for Diversability	March 2021	Disability Champion

	making	Create a memorandum of understanding between Diversity & Inclusion team and Diversability		
	Review the Risk Register and identify any gaps and potential risks race equality may face.	Recorded on Datix, scored and the Trust-wide impact clearly assessed in accordance with risk management practices Identified controls to mitigate risks	Ongoing	Inclusion & Diversity Manager
	Review the Diversity & Inclusion policy	Embed all of the recommendations following BDO audit	May 2021	Inclusion & Diversity Manager

Appendix 2

Mental Health	
ACTION	**IMPACT**
• **Employee Assistance Programme –** a 24-hour helpline available to all providing access to counselling, both telephone and face to face, support and a general adviceline.	Relies on being communicated well – take up is slowly growing, though low. Current figures indicate that if usage continues at current level, 14% of staff will have used the service over a year.
• **Shift Your Stress** – a flexible online programme based on Acceptance and Commitment Therapy (ACT) – can be completed in anything from five weeks to twelve months, depending on what suits the individual.	We know that many staff either cannot be released or don't have the time to attend face to face workshops. This has proved popular so far with 70 registrations in the five months since October. Is charged per registration
• **Understanding Stress and Building Resilience** – half day sessions across all sites. A three hour workshop that has received excellent feedback across the Trust. Have also offered a reduced one-hour option to certain areas on request.	Evaluations from these sessions are consistently extremely positive with 93% of attendees saying that they felt better able to cope following the course. Propose 6 sessions in total, funded in part via annual budget

• **Weekly visit from onsite counsellor** to rotate across areas of need. Runs successfully in the Medical wards and A&E, is in the process of starting in Maternity. Costs are charged 50/50 to the relevant divisions. This was originally set up by ITU who continue to self-fund this for themselves.	Feedback has shown that many staff are reluctant to seek counselling and claim to be coping when in fact they are not. Many have benefitted from talking to the counsellor in the workplace on an informal basis and managers have reported on occasion that this has prevented some taking sick leave. Counsellor can also be called upon when an incident occurs in another area ensuring a more pro-active approach and lessening the likelihood of long-term impact
• **Monthly relaxation days** – these provide an opportunity for staff to book a subsidised monthly massage treatment. Runs monthly at Watford and bi-monthly at SA and HH, all usually fully booked	These take place on the last Friday of each month in Watford, and the third week of each month at SA and HH alternately. They are part-funded by staff.and enable to take some time out at minimal cost (£5) after a stressful week. Excellent feedback – has helped some to relax where they haven't previously been able to and has helped some with reducing pain due to stress and tension, which contributes to many MSK problems. Always busy.
• **Mental Health First Aid and Awareness Training** – awareness courses for managers and colleagues to help them to recognise signs that might otherwise go unnoticed, and provide them with the tools to help them manage and support others and themselves	Not understanding or recognising mental health issues can lead to a variety of difficulties for individuals and teams. Problems not necessarily related to the workplace could be picked up sooner and appropriate support offered to individuals concerned. Promotes better understanding between colleagues and can contribute to a reduction in the perception of bullying and harassment. Each course can provide training for 25 people.
• **Mindfulness courses** – offered as a 90-minute introductory session with lunch provided. Is a highly rated lifestyle change used in many businesses that include Transport for London, Google, GlaxoSmithKline, the Home Office, the Cabinet Office, KPMG, and Pricewaterhouse Coopers. Attendees will be able to find out how Mindfulness can help and take away the tools to practise with.	Benefits include improvements to physical and mental health, with an increased ability to be resilient and manage stress. TfL, for example, has seen the number of days taken off because of stress, anxiety and depression fall by 71% since introducing employees to mindfulness
• **Schwartz round lunches -** The Schwartz Rounds run on a monthly basis.	Always highly rated and well attended. Feedback consistently shows how much staff and students value the opportunity to share and reflect on the emotional impact of their roles
• **Printing**	Producing a bi-monthly newsletter with a calendar of events, plus posters for all activity and mental wellbeing folders
Health Awareness	

• **Lunchtime talks –** topics arranged this year have been healthy eating, the menopause and migraine	Talks are arranged in response to feedback and direct requests from staff. A nutritional therapist discusses how best to eat to sustain energy over long shifts, providing healthy ideas and recipes to save time and money. Feedback has shown these to be well-received and very helpful to those that attended – a 50% increase of attendance on last year
• **Health events** - held monthly in line with the national calendar to raise awareness of their own wellbeing and encourage a healthy lifestyle • **Seated mini massage** treatments are offered at all events and also delivered in the workplace to wards/areas where staff are unable to get away to attend events	Depending on the nature of the event, costs could include mini massage treatments, equipment, hospitality, promotional literature and taster sessions Apart from helping to relax and reduce pain, these act as an incentive to bring staff to awareness events to inform and encourage a healthy lifestyle
• **Health challenge prizes** – recent challenges have been the North Pole walking challenge and the Biggest Loser weight loss challenge	Workplace activity challenges (cycling / walking) have been re-introduced with staff forming teams to compete for prizes. Positive feedback has shown these challenges have benefited staff engagement as well as increasing physical activity levels and raising morale.
• **Health checks** – Busy staff often find it difficult to make the time to visit a GP when they need to and offering them health checks is one way of trying to keep on top of potential areas of concern, alerting them to make that appointment if results are less than desirable. • **Health MOTs** – 15 min 1:1 appointments with a health advisor – an increase to five days across all sites twice each year as these were heavily oversubscribed and much in demand each time • **Cholesterol and blood glucose testing** on each site twice each year	With the opportunity and encouragement to check their health statistics regularly, along with information available to educate and inform, the health profile statistics provided would be expected to improve
Financial Wellbeing	
• **Pre-retirement seminars –** a full day seminar for those thinking of retiring within the near future to help them with planning for the future • **Mid-career seminars –** half day sessions to explain the NHS pension and encourage people to plan ahead • **Pension tax guidance and support –** a full day of group and individual counselling sessions initially aimed at those paying tax at the higher rate.	There is a clear link between financial wellbeing and mental health, with money worries contributing to stress and anxiety. These seminars have always had positive feedback and been well attended but a new provider is currently being sought and the cost is likely to increase. The retirement seminars however are also a source of income as places are sold to HCT. Multiple changes in tax allowances for pension scheme members have

	caused it to become more complex than before and employees need help with understanding their options.
Reward and Recognition	
Rewarding employees for positive behaviour, loyalty or long service can be a cost-effective way of demonstrating Trust values. In turn, employees who feel that they have been rewarded for a job well done may become more engaged and improve their productivity. • **Annual tea parties** - an opportunity for directors to talk to staff and say thank you. All staff are invited, and engagement currently runs at approximately 15%. Positive feedback received each year. The larger tea parties are run at all three hospitals with a smaller version also arranged at Jackett's Field (Physiotherapy) and Gate House in Welwyn (Procurement)	Those staff that have been with the NHS for a great length of time carry with them a wealth of valuable experience that is lost when they decide to move on to other trusts. They need to feel valued and appreciated. By recognising their value and rewarding them for their loyalty, this will help to retain some that may otherwise not remain with the organisation. Employees need to feel that their contribution is valued, that the organisation cares about their wellbeing and is ready to offer help when needed. This is referred to as "perceived organisational support', the effects of which have been studied and found to be • Increased commitment • Improved job satisfaction and mood • Increased interest in work • Increased performance • Decreased psychological strain • Increased desire to remain working for the organisation • Decreased withdrawal (including decreased lateness, absenteeism and turnover)
• **Long service awards –** an event held annually for all those that have worked for WHHT for longer than 15 years, as they reach each five year threshold	

Board
5 November 2020

Title of the paper	**Workforce Race Equality Standard Report 2019-2020**
Agenda Item	**16/84**
Presenter	**Paul Da Gama, Chief People Officer**
Author(s)	**Arfan Bhatti, Inclusion & Diversity Manager**
Purpose	**For approval** √ ; **For discussion** √ ; **For information**
Executive Summary	This document reports on the Trust's data and activity from April 2019 – March 2020. We are reporting this information in November following the reporting deadline extension from NHS England due to Covid-19. The reporting period therefore demonstrates: – BAME staff population continues to grow from 37% to at least 40% - Decreasing and below national average reported rates of BAME colleagues: ➢ entering formal disciplinary processes > experiencing discrimination from colleagues - closing the gap in relation to BAME applicants success at shortlisting stage It also seeks to highlight the actions taken, which include: – Increasing our Inclusion & Diversity Manager from a part-time to full-time post – Our Staff Survey Big 5 campaign – The integrity of our disciplinary process Significantly, there are a number of areas which require improvement, which include: – BAME colleagues are experiencing an increasing and above national average amount of bullying, harassment and abuse from patients, relatives or the public – The experience of equal opportunities for development and promotion The report also seeks to highlight some of the context and causation behind our performance indicators.
Trust strategic aims	**Aim 1** Best care ; **Aim 2** Great team ; **Aim 3** Best value ; **Aim 4** Great place

(please indicate which of the 4 aims is relevant to the subject of the report)	***Objectives 1-4***	***Objectives 5-8***	***Objective 9***	***Objective 10-12***

Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	

Committee/Group	Date
Connect	3 September 2020
Connect	7 September
Connect	16 September
Connect	23 September

Action required	The Board is asked to receive this report for assurance and to approve for publication.

Agenda item: 16/84

TRUST BOARD – 05 November 2020

Workforce Race Equality Standard Report 2019/20

Presented by: Paul Da Gama Chief People Officer

1. Purpose

1.1 This paper provides a summary of the 2019-2020 Workforce Race Equality Standard (WRES) findings.

1.2 A 2 year action plan has been created on the basis of these findings as well as other research. This was developed in partnership with the Trust's Connect Black, Asian and Minority Ethnic (BAME) staff network.

1.3 This report will be published on our website, alongside the WRES action plan.

1.4 The Board is asked to receive this report for information and approve for publication.

2. Background

2.1 In April 2015, NHS England introduced the WRES in response to consistent findings over 20 years that BME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BAME Board representation.

2.2 Since April 2015, the WRES has been included in the full length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.

2.3 There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BAME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

2.4 The WRES is produced in line with Technical Guidance issued by NHS England which this year is a few months later due to the pandemic.

2.5 Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from the reporting period of April 2019-March 2020. All other indicators are from the 2019 staff survey and therefore do not take into account actions taken during the pandemic.

2.6

3. WRES performance for 2019/20

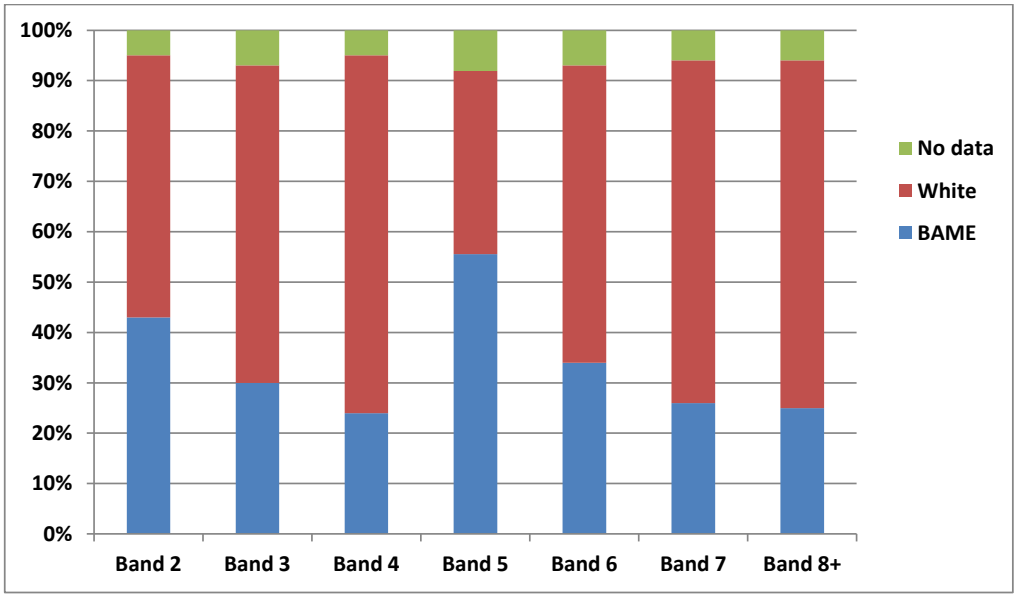
Indicator		London average	West Herts	West Herts direction since 2018	
1.	Percentage of staff in each of the Agenda for Change (AfC) Bands	44%	40%	↑	**Positive**
2.	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	1.6	1.7	↑	**Positive**
3.	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	1.7	1.01	↑	**Positive**
4.	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff	0.95	1.3	↓	**Negative***
5.	BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	32%	34%	↓	**Negative**
6.	BAME staff experiencing harassment bullying or abuse from staff in the last 12 months	31%	27%	↑	**Positive**
7.	BAME staff believing that organisation provides equal opportunities for career progression or promotion	66%	73%	↓	**Negative**
8.	BAME staff experiencing discrimination at work from manager/leader/ or other colleagues.	17%	14%	↑	**Positive**
9.	Percentage difference between the organisations' board voting membership and its overall workforce	17%	27%	→	Neutral

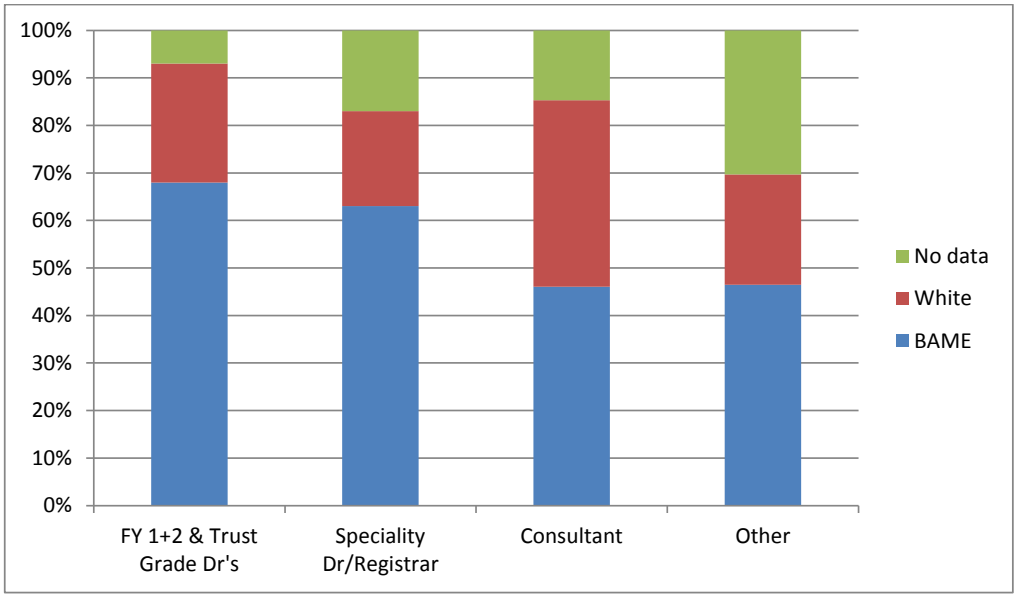
* Despite the direction of travel being negative in relation to this metric (which is produced from the staff survey) our data suggests the BAME profile of our successful CPD applications directly correlates with BAME representation overall

3.1 Indicator one:

Percentage of staff in each of the Agenda for Change (AfC) Bands

*Notes:
- VSM includes executive Board members and senior medical staff
- The total overall workforce includes all staff on permanent and fixed term contracts only (thereby excluding bank and locum staff).





Narrative:

- Overall BAME representation has increased from 37% to 40% across the Trust.
- For the purpose of this report the BAME staff demographic does not include colleagues of White European heritage

- "No data" has decreased from 8% to 7%
- Our workforce is significantly more diverse than the local population which ranges from 9% in Hemel Hempstead to 19% in Watford
- A major factor in relation to over-representation at Band 5 is our international recruitment of staff nurses. Since 2017 we have recruited more than 360 mainly from India and the Philippines.

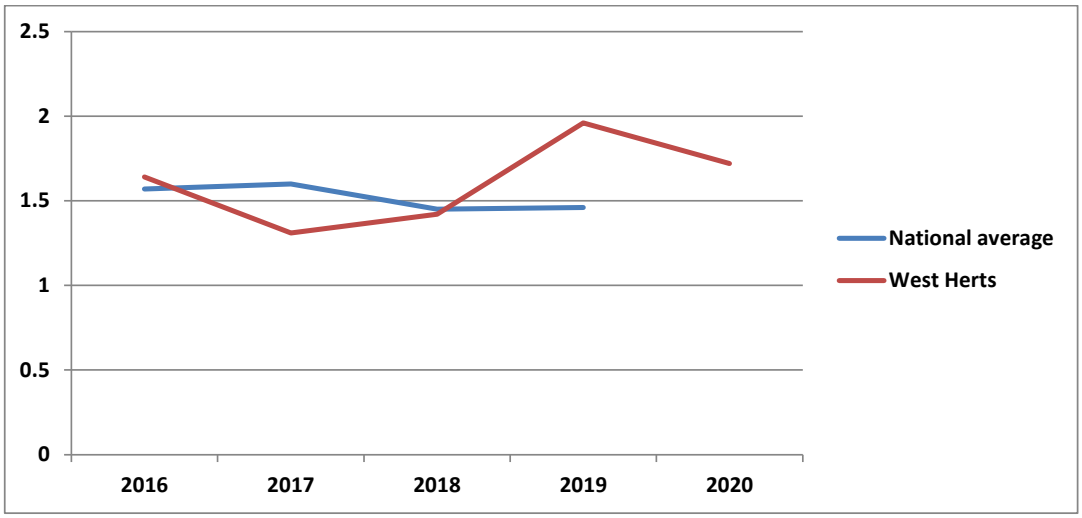
Actions taken (April 2019-March 2020)**:**

- Displaying a pop-up banner at our main Watford General Hospital entrance which highlights and celebrates the number of nationalities working at the Trust

- Communications, canteen menus as well as events to mark awareness days such as Black History Month

3.2 <u>Indicator two</u>:

Relative likelihood of White applicants being appointed from shortlisting compared to BAME applicants



Narrative:

- It should be noted the majority of our nurses (the majority of whom are BAME) are recorded as not shortlisted despite being interviewed due to their applications being expedited. It's extremely likely our significant recruitment in relation to nurses is therefore contributing to this disparity.

- It should also be noted the above figure is calculated via the Trust's recruitment software TRAC, which excludes overseas nurses and Doctors.

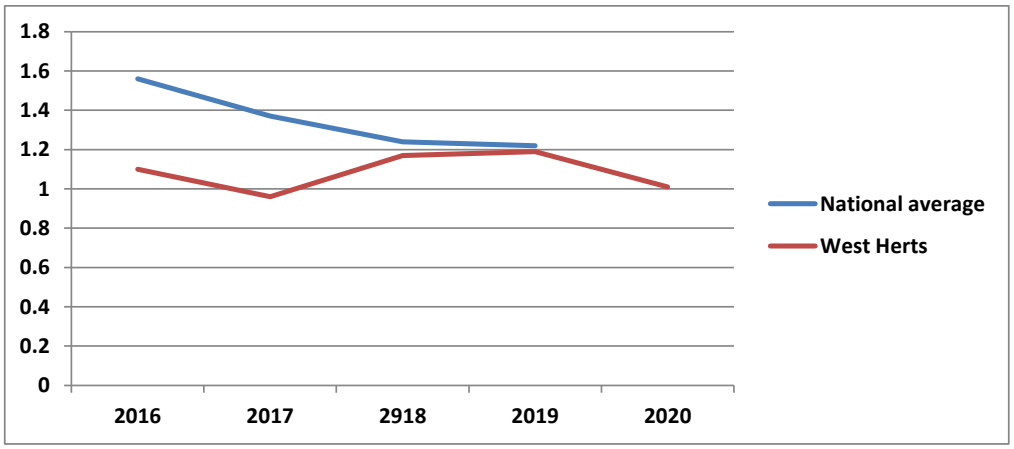
- Therefore a revised calculation including overseas nurses and Doctors via ESR instead of TRAC suggests our ratio is in fact 1.37, which is below the national average and just outside the non-adverse rand of 0.8 - 1.2. However, ESR data excludes medical staff.
-

Actions taken (April 2019-March 2020)**::**

- advertising acting up as well as vacancies in our bi-weekly Trust newsletter to promote transparency
- cultural competence of recruitment companies adhering to our inclusive procurement guidelines
- recruitment & selection guide “Choosing the best talent” which promotes fairness and inclusion is embedded in panel preparation material
- Recruitment Team being part of interview panels to help ensure inclusive processes
- recruitment and selection training offered twice a year

3.3 <u>Indicator three:</u>

Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff



Narrative:

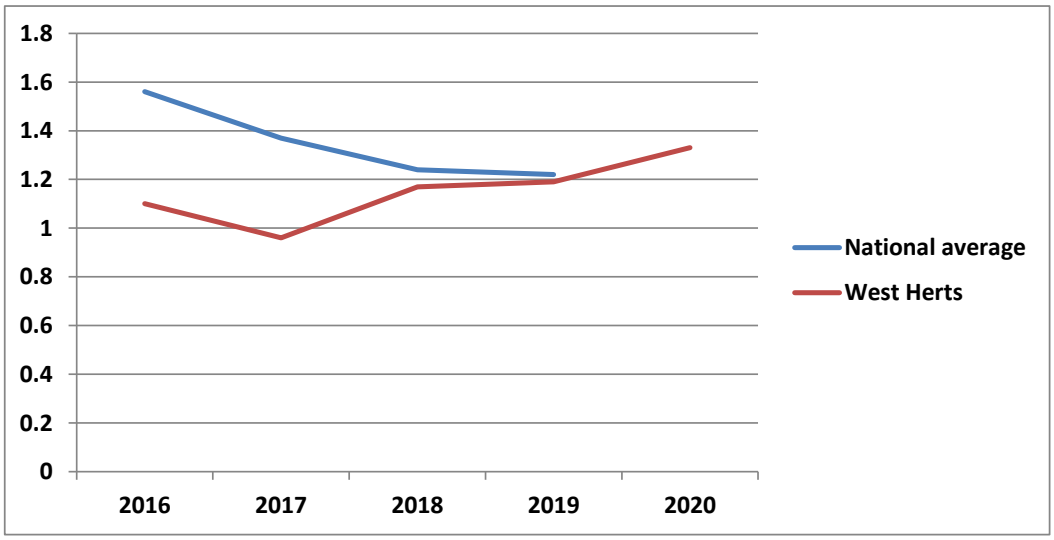
- Refers to staff who have entered a formal investigation as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation are also included in this definition.
- Staff who have been subject to an investigation, but for whom no further action was taken are also counted.
- Cases where mediation has taken place rather than any kind of formal investigation or disciplinary are not counted.
- In July 2019 NHS England/NHS Improvement published “A fair experience for all: closing the ethnicity gap in rates of disciplinary action across the NHS Workforce” which set a target for 51% of NHS organisations to be within the non-adverse range of WRES reporting, between 0.8 and 1.25, by 2020. We are pleased to fall within this range.

Actions taken (April 2019 – March 2020):

- Our Just Culture Action plan includes the following:
    - Updating our Disciplinary Policy against GMC and NMC guidance to improve the running of investigations
    - inclusion embedded into investigating managers training
    - investigators appointed internally chosen from outside the area where the investigation is to be carried out to ensure impartiality. We never allow a grandparent manager to carry out the investigation
    - the panel chair will have had no prior involvement with the case and where appropriate work in another division
    - robust preliminary process overseen by senior managers prior to any disciplinary investigation being commissioned
    - further tightening the preliminary process to ensure that where possible cases are resolved and managed informally with only the most serious cases progressing formally – this means collating all evidence in advance of an investigation to determine whether it is necessary to proceed in this way.
    - outcome given on the day in majority of disciplinary cases. Only where time does not allow for this will we communicate the decision in writing and only with their consent
    - if a challenge to a particular panel member or case investigator is received, the person can be changed

3.4 Indicator four (Staff Survey)

Perceptions of relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff



Narrative/actions:

- This indicator is calculated via Quality Health who have analysed the BAME responses from Question 20 of the staff survey which asks “Have you had any (non-mandatory) training, learning or

development in the last 12 months?"

- However, we are now able to capture the demographic of our successful CPD applications and did so in relation to 99% of CPD applications last year

- The data tells us of the 313 CPD courses taken up in this reporting period, 126 (40%) identified as being from a BAME background. This correlates with the 40% BAME staff representation at the Trust and is therefore an encouraging comparison in relation to the above figure which is derived from 853 White and 478 BAME responses

- Non-mandatory training – refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation (e.g. clinical records system training).

- Last year the CPD budget was £429k for Trust CPD and £112k HEE totalling £541k available for the non-medical workforce. (CPD funds are not for medical staff)

Actions taken (April 2019-March 2020)**:**

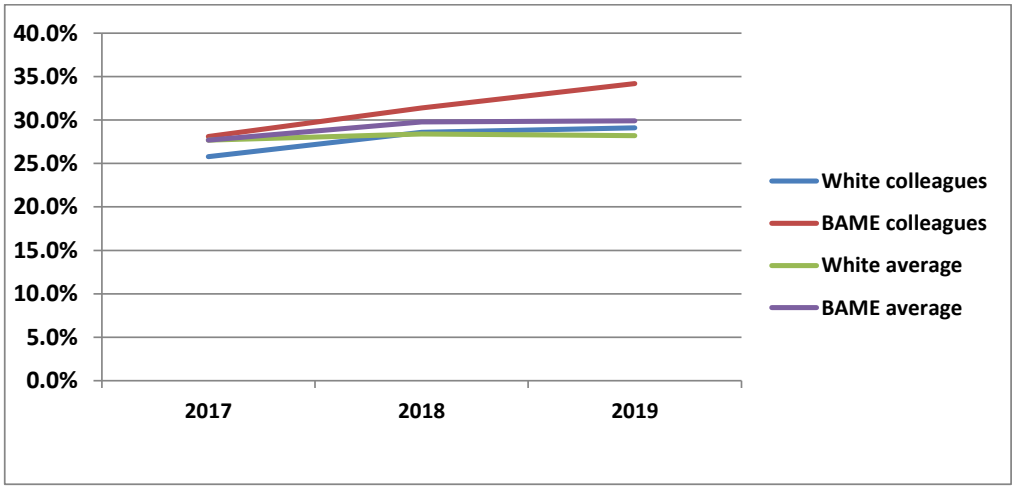
- Creating our new workforce 2020-2023 People Strategy which includes: (a) supporting and engaging as well as (b) developing our people; as two of the four main pillars. (Living our values as well as diversity and inclusion are one of four threads which run throughout the strategy)

- Publicising the NHS Leadership Academy's: Stepping Up and Ready Now programmes

- Commencement of the "Transform" Clinical Leadership programme for all current and aspirant clinical and divisional directors, which contain a majority of BAME trainees

3.5 Indicator five (Staff Survey)

Percentage of staff experiencing harassment, bullying or abuse (BHA) from patients, relatives or the public in the last 12 months.



Narrative:

- 37% (752) of our BAME staff responded to this question in 2019, which is almost 100 more than in 2018; this may be an outcome from requesting staff to report incidents

- The Trust has an open culture and one of "speak up" where employees are asked to be open and

honest and to report adverse incidents and experiences where they may not have been declared previously. This culture, although increases likelihood of reporting also enables the Trust to respond where improvements are required.

- Nationally BAME nurses are the staff group that encounter the most BHA from patients, relatives or the public which correlates with anecdotal evidence at the Trust.

Actions taken (April 2019-March 2020)**:**

- Running a campaign called the "Big 5" which focused on 5 key themes from the staff survey. May was themed as "Protecting you" which included:
    - implementation of zero tolerance to violence or threatening behaviour posters
    - encouraging staff to report issues or concerns (which are taken up via Datix and investigated)
    - promoting our Speak Up Champions

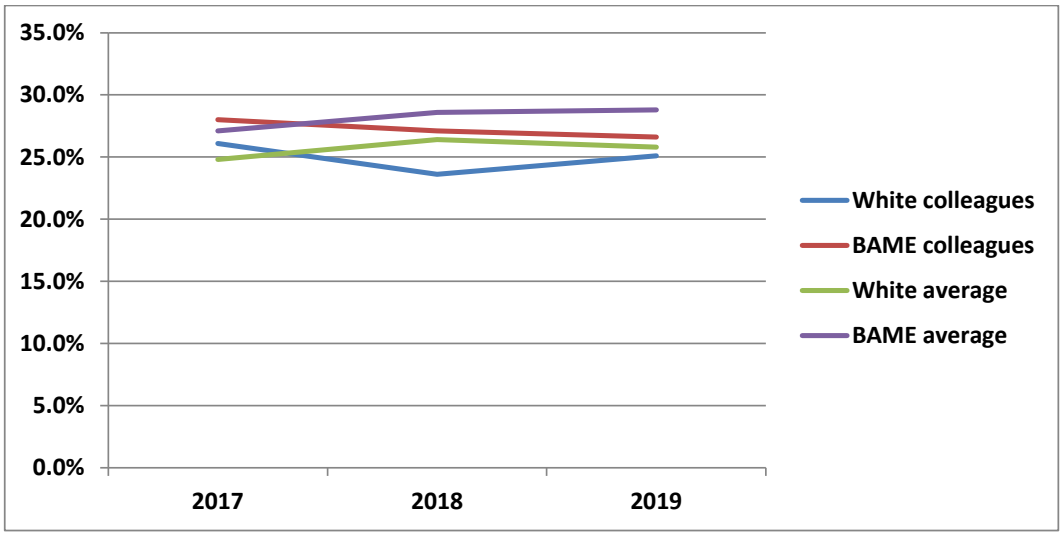
- drafting a Memorandum of Understanding (MOU) between the Trust and Hertfordshire Constabulary in relation to requests for emergency police assistance during incidents involving a threat of harm to person(s) and at other times of exceptional crises where NHS staff cannot manage the incident alone

- updated our following Clinical Staff- Security Support Strategy as well as Violence & Aggression Policy

- cultural and spiritual interventions on the wards via the Chaplaincy team

3.6 <u>Indicator six (Staff Survey)</u>:

Percentage of staff experiencing harassment bullying or abuse from staff in the last 12 months



Narrative:

- 37% (753) of our BAME staff responded to this question in 2019, which again is almost 100 more than in 2018 which may be an outcome from requesting staff to report incidents

Actions taken (April 2019-March 2020)**:**

- The Trust launched a new appraisal process, which reviews performance including behaviours section aligned to our Trust values (care, quality, commitment). If an employee does not demonstrate the behaviours aligned to our organisation, the appraisal will include a discussion about that and the score attributed reflective of the behaviours demonstrated.

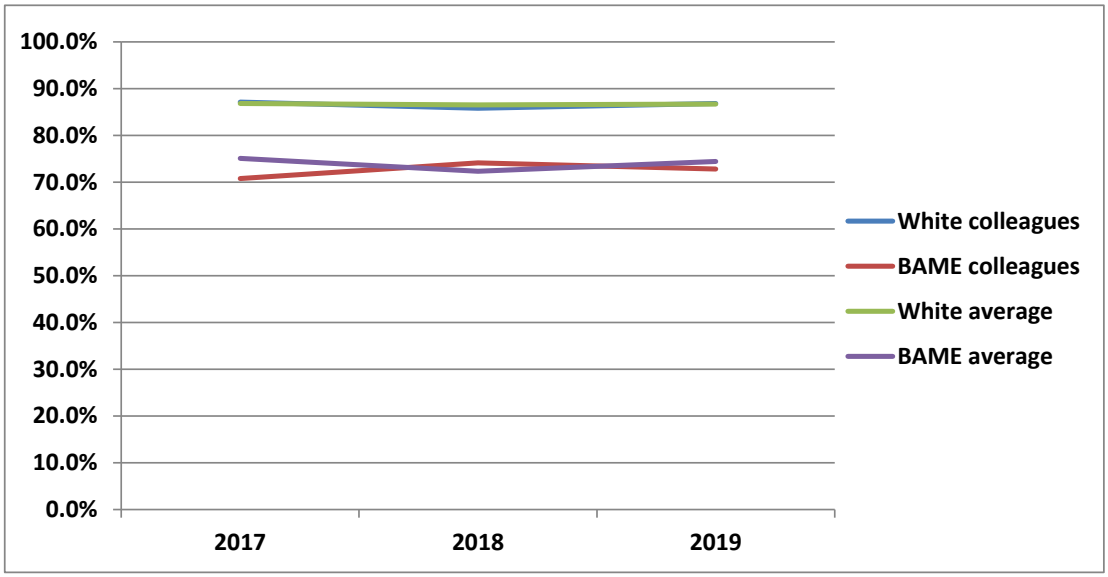
- As part of the Trust's commitment to eradicating bullying and harassment, and encouraging staff to raise concerns as part of the Freedom to Speak Up campaign the Trust has more than 20 Speak Up Champions with whom staff can discuss and raise concerns that they may have.

- Providing staff with psychological safety as well as standing in order to better understand the kinds of BHA taking place and implementing interventions accordingly

- continuing to implement a number of wellbeing events and initiatives, such as the Employee Assistance Programme

3.7 Indicator seven:

Percentage of staff believing that organisation provides equal opportunities for career progression or promotion.



Narrative:

- 24% (496) of our BAME staff responded to this question in 2019, which is 41 more than in 2018

Actions taken (April 2019-March 2020)**:**

- Integration of CPD records and ESR in order to monitor diversity

- Vacancies being advertised in our bi-weekly staff newsletter to promote transparency

- Offering staff comprehensive annual appraisals with a focus on behaviours, objectives and career aspirations so these can be achieved

- Running a campaign called the “Big 5” which focused on 5 key themes from the staff survey. June was themed as “Race for Equality” which called for staff to:
    - make sure staff know that it’s okay to talk about any equality issues and who to speak to should they have any concerns
    - break down barriers by showcasing the various career progression options available for staff from different background

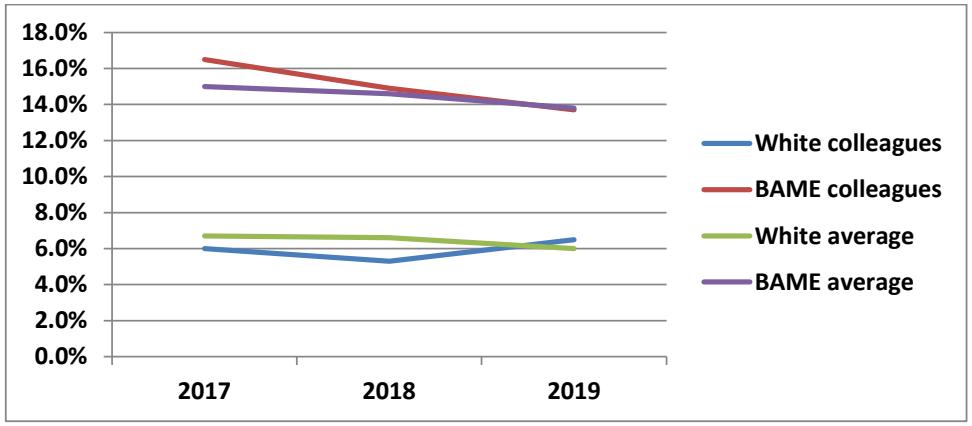
- April marked “Keep talking” in the “Big 5” campaign which enabled:
    - staff to communicate to senior leaders in the organisation to highlight what they need to support the best quality care via “Back to the floor” as well as “Night walk” events

- Creating our new workforce 2020-2023 People Strategy which includes plans to:
-

- Become a recognised Teaching Hospital
- Provide a comprehensive careers development service encompassing advice, coaching, mentoring, networking and talent management
- Developing our staff to work differently; supporting, training and developing our existing workforce to work in new ways or perform new roles within the system
- Creating a coaching culture of distributed leadership where everyone can lead
- A new talent management framework setting out how we will attract and develop future leaders
- Providing quality improvement training at all levels to enable a culture of continuous improvement
- Give people the opportunity to develop outside of their specialism

3.8 Indicator eight:

In the last 12 months have you personally experienced discrimination at work from manager/leader/ or other colleagues.



Narrative:

- 36% (744) of our BAME staff responded to this question in 2019,, which is 96 more than in 2018

Actions taken (April 2019-March 2020)**:**

- As part of the Trust's commitment to eradicating bullying and harassment, and encouraging staff to raise concerns as part of the Freedom to Speak Up campaign the Trust has more than 20 Speak Up Champions with whom staff can discuss and raise concerns that they may have.

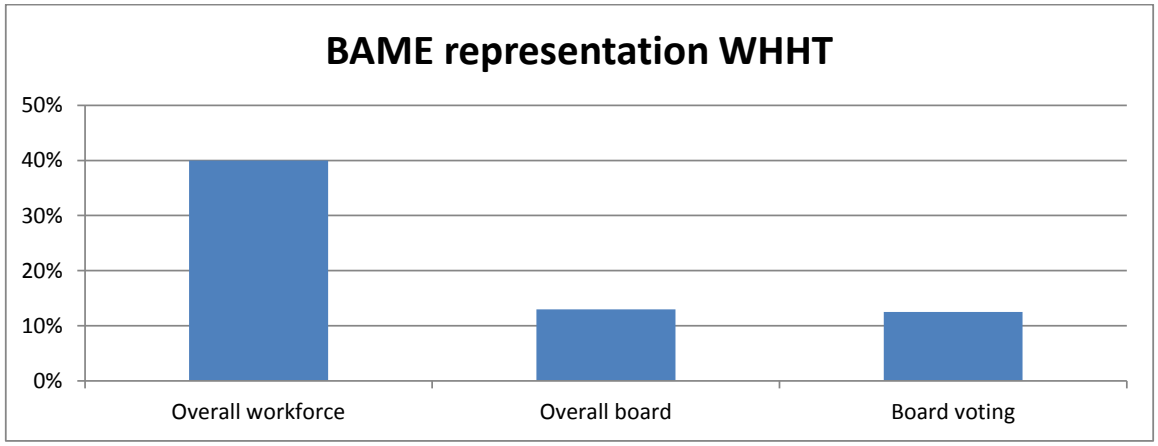
- Running a campaign called the “Big 5” which focused on 5 key themes from the staff survey. June was themed as “Race for Equality” which called for staff to:
  - make sure staff know that it’s okay to talk about any equality issues and who to speak to should they have any concerns
  - break down barriers by showcasing the various career progression options available for staff from different background

- Creating a new equality impact assessment which includes a comprehensive toolkit to equip staff with knowledge of discrimination and how to combat it

- Providing staff with psychological safety as well as standing in order to better understand the kinds of BHA taking place and implementing interventions accordingly

3.9 **<u>Indicator nine</u>:**

Percentage difference between the organisations' board voting membership and its overall workforce



Narrative:

- We are above the national average for BAME representation at Board level, which is 8% and East of England which is 6%. London's average is 17%
- However, at voting level that equates to one BAME individual

Actions taken (April 2019-March 2020)**:**

- addressing the lack of ethnic diversity in very senior management through our reverse mentoring programme; pairing Board members with BAME reverse mentors in order to educate leaders about diversity issues by exposing them to challenging and insightful conversations and experiences that they may otherwise never encounter
- Chief Executive ensuring all Executive Directors meet equality, diversity and inclusion objectives as part of the appraisal process
- BAME inclusion is championed by our Chief People Officer, who is the executive lead for diversity and inclusion. We have also increased our Inclusion & Diversity Manager from a part-time to full-time post, who plays a key role in supporting them.
- Our Chief Nurse continuing a direct communication channel with BAME staff in nursing, midwifery and allied health professionals
- Sending BAME staff to the Accelerated Director Development Scheme that identifies, develops and deploys aspiring Executive Directors from health and social care organisations from Hertfordshire and West Essex, BLMK Integrated Care System.
- A new BAME non-Executive Director has also been recruited and is due to start in 2020

3.7 WRES action plan

The WRES action plan can be found in the Appendix and sets out how the Trust seeks to improve its performance in relation to each of the indicators.

some of the new "big ticket" actions we have planned: publishing our BAME Pay Gap, overhauling recruitment and promotion practices, producing quarterly figures for the Integrated Performance report as well as developing sponsorship and mentoring opportunities.

Given we are half way through this reporting period some of the "big ticket" items that have already been actioned: embedding risk assessments with ethnicity as a risk factor, automatically admitting COVID19 positive staff into our Virtual Hospital, evaluating and sharing BAME responses to the COVID19 staff survey, pro-actively contacting BAME staff making them aware of support and initiatives via our Absence Hub and recruiting a Freedom to Speak Up Guardian.

Connect have also recruited a new steering group, finalised a TOR and action plan as well as secured significant funding for Cultural Intelligence training and staffing support.

3.8 Governance

Overall accountability for our equality and diversity agenda is held with our People, Education and Research Committee (PERC) which is a sub-committee of the Board and chaired by a non-executive Director. It meets and reviews this work every two months.

Connect, the Trust's BAME staff network are also a crucial stakeholder in relation to formulating the plan in Appendix 1 and monitoring its implementation.

Connect's new governance structure includes specific roles for representatives on PERC as well as the Trust's Joint Consultative Committee.

Our Great Place to Work meetings are also aligned against the Trust's People Strategy implementation plan.

4. Risks

Non-compliance with WRES would lead to a breach of the standard NHS contract.

Implementation of planned action, as outlined in Appendix 1 could be impacted if there is a second spike in Covid-19 infections.

5. Recommendations

Board is asked to receive this report for assurance and approve for publication.

Paul Da Gama
Chief People Officer

12 October 2020

Appendix 1 – WRES Action Plan April 2020- March 2021

WRES Metric	Action	Measure	Date	Lead
1. Representation	Ensure that at every level, the workforce is representative of the overall BAME workforce	Publish and action plan progress against the Model Employer goals in future reports	April 2021	Chief People Officer
	Identify whether a negative BAME Pay Gap exists	Publish, communicate and address the potential impact across the Divisions	March 2021	Inclusion & Diversity Manager
	Complete cohort one of reverse mentoring programme	At least six meetings between mentor and mentee	Dec 2020	Inclusion & Diversity Manager
	Increase + diversify Connect membership	Recruit and on-board new steering group	Ongoing	Connect
	Create a Connect governance structure and TOR	Representation at PERC and JCC	Sept 2020	Connect
	Audit representation at key decision making meetings	Create report figures/percentages	Dec 2020	Trust Secretary
	Equip People Directorate with knowledge and awareness to effectively work in BAME staffs interest	Contribute to HPMA/Synergised Solutions analysis to better understand system wide under-representation in H.R and implement recommendations from analysis Create a programme of D&I training for all H.R staff to roll on	May 2021	Inclusion & Diversity Manager

2. Shortlisting	Overhaul recruitment and promotion practices to ensure staffing reflects the diversity of the community as well as regional and national labour markets	Review (a) Approval to Recruit (b) Secondment & Acting Up (c) Redeployment (d) Recruitment & Selection policies; and clearly communicate proposed changes which include: - Panel for posts 8b and above including at least one appropriately trained BAME staff member - Mandatory D&I training for recruiting managers within six months of employment - Direct feedback from recruiting manager to unsuccessful BAME applicants through a Quality Improvement approach - values based recruitment embedded	Oct 2020	Recruitment Manager
	Reduce bias in interview process by increasing BAME representation on panels	Monthly training opportunities communicated targeting BAME colleagues that equip them with psychological standing to have a strong voice on panels Monitor uptake of training being offered and has the recruitment team had HR inclusion training.	Jan 2021	Inclusion & Diversity Manager
3. Disciplinary	Identify disciplinary hotspots and trends	Produce quarterly figures in Integrated Performance Report Ensure non-adverse range of reporting between 0.8 - 1.25	Oct 2020	Head of Employee Relations
4. Training & continuous personal development	Investigate the data further to understand the causes of the disparity and identify any potential barriers.	Include data on unsuccessful CPD applications in the 2021 WRES report Evaluate percentage of mentorship CPD applications for BAME staff	May 2021	CPD Manager
	Ensure successful applications for CPD reflect BAME representation for each Division	A non-adverse range of take-up between 35-45% Audit transparency/accessibility of application process	April 2021	CPD Manager

		Establish whether a correlation between seniority and uptake of CPD exists Evaluate and essential and non-essential training and feedback to relevant divisions to formulate action plan to improve their position		
	Create a widely disseminated portfolio of all educational opportunities at all levels and publicise to the entire Trust, thus raising awareness of opportunities.	Portfolio created Portfolio (in brochure form) available to all staff via intranet and all departments in hard copy	Jan 2021	Head of Education, Learning and Development
	Cascade information on career development opportunities, non-mandatory training and CPD	Regular updates in Connect newsletter Actively encourage managers to ask BAME staff to apply	Jan 2021	Connect co-ordinator
	Explore possibility of integrating equality data into the Trust's Learning Management Systems for the provision of better equality data.	Review to take place in Spring 2021 after tender for LMS is complete	June 2021	Head of Education, Learning and Development
5. Bullying, harassment and abuse from patients, relatives and public	Undertake further analysis of hot spot areas	Include incidents from Datix and other sources in Integrated Performance Report as well as divisional performance review meetings	Ongoing	All staff
	Update the Management of Violence & Aggression policy	Produce: (a) information on unacceptable behaviour; (b) guidance for staff experiencing racial abuse from patients with cognitive impairments	Dec 2020	Head of Security/ Dementia team
	Increase security staff	Hire: (1) a dedicated Security Officer (SO) in A&E/ AAU; and (2) an additional Supervisor SO to cover nightshifts and weekends	Dec 2020	Head of Security
6. Bullying,	Pro-actively contact BAME staff making them aware of support and initiatives	Absence Hub Managers to call BAME staff	May 2020	Deputy Director for Human Resources

harassment and abuse from staff		Secure funding to continue Absence Hub. If successful, explore other Hub related support such as calling BAME staff who are experiencing bullying and harassment Encourage signposting to Connect BAME network		
	Create a "BAME Support Service Line"	Set-up a 7 day a week, Freephone number with appropriate staffing and publicity	July 2020	Inclusion & Diversity Manager
	Increase awareness and accessibility of Freedom to Speak Up (FTSU)	Recruit a Freedom to Speak Up Guardian Launch FTSU post boxes to allow a method of additional access for staff, particularly for staff who do not have access to computers/IT Drop in sessions set up for all 3 sites from September-December 2020 Trust bullying and harassment zero tolerance campaign led by CEO Review and then communicate behavioural boundaries as well as appraisal and performance management process, speaking up conversations to be encouraged between manager and staff members Commission a quarterly West Herts staff bullying and harassment Increase FTSU Champions BAME representation to 40% and include diversity and inclusion training during onboarding process Provide bullying and harassment training to line managers	April 2021	Freedom to Speak Up Guardian

	Increase staff awareness of bullying, harassment or abuse and where they can access support	Create a guide on "How to react, act and report" bullying, harassment and abuse Increase staff wellbeing initiatives via new Wellbeing Strategy, including a new prayer room Discuss equality, diversity and inclusion as part of health and wellbeing conversations on topics such as: appropriate PPE, home working and access to psychological support (People Plan action)	March 2021	Wellbeing Team
7. Equal opportunities	Increase opportunities for BAME staff to have a direct line of communication with individuals working in roles they are aspiring to	Quarterly opportunities through channels such as: "Career Lounges" Further collaborative working with Connect to support signposting for BAME staff	January 2021	Inclusion & Diversity Manager
	Develop a sponsorship pathway for West Herts	Explore application process and implementation plan	Feb 2021	Inclusion & Diversity Manager
	Develop mentorship/buddying programme	Develop application process and implementation plan	Feb 2021	Connect
	Explore implementation of a talent management conversation within first year of role	Embedded into updated appraisal policy	Dec 2020	Deputy Director for Human Resources
	Extend capacity for coaching across the Trust	Introduction of more in-depth coach training programmes to provide more available coaches within the organisation If capacity is increased sufficiently, allowing the Trust's coaching service to be available on demand to all staff	Dec 2021	Head of Education, Learning and Development
8. Discrimination from staff	Acknowledge and address structural racism as well as indirect discrimination	Complete equality impact assessments with every new or updated policy	Ongoing	All

		Regular comms increasing knowledge and awareness in relation to structural barriers Roll out Cultural Intelligence (CQ) training that embeds a “Board to floor” commitment to embed CQ as part of West Herts daily function Update mandatory training module on Acorn		
	Provide staff with psychologically safe environments to raise concerns	Connect to run bi-monthly safe space sessions Confidential themes from the sessions to be fed back to senior management who can embed actions accordingly	Ongoing	Connect
	Ensure a safe working environment for our BAME staff	All staff comms highlighting and explaining BAME over-representation in COVID19 mortality Training session delivery at Board development day to develop and action plan Ensure appropriate risk assessments are designed and implemented Improving uptake of the flu vaccination in underrepresented ‘at risk’ groups Support flexibility and phased return to work Evaluate and share BAME staff responses to COVID19 staff survey	Jan 2020	Occupational Health
Indicators 5-8	Increase feedback rates including that of the staff survey to ensure that the results are indicative of the organisation and not skewed by a low response rate.	Increase responses from BAME staff by engaging with BAME network and using different forums in gathering feedback	November 2020	Deputy Director for Human Resources

9. Board diversity	Establish a direct line of communication between executive members and Connect	Chief Executive to host quarterly meetings Paul Da Gama to host bi-monthly meetings	Ongoing	Chief Executive & Chief People Officer
	Ensure leadership is representative of the overall BAME workforce and publish progress against the Model Employer goals *(People Plan)*	Agree our talent management strategy and approach with our staff side, staff networks and stakeholders Adapt our existing appraisal processes to ensure that all conversations include assessments of performance, potential, aspirations, readiness, development and support Publish a 5 year action plan *(Phase 3 recovery)* Establish Board talent review approaches to meet the requirement of having a robust succession plan in place at this level Promoting the Stepping Up Programme	May 2021	Head of Organisational Development
All indicators	Explore targeted interventions at Divisional level	Produce BAME data from WRES metrics specifically for Divisions Feedback to be given at monthly performance review meetings	Dec 2020	Inclusion & Diversity Manager
	Continue to work with other organisations to review and provide fresh perspective on our work	Conduct an audit and assurance service through BDO Participate in the NHS Diversity & Inclusion Partners Programme 2020/2021 Contribute and influence a system wide approach at ICS level	Ongoing	BDO
	Review governance to ensure staff	Establish an executive sponsor for Connect	March 2021	Connect /

	networks contribute and inform decision-making *(People Plan)*	Create a memorandum of understanding between H.R function and Connect		Inclusion & Diversity Manager
	Review the Risk Register and identify any gaps and potential risks race equality may face.	Recorded on Datix, scored and the Trust-wide impact clearly assessed in accordance with risk management practices Identified controls to mitigate risks	Ongoing	Inclusion & Diversity Manager
	Review the Diversity & Inclusion policy	Embed all of the recommendations following BDO audit	May 2021	Inclusion & Diversity Manager

Trust Board 05 November 2020

Title of the paper	**Strategic Priorities Update**
Agenda Item	17/84
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: 17/84

Trust Board – 05 November 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				✓

2.0 Clinical Strategy

2.1 Six **Clinical Strategy** workshops were held during September to seek input to the key themes for the strategy. In addition two stakeholder reference group meetings were held to discuss the emerging strategy. The first draft of the strategy has now been produced and is being reviewed internally. An engagement version of the strategy will be brought to the Trust Board in December, ahead of a two month period of wider engagement during January and February with the public and partners.

2.2 A new pathway for **Inpatient Chemotherapy** to be provided at WGH for appropriate patients was implemented in August 2020. To date 5 patients have benefitted from this pathway. This is in line with the initial estimate of c 20-30 patients per year. As well as benefitting patients who are able to access care locally, the introduction of this service supports medical and nursing staff recruitment and retention and meets the requirements set by the Deanery to retain speciality training which is key to the overall delivery and development of the Haematology service

2.3 **The Interventional Radiology (IR)** project is currently at the design stage. The internal team have commenced work and c. £23k of funding was approved to get external designs and surveys to get to OBC standard. Discussions are focused on the activity modelling and the design at present.

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 on the IR suite, subject to confirmation of funding.

2.4 Following a pause in the **Mount Vernon Cancer Centre Review** between March and June 2020, work has recommenced on a revised timeline which would see the consultation on the reprovision of services starting in June 2021 and the transfer of services from ENHT to UCLH in April 2022 (subject to satisfactory completion of due diligence).

The focus of the Programme between August and October 2020 has been on the development of the clinical model, engagement with the six Integrated Care System's (ICS's) with significant patient flows into Mount Vernon and planning Phase 2 of the staff and patient engagement events.

2.5 Respiratory and Cardiology have been conducting the **Senior Medics Assigning & Re-designing the Take (SMART)** pilot. Staffing continues to be a challenge, in particular, due to mandated isolation requirements. The project team have been actively engaging and encouraging registrars to volunteer in addition to providing evening support.

Informatics continue to capture patients who have gone through the SMART process in order to produce a patient outcome report, in conjunction with clinical leads. The team will meet again in November to review the data.

2.6 **The Vascular Hub** project is currently at the impact assessment/Outline Business Case (OBC) finalising stage. The full financial and workforce impact is currently being assessed and the hub team leading the work at East and North Hertfordshire NHS Trust have been given additional

resource to support delivery, although the timelines are a challenge for this. The WHHT vascular team are engaged, with the data analysis being the main limiting factor at present.

2.7 The work to progress the **Integrated Care Partnership (ICP)** continues in line with previous updates. Six of the eight supporting workstreams have now restarted and the first of two workshops to map the overall programme plan and identify the critical path to achieving this year's milestones was held on 5 October. Additional resources to support the ICP are being secured, and interviews for an Associate Director of ICP Development were held on 15 October.

A meeting was held in September with the new Accountable Officer and Chief Finance Officer for the ICS to discuss the direction of travel of the West Herts ICP and ensure that it is aligned with their vision for the future direction of the Integrated Care System (ICS). Both were supportive of the ambitions and direction of the ICP, while recognising that some elements will take longer to achieve than others.

3.0 Integrated Care Joint QIPP (part of Transformation Plan)

3.1 **Frailty** outreach continues to support patients in the Emergency Department identified through the Clinical Frailty Score (Rockwood) as being frail to support options for admission avoidance. The Frailty Unit opened on 8 October in the old Minor Assessment Unit (MAU) and is an invaluable space for completing a patient's comprehensive geriatric assessment with the Multi-Disciplinary Team (MDT). Work is underway to finalise the frailty pathway (now that the Frailty Unit has re-opened) to include how we bring together both the single clinical offer with Community Services and Primary Care to include Rapid Response and the Frailty Hotline.

Community MDTs and Rapid Response with Care of the Elderly consultant clinical support continue. The community clinics are a challenge to support due to the increased demand of Covid admissions and deployment of clinicians to support the Emergency Department and the isolation wards.

3.2 Priority areas for **Outpatient Transformation** have jointly been agreed between WHHT & Herts Valleys CCG to include Urology, Dermatology and Rheumatology now and Neurology from April 2021, to align with the community service plans. Scoping of opportunities from a WHHT perspective have been completed for Urology. WHHT are part of the Sustainability and Transformation Partnership (STP) Patient Initiated Follow Up (PIFU) Group and Rheumatology has been identified as the next service for PIFU implementation.

3.3 **Children's and Young People** - Two targeted pieces of work have commenced regarding a community Jaundice pathway and the Cystic Fibrosis pathway and the relationship with tertiary providers. The Paediatric Transformation Board starts this month, with the overall aim of the group to review current paediatric & young person's service models and identify opportunities for transformation.

3.4 **Watford General Hospital (WGH) Urgent Treatment Centre** – The first contract review meeting is now planned for November. Executive sponsorship has been confirmed, additional corporate

support has been identified to manage the contract in the short term until there is consistent delivery against key targets.

3.5 Hemel Hempstead Hospital (HHH) Urgent Treatment Centre – The decision has been taken to pause procurement of the service and review in January 2021. Current contract arrangements with Herts Urgent Care (HUC) have now been formally signed off.

3.6 St Albans City Hospital (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. A paper setting out rationale and possible options has been presented to the Joint Urgent Care Programme Board and a task force will be set up in early November.

4.0 Capital Programme

4.1 The main construction contractor for the **WGH Theatres Reconfiguration** project, Vinci, has been working collaboratively with the Capital Team to establish working practices prior to a start on site.

Pre-enabling works are progressing in accordance with the Phasing and Access Strategy previously approved with the Department and Clinical Leads. Key milestones are:

- An initial three week contractor mobilisation period due to commence w/c 19/10/20.
- Main construction works will commence from w/c 09/11/20.
- The first of six construction phases will commence w/c 07/12/20.
- The remaining five phases will be undertaken throughout 2021, with an expected completion of all construction works by January 2022.

In parallel with the main construction works and commencing March 2021, will be the fitting out of a new ultraclean Theatre 5 by Howorth Ventilation. Final design, equipment specifications and authorised engineer approvals are currently being finalised. The anticipated completion of construction of this project is September 2021.

4.2 The **Emergency Department Development** project scope has been refined following direction from TMC. The OBC and £350k investment needed for creation of the FBC was approved via TMC and is included in the capital plan. The FBC has been rescheduled with a target date to go to the Trust Board in December 2020. The supplier for the modular unit is now engaged and the final design scope is to be agreed in November (internal and external works). Regulatory approval and confirmation of funding will be required before target start and completion dates can be confirmed.

4.3 The winter plan for 2020-21 is for a modular unit (up to 20 beds) to be placed in Shrodell's garden, to be linked to the previous **Emergency Assessment Unit (EAU) Expansion**. The design for the unit is finalised, with work on the linkage underway. Good progress has been made on the operational model and internal changes to accommodation. Drafts of the staff and

equipment list have been completed and it is expected that the unit will be in place by Christmas 2020. Work on a final (retrospective) business case is being led by the Emergency Division for approval via Trust Governance processes in November / December 2020.

4.4 The **Local Area Network (LAN)** upgrade is in the final stages of closedown. All sites have now been remediated and final snagging is underway, along with the full report detailing all changes that have occurred as part of this project. The **Windows 10** roll out is proceeding as planned. An additional business case has been worked up; the case is seeking to secure investment to procure additional desktop computers and associated deployment services to complete this programme of work. The business case has been submitted to the Capital Finance Planning Group (CPFG).

4.5 The business case for the **Off Site Back Office Project** (Administrative Staff project) was approved by the Trust Board and is an essential enabler for creating additional clinical capacity on the WGH site. The preferred option has been agreed as Unit 11 Trade City, Thomas Sawyer Way due to the proximity to WGH and value for money. A feasibility study is now underway to create a final design and pre-application has been submitted for change of planning use from a light industrial unit to offices.

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. All service baselines have been collected and analysed and proposed staffing numbers are under final review. Work will now commence on writing the FBC. The Health Records team are connected with the Electronic Patient Records (EPR) programme team and working in parallel.

4.7 **MRI SACH** - NHS E have confirmed funding for an MRI in a box for SACH as part of Covid recovery. A major upgrade to the HV electricity system is required to support the MRI. This is currently being scoped by the Environment team, with relevant specialist expertise secured to support the final specification and plan. The target timeline is to complete all works in this financial year, subject to final plans being confirmed and contractors secured.

4.8 **CT WGH** - We need to install the two ED x-ray rooms first to increase our efficiency and allow us to lose the AAU Level 1 x-ray room where the new CT scanner will be installed by end of 2020/21 financial year. Work has completed on the first ED x-ray room. The purchase order has been raised to replace the second ED X-ray room and work will commence in two weeks. The CT scanner for Level 1 AAU has been ordered.

4.9 The **Backlog Maintenance Programme** (BLM) comprises over 30 projects, all in different phases of preparation and procurement, however in general project management terms, the programme is currently on plan. Some elements of the plan may need to be postponed into 2021 / 2022 given overall pressure on the capital programme, uncertainty about some elements of Covid spend and potential delivery risks linked to team capacity and availability of contractors.

Over the past month focus has been on appointing Consultants to undertake surveys for the larger projects on the programme. In the last month, a range of projects have progressed to a design stage, the majority of these designs should be completed in November, with work (subject to business case approval), beginning in December and running through to March 2021.

Some of the smaller works such as water safety measures and replacing the Renal Building boiler at WGH are complete, having been procured under revenue. We are currently tendering works for boiler upgrades at Verulam Ward in HHH and Sycamore House at WGH, the replacement of the Hot Well Boilers at SACH and roof repairs to the Fracture Clinic at HHH and the restaurant at WGH. These tenders are likely to be assessed within the next three weeks, enabling appointments in November.

4.10 Currently finalising plans for works to commence on the **Cardiac Cath Lab** on 2 November 2020. The timeline for completion of cath lab 1 is February 2021 and lab 2 early May 2021. In order to minimise capital spend the project team will be managing the finances very closely to ensure as much spend as possible, if not all, falls in this financial year.

For assurance there have been discussions with the Electronic Patient Records (EPR) team to ensure that they are aware of the cardiology IT packages and how they may interact with the new EPR. As Cerner could not facilitate all the aspects of the cardiology requirements it was agreed that the items could be ordered and the EPR team would work with the cath lab project team to ensure compatibility and correct data storage is achieved. There is some contingency in the budget to facilitate some overspend if this is necessary.

During this time the team are working on a Transition plan to demonstrate the mitigations and assurance that patient safety and the optimisation of the capacity is being managed appropriately during this time. This will incorporate clinical prioritisation and risk stratification of cases, this process will be signed off through the Clinical Decision Panel. Close management and planning of activity will occur to ensure that there is capacity for both emergency and elective cases, the lab will extend its opening hours to facilitate this across the week and into the weekend. In order to mitigate some of the expected reduction in capacity the team have been facilitating extra capacity with additional elective lists over the last couple of months.

4.11 As in previous years, a material element of the **Fire Safety Improvements** will address remedial works in relation to fire door set replacement, fire compartmentation repair and the replacement/extension of emergency lighting (predominantly at SACH and HHH).

For emergency lighting, tender specifications are being produced for a retro-fitted new system at SACH and HHH to mirror that installed on the WGH site. The bids are expected to be of considerable value and therefore a phased priority based plan will be developed with a proportion of the works achieved in the 2020/21 financial year.

For fire alarms, tender documents are being prepared for replacements and improvements primarily at the SACH site. Tender release is targeted for end of October for works to commence in January 2021.

The programme for fire door installations progresses as planned, with current concentration in the Cardiac Centre and Cherry Tree house at WGH. Through October and November the Admin Block and Willow House will also be progressed.

Following due diligence reviews of the Trusts Fire compartmentation lines by the Trusts Authorised Engineer for Fire, additional works have been identified and being actioned in the Moynihan building at SACH. The expected value is circa £200k. Further remedial works are expected in the continuing review of the Trusts compartmentation lines.

4.12 A progress update and associated RAG rating on the **£1m Miscellaneous Medical Equipment** project is set out below:

Equipment	£000	Progress Update	RAG Rating
Anaesthetic machines	£312k	Order placed. Expected delivery 15/01/21	
Foetal Recorder CTG	£200k	Clinical trial in progress. Target January CFFG for business case approval & order to be raised. 4-6 week lead in time for delivery.	
Epidural Volumetric Pump	£60k	National supply issue due to Covid. Awaiting confirmation from supplier re availability / date.	
Tourniquet machines	£28k	Clinical trial in progress to confirm preferred equipment. Target January CFPG for business case approval and order to be raised.	
Defibrillators	£400k	Original allocation was to replace 40 end of life defibrillators. Standard model across the Trust not now in production. Requirement is to have standard model in all clinical settings therefore business to be developed to replace all defibrillators Trust wide – with potential to fund across 2 financial years (20/21 and 21/22). Clinical trial in process to identify preferred supplier.	
Total	£1000k		

4.13 **The Multi-Storey Car Park (MSCP)** project is being delivered in three phases:

- Pre-Enabling Works (now complete).
- Enabling Works - Funding has been confirmed in letter from DHSC and work is underway. On programme to complete in February 2021.
- Main Build is to be delivered under Design & Build contract let and managed by Riverwell LABV (Local Asset Backed Vehicle). Funding dependent on FBC approval by NHSI&E.

The FBC is to be submitted to the Trust Board in November 2020, then forwarded to NHSI & E and DHSC Joint Investment Sub-Committee (JISC) for review and approval, provisionally programmed for late November. The target date for signature of the main construction contract is 16 December 2020, following NHSI & E and Trust Board approval. Project on programme for target completion date of 25 March 2022.

5.0 Recommendation

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

Trust Board Meeting
05 November 2020

Title of the paper	**Annual review of standing financial instructions, standing orders and scheme of delegation**
Agenda Item	*Please leave this blank, it will be completed by the administrator*
Presenter	**Don Richards, Chief Financial Officer** **Rod While, Trust Secretary**
Author(s)	**Philip Ridout, Financial Accountant** **Rod While, Trust Secretary**
Purpose	*Please tick the appropriate box* *For approval*: x *For discussion*: *For information*:
Executive Summary	The Trust reviews its standing financial instructions, standing orders and scheme of delegation on an annual basis. This review has been carried out and the documents updated as required. A summary of the amendments made can be found in Schedule B of the amended SFIs. The main change concerns procedural changes when procurement requires a waiver requiring Board approval to be made. There have been some minor textural changes to the standing orders and scheme of delegation, which are set out in the paper. In the 2019 paper on SFIs a pending action was to compare the delegated limits of other Trusts in presenting this paper, and a summary of the results and recommendation can be found in sections 3.2 and 3.3 of this paper. The delegated limits of these other Trusts are in line with West Herts and the recommendation is to make no changes in these limits.
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* — x **Aim 3** Best value — *Objective 9* — x **Aim 4** Great place — *Objective 10-12* — x
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?

<table>
<tr><td></td><td>☒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>Audit Committee</td><td>09 October 2020</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Audit Committee recommends the updated standing financial instructions, standing orders and scheme of delegation to the Board for approval.</td></tr>
</table>

Agenda Item: 18/84

Trust Board Meeting – 05 November 2020

Annual review of standing financial instructions, standing orders and scheme of delegation

Presented by: Don Richards, Chief Financial Officer and Rod While, Trust Secretary

1. Purpose

1.1 To aim of this paper is for the Board to receive revised standing financial instructions (SFIs), standing orders (SOs) and scheme of delegation (SoD), which are reviewed on an annual basis.

2. Background

2.1 The Trust's SFIs, SOs and SoD are core governance documents and, as such, it is important they reflect current practice. Best practice is that the Audit Committee reviews the documents and makes changes if any on an annual basis.

2.2 Following approval by the Board, the documents will be published on the Trust's website and intranet.

3. Standing Financial Instructions

3.1 The SFI's have been reviewed and as well as some minor text amendments and formatting, the amendment as below is recommended.

- Where a waiver is required that requires Board Approval, procurement should contact the Chief Financial Officer directly (section 9.5.2). This is to ensure that waivers are dealt with in a prompt way.

3.2 At the Board meeting in October 2019, a review was requested of the delegated approval limits for the Board as set out in the SFIs. The current limit is set at £1m for both revenue and capital expenditure. A benchmarking exercise was carried out to check across other trusts and three trusts responded. The results of the benchmarking exercise are set out in the table below.

Trusts	Board Approval Limits	Details
Mid Yorkshire Hospitals NHS Trust	£1m	Both capital and revenue
North Middlesex University Hospital NHS Trust	£1m	Both capital and revenue
University Hospital Plymouth NHS Trust	£1m	Capital limit is £0.5m to be increased to £1.0m
West Hertfordshire Hospitals NHS Trust	£1m	Both capital and revenue

3.3 As all three trusts in the benchmarking exercise have set limits at £1m, it was recommended that the Trust continues with a delegated limit of £1m in 2019 with a review

in 2020. The limits of the above Trusts were reviewed in September 2020 and no changes were noted, and it is recommended that West Herts does not change its delegated limits.

4. Standing Orders

4.1 The Standing Orders have been reviewed and it is proposed that the only necessary amendment beyond the correction of minor typographical error is to include the Great Place Committee alongside the descriptions of other Board Committees.

5. Scheme of Delegation

5.1 Following the review of the Scheme of Delegation, only minor textural amendments have been made, including the addition of the Great Place Committee as a Committee of the Board

6. Risks

6.1 Failure to annually review and update the SFIs, SOs and SoD opens the Trust up to being unaware of changes to legal and financial frameworks which could lead to breaches in working practices within the Trust.

7. Recommendation

7.1 The Trust Board is recommended by the Audit Committee to approve the updated standing financial instructions, standing orders and scheme of delegation.
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Don Richards
Chief Financial Officer

Rod While
Trust Secretary

05 November 2020

SFI/ Version 7.0
Ratified by: Audit Committee
Date of Ratification: October 2020
Date of Review: August 2021

STANDING FINANCIAL INSTRUCTIONS

2020-2021

Change History -
Version 2.0 Expired March 2014
Version 3.0 Version 1.5 updated as detailed in schedule B
Version 4.0 Version 1.6 updated as detailed in schedule B
Version 5.0 Version 1.7 updated as detailed in schedule B
Version 6.0 Version 1.8 updated as detailed in schedule B
Version 7.0 Version 1.9 updated as detailed in schedule B

ID Number	Version 7.0
Author"s name	Don Richards
Author"s job title	Chief Financial Officer
Division	Corporate
Department	Finance
Version number	Version 7.0
Ratifying Committee	Audit Committee
Ratified date	9 October 2020
Review date	August 2021
Name of manager responsible for review	Philip Ridout
Job title of manager responsible for review	Financial Accountant
Email address for this manager	p,ridout1@nhs.net
Referenced (Yes/No)	Yes
Key words (to aid searching)	All staff, disciplinary, delegated, authorised
User Group	All Staff
Equality Impact Assessment Completed	Yes

The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason in the application of this policy, and recognising the need to work in partnership with and seek guidance from other agencies and services to ensure that special needs are met.

SFI/ Version 7.0
Ratified by: Audit Committee
Date of Ratification: October 2020
Date of Review: August 2021

STANDING FINANCIAL INSTRUCTIONS

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INTRODUCTION

Governance Framework

These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree SFIs for the regulation of the conduct of its Members and Officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

Purpose

These SFI's are issued for the regulation of the conduct of the Trust. They are designed to ensure the Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way the Trust manages public resources. They should be used in conjunction with the Reservation of Powers and Scheme of Delegation.

Authority and Compliance

These SFI's identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

All aspects of these SFIs are relevant to both Trust spending and charitable funds for which the Trust Board is responsible as corporate trustee.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer must be sought before acting. The users of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

Failure to comply with SFIs and SOs can in certain circumstances be regarded as a disciplinary matter that may be subject to a full investigation and appropriate disciplinary action, which could result in dismissal. Where failure to comply constitutes a criminal offence it may result in criminal investigation, and criminal sanctions will be considered and applied as appropriate.

Overriding Standing Financial Instructions – If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and all staff have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible. The Chief Financial Officer will report all potential breaches of the SFIs to the LCFS.

Monitoring of compliance is also the responsibility of all staff. The Chief Financial Officer should be advised of any refraction. In addition compliance is monitored by the Finance Department on an on-going basis.

Responsibilities and delegation

The Trust Board

The Board exercises financial supervision and control by:

- formulating the financial strategy;
- requiring the submission and approval of budgets within approved allocations/overall income;
- defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
- defining specific responsibilities placed on members of the Board and employees as indicated in the Reservation of Powers and Scheme of Delegation document.

The Board has resolved that it may only exercise certain powers and decisions in formal session. These are set out in the Reservation of Powers and Scheme of Delegation document. All other powers have been delegated to such other Committees as the Trust has established.

The Chief Executive and Chief Financial Officer

The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control. Within these SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

The Chief Financial Officer

The Chief Financial Officer is responsible for:

- implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of

the Chief Financial Officer include:

- the provision of financial advice to other members of the Board and employees;
- the design, implementation and supervision of systems of internal financial control;
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
- ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;
- deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
- ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

    - A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
    - major internal financial control weaknesses discovered;
    - progress on the implementation of internal audit recommendations;
    - progress against plan over the previous year;
    - strategic audit plan covering the coming three years; and
    - a detailed plan for the coming year.

- The Chief Financial Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

    - access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
    - access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
    - the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
    - explanation of any matter under investigation.

Board Members and Employees

All members of the Board and employees, severally and collectively, are responsible for:

- the security of the property of the Trust, avoiding loss
- exercising economy and efficiency in the use of resources;
- conforming with the requirements of SOs, SFIs, Financial Procedures and the Reservation of Powers and Scheme of Delegation;
- in carrying out a financial function, ensuring the form in which financial records are kept and the manner the duty is performed is to the satisfaction of the Chief Financial Officer.

Contractors and their employees

The Chief Executive will ensure any contractor or employee of a contractor who is empowered by the Board to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

STANDING FINANCIAL INSTRUCTION NO. 1

AUDIT AND COUNTER FRAUD SERVICES

1.1 Audit Committee

1.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the latest NHS Audit Committee Handbook and the Cabinet Office Combined Code of Corporate Governance, which provide an independent and objective view of internal control.

1.1.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control. Across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's organisational objectives. The committee is also responsible for:

- overseeing Internal and External Audit services;
- reviewing financial and information systems, monitoring the integrity of the annual financial statements and reviewing significant financial reporting judgments;
- monitoring compliance with Standing Orders and Standing Financial Instructions;
- reviewing schedules of losses and compensations and making recommendations to the Board;
- reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;
- reviewing the information to support the annual governance statement prepared on behalf of the Board and advising the Board accordingly; and
- examining areas of compliance (not just financial).

1.1.3 The committee will be supported by the Finance department and the Trust Secretary to ensure that it is fully informed of activity in other sub-committees and so it may take action, through the Trust Secretary where appropriate, to discharge its duties robustly. If the Audit Committee and Trust Secretary are confident that an issue can be resolved at sub-committee level, it need not be brought to the Board. Where there is a high level of risk, it will be referred to the Board for debate and decision.

1.1.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health via the Chief Financial Officer in the first instance.

1.1.5 It is the responsibility of the Chief Financial Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

1.2 Role of Internal Audit

1.2.1 Internal Audit will review, appraise and report upon:

- the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- the adequacy and application of financial and other related management controls;
- the suitability of financial and other related management data;
- the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

    - fraud and other offences;
    - waste, extravagance, inefficient administration;
    - poor value for money or other causes.

- Internal Audit shall also independently verify the Assurance Framework Statements of Internal Control and registration with the Care Quality Commission.
- The efficient use of resource and achievement of value for money;
- The suitability, reliability and integrity of management information systems;
- The management of risk within the Trust.

1.2.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

1.2.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

1.2.4 The Chief Internal Auditor shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

1.2.5 The designated officers must carry out agreed audit recommendations within the timescale for action agreed in audit reports. Failure to do so shall be reported to the Audit Committee and if unresolved escalated to the Chief Executive who shall take action to ensure compliance with the recommendations.

1.3 External Audit

1.3.1 The External Auditor is appointed by the Trust as from 1 April 2017 under the Local Audit and Accountability Act 2014. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Audit Committee if the issue cannot be resolved. The Audit Committee manages the terms of engagement of the External Auditor and reviews their work and findings. For further details on External Auditor please refer to terms of reference for the Audit Committee available from the Trust offices at Watford General Hospital.

1.4 Fraud, Bribery and Corruption

1.4.1 "Fraud" shall mean any person who dishonestly makes a false representation to make a gain for themselves or another, or who dishonestly fails to disclose to another

person information which he is under a legal duty to disclose or commits fraud by abuse of position including any offence as defined in the Fraud Act 2006.

1.4.2 "Bribery", shall mean giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.

1.4.3 The Bribery Act 2010 replaces the fragmented and complex offences at common law, the Public Bodies Corrupt Practices Act 1889 and in the Prevention of Corruption Acts 1889-1916. The 2010 Act broadly defines the sections below:

(1) to give, promise or offer a bribe,
(2) to request, agree to receive or accept a bribe,
(3) bribing a foreign public official, and
(4) failure of a commercial organisation to prevent bribery being undertaken on its behalf.

1.4.4 The Bribery Act 2010 makes corrupt activity in the public sector a criminal offence and the Act includes reversal of the normal presumption of innocence so that where a payment is made to an employee of a public body it is for the defence to prove that the payment was not illegal.

1.4.5 It is a common law offence of bribery to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

1.4.6 The Trust will be liable to prosecution if a person associated with it bribes another person intending to obtain or retain business or an advantage in the conduct of business for that organisation, unless it can show that despite a particular case of bribery it nevertheless had adequate procedures in place to prevent persons associated with it from bribing.

1.4.7 In line with their responsibilities, the Trust Chief Executive and Chief Financial Officer shall monitor and ensure compliance with Directions issued by the Secretary of State on fraud, bribery and corruption and the NHS Counter Fraud Authority Standards for Providers.

1.4.8 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud Authority guidance.

1.4.9 The CFS shall report to the Trust Chief Financial Officer and shall work with staff in the NHS Counter Fraud Authority in accordance with the Standards for Providers. The Chief Financial Officer shall decide at what stage to involve the police in any investigation.

1.4.10 In accordance with the Counter Fraud Policy and Anti-Bribery Policy, suspected offences of fraud or bribery should be reported to the Trust's LCFS for formal investigation. The Chief Financial Officer should inform the LCFS of any referrals received directly.

1.4.11 The Trust will ensure that policies and procedures for all work related to fraud and bribery are implemented. The Trust will consider the major findings of investigations and respond accordingly.

1.4.12 The LCFS will attend audit committee meetings on a periodic basis and provide a written report, at least annually, on counter fraud work within the Trust or as specified in the contract.

1.4.13 The Trust is required to complete the Self-Review Toolkit (SRT), a self-assessment tool developed by the NHS Counter Fraud Authority, to measure the effectiveness of counter fraud processes and demonstrate the level of compliance with NHS Counter Fraud Authority Standards on an annual basis.

1.5 Security Management

1.5.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State on NHS security management.

1.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State in guidance on NHS security management.

1.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

1.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

STANDING FINANCIAL INSTRUCTION NO 2

ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

2.1 Preparation and Approval of Annual Plans and Budgets

2.1.1 The Chief Executive, with the assistance of the Chief Financial Officer shall, prior to the start the financial year, compile and submit to the Board a plan that takes into account relevant financial and non-financial targets. The plan will contain:

- a statement of the significant assumptions on which it is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.

2.1.2 The Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit Revenue & Capital Budgets for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the plan;
- be in accord with workload and manpower plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds; and
- identify potential risks.

2.1.3 All budget holders will participate in the budget setting process, agree and sign up to their allocated budgets at the commencement of each financial year.

2.1.4 The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board. As a consequence the Chief Financial Officer shall have right of access to all records that may have an implication of a financial nature.

2.1.5 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

2.2 Budgets

2.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the budget holder;
- the amount of the budget;
- the purpose(s) of each budget heading; individual and group responsibilities; authority to exercise virement; achievement of planned levels of service; the provision of regular reports.

2.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

2.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

2.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer.

2.2.5 The Chief Executive shall require the Chief Financial Officer to devise and maintain systems of budgetary control in accordance with the above and in addition to include:

- monthly financial reports to the Board in a form approved by the Board containing:
    - income and expenditure to date showing trends and forecast year-end position;
    - movements in working capital;
    - movements in cash and capital;
    - capital project spend and projected outturn against plan;
    - explanations of any material variances from plan;
    - details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;
- the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- investigation and reporting of variances from financial, workload and manpower budgets;
- monitoring of management action to correct variances; and
- arrangement for the authorisation of budget transfers.

2.2.6 In carrying out their delegated responsibility each Budget Holder is responsible for ensuring that:

- any planned overspending or reduction of income that cannot be met by virement is incurred only with prior approval of relevant business cases:

Delegation	Limit
Trust Executive Committee (for revenue expenditure) and Capital Finance Planning Group (for capital expenditure)	£0 - £150,000
Trust Executive Committee	£150,001 up to £1,000,000
Trust Board (Revenue)	Over £1,000,001
Trust Board (Capital)	Over £1,000,000 up to £5,000,000
NHS Improvement (Capital)	Over £5,000,000

[1] The Trust Board's objectives ensure that agreement supports the delivery of the approved Annual Plan.

- the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
- no permanent employees are appointed without the approval of the Chief Executive or other approval mechanisms in force from time to time other than those provided for within the available resources and manpower establishment as approved by the Board.

2.2.7 The Trust Executive is responsible for recommending to the Board cost improvements, cost savings and income generation initiatives in accordance with the Annual Plan, for monitoring implementation and delivering of associated performance.

2.2.8 Capital Expenditure; the general rules applying to delegation and reporting shall also apply to capital expenditure. (see also SFI No. 11 Capital Investment, private financing and leasing)

2.3 External financing limits (EFLs) and External Borrowing

2.3.1 The Chief Executive shall require the Chief Financial Officer to ensure the Trust does not breach the Trust's EFL as set by the Department of Health. All external borrowing to be authorised by the Board and agreed through the EFL with the Department of Health. (see also SFI 4.5)

2.4 Monitoring Returns

2.4.1 The Chief Executive is responsible for ensuring that all required monitoring forms are submitted to the requisite monitoring organisation in a timely manner.

STANDING FINANCIAL INSTRUCTION NO. 3

ANNUAL ACCOUNTS AND REPORTS

3.1 Role of Chief Financial Officer

3.1.1 The Chief Financial Officer, on behalf of the Trust, will:

3.1.1 Prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice.

3.1.2 Prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines.

3.1.3 Submit financial returns to the Department of Health* in accordance with the timetable prescribed.

3.1.4 Ensure the Trust's Annual Accounts are audited by an auditor appointed by the Public Sector Audit Appointment Limited. The Trust's audited Annual Accounts are presented at the Annual General Meeting of the Board and made available to the public.

3.2 Annual report

3.2.1 The Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts and other relevant good practice.

*(*Reference to Department of Health may be read as appropriate reporting body such as the Trust Development Agency or NHS Improvement)*

STANDING FINANCIAL INSTRUCTION NO. 4.

BANK AND GOVERNMENT BANKING SERVICE

4.1 General

4.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance / Directions issued from time to time by the Department of Health. In line with Cash Management in the NHS the Trust will minimise the use of commercial bank accounts.

4.1.2 The Board shall approve the banking arrangements.

4.2 Bank and Government Banking Service Accounts

4.3 The Chief Financial Officer is responsible for all bank accounts and the Government Banking Service (GBS) accounts including:

- establishing separate bank accounts for the Trust's non-exchequer funds; ensuring payments made from bank or consolidated GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and
- reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;
- monitoring compliance with Department of Health guidance on the level of cleared funds.

4.4 Banking Procedures

4.4.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- the conditions under which each bank and GBS account is to be operated;
- those authorised to sign cheques or other orders drawn on the Trust's accounts within delegated limits as set out in schedule A.

4.4.2 The Chief Financial Officer will ensure the Trust's commercial bank accounts are operated in accordance with signed mandates.

4.4.3 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

4.4.4 All funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer shall open any bank account in the name of the Trust.

4.4.5 The Chief Financial Officer shall be authorised to make payments using BACs and CHAPS and to establish appropriate procedures in accordance with locally agreed arrangements.

4.4.6 All payment instruments shall be treated as controlled stationery and be the responsibility of the Financial Controller who will maintain records as prescribed by the Chief Financial Officer.

4.4.7 Where payments are made by direct debit, each mandate shall be approved by the Chief Financial Officer, and shall be recorded in a register. Payments shall be verified against such approvals on a periodic basis.

4.4.8 The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent value for money. Where appropriate, competitive tenders shall be sought, this is not necessary for GBS accounts.

4.5 External Borrowing and Public Dividend Capital

4.5.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay interest on, and repay the Public Dividend Capital and any Department of Health Loans; advise the Board of the Trust's borrowing limit as set by the Department of Health.

4.5.2 The Chief Financial Officer is also responsible for reporting periodically to the Board concerning outstanding loan balances and interest payments.

4.5.3 All external borrowing must be approved by the Board.

4.6 Charitable Donations and Funds Held in Trust

4.6.1 Standing Orders outline the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust.

4.6.2 The discharge of the Trust's corporate trustee responsibilities are distinct from Its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

4.6.3 The Chief Financial Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and requirements.

4.6.4 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

4.6.5 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. The Board of Directors must take account of that guidance before taking action.

4.6.6 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

4.6.7 The over-riding principle is that the integrity of each Trust fund must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

4.6.8 The charitable funds associated with the Trust are administered by the Trust Board as corporate trustee. The Charitable Fund operates general funds, held in a separate bank account not to be confused with those operated by the Trust for its Exchequer funds. The opening of Bank accounts is the sole responsibility of the Chief Financial Officer see Standing Financial Instruction 4.3.3.

STANDING FINANCIAL INSTRUCTION NO. 5

INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

5.1 Income Systems

5.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collecting and coding of all monies due, including NHS, commercial and Development (R&D) income.

5.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

5.2 Fees and Charges

5.2.1 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the Trust's commercial sponsorship policy must be fully complied with.

5.2.2 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they manage, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.3 All employees must seek the advice of the Chief Financial Officer in advance of entering into service agreements or contracts for the provision of patient or other services. Agreement to service agreements or contracts is subject to the boundaries of delegated authority.

5.2.4 No employee, except within the boundaries of any delegated authority, is allowed to confirm or agree with a third party a reduction or waiver to the Trust's normal charges, without the prior express authority of the Chief Financial Officer.

5.3 Debt Recovery

5.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

5.3.2 Income not received should be dealt with in accordance with losses procedures.

5.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

5.3.4 No employee, without prior express authority from the Chief Financial Officer is allowed to agree with any third party, to the cancellation or reduction of a legitimate debt owed to the Trust.

5.4 Security of Cash, Cheques and other Negotiable Instruments

5.4.1 The Chief Financial Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- arranging for the ordering and secure control of any such stationery;
- the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

5.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

5.4.3 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

5.4.4 Any loss or short-fall of cash, cheques or other negotiable instruments however occasioned shall be reported to the Chief Financial Officer.

5.4.5 The opening of incoming post should where possible be undertaken by two officers unless otherwise formally agreed by the Chief Financial Officer. All cash, cheques and postal orders and other forms of payment received by an officer is passed to cashiers who will then enter immediately in an approved form of register.

5.4.6 An official receipt shall be made out by the cashier for every sum of cash received and shall show the type of remittance and the reason for payment.

5.4.7 The opening of cash tills and other coin operated machines and the counting and recording of takings shall be recorded by two officers together. Both shall sign the records and the keys shall be held by a separate nominated officer.

5.4.8 The Chief Financial Officer shall ensure that there is a system for recording the transfer of custody of cash, cheques and other negotiable instruments from one person to another, and in what circumstances such records should be made.

5.4.9 Any employee who has any indication that the safe custody of cash, etc on the Trust's premises or in transit may be at risk, must immediately notify the Chief Financial Officer or the Financial Controller.

5.4.10 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

STANDING FINANCIAL INSTRUCTION NO. 6

CONTRACTS FOR THE PROVISION OF HEALTHCARE SERVICES

6.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Contracts, with Commissioners, using the standard NHS contract terms and conditions, detailing the basis on which the Trust will provide healthcare services. Contracts will take account of national policies and initiatives at the time of negotiation. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation.

6.2 The Chief Executive has delegated the Chief Financial Officer as the officer responsible for negotiating contracts for the provision of services to patients in accordance with the Annual Plan. The contracts are to include the costing and pricing of services, payment terms and conditions and arrangements for contract amendments.

6.3 Contracts should be so devised as to achieve activity and performance targets, minimise risk, and maximise the Trust's opportunity to generate income. The Chief Financial Officer will produce local tariffs in accordance with NHS guidelines, for services outside the scope of the national tariff.

6.4 The Chief Financial Officer shall ensure that a summary of the Trust's agreed contracts is reported annually to the Board, prior to the start of the financial year. The Chief Financial Officer shall also produce regular reports to the Board detailing actual and forecast contract income with a detailed assessment of the variable elements of income.

STANDING FINANCIAL INSTRUCTION NO. 7

PAYMENT AND TERMS OF SERVICE OF DIRECTORS AND EMPLOYEES

7.1 Remuneration Committee

7.1.1 The Board should formally agree and record in the minutes of its meetings, the terms of reference of the Remuneration Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

7.1.2 In accordance with Standing Orders, the Board shall formally establish a Remuneration Committee, the terms of reference will:

- advise the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors and other senior employees as necessary on:
  - all aspects of salary (including any performance-related elements/bonuses);
  - provisions for other benefits, including pensions and cars; and
  - arrangements for termination of employment and other contractual terms.

- make such recommendations to the Board on the remuneration and terms of service of Executive Directors and other senior employees to ensure they are fairly rewarded for their individual and collective contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

- Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

- Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.

7.1.3 The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State.

7.1.4 The committee will be responsible for authorising pay awards for all staff with significant financial responsibilities.

7.2 Funded Establishment

7.2.1 The funded establishment is to be contained within the Annual Financial Plan.

7.2.2 The funded establishment of any department may not be varied without the prior approval of the Chief Executive.

7.3 Staff Appointments and Redundancies

7.3.1 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration unless:

- it is within the approved budget and funded establishment and the Director or employee has appropriate delegated responsibility;
- the proposal conforms to establishment control procedure in place at the time
- associated costs are budgeted for through approved virement.

7.3.2 All vacancies have to be approved by the Vacancy Panel.

7.3.3 All consultant appointments whether new or replacement must be supported by a Trust Business Case and approved by the Trust Executive Committee.

7.3.4 No Director or employee must commit the Trust to any redundancy, early retirement, or negotiated employment termination settlement without the approval in advance of the Chief Financial Officer and Chief People Officer or the Vacancy Panel.

7.3.5 All interim arrangements for staff with significant financial responsibilities must be on payroll.

7.3.6 All appointments with a gross cost of more than £100,000 per annum must be supported by a business case and approved by the Trust Executive Committee.

7.4 Processing of Payroll

7.4.1 The Chief Financial Officer is responsible for specifying timetables for submission of properly authorised time records and other notifications. These include:

- the final determination of pay and allowances;
- making payment on agreed dates;
- agreeing method of payment; and
- issuing instructions (as listed in SFI 7.4.2).

7.4.2 The Chief Financial Officer will issue instructions regarding:

- verification and documentation of data;
- the timetable for receipt and preparation of payroll data and the payment of employees and allowances
- maintenance of subsidiary records for superannuation, income tax, social security and other authorized deductions from pay;
- security and confidentiality of payroll information;
- checks to be applied to completed payroll before and after payment;
- authority to release payroll data under the provisions of the Data Protection Act; methods of payment available to various categories of employee and officers; procedures for payment by cheque, bank credit, or cash to employees and officers;
- procedures for the recall of cheques and bank credits, pay advances and their recovery;
- maintenance of regular and independent reconciliation of pay control accounts, separation of duties of preparing records and handling cash;
- a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust; and
- Salary sacrifice schemes which the Trust's staff are using.

7.4.3 Budget Holders have delegated responsibility for:

- submitting time records, and other notifications in accordance with agreed timetable
- completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;
- submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement.

7.4.4 Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

7.4.5 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and, that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.5 Contract of Employment

7.5.1 The Chief People Officer is responsible for:

- ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;
- dealing with variations to, or termination of, contracts of employment.

7.6 Staff Expenses

7.6.1 The Chief Financial Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief Financial Officer shall arrange for duly approved expense claims to be processed through the Trust's payroll system.

7.6.2 Expense claims shall be authorised in accordance with the Scheme of Delegation.

7.6.3 Travel expenses will be settled as determined by the Trust's expenses system, unless a clear explanation is provided and approved in accordance with the Scheme of Delegation.

7.6.4 The Chief Financial Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims where there are material breaches of Trust policies. In this regard the Chief Financial Officer shall liaise with the Chief Executive where appropriate.

STANDING FINANCIAL INSTRUCTION NO. 8

NON-PAY EXPENDITURE

8.1 Delegation of Authority

8.1.1 All employees have a responsibility to ensure the Trust is only committed to budgeted expenditure.

8.1.2 No employee shall commit or authorise expenditure unless they have delegated authority to do so.

8.1.3 As part of the approval of annual budgets as set out in SFI No. 2, the Board will approve non-pay budgets.

8.1.4 Budget holders have delegated authority to commit or authorise non pay expenditure up to the budget for the purpose of the budget subject to the limits set out in paragraph 8.1.7.

8.1.5 Virement of budget is permissible within the Trust's virement policy.

8.1.6 Total spending after virement in excess of delegated budget must be approved by the Chief Executive or Board, as below

Delegation	**Limit**
Chief Executive	£0 - £1,000,000
Trust Board	More than £1,000,000 (including Business Case)

8.1.7 Most goods or services will be ordered by Hertfordshire NHS Procurement following a requisition raised by requisitions'. The limits budget holders may authorise in a single requisition are as follows:

Employee	**Limit**
Budget holder	£25,000
Associate Directors / Divisional Directors / Divisional Managers / Deputy Directors / Heads and Deputy Heads of Departments	£100,000
Executive Director	£250,000
Chief Executive/Chief Financial Officer	£1,000,000
Trust Board	More than £1,000,000 (no limit on inter NHS contracts)

8.1.8 A single requisition may involve, for example, the requisition of a contract involving a number of annual payments. These payments must be added together to determine the limit.

8.1.9 Requisitions may not be split or otherwise placed in a manner devised so as to avoid the financial limits tabled above.

8.1.10 An Order for goods or service may result in a contract or license is to be signed by both the Trust and the supplier. These documents may only be signed in accordance with the delegated limits tabled below.

Employee	Limit
Executive Director	£250,000
Chief Executive or Chief Financial Officer	£1,000,000
Chief Executive (after approval by the Board)	More than £1,000,000 (no limit on inter NHS contracts)

8.1.11 Most invoices relating to goods requisitioned and purchased via an Order issued by Hertfordshire NHS Procurement do not require authorisation. Hertfordshire NHS Procurement matches the confirmation of receipt with the invoice and invoice value, and resolves any differences. Occasionally Hertfordshire NHS Procurement will seek budget holder assistance with this.

8.1.12 Where there is an ongoing contract and an order has not been matched, the delegated limits for confirming the Trust is required to make payment are set out below.

Employee	Limit
Employee delegated by budget holder	£1,000
Budget holder	£25,000
Associate Directors / Divisional Directors / Divisional Managers / Deputy Directors / Heads and Deputy Heads of Departments	£100,000
Chief Executive / Chief Financial Officer (or nominated deputies)	£1,000,000
Chief Executive / Chief Financial Officer Collectively	No limit

8.1.13 The Chief Financial Officer is responsible for maintaining the lists of employees and their delegated limits. Managers are responsible for advising the Chief Financial Officer of all changes (see paragraph 8.3 below).

8.1.14 Over £50,000 contracts for management consultancy will require approval from NHS Improvement if the Trust is in receipt of financial support. Under £50,000 will need Trust Executive Committee sign off.

8.2 Procedures for obtaining Goods and Services

8.2.1 In choosing the item to be supplied (or the service to be performed) the advice of Procurement (Hertfordshire NHS Procurement) shall be sought. This is to obtain value for money and as far as possible meet the sustainability obligations of the Trust.

8.2.2 The only exception to the above is the Pharmacy. Pharmacy is permitted to procure drugs without seeking the advice of Procurement (Hertfordshire NHS Procurement).

8.2.3 Where the advice of Procurement (Hertfordshire NHS Procurement) is not acceptable, the Chief Financial Officer (and/or the Chief Executive) shall be consulted and may approve procurement contrary to the advice received.

8.2.4 Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

8.2.5 The procedure that Procurement (Hertfordshire NHS Procurement) shall follow to raise Official Orders and the employees' role in this is set out in SFI No. 9 and 10.

8.2.6 No Order shall be issued for any item or items to any firm which has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, conventional hospitality such as lunches in the course of working visits.

8.2.7 These SFIs apply equally to goods or services relating to charitable expenditure (see SFI No. 9.10.3 for delegated limits).

8.3 Confirmation of Receipt of Goods and Services

8.3.1 The system for receipt of goods and services shall provide for:

- a list of Trust employees authorised to certify invoices (see paragraph 8.1.8);
- certification that goods have been duly received, examined and are in accordance with specification and the prices are correct;
- certification that work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, that the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; the account is in order for payment;
- instructions to employees regarding the handling and payment of accounts within the Finance Department.

8.4 Payment for Goods or Services

8.4.1 All contracts, for example' leases, tenancy agreements and other commitments, which may result in a liability, shall be notified to the Chief Financial Officer.

8.4.2 The Chief Financial Officer is responsible for the prompt payment of accounts and claims these shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

8.4.3 The Chief Financial Officer is responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

8.4.4 The Chief Financial Officer is responsible for designing and maintaining procedures regarding the use and control of purchasing cards.

8.4.5 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- the budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

- the Chief Financial Officer may approve the prepayment, permitting the prepayment arrangement to progress if:

    - the proposed arrangements takes into account the EU public procurement rules where the contract is above a stipulated financial threshold; and
    - the financial advantage outweighs the disadvantages.

- the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately advise the appropriate Director or Chief Executive if problems are encountered.

8.5 Petty Cash

8.5.1 Purchases from petty cash are restricted in value and by type of purchase as tabled below and must be supported by receipt(s) and certified by a budget holder within their delegated limit. (see 8.1.7 above)

Description	Amount
Return of Patients Cash	Up to the amount of cash deposited for Safe-keeping
Payment of Patients Fares or Funeral expenses for which the Trust is liable	Up to the amount of fares paid or funeral expense
All other petty cash payments	£100

8.5.2 The Chief Financial Officer will determine record keeping and other instructions relating to petty cash.

STANDING FINANCIAL INSTRUCTION NO. 9

TENDERING AND CONTRACTING FOR NON PAY EXPENDITURE

9.1 Duty to comply with Standing Orders and Standing Financial Instructions

9.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where SO 4.13 Suspension of Standing Orders is applied).

9.1.2 All contracts will:

- be within the Trust's powers as delegated by the Secretary of State;
- comply with relevant Department of Health guidance as advised by the Director of Procurement (Hertfordshire NHS Procurement);
- incorporate such of the Standard NHS terms and conditions as are applicable; and
- endeavour to obtain best value for money.

9.1.3 These SOs and SFIs apply also to where the Trust elects to invite tenders for the supply of health care services.

9.1.4 Directives by the Council of the European Union promulgated by the Department of Health prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs and SFIs.

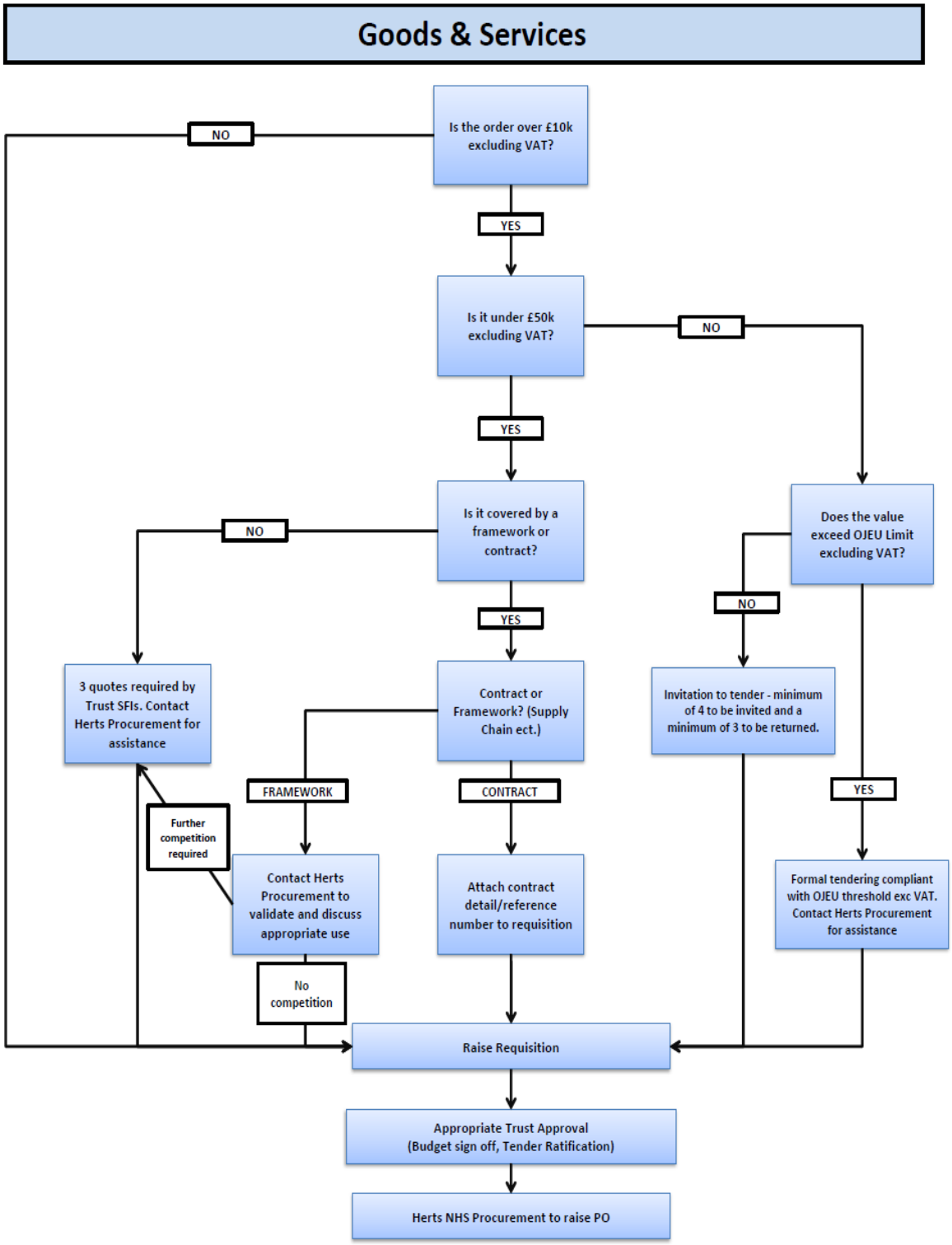
9.2 Procedure for procurement of non-pay items (other than the "employment of temporary staff" - see SFI No. 10)

9.2.1 SFI No. 8.2.2 refers to procedures concerning the procurement of drugs. In this instance the Trust is not required to use Hertfordshire NHS Procurement. The head of pharmacy is to follow similar procurement procedures as those set out below.

9.2.2 The budget-holder or other employee within their delegated limit (see SFI No. 8.1.7) will requisition Hertfordshire NHS Procurement to order the required goods or services.

9.2.3 Hertfordshire NHS Procurement will follow the process as set out in the flow charts for the procurement of goods or services dependent on the likely cost as tabled below. (OJEU Limits: based on prevailing EU procurement thresholds.)

Limits	Procedure
£0 - £10,000 excluding VAT	Obtain best value
£10,000 to £50,000 excluding VAT	Quotations: At least 3 to be issued and at least 3 returned
£50,000 excluding VAT to Current OJEU Threshold Limit excluding VAT	Formal tendering: At least 4 tenders to be issued and at least 3 returned
More than Current OJEU Threshold Limit excluding VAT	Formal tendering complying with OJEU
Works £10,000 to Current OJEU Limit which excludes VAT	Formal tendering: At least 4 tenders to be issued and at least 3 returned
OJEU Threshold Link which shows current limits	www.ojec.com/Thresholds.aspx


Goods & Services
Is the order over £10k excluding VAT?
NO
YES
Is it under £50k excluding VAT?
NO
YES
Is it covered by a framework or contract?
NO
YES
Does the value exceed OJEU Limit excluding VAT?
NO
YES
3 quotes required by Trust SFIs. Contact Herts Procurement for assistance
Contract or Framework? (Supply Chain ect.)
Invitation to tender - minimum of 4 to be invited and a minimum of 3 to be returned.
FRAMEWORK
CONTRACT
Further competition required
Contact Herts Procurement to validate and discuss appropriate use
Attach contract detail/reference number to requisition
Formal tendering compliant with OJEU threshold exc VAT. Contact Herts Procurement for assistance
No competition
Raise Requisition
Appropriate Trust Approval
(Budget sign off, Tender Ratification)
Herts NHS Procurement to raise PO

9.2.4 Hertfordshire NHS Procurement to use their knowledge base and compiled catalogues of suppliers and prices to obtain best value.

9.2.5 A minimum of three written quotations are required where the contract value is expected to be between £10,000 and £50,000 (excluding works).

9.2.6 Competitive quotations should:

- be obtained based on specifications or terms of reference prepared by, or on behalf of, the budget-holder;
- be in writing;
- be treated as confidential and should be retained for inspection; and
- be evaluated by Procurement and the quote which gives the best value for money should be selected. If this is not the lowest quotation, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

9.2.7 Items estimated to be below the limit set in this SFI that subsequently exceed the limit shall be reported to the Chief Financial Officer and Audit Committee along with circumstances where formal tendering procedures have been waived.

9.2.8 Where the likely contract value exceeds £50,000 for goods or services and £10,000 for works, formal tendering will be undertaken.

9.2.9 Following receipt of a requisition for goods or services likely to cost in excess of £50,000 and requisitions for works in excess of £10,000, Hertfordshire NHS Procurement will advise the budget-holder that a formal tender is required and request details of the project team to be involved in completing this. Hertfordshire NHS Procurement will lead the tendering process on behalf of the budget-holder.

9.3 Procedure for tendering

9.3.1 All tenders will be undertaken through the Bravo Solutions (Jaggaer Advantage) NHS Collaborative **e-**Procurement Portal. This will enable:

- the required levels of calls for competition a supplier information database
- a process to request for prequalification information evaluation of Expression of Interest & prequalification creation of quotation /tender documents
- an invitation to Tender receipt of Tenders opening Procedures
- an evaluation award and ratification contract management; and archiving of Tender documentation

9.3.2 Tenders will be returned to an electronic safe and locked until the due date for the receipt of bids from invited suppliers:

- As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the tenders shall be opened by the Director of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated representative. Should the Director of Procurement (Hertfordshire NHS Procurement) not be available the task may be further delegated to a Hertfordshire NHS Procurement staff member trained in the use of Bravo / Jaggaer Advantage.

9.3.3 The Director of Procurement (Hertfordshire NHS Procurement) as guardian for the Bravo / Jaggaer Advantage system is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of:

- The name of all firms or individuals invited to tender;
- The names of firms or individuals from which tenders have been received;
- The date the tenders were opened.

9.3.4 There is generally no discretion to receive tenders after the due date. In exceptional circumstances the Director of Procurement (Hertfordshire NHS Procurement) may approve the inclusion of a late tender. The request will include an explanation of the exceptional circumstance and assurance that the tender process has not been compromised.

9.3.5 Acceptance of tender

- If less than three tenders are received, the Chief Executive, Director of Procurement or Chief Financial Officer shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.
- Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender.
- The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.
- No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
- The use of these procedures must demonstrate that the award of the contract was the most economically advantageous tender.

9.3.6 The Director of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated officer responsible for tendering will report to the Trust Board on an exceptional circumstance basis as required by the Chief Executive.

9.4 Firms invited to quote or tender

9.4.1 The Director of Procurement (Hertfordshire NHS Procurement) on behalf of the Chief Executive will ensure the Trust's register of firms/individuals suitable for the supply of goods or services is kept via Bravo / Jaggaer Advantage and will access such other registers available for use by the NHS for example:

- Government frameworks
- Construction line Procure 22
- Crown Commercial Service frameworks
- EOECPH - East of England Collaborative Procurement Hub NHSSC – NHS Supply Chain
- Other relevant compliant frameworks

9.4.2 The Director of Procurement (Hertfordshire NHS Procurement) will determine which register (framework agreements) may be used.

9.4.3 The Director of Procurement (Hertfordshire NHS Procurement) shall ensure all tenders provide open competition and comply with relevant DH guidance. This does not preclude the assessment at either or both pre-qualification questionnaire or evaluation of tender of contractor suitability in for example:

- experience and qualifications understanding of the Trust's needs
- feasibility and credibility of proposed approach viability to deliver the goods or services
- health and safety record environmental considerations
- financial standing (Chief Financial Officer responsibility) clinical governance (Chief Medical Director responsibility).

9.4.4 Exceptions to usual procurement arrangements – Tender Quotation Waiver Request

- The waiving of competitive tendering procedures should not be used to:
  - avoid competition
  - be for administrative convenience
  - award further work to a consultant originally appointed through a competitive procedure.
- Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented using a waiver form obtained from the Director of Procurement (Hertfordshire NHS Procurement).

9.4.5 The Chief Financial Officer should ensure that the waiver register includes details of previous waivers to the same supplier. Where procurement contest the use of the waiver there should be a clear documented escalation to the signatories to set out the risks identified.

9.4.6 Authorised waivers are reported to the Audit Committee at each meeting.

9.5 Where it is not possible to obtain three quotations/tenders.

- This may occur where the goods or services are only available from a single supplier
- In very exceptional circumstances where formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, the circumstances must be detailed in an appropriate Trust record
- Where specialist expertise is required and is available from only one source
- When an unforeseeable task is required for a recently completed project and engaging different consultants for the new task would be inappropriate
- Where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.
- For the provision of legal advice and services from a legal firm or partnership commissioned by the Trust.
- Where permitted by DH guidance, details of must be documented in waiving formal tendering.
- Where a tender process has been properly followed, but insufficient returns have been received.
- Where the Chief Executive recommends urgent capital works need to be carried out. In this case, written confirmation must be obtained from the Chief Executive and forwarded to the Chief Financial Officer with an agreed timetable for completion of

procedures as detailed in SFI 9.2.

9.5.1 Please see 9.2 for quotation/tender limits.

9.5.2 It is Trust policy that all requests to progress with waivers must receive prior approval through the waiving of Standard Financial Instructions' procedure. All such Non Competitive Action (NCA) will require the completion of a Waiver Form. Waiver forms still require authorisation in line with the Trust's Scheme of Delegation. This is set out in the table below:

Revenue Spend	Trust Money
Director of Procurement (Hertfordshire NHS Procurement)	£0 - £50,000
Chief Executive or Chief Financial Officer	£50,000 - £100,000
Chief Executive and Chief Financial Officer Collectively	£100,000 - £250,000
Board/Chairman	Above £250,0000

Any waivers requiring Board approval will be sent to the Chief Financial Officer by procurement with a covering narrative asking for the waiver request to be taken to the Board for formal approval.

9.5.3 It should be noted that European Procurement Law applies at all times and in particular to proposed procurements in excess of the financial threshold appertaining at the time (OJEU Limits January 2020 Supply, Services and Design Contracts £122,976, Works £4,733,252).

9.5.4 European Procurement Law cannot be waivered and the Trust Procurement will advise Budget holders as to how compliance can be achieved.

9.5.5 It should be noted that procurements estimated to be below limits set out as above for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the appropriate Trust Senior Officer.

9.5.6 The Audit Committee may, at its discretion, invite regular users of the waiver and non-competitive action procedures to explain the need and to advise how this action may be avoided.

9.5.7 The Director of Procurement will provide a bi-monthly report to the Audit Committee detailing the use made of NCA and an annual report highlighting an analysis by budget holder and the reason for the use of waivers.

9.6 Acceptance of a quote or tender

9.6.1 Following evaluation and provided the winning quote or tender is within budget an official order is raised. Official orders must:

- be consecutively numbered;
- be in a form approved by the Chief Financial Officer, state the Trusts terms and conditions of trade, and
- only be raised by those authorised by the Chief Executive.

9.6.2 Those authorised by the Chief Executive are:

- Procurement (Hertfordshire NHS Procurement)
- Pharmacy (for procurement of drugs)

9.6.3 Verbal orders may only be issued very exceptionally by an employee listed in 9.6.1 and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”.

9.7 Auctions

9.7.1 Should the Trust choose to access Auctions (of any kind) as a process for procurement, this must be done through Hertfordshire NHS Procurement and the Chief Financial Officer must be assured the process complies with best practice guidelines https://www.gov.uk/government/organisations/crown-commercial-service.

9.8 Disposals

9.8.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

- any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or Director of Procurement (Hertfordshire NHS Procurement);
- obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
- items to be disposed of with an estimated sale value of less than £5,000;
- items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- land or buildings concerning which Department of Health guidance has been issued which shall be disposed of in compliance with such guidance.

9.9 In-house Services

9.9.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

9.9.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- specification group, comprising the Chief Executive or nominated lead Officer and specialist;
- in-house tender group, comprising a nominee of the Chief Executive and technical support; and,
- evaluation team, comprising normally a specialist officer, supplies officer and a Chief Financial Officer representative.

9.9.3 Each group shall work independently of each other and individual Officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

9.9.4 The evaluation team shall make recommendations to the Board.

9.10 Applicability to funds held in trust

9.10.1 Standing Order No.4.6.1 outlines the Trust's responsibilities as a Corporate Trustee for the management of funds it holds on trust.

9.10.2 The Authority and Compliance section at the start of these SFIs makes it clear SFIs apply equally to charitable funds. In addition there shall be full compliance with the legal requirements and best practice required by the Charity Commission.

9.10.3 The Chief Financial Officer shall ensure that each trust fund that the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements. Delegated limits for funds are:

Employee	Limit
Fund manager	£1,000
Divisional Clinical Director/Executive Director/Divisional Manager	£5,000
Chief Financial Officer	£25,000
Charitable Funds Committee	£100,000
Board of Trustee	No limit up to available funds

9.11 Contract and Contract Variation

9.11.1 Any legally binding agreement voluntarily entered into by two or more parties that places an obligation on each party to do or not do something for one or more of the other parties and that gives each party the right to demand the performance of whatever is promised to them by the other parties.

9.11.2 To be valid, all parties must be legally competent to enter a contract, neither the objective nor any of the obligations or promised performances may be illegal, mutuality of the agreement and of its obligations must exist, and there must be consideration.

9.11.3 For contract variation, please refer to the specific NHS Terms and Condition of contract, if you have bespoke Terms and Conditions refer to the section on variations.

9.12 Framework

9.12.1 A framework agreement is an umbrella agreement between one or more contracting authorities and one or more economic operators setting out all or some of the terms on which the parties can enter into contracts (call-offs) throughout the term of the umbrella agreement.

9.12.2 Call-offs are based on the terms of the framework agreement and may be either direct award or through further competition.

9.12.3 The terms of the framework agreement must be adhered to.

9.12.4 For further details on procurement please see the intranet pages or visit www.hertsprocurement.nhs.uk.

STANDING FINANCIAL INSTRUCTION NO. 10

EMPLOYMENT OF TEMPORARY STAFF

10.1 Personnel and Agency or Temporary Staff Contracts

10.1.1 To ensure the Trust achieves best value and that where appropriate DBS checks have been made temporary staff will only be employed in accordance with this SFI.

10.2 Temporary Medical Staff

10.2.1 Budget holders within their delegated limit and budget constraint may employ temporary staff. All requests must be approved by the Chief Medical Officer during normal working hours and outside working hours to be approved by the Senior Manager on call.

10.3 Temporary Nursing Staff

10.3.1 Temporary nursing staff requests must be authorised by the Chief Nurse at weekly rota review meetings. Any emergency requests for nursing staff additionally require senior manager on call approval.

10.3.2 All requests for temporary staff must be made through the Trust's temporary staff provider.

10.3.3 Any two of the following directors must approve the rate of pay for the shift where it is in excess of the agreed rate card[1],

- Chief Financial Officer
- Chief People Officer
- Chief Medical Officer
- Chief Operating Officer

10.3.4 Should temporary staff not be available via the Trust's nominated bank temporary staff provider, budget holders, within their delegated limit and budget constraint, may employ staff from agencies where a framework agreement is in place. The request must be authorised by the Vacancy Review Panel. Once authorised, the booking must be placed via the Trust's mandated booking system.

10.3.5 The maximum rates set for grades and specialties will be in line with nationally mandated restrictions and will be reviewed periodically. The agreed rates will be available from the Chief Financial Officer. Under any other circumstance, approval of the Chief Executive is required.

10.3.6 The Chief Financial Officer will be responsible for managing the agency spend to a limit if set by NHS Improvement.

10.4 Interim Managers

10.4.1 Managers are required to enter into formal contract for all interims either (a) NHS framework contract (b) Trust standard contract or (c) a negotiated contract approved by the Chief People Officer and Chief Financial Officer.

10.4.2 Purchase order raised cannot be greater than £100,000 or six months of service. Any variation to this contract in excess of £100,000 or six months of service to be reported to the Trust's Remuneration Committee.

10.4.3 All interim staff contracts must be submitted to the Chief Financial Officer via the submission of the necessary approval forms and processes as mandated by the Chief Executive Officer.

10.4.4 As stated under HMRC Regulation IR 35, any temporary appointments of staff and engagement agreed via a personal service company, partnership, nationally mandated off payroll engagement rules apply.

10.4.5 The Trust is responsible for deducting the tax and national insurance relevant to these off payroll engagements.

10.4.6 Prior to agreeing such appointments, the Trust's interim staff co-ordinator and the Financial Controller must be notified in order to carry out tests using the HMRC toolkit. Any decision will be assured by using an IR35 specialist who will issue a certificate of the decision. The correct tax and national insurance will be deducted at source.

10.4.7 Further guidance is available on the HMRC website https://www.gov.uk/guidance/ir35-find-out-if-it-applies.

STANDING FINANCIAL INSTRUCTION NO. 11

CAPITAL INVESTMENT, PRIVATE FINANCE AND LEASING

11.1 Capital Investment

11.1.1 The Chief Executive:

- shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- will delegate responsibility to a named individual for the delivery of all stages of capital schemes and for ensuring that schemes are on time and to cost;
- shall ensure that the capital investment is not undertaken without confirmation of sufficient funding to meet any future revenue consequences, including capital charges.

11.1.2 The approval of a capital programme shall not constitute approval for expenditure on any scheme. Scheme agreement will be in accordance with the delegated limits tabled below; however expenditure may not be committed until the Chief Financial Officer has issued capital expenditure approval (see paragraph 11.4.3)

Delegation – Trust *	**Limit (excluding VAT)**
Capital Finance Planning Group	£5,000- £150,000
Trust Executive Committee	£150,000 - £1,000,000
Trust Board	More than £1,000,000
NHS Improvement	In excess of Trust delegated limit

*Charity authorization limits available in Charity policies & procedures

11.1.3 For every capital expenditure proposal the Chief Executive shall ensure that a Capital Approval Document and where necessary a pre-business case document (for schemes over £5k but less than £150k) or detailed Business Case (for schemes over £150k) is produced. This will be submitted to the relevant groups and committee for approval. The business case must include:

- an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
- the involvement of appropriate Trust personnel and external agencies, appropriate project management and control arrangements;
- that the relevant budget manager has certified to the future costs and revenue consequences detailed in the business case.

11.1.4 For capital schemes where the contracts stipulate stage payments these shall comply with any relevant DH guidance.

11.1.5 The Chief Financial Officer shall operate the construction industry tax deduction scheme in accordance with HMRC.

11.1.6 The Chief Financial Officer shall regularly report expenditure and commitment against authorised expenditure to the Trust Board.

11.2 Post Project Evaluation

11.2.1 Post project evaluation will be undertaken on all programmed capital investments and where the Business Case is approved by the Board the post project evaluation will be reviewed by the Board.

11.2.2 The project evaluation shall as a minimum consider:

- the extent to which the original objectives have been met;
- the cost and the extent to which value for money can be demonstrated;
- the outcome compared with, the do nothing or do minimum option; risk;
- user satisfaction;
- procurement route;
- implementation compared with plan; time and resources; and lessons learnt

11.3 Private Financing (including Leasing)

11.3.1 The Trust should normally test for PFI or leasing when considering capital procurement. When the Trust proposes to use PFI or leasing (regardless of whether the lease is an operating or finance lease), the following procedures shall apply:

- the proposal must obtain approval commensurate with that which is required were the assets, goods or services to be obtained by outright purchase;
- the budget holder for the associated PFI/Lease cost must authorise that the costs are acceptable within their managed budget;
- the Chief Financial Officer shall demonstrate that the financing represents value for money and genuinely provides the desired transfer of risk; and
- any finance or lease document must be signed by the Chief Financial Officer and where this is in excess of the Chief Financial Officer's delegated limit, by the Chief Executive also.

11.3.2 In all other respects the procurement process contained within SFI 9 applies to PFI and Leasing.

11.3.3 All PFI contracts must be approved by the Board.

11.4 Capital Delegated Limits

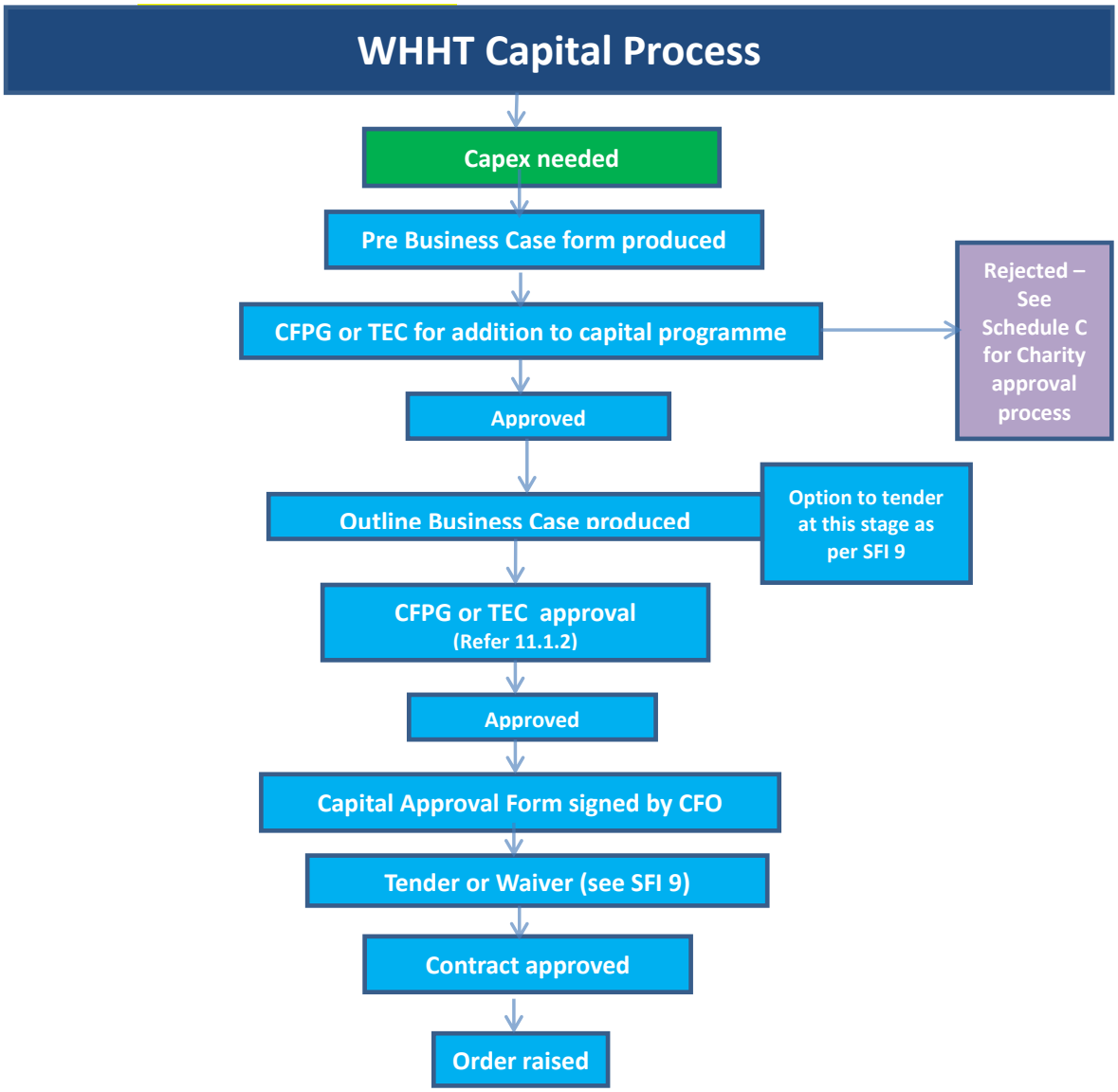
11.4.1 All initial allocations for capital schemes within the constraints of the Board approved programme will be set by Finance.

11.4.2 Following a tendering/quotation action and the approval of a business case, a Capital Expenditure Approval Request Form must be approved by the Chief Financial Officer and a Capital Approval Number (CAN) set up on the financial ledger in order for a purchase order to be raised. See the flow diagram (paragraph 11.4.4) below detailing the process to be followed before any capital commitment can be made.

11.4.3 The limits set out below relate to the subsequent authorisation of all requisitions, orders and invoices. All procurement is subject to the procedures set out in SFI No. 9

Employee	Limit
Project Manager	£100,000
Chief Executive / Director / Project Director / Financial Controller	£1,000,000
Chief Executive/ Chief Financial Officer Collectively	No limit

11.4.4 Any waivers raised should be in accordance with SFI 9 section 9.5.



STANDING FINANCIAL INSTRUCTION NO. 12

PROPERTY, PLANT and EQUIPMENT and INTANGIBLE ASSET REGISTERS, AND SECURITY

12.1 Asset Registers

12.1.1 The Chief Financial Officer is responsible for the maintenance of registers of assets, and arranging for a periodic physical check of assets against the asset register.

12.1.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified by the Department of Health Financial Reporting Manual (FReM).

12.1.3 Additions to the fixed asset register must be clearly identified so that it may be physically verified by reference to:

- Existence;
- Suppliers' invoices and other documentary evidence in respect of transfer of ownership;
- stores, requisitions and wages records for own materials and labour including appropriate overheads; and,
- lease agreements in respect of assets held under a finance lease and capitalised.

12.1.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.1.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.1.6 The asset register will show:

- The historical cost of each asset;
- adjustments for valuation in accordance with FReM and Trust accounting policies; and,
- depreciation in accordance with FReM and Trust accounting policies.

12.1.7 The Chief Financial Officer shall calculate and pay capital charges as specified by the Department of Health.

12.2 Security of Assets

12.2.1 The overall control of assets is the responsibility of the Chief Executive.

12.2.2 Asset control procedures (including plant, property and equipment, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

- recording managerial responsibility for each asset; identification of additions and disposals;
- identification of all repairs and maintenance expenses; physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

12.2.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.2.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

12.2.6 Where practical, assets should be marked as Trust property.

STANDING FINANCIAL INSTRUCTION NO. 13

MANAGEMENT OF INVENTORIES (including stores and stocks)

13.1 Stores

13.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- kept to a minimum;
- subjected to annual stock take;
- valued at the lower of cost and net realisable value.

13.1.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

13.1.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.1.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.2 Stocks

13.2.1 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

13.2.2 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

13.2.3 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 14 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

STANDING FINANCIAL INSTRUCTION NO. 14

DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.1 All unserviceable articles shall be:

- condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;
- recorded by the Condemning Officer in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

14.1.2 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

14.2 Losses and Special Payments

14.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

14.2.2 Any employee or officer discovering or suspecting a loss of any kind must immediately inform their head of department, who following investigation must inform the Chief Executive and the Chief Financial Officer and notify the employee discovering or suspecting the loss of their action. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud, bribery or corruption, the Chief Financial Officer must inform the relevant LCFS in accordance with the NHS Counter Fraud Authority Standards for Providers. All losses and Compensation claims will be reviewed by the Litigation Department / Patient Affairs before sending to Finance for final approval and payment.

14.2.3 The Chief Financial Officer must notify the NHS Counter Fraud Authority and the External Auditor of all frauds.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify the Board.

14.2.5 The write-off of losses will be approved within the delegated limits set out below and reported to the audit committee for review.

DESCRIPTION	£000	£000	£000
Cash Losses (Theft Fraud, Salary Overpayments, Losses of Cash)	0-1 Head Of Financial Accounts/Charity 1-10 Financial Controller	10-50 Chief Financial Officer	>50 Board
Loss or damage to personal property or effects	0-1 Head Of Financial Accounts/ Charity 1-10 Financial Controller	10-50 Chief Financial Officer	>50 Board
Bad Debts and Abandoned Claims	0-50 Financial Controller	50-250 Chief Financial Officer	>250 Board
Fruitless Payments (including Abandoned Capital Schemes)	0-50 Estates Director	50-100 Chief Financial Officer	100-250 Chief Executive
Loss of Damage to Trust Buildings, Property, Equipment	0-50 Estates Director	>50 Board	
Loss of Stock	0-50 Relevant Divisional Director	>50 Board	
Extra Contractual Payments to Contractors	0-50 Chief Financial Officer	>50 Board	

14.2.6 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.7 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

14.2.8 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

14.2.10 All losses and special payments must be reported to the Audit Committee at every meeting.

STANDING FINANCIAL INSTRUCTION NO. 15

COMPUTERISED SYSTEMS AND FREEDOM OF INFORMATION

15.1 Responsibilities and duties of the Chief Financial Officer

15.1.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

- devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
- ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
- ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Financial Officer may consider necessary is being carried out.

15.1.2 The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.1.3 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall ensure that:

- systems acquisition, development and maintenance are in line with corporate policies such as an IM&T Strategy;
- data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- such computer audit reviews as are considered necessary are carried out.

15.1.4 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.1.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

15.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application.

15.2.1 The Chief Executive will ensure each system is the responsibility of a designated officer.

15.2.2 Each designated officer will ensure the information contained is necessary for the operation of Trust business and as far as possible is accurate and up to date.

15.2.3 All Trust systems are operated in accordance with relevant Trust practices.

15.2.4 Each designated officer shall ensure that risks to the Trust arising from the use of each system are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.3 Freedom of Information

15.3.1 The Chief Information Officer and SIRO as the Chief Executive's nominated officer, shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. The Publication Scheme is a complete guide to the information routinely published by the Trust it describes the classes or types of information publicly available.

STANDING FINANCIAL INSTRUCTION NO. 16

PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") that is either handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt by:

- notices and information booklets; (notices are subject to sensitivity guidance) hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,.

16.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

STANDING FINANCIAL INSTRUCTION NO. 17

ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

17.1 The policy on acceptance of gifts, hospitality and sponsorship is detailed in the Trust's Conflicts of Interest policy. This policy is also relevant in respect to bribery prevention.

17.2 All Trust employees should be aware that they are responsible for public funds. Where staff wish to offer hospitality to third parties this shall be approved in accordance with the Scheme of Delegation, having due regard for materiality and intention and must comply with the Trust's Anti-Bribery and Conflicts of Interest Policy. The Trust Secretary shall be responsible for ensuring that all senior managers retain full records of all hospitality provided, with clear explanations of the hospitality offered, names of all Trust employees and third parties involved and the financial cost incurred by the Trust.

17.3 It is an offence to offer, promise or give a financial advantage, or request, agree to receive or accept a financial or other advantage where the offeror or recipient believes, intends or knows that the financial or other advantage will lead to improper performance of a relevant function. For further information on the Bribery Act 2012, please refer to the Trust's Anti Bribery Policy.

17.4 All staff must be aware of the potential risks in accepting gifts, hospitality and sponsorship, even where they have acted in good faith. All staff must comply with the Trust's Conflicts of Interest Policy.

17.5 The Trust Secretary must be formally notified of, and is responsible for maintaining a register of, all offers of gifts and hospitality, both accepted and rejected.

17.6 Compliance with the Conflicts of Interest Policy must be reported to the Audit Committee regularly.

STANDING FINANCIAL INSTRUCTION NO. 18

RETENTION OF RECORDS

18.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

18.2 The records held in archives shall be capable of retrieval by authorised persons.

18.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

18.4 The Chief Financial Officer shall provide advice on the retention of financial records.

STANDING FINANCIAL INSTRUCTION NO. 19

RISK MANAGEMENT AND INSURANCE

19.1 Programme of Risk Management

19.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board. The risk management strategy is approved at Risk Review Group and ratified at the Integrated Risk & Governance Committee a sub-committee of the Board. Due consideration should also be given to Risk Evaluation for Investment Decisions (REID) which outlines best practice governance and decision making processes (http://www.monitor-nhsft.gov.uk/sites/default/files/Monitor%20Investment%20Risk%20Evaluation.pdf)

19.1.2 The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities; engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk; contingency plans to offset the impact of adverse events; audit arrangements including; Internal Audit, clinical audit, health and safety review;
- a clear indication of which risks shall be insured; arrangements to review the Risk Management programme.

19.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by current Department of Health guidance.

19.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes, administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3 Insurance arrangements with commercial insurers

19.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions:

- The Trust may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use.
- where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

- where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the Department of Health.

19.3.2 The Trust has a specialist broker in place to deal with all commercial insurance, and all insurance should be managed through this broker.

19.4 Arrangements to be followed by the Board in agreeing Insurance cover

19.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

19.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the deductible). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Schedule A

Bank Authorisation and Access to Public Dividend Capital or Loans agreed by the Department of Health

Government Banking Services (GBS) Bank accounts

The signatory panel is for authorising the transfer of funds from the Trust's bank account in settlement of a Trust liability(s) that has been authorised in accordance with the Trust's SFIs.

Authorisation shall be any one of the following signatories;

- Chief Executive
- Chief Financial Officer
- Financial Controller
- Senior Finance Managers (≥Grade 7))

Commercial Bank

The signatory panel is for authorising the transfer of funds from the Trust's commercial bank account, in settlement of a Trust liability(s) that have been authorised in accordance with the Trust's SFIs. These payments will usually be urgent payments or transactions with non UK organisations.

Name (Signatory)	Group
Chief Executive	A
Chief Financial Officer	A
Financial Controller	B
Senior Finance Manager ≥Grade 7	B

Signing Limits

Up to £19,999.99	Any Two signatories
£20,000 - £49,999.99	Two signatories of which one must be an “A"
£50,000 and over	Two signatories both of which one must be an “A"

Public Dividend Capital

The signatory panel is for transferring to the Trust’s bank account additional public dividend capital and/or loans agreed by the Department of Health.

Authorisation shall be any two of the following signatories:

- Chief Executive
- Chief Financial Officer, Chief Operating Officer, Chief Medical Officer
- Chief Nurse and Director of Infection Prevention and Control

Schedule B

Version 1.9 Updates

1.0 The SFIs were reviewed and the changes are detailed below. Changes are minor and mainly updating with better controls as suggested and reflecting any changes to current legislation, and the change in the name of the procurement computer system (SFI 9). Specifically further increased disclosure regarding waivers has been included within this update.

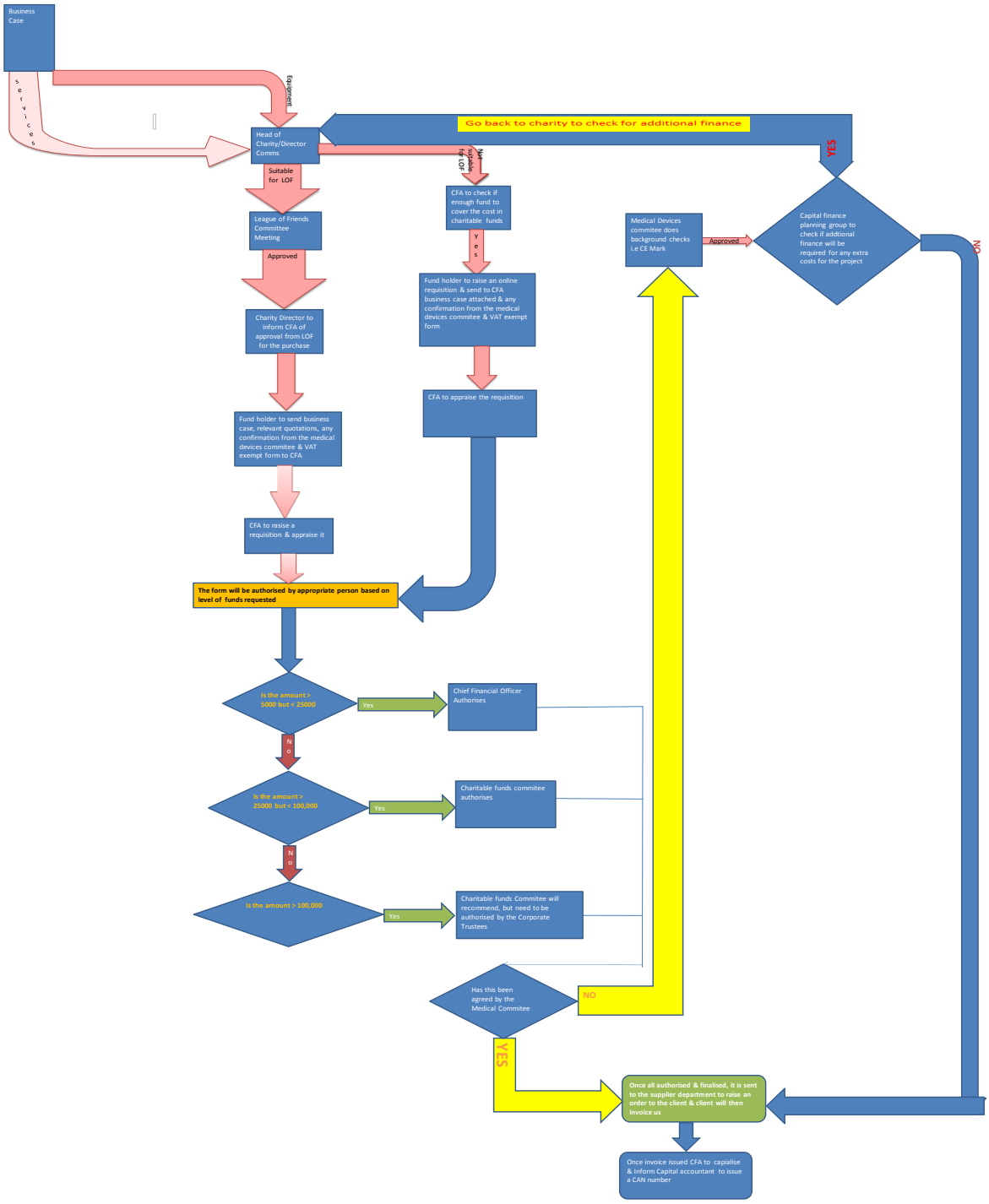
9.5.2 Procurement should contact directly the Chief Financial Officer where a waiver requiring Board approval is required. The Chief Financial Officer should be responsible for ensuring that the Board provides the approval and minute confirmation of these waivers

19.3.1 The Trust has a specialist broker in place to deal with all commercial insurance, and all insurance should be done through this broker

SFI/ Version 7.0
Ratified by: Audit Committee
Date of Ratification: October 2020
Date of Review: August 2021

Schedule C

West Herts Charity Capital Process



SO/ Version 2.5
Ratified by: Trust Board
Date of Ratification: xxxxx
Date of Review: August 2021

STANDING ORDERS

Change History

Version 1.0	SOs ratified by audit Committee June 2010
Version 1.1	SO No. 5 updated for Bribery Act ratified by audit Committee March 2011
Version 1.2	SO No. 5, 6 and 8 updated to include Capsticks (legal) advisors comments re Bribery Act. Cross references within the document amended.
Version 1.3	Version 1.2 reviewed no material changes made.
Version 1.4	Update to reflect recent legislation and to include Interpretation and Definitions
Version 2.0	Complete review of Standing Orders
Version 2.1	Complete review and minor changes made
Version 2.2	Minor changes made to reflect changes to the committee structure
Version 2.3	Document reviewed and no changes made
Version 2.4	Narrative added to highlight the Trust's responsibilities with regard to the Modern Slavery Act, updating of the voting executive directors, reflecting changes to the committee structure and a section added on the standards of business conduct.

ID Number	Version 2.5
Author's name	Jean Hickman
Author's job title	Trust Secretary
Division	Corporate
Version number	Version 2.5
Ratifying Committee	Audit Committee
Ratified date	x
Review date	August 2021
Name of manager responsible for review	Rod While
Job title of manager responsible for review	Trust Secretary
Email address for this manager	rod.while@nhs.net
Referenced (Yes/No)	Yes
Key words (to aid searching)	Membership, quorum, duties, delegated
User Group	All Staff
Equality Impact Assessment Completed	Yes

The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason in the application of this policy, and recognising the need to work in partnership with and seek guidance from other agencies and services to ensure that special needs are met.

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Foreword to Standing Orders

NHS Trusts are required by law to make Standing Orders, which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money. The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

Additional documents, which form part of these "extended" Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Reservation of Powers and Schedule of Delegation, which are designed to facilitate devolved decision making and personal accountability and set out delegated levels of authority and responsibility.

These extended Standing Orders set out the ground rules within which Board, Executive Directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values.

As well as protecting the Trust's interests, Standing Orders, Standing Financial Instructions and Reservation of Powers and Schedule of Delegation protect staff from any possible accusation of having acted less than properly. All executive and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

1. Interpretation and Definitions

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Board of the Trust shall be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive).

1.2. In these Standing Orders, words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa. References to any statutory body shall be deemed to include any successor body or bodies which may from time to time assume all or substantially all of the functions of that original statutory body.

1.3. References to any statute or statutory provision shall be deemed to include any instrument, order, regulation or direction issued under it and shall be construed to include a reference to the same as it may have been, or may from time to time be, amended, modified, consolidated, re-enacted or replaced.

1.4. Any expression to which a meaning is given in the National Health Service Acts 1977 and 2006, National Health Service and Community Care Act 1990, Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and in addition:

a) **"Accounting Officer"** means the Chief Executive and Accountable Officer who is responsible and accountable for funds entrusted to the Trust. The Accounting Officer is responsible for ensuring the proper stewardship of public funds and assets.

b) **"Board"** means the Chair, Executive Directors and Non-Executive Directors of the Trust, collectively as a body.

c) **"Budget"** means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of its functions.

d) **"Budget holder"** means the Executive Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation's budget.

e) **"Chair of the Board (or Trust)"** is the person appointed by the Appointments Commission on behalf of the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice Chair of the Trust, if there is one, if the Chair is absent from the meeting or is otherwise unavailable.

f) **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services for the Trust within available resources.

g) **"Committee"** means a Committee or sub-Committee created and appointed by the Board.

h) **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific Committees**.**

i) **"Contracting and procuring"** means the systems for obtaining the supply of good, materials, manufacturing items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

j) **"Chief Financial Officer"** means the executive director with responsibility for ensuring the Trust meets its statutory duties in relation to finance

k) **"Employee"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

l) **"Executive Director"** means an executive member of the Board who is either an executive member of the Board or is to be treated as such by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

m) **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, and now contained under Schedule 2, paragraph 12; Schedule 6, paragraph 8; and Schedule 5, paragraph 8 of the NHS Act 2006, as amended. Such funds may or may not be charitable.

n) **"HSCA 2015"** means the Health and Social Care Act 2015.

o) **"Member"** means an executive or non-executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.

p) **"Membership and Procedure Regulations"** means National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) and subsequent amendments.

q) **"Motion"** means a formal proposition to be discussed and voted on during the course of the meeting.

r) **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

s) **"Non-Executive Director"** means a member of the Board who is not an officer of the Trust.

t) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

u) **"Officer member"** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

v) **"SFIs"** means Standing Financial Instructions.

w) **"Trust"** means West Hertfordshire Hospitals NHS Trust.

x) **"Trust Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, Department of Health and Social Care or other regulatory body governance.

y) **"Vice Chair"** means the non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

2. INTRODUCTION

2.1 Statutory Framework

2.1.1 The West Hertfordshire Hospitals NHS Trust (the Trust) is a statutory body that came into existence on 23 March 2000 under West Hertfordshire Hospitals NHS Trust (Establishment) Order SI 2000/732 (the Establishment Order).

2.1.2 The principal places of business of the Trust are Watford General Hospital, Vicarage Road, Watford, Hertfordshire, WD18 0HB; Hemel Hempstead Hospital, Hillfield Road, Hemel Hempstead Herts, HP2 4AD and St Albans City Hospital, Waverley Road, St Albans Hertfordshire AL3 5PN.

2.1.3 NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the National Health Service Act 2006. In addition, the amendments to the National Health Service Act 2006 provided for under the Health and Social Care Act 2012.

2.1.4 The functions of the Trust are conferred by the above legislation.

2.1.5 As a statutory body, the Trust has specified powers to contract in its own name and to act as a Corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State.

2.1.6 The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and as now contained under Sections 256 and 257 of the NHS Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

2.1.7 The NHS Membership and Procurement Regulations 2014 requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

2.1.8 The Trust will also be bound by such other statutes and legal provisions that govern the conduct of its affairs.

2.1.9 Should any difficulties arise regarding the interpretation or application of any of the Standing Orders, advice should be sought from the Trust Secretary before acting. The user of these Standing Orders should also be familiar with and comply with the

provisions of the Trust's SFIs. Note in particular procedures for tendering, quotations and contracts and the Schedule of Powers Reserved to the Board.

2.1.10 Failure to comply with the Standing Orders, Standing Financial Instructions or Scheme of Delegation can, in certain circumstances, be regarded as a disciplinary matter that could result in dismissal.

2.1.11 All members of the Board and employees have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.

2.2 Equality and Human Rights

2.2.1 The Trust recognises that all sections of society may experience prejudice and discrimination. This can be true in service delivery and employment. The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have rights to be treated with dignity and respect. The Trust is working towards, and is committed to the elimination of unfair and unlawful discriminatory practices. All employees have responsibility for the effective implementation of the policy. They will be made fully aware of this policy and without exception must adhere to its requirements.

2.2.2 The Trust is also aware of its legal duties under the Human Rights Act 1998 and the Modern Slavery Act 2015.

2.2.3. The Trust is committed to carrying out its functions and service delivery in line with the Human Rights FREDA principles (i.e. **F**airness, **R**espect, **E**quality, **D**ignity and **A**utonomy).

2.3 NHS Framework

2.3.1 In addition to the statutory requirements the Secretary of State, through the Department of Health, issues further directions and guidance. These are normally issued under cover of a Department Circular or Departmental Letter.

2.3.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives. These are contained within the document 'Reservation of Powers and Scheme of Delegation'. The Code of Accountability also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference.

2.3.3 The Code of Conduct makes various requirements concerning possible conflicts of interests of Board Members.

2.3.4 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS. As from 1 January 2005, this was superseded by the Freedom of Information Act 2000.

2.4 Delegation of Powers

2.4.1 The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements.

2.4.2 Under the Standing Order relating to the Arrangements for the Exercise of Functions (Standing Order 6) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a Committee, sub-Committee or joint Committee appointed by virtue of Standing Order 5 or by an officer of the Trust. In each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct.

2.4.3 Delegated Powers are covered in a separate document (Reservation of Powers and Scheme of Delegation), this document has effect as if incorporated into the Standing Orders.

2.5 Integrated Governance

2.5.1 The Trust is committed to integrated governance which ensures that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

3. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP

3.1 Introduction

3.1.1 All business shall be conducted in the name of the Trust. All funds received in trust shall be held in the name of the Trust as a Corporate Trustee. In relation to funds held on trust, powers exercised by the Trust as a Corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.1.2 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 5. Directors acting on behalf of the Trust as a Corporate Trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to the Secretary to State for Health.

3.1.3 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Scheme of Delegation of powers and have effect as if incorporated into the Standing Orders.

3.2 Composition of the Membership of the Board

3.2.1 In accordance with the Establishment Order and Membership and Procedure Regulations, the composition of the Board shall be:

3.2.1.1 The Chair of the Board (appointed by NHS Improvement);

3.2.1.2 Up to 6 Non-Executive Directors (appointed by NHS Improvement);

3.2.1.3 Up to 5 Executive Directors (but not exceeding the number of Non-Executive Directors) including:

a) the Chief Executive
b) the Deputy Chief Executive
c) the Medical Director
d) the Chief Financial Officer
e) the Chief Nurse

3.2.1.4 The Trust shall have no more than eleven and not less than eight members (unless otherwise determined by the Secretary of State and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

3.3 Appointment and tenure of the Chair and Members of the Board

3.3.1 The appointment of the Chair and members are set out in the NHS Membership and Procedure Regulations 2014.

3.3.2 Regulation 7 of the Membership and Procedure Regulations sets out the period of tenure of office of the Chair and members and Regulations 8 and 9 of the Members and Procedure Regulations set out provisions for the termination or suspension of office of the Chair and Members.

3.4 Appointment and Powers of Vice-Chair

3.4.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Chair and members of the Board may appoint one of their number, who is not an Executive Director, to be Vice-Chair for such a period, not exceeding the remainder of their term as a Non-Executive Director of the Board, as they may specify on appointing them.

3.4.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and Board of Directors may thereupon appoint another Non-Executive Director as Vice-Chair.

3.4.3 In order to appoint the Vice-Chair, nominations will be invited. Where there are more than one nomination a postal vote will be conducted and the results will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this is being acceptable to the Directors present; the Board will be requested to confirm that person as Vice-Chair at the meeting in which the nomination is made.

3.4.4 Where the Chair of the Board has died or has ceased to hold office, or where he has been unable to perform his duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

3.5 Joint Members

3.5.1. Where the office of a member of the Board is shared jointly by more than one person:

a) Either or both of those persons may attend or take part in meetings of the Board;

b) If both are present at a meeting they should cast one vote if they agree;
c) In the case of disagreements no vote should be cast;
d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 4.11 Quorum;
e) If only one person attends the meeting, they shall be entitled to cast a vote.

3.6 Roles of Board Members

3.6.1 The Board will function as a corporate decision-making body; Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

a) Non-Executive Directors

i. The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

b) Chair

i. The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

ii. The Chair shall liaise with NHS Improvement over the appointment of the Non-Executive Board members and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments and their performance.

iii. The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform and debate and ultimate resolutions.

c) Executive Directors

i. Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Reservation of Powers and Scheme of Delegation.

d) Chief Executive

i. The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They are the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

e) Chief Financial Officer

i. The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

3.7 Corporate role of the Board

3.7.1 All business shall be conducted in the name of the Trust.

3.7.2 All funds received in trust shall be held in the name of the Trust as Corporate Trustee.

3.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 2.

3.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

3.7.5 The Board should undertake a formal and rigorous annual evaluation of its own performance and that of its Committees and individual directors.

3.8 Schedule of Matters Reserved to the Board and Scheme of Delegation

3.8.1 The Board has resolved that it may only exercise certain powers and decisions in formal session. These powers and decisions are set out in the 'Reservation of Powers and Scheme of Delegation' and shall have effect as if incorporated into the Standing Orders. Those powers that it has delegated to officers and other bodies are contained within this document.

3.9 Lead Roles for Board Members

3.9.1 The Chair will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health and Social Care and NHS England/NHS Improvement or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

4. MEETINGS OF THE TRUST

4.1 Calling meetings

4.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

4.1.2 The Chair may call a meeting of the Board at any time.

4.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

4.2 Notice of Meetings and the Business to be transacted

4.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member either by hand, by electronic means or post, so as to be available to members at least three clear days before the meeting. The notice shall be authorised by the Chair and may be issued by an officer authorised by the Chair.

4.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

4.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 4.6.

4.2.4 A member desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 14 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 14 days before a meeting may be included on the agenda at the discretion of the Chair.

4.2.5 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

4.3 Agenda and Supporting Papers

4.3.1 The agenda will be sent to members six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

4.3.2 Requests made less than eleven days before a meeting may be included on the agenda at the discretion of the Chair.

4.3.3 In the event of a petition (i.e. a letter or form of request submitted by a member or section of the public) being received by the Trust, the petition will be forwarded to the Trust Secretary for advice as to the appropriateness of that request being included in any part of the agenda for the Trust's next Board meeting.

4.4 Petitions

4.4.1 Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

4.5 Notice of Motion

4.5.1 Subject to the provision of Standing Orders 4.7, a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

4.5.2 The notice shall be delivered at least fourteen clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations.
This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

4.6 Emergency Motions

4.6.2 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 4.7, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.7 Motions: Procedure at and during a meeting

4.7.1 Who may propose

a. The Chair of the meeting or any member of the Board present may propose a motion. Another member of the Board must second it.

4.7.2 Contents of motions

a) The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

i. The reception of a report;
ii. Consideration of any item of business before the Board;
iii. The accuracy of minutes;
iv. That the Board proceed to next business;
v. That the Board adjourn;
vi. That the question be now put.

4.73 Amendments to motions

a. A motion for amendment shall not be discussed unless it has been proposed and seconded.

b. Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

c. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.7.4 Rights of reply to motions

a. Amendments

i. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b. Substantive/original motion

i. The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

4.7.5 Withdrawing a motion

a. A motion, or an amendment to a motion, may be withdrawn at any point of the proceedings of the Board.

4.7.6 Motions once under debate

a. When a motion is under debate, no motion may be moved other than:
   i. An amendment to the motion;
   ii. The adjournment of the discussion, or the meeting;
   iii. That the meeting proceed to the next business;
   iv. That the question should be now put;
   v. The appointment of an 'ad hoc' Committee to deal with a specific item of business;
   vi. That a member/director be not further heard;
   vii. A motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 2.17).

b. In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate.

c. If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

4.8 Motion to Rescind a Resolution

4.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Board who gives it and also the signature of three other members of the Board, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

4.8.2 When any such motion has been dealt with by the Board, it shall not be permitted for any member of the Board other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.9 Chair of meeting

4.9.1 At any meeting of the Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair (if the Board has appointed one), if present, shall preside.

4.9.2 If the Chair and Vice-Chair are absent, a Non-Executive Director member present shall preside. An Executive Director may not chair.

4.9.3 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the Standing Orders shall be final. In this interpretation he shall be advised by the Chief Executive and the Trust Secretary and in the case of Standing Financial Instructions he shall be advised by the Chief Financial Officer.

4.10 Chair's ruling

4.10 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.11 Quorum

4.11.1 No business shall be transacted at a meeting unless the agreed quorum in the terms of reference is in place.

4.11.2 An officer in attendance for an Executive Director on the Board but without formal acting up status will not count towards the quorum.

4.11.3 If the Chair or a member of the Board has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.8) that person shall no longer count towards the quorum.

4.11.4 If a quorum is not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.12 Voting

4.12.1 Every question put to a vote at a meeting shall be determined by a majority of the votes of members of the Board present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have a second, and casting vote.

4.12.2 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

4.12.3 If at least one third of the members of the Board present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

4.12.4 If a member of the Board so requests, their vote shall be recorded by name.

4.12.5 In no circumstances may an absent member of the Board vote by proxy. Absence is defined as being absent at the time of the vote.

4.12.6 A manager who has been formally appointed to act up for an Executive Director on the Board during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Member of the Board.

4.12.7 A manager attending the Trust Board meeting to represent an Executive Director member of the Board during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director member of the Board of Directors.

4.12.8 For the voting rules relating to joint members see Standing Order 3.5.

4.13 Suspension of Standing Orders

4.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 4.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the Board of Directors are present (including at least one Non Executive Director and one Executive Director member of the Board) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board's minutes.

4.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Board.

4.13.3 No formal business may be transacted while Standing Orders are suspended.

4.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

4.14 Variation and Amendment of Standing Orders

4.14.1 These Standing Orders shall not be varied except in the following circumstances:

a. Upon a notice of motion under Standing Order 4.7;
b. Upon a recommendation of the Chair or Chief Executive included on the agenda for a meeting;
c. That two thirds of Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Non-Executive Directors vote in favour of the amendment;
d. Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

4.15 Record of Attendance

4.15.1 The names of the Chair and Non-Executive Directors, Executive Directors on the Board, Executive Directors without voting rights and Officers in attendance present at the meeting shall be recorded.

4.16 Minutes

4.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where the person presiding at it shall sign them.

4.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

4.16.3 Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

4.17 Admission of public and the press

4.17.1 Admission and exclusion on grounds of confidentiality of business to be transacted

a. The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw at the point at which the Chair declares:

   i. 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960.

   ii. Guidance should be sought from Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

4.17.2 General disturbances

a. The Chair, Vice Chair or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

   i. *'That in the interests of public order the meeting adjourns for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960*'

4.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting

a. Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

b. Non-Executive Directors, Executive Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Chair. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

4.17.4 Use of mechanical or electrical equipment for recording or transmission of meetings

a. Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives, of recording, transmitting, videoing or similar apparatus into meetings of the Board or Committee. Such permission shall be granted only upon resolution of the Board.

4.17.5 Observers at Trust meetings

a) The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4.18 Annual General Meeting

4.1.8.1 The Trust will publicise and hold an Annual General Meeting in accordance with the NHS Trust's (Public Meetings) Regulations 1991 (SI (1991) 482). The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

5. APPOINTMENT OF COMMITTEES

5.1 Appointment of Committees

5.1.1 Subject to such directions as may be given by the Secretary of State for Health, the Board may appoint Committees of the Trust

5.1.2 The Board shall determine the membership and terms of reference of Committees and sub-Committees and shall if it requires to, receive and consider reports of such Committees.

5.1.3 The Standing Orders, as far as they are applicable, shall apply with appropriate alternation to meetings of any Committees or sub-Committees established by the Board. Each such Committee shall have terms of reference and powers and be subject to such conditions (such as reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.1.4 The Board may elect to change the Committees, sub-Committees and joint-Committees of the Trust, as necessary, without requirement to amend these Standing Orders.

5.1.5 Any Committee or sub-Committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Board or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

5.1.6 Committees may not delegate their executive powers to a sub-Committee unless expressly authorised by the Board.

5.2 Joint Committees

5.2.1 Joint Committees may be appointed by the Trust by joining together with other Trusts consisting of, wholly or partly of the Chair and Board members. Any joint Committee appointed under this standing order, subject to such directions as may be given by the Secretary of State or the Board or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committees.

5.3 Confidentiality

5.3.1. A member of a Committee or sub-Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.3.2 A Director of the Trust or member of a Committee or sub-Committee shall not disclose any matter reported to the Board or otherwise dealt with by the Committee or sub-Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee shall resolve that it is confidential.

5.4 Applicability of Standing Orders and Standing Financial Instructions to Committees

5.4.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Board. In which case the term “Chair” is to be read as a reference to the Chair of the other Committees as the context permits, and the term “member” is to be read as a reference to a member of other Committees also as the context permits. (There is no requirement to hold meetings of Committees established by the Board in public.)

5.5 Terms of Reference

5.5.1 Each Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.6 Delegation of Powers by Committees to Sub-Committees

5.6.1 Where Committees are authorised to establish Sub-Committees they may not delegate executive powers to the Sub-Committee unless expressly authorised by the Board.

5.7 Approval of Appointments to Committees

5.7.1 The Board shall approve the appointments to each of the Committees that it has formally constituted.

5.7.2 Where the Board determines, and regulations permit, that persons, who are neither Non-Executive Directors, Executive Directors or otherwise an employee of the Trust, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State.

5.7.3 The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.8 Appointments for Statutory functions

5.8.1 Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Secretary of State, and where such

appointments are to operate independently of the Board such appointment shall be made in accordance with the Regulations and Directions made by the Secretary of State.

5.9 Committees established by the Trust Board

5.9.1. The assurance Committees established by the Board are:

a. Audit Committee

i. In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and the Higgs report, an Audit Committee will be established and constituted to provide the Board with an independent and objective review of its financial systems, financial information, organisational governance and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Board and reviewed on an annual basis.

ii. The Higgs report recommends a minimum of three Non-Executive Directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

b. Remuneration Committee

i. In line with the requirements of the NHS Codes of Conduct and Accountability, and the Higgs report, a Remuneration Committee will be established and constituted.

ii. The Higgs report recommends the Committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

iii. The purpose of the Committee will be to advise the Board on appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other Directors of the Trust, including:

- Agree and review the overall remuneration policy of the Trust
- Set the individual remuneration for Executive Directors
- Ensure that appropriate and robust processes are in place to provide appropriate performance management of the Chief Executive
- Agree compromise agreements, settlements and redundancy payments which require final approval by NHS Improvement/HM Treasury and any proposed termination payments to very senior management

iv. The Committee shall report to the Board on the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors and senior employees.

v. Minutes of the Board's meetings should record such decisions.

c. Charity Committee

In line with its role as a Corporate Trustee for any funds held in trust, either as charitable or non-charitable funds, the Board will establish a Charitable Funds

Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

d. Quality Committee

The purpose of the Quality Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes that are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

e. People, Education and Research Committee

A Committee of the Board which provides assurance on all aspects of the workforce, organisational development and learning development and research.

f. Finance and Performance Committee

A Committee of the Board established to provide the Board with assurance on the financial strategy and plan to ensure long term financial viability and performance against the access standards.

g. Great Place Committee

A Committee of the Board established to gain assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and to provide senior level leadership to shape and drive the implementation of the Great Place elements of the Trust's strategy.

5.10 Other Committees

5.10.1 The Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5.11 Confidentiality

5.11.1 A member of a Committee will not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee will have reported to the Board or will otherwise have concluded on that matter.

5.11.2 A Board or Committee member, or anybody attending a Committee meeting, will not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee will resolve that it is confidential.

6. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

6.1 Delegation of Functions to Committees, Officers or Other Bodies

6.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of SO 5, or by an Officer of the

Trust, or by another body as defined in SO 6, in each case subject to such restrictions and conditions as the Board thinks fit.

6.1.2 Paragraph 18 of Schedule 4 of the NHS Act 2006 allows the functions of the Trust to be carried out jointly with any one or more of the following: NHS Trusts, NHS Improvement or any other body or individual (excluding Clinical Commissioning Groups).

6.1.3. Regulation 16 of the NHS Membership and Procedure Regulations 2014 permits the Trust to make arrangements for the exercise of behalf of the Trust of any of its functions by a Committee appointed pursuant to Regulation 15 of the membership and Procedure Regulations.

6.2 Emergency Powers and Urgent Decisions

6.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 3) may in an emergency or for an urgent decision, be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public session for formal ratification.

6.3 Delegation to Committees

6.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees or joint Committees, which it has formally constituted in accordance with Regulation 15 of the NHS Membership and Procedure Regulations 2014. The terms of reference of these Committees or joint Committees, and their specific executive powers shall be approved by the Board.

6.3.2 When the Board is not meeting in public session, it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Board in public session.

6.4 Delegation to Officers

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to Committee or joint Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

6.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board.

6.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

6.5 Reservation of Powers and Scheme of Delegation

6.5.1 The arrangements made by the Board as set out in the Reservation of Powers and Scheme of Delegation document shall have effect as if incorporated into these Standing Orders.

6.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

6.6.1 If for any reason the SO and SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and employees of the Trust have a duty to disclose any non-compliance with the Standing Orders and SFIs to the Chief Executive as soon as possible.

7. OVERLAP WITH OTHER TRUST POLICY, STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

7.1 Policy Statements: general principles

7.1.1 The Board will from time to time agree and approve Policy Statements/ procedures, which will apply to all, or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders
and SFIs. The Board may delegate the approval of specific policies to its Committees.

7.2 Specific Policy Statements

7.2.1 Notwithstanding the application of SO 7, the Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy Statements:

- Conflicts of interest policy
- Anti-bribery policy;
- The staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

7.3 Standing Financial Instructions

7.3.1 Standing Financial Instructions adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

7.4 Specific Guidance

7.4.1 Notwithstanding the application of SO 7, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000;
- The Public Contracts Regulations 2006;

- Confidentiality: NHS Code of Practice 2003;
- Standards of Business Conduct for NHS Staff;
- The NHS Constitution for England 2013.

8. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS AND ALL STAFF UNDER THESE STANDING ORDERS

8.1 Conflicts of Interests

8.1.1 Requirements for Declaring Conflicts of Interests and applicability to Board Members

8.1.1.1 In addition to the statutory requirements relating to pecuniary interests dealt with in Standing Order 9, under the Trust's Conflicts of Interests policy directors are required to declare interests which are relevant and material to the Board. All existing directors and any senior officers who may act up into an Executive Director post should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and senior officers appointed subsequently should declare these interests on appointment.

8.1.2 Declarable interests –

8.1.2.1 Interests that should be declared are:

- Financial interests: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

- Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- Indirect interests: Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

8.1.2.2 Any member of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8 and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

8.1.2.3 It is important to ensure that all declarations are submitted and up to date, to ensure the Trust has a robust system to prevent bribery. Trust employees should refer to the Trust's Counter Fraud Policy and Anti-Bribery Policy for further information in relation to fraud and bribery offences. Failure to adhere to these

policies could, depending upon the circumstances, amount to a criminal offence and lead to the individual(s) being subject to disciplinary action and/or criminal investigation.

8.1.3 Advice on Interests

8.1.3.1 Membership and Procedure regulations require that the pecuniary interest of directors' spouses and cohabiting partners, in contracts should be declared. Any members of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her has pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

8.1.3.2 If Directors have any doubts about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

8.1.4 Recording of interests in Board minutes

8.1.4.1 At the time Board members' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

8.1.5 Publication of declared interests in Annual Report

8.1.5.1 Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

8.1.6 Conflicts of interest that arise during the course of a meeting

8.1.6.1 During the course of a Board meeting, if a conflict of interest is established, the Board member should declare such likely conflict of interest and withdraw from the meeting, unless requested to remain by the Board members present. The Director should play no part in the relevant discussion or decision.

8.2 Register of Interests

8.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests that have been declared by both Non-Executive and Executive Directors.

8.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

8.2.3 The Register will be made available to the public.

8.3 **Standards of Business Conduct**

8.3.1 All staff must comply with the 'Standards of Business Conduct for NHS staff', 'Code of Conduct for NHS Managers' 2002 and the seven principles set out by the Committee on Standards in Public Life, published by the Professional Standards Authority, November 2012.

8.3.2 All staff must declare any relevant and material interest, such as those described in Standing Order 8. The declaration should be made on appointment or, if the interest is acquired, or recognised subsequently, at that time to the Executive Director, clinical director, or senior manager to whom they are accountable. Such director or senior manager shall ensure that such interests are entered in a Register of Interests, kept for that purpose.

8.3.4 Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the placing of contracts by the Trust, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

8.3.5 If an officer becomes aware of a potential or actual contract in which he has an interest, he shall immediately advise the Trust Secretary. This requirement applies whether or not the officer is likely to be involved in administering the proposed, or awarded contract to which he has an interest.

8.3.6 Gifts and hospitality shall only be accepted in accordance with the Trust's Conflicts of Interest policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

9. EXCLUSION OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNTOF PECUINARY INTEREST

9.1.1. Subject to the following provisions of this SO, if the Chair or a member of the Board of Directors, non-voting Executive Director or Trust employee has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after it's commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.1.2. The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this SO in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

9.1.3. The Board may exclude the Chair member of the Board of Directors, non-voting Executive Director or employee of the Trust from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

9.1.4. Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of Schedule 4 National Health Service Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

9.1.5. This Standing Order applies to a Committee, Sub-Committee, Joint Committee or Joint Sub-Committee as it applies to the Board and applies to a member of any such

Committee or Sub-Committee (whether or not he/she is also a member of the Board) as it applies to a member of the Board.

9.2 Powers of the Secretary of State for Health

a. Power of the Secretary of State to remove disability

i. Under Regulation 20(2) of the NHS Membership and Procedure Regulations 2014, there is a power for the Secretary of State to, subject to any conditions the Secretary of State may think fit to impose, remove any disability imposed by Regulation 20, in any case in which it appears to the Secretary of State in the interests of the health service that the disability (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) should be removed.

9.3 Interest of Officers in Contracts

a. Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable.

b. An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

c. The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

d. The Trust is required to disclose in its Annual Report and Annual Financial Accounts, material related party transactions in compliance with Financial Reporting Standards (FRS) 8: Related Party Disclosures.

9.4 Tendering and contract procedure

9.4.1. The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders is applied).

9.4.2 Full information on the Trust's tendering and contract procedures can be found in the Standing Financial Instructions.

9.5 Canvassing of and Recommendations by Members in Relation to Appointments

a. Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the SO shall be included in application forms or otherwise brought to the attention of candidates.

b. Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this SO shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

c. Informal discussions outside appointment panels or Committees, whether solicited or unsolicited should be declared to the panel or Committee

9.6 Relatives of Members or Officers

a. Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

b. The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

c. On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

d. Where the relationship to a member of the Board is disclosed, the Standing Order headed Exclusion of Chair and Board Members in proceedings on account of pecuniary interest shall apply. (SO 9)

9.7. Canvassing of and Recommendations by Board Members in Relation to Appointments

a. Canvassing of a member of the Board or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

b. Members of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

10.1 Custody of Seal

10.1.1 The Chief Executive shall keep the Common Seal of the Trust, or a person nominated by them such as the Trust Secretary, in a secure place.

10.2 Sealing of Documents

10.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed by the Chief Executive or his/her nominated representative and witnessed by an Executive Director or Officer duly authorised by the Chief Executive. The witness

cannot be from the originating department.

10.2.2 Before any building, engineer, property or capital document is sealed, it must be approved and signed by the Chief Financial Officer (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate)

10.3 Register of Sealing

10.3.1 The Chief Executive shall keep a Register in which they, or an Executive Director Officer of the Trust authorised by them, shall enter a record of the sealing of every document.

10.3.2 An entry of every sealing shall be made and number consecutively in a book provided for that purpose, and shall be signed by the person who shall have approved and authorised the document and those who witnessed the seal. A report of all sealings shall be made to the Board via the Audit Committee on a quarterly basis. The report shall contain details of the seal number, the description of the document and date of sealing.

10.4 Signature of documents

10.4.1 **Delegated Authority in Legal Proceedings**

10.4.1.1Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director on the Board.

10.4.1.2In land transactions, where the signing of certain supporting documents may be required these will also be signed by the Chief Executive or Executive Director Board.

11. MISCELLANEOUS

11.1 Joint Finance Arrangements

11.1.1 The Board may confirm contracts to purchase from a voluntary organisation or a Local Authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999. All transactions must comply with the Trust's Anti-Bribery Policy.

11.2 Standing Orders to be given to Board Members and Officers

11.2.1 It is the duty of the Chief Executive to ensure that existing Board Members and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

11.3 Documents having the standing of Standing Orders

11.3.1 Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers and the Detailed Scheme of Delegation shall have effect as if incorporated into Standing Orders.

11.4 Review of Standing Orders

11.4.1 Standing Orders shall be reviewed annually by the Audit Committee and recommended to the Board for approval. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

RESERVATION OF POWERS AND SCHEME OF DELEGATION

2020-21

ID Number	Version 1.10
Author's name	Jean Hickman
Author's job title	Trust Secretary
Division	Corporate
Version number	Version 1.10
Ratifying Committee	Audit Committee
Ratified date	xx
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Name of manager responsible for review	Rod While
Job title of manager responsible for review	Trust Secretary
Email address for this manager	Rod.while@nhs.net
Referenced (Yes/No)	Yes
Key words (to aid searching)	Membership, quorum, duties, delegated
User Group	All Staff
Equality Impact Assessment Completed	Yes

The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason in the application of this policy, and recognising the need to work in partnership with and seek guidance from other agencies and services to ensure that special needs are met.

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RESERVATION OF POWERS AND SCHEME OF DELEGATION

INTRODUCTION

The attached schedules set out the major delegations of authority which have been approved for operation within The West Hertfordshire NHS Trust. They are designed to facilitate devolved decision making and personal accountability.

The Chief Executive is ultimately responsible for the management of the day to day operational services and the effective use of resources. This responsibility is, however, delegated to operational directors, supported by their management teams.

Where the Trust Board or one of its committees has reached a decision under its terms of reference, the subsequent documentation committing the Trust to that decision will be signed by the Chair of the committee or the Chief Executive.

It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases. These financial authorities form part of the Trust's overall financial control framework as set out in the Standing Financial Instructions and other procedural guidance notes.

Each corporate function is constrained by its agreed annual plan, which governs manpower, facilities and financial resources. Corporate functions may not exceed agreed budgets or deviate from approved plans without prior agreement of the Chief Executive.

All projects are bound by these schemes of delegation even where funded partly or wholly from charitable or third party funds. Approval for business cases, and subsequent approval to commit expenditure must be in strict accordance with the detailed scheme of delegation, in addition to the requirement for approval to release funds which are set out in the Trust's charity procedures.

These schemes of delegation cover only matters delegated by the Trust to its senior officers. Each Executive Director is responsible for delegations within their function and should produce their own scheme of delegation, which should be distributed to all relevant staff.

Director schemes of delegation may not exceed the limits set out in this framework but they may restrict delegation further. All such schemes of delegation should include the requirement that all officers with delegated authority must make formally documented arrangements to cover their delegations in circumstances where they are absent for more than 48 hours.

SECTION 1
MATTERS RESERVED TO THE BOARD

DECISIONS RESERVED TO THE BOARD
General Enabling Provision The Board may determine any matter for which it has delegated or statutory authority it wishes in full session, within its statutory powers.
Regulations and Control 1. Approve Standing Orders (SOs), matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 4.2 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Approve arrangements for dealing with complaints. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 9. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 10. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

DECISIONS RESERVED TO THE BOARD
Regulations and Control continued. 12.Establish terms of reference and reporting arrangements of all committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 14. Authorise use of the seal. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 6.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.
Appointments/Dismissal 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 3.3). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Trust Secretary. 6 Approve proposals of the Remuneration Committee regarding directors and senior employees and proposals of the Chief Executive for staff not covered by the Remuneration Committee.
Strategy, Plans, Budgets and Capital 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment more than £1m. 5. Approve Revenue and Capital Budgets. 6. Approve annually the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

DECISIONS RESERVED TO THE BOARD
Strategy, Plans, Budgets and Capital continued 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation set out in SFI No. 14. 12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. 14. Review use of NHS Resolution's risk pooling schemes (LPST/CNST/RPST).
Policy Determination 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
Audit 1. Approve the appointment (and where necessary dismissal) of External Auditors appointed by The Trust. Approval of external auditors' arrangements for the separate audit of funds held on trust, and the submission of reports to the Audit Committee meetings who will take appropriate action. 2. Receive the annual management letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate of the Audit Committee.

DECISIONS RESERVED TO THE BOARD
Annual Reports and Accounts 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
Monitoring 1. Receipt of reports as the Board sees fit from committees in respect of their exercise of delegated powers. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. All monitoring returns required by the Department of Health and Social Care and the Charity Commission shall be reported, at least in summary, to the Board. 4. Receive reports from Chief Financial Officer on financial performance against budget and Local Delivery Plan.

SECTION 2
COMMITTEE DELEGATION

REF	COMMITTEE	
SFI 1.1	AUDIT COMMITTEE	The Committee's role focuses on the scrutiny of all Trust's activity. The Committee will: 1 Oversee Internal and External Audit services, including local counter fraud services; 2 Review financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments; 3 Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 4 Monitor compliance with Standing Orders and Standing Financial Instructions; 5 Review schedules of losses and compensations and making recommendations to the Board; 6 Review the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly; 7 Receive and approve the Annual Audited Accounts; 8 Scrutinise established sub committees; 9 Receive assurance of compliance from financial audit, clinical audit, clinical governance and associated clinical risk assessment; 10 Be supported by the finance department and the Trust Secretary to ensure that it is fully informed of activity in other sub-committees and so it may take action, through the Trust secretary where appropriate, to discharge its duties robustly. If the Audit Committee and Trust Secretary are confident that an issue can be resolved at sub-committee level, it need not be brought to the Board. Where there is a high level of risk, it will be referred to the Board for debate and decision; 11 Monitor the Auditor Panel to ensure it meets its terms of reference; 12 Monitor that procedure in place for whistle-blowing are efficient and effective.

SFI 7.1	REMUNERATION COMMITTEE	The Committee will: 1. Agree and review the overall remuneration policy of the Trust 2. Set the individual remuneration for Executive Directors 3. Ensure that appropriate and robust processes are in place to provide appropriate performance management of the Chief Executive 4. Agree compromise agreements, settlements and redundancy payments which require final approval by NHS Improvement/HM Treasury and any proposed termination payments to very senior management
SFI 9.10	CHARITY COMMITTEE	The Committee will: 1. Management of charitable funds 2. Ensuring best value of funds 3. Encouraging further donations 4. Monitoring systems comply with regulations and governance of NHS Charities

SECTION 3

EXECUTIVE DELEGATION

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
CE & CHIEF FINANCIAL OFFICER (CFO)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Department of Health and Social Care. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
CE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
CE	Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively.

CHAIR	Implement requirements of corporate governance.
CE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and Care Quality Commission.
CE / CFO	CE has a primary duty to see that CFO discharges this function. The CFO has operational responsibility for effective and sound financial management and information.
CE & CFO	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
CE & CFO	CE, supported by CFO, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
CE	If CE considers the Board or Chairman is doing something that might infringe probity or regularity, he should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the NHS Improvement and Department of Health and Social Care.
CE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that the CE is overruled it is normally sufficient to ensure that advice and the overruling are clearly apparent from the papers. Exceptionally, the CE should inform NHS Improvement and the Department of Health and Social Care. In such cases, and the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

CE	Is directly accountable to the Board for meeting their objectives and as Accountable Officer, to the Chief Executive of the NHS the performance of the organisation. For ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.
ALL BOARD MEMBERS	Subscribe to Code of Conduct. Board members share corporate responsibility for all decisions of the Board.
BOARD	Are required to meet regularly and to retain full and effective control over the organisation
CHAIR AND NON EXECUTIVE/ OFFICER MEMBERS	Chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
CHAIR	The key responsibilities of the Chair: - leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda; - ensuring the provision of accurate, timely and clear information to directors; - ensuring effective communication with staff, patients and the public; - arranging the regular evaluation of the performance of the board, its committees and individual directors; - facilitating the effective contribution of non- executive directors and ensuring constructive relations between executive and non-executive directors.

BOARD	It is the Board's duty to: - be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs - provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed - set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance - set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met. ***Further details may be obtained from NHS Guide: The Healthy NHS Board Principles for Good Governance***

NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHS Improvement to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care to Ministers and to the local community. The duties of the non-executive directors are to: - constructively challenge and contribute to the development of strategy; - scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance; - satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible; - determine appropriate levels of remuneration of executive directors and have prime role in appointing and where necessary , removing senior management and in succession planning and ; - ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses. Non-Executive directors also have a key role in assurance board committees: - Audit Committee - Remuneration Committee - Quality Committee - Finance and Performance Committee - Charity Committee - People, Education and Research Committee - Great Place Committee ***Further details may be obtained from NHS Guide: The Healthy NHS Board Principles for Good Governance***

SECTION 4
STANDING ORDERS DELEGATION

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.3	BOARD	Appointment of Vice Chairman
3.3	CHAIR	Chair all Board meetings and associated responsibilities.
4.1	CHAIR	Call meetings.
4.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
4.12	CHAIR	Having a second or casting vote
4.13	BOARD	Suspension of Standing Orders
4.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
4.14	BOARD	*Variation or amendment of Standing Orders*
5.1	BOARD	Subject to such directions as may be given by the Secretary of State, the Board may appoint Committees of the Board. The Board shall approve the membership and terms of reference of Committees and shall if it requires to, receive and consider reports of such Committees. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)

6.1	CHAIR & CHIEF EXECUTIVE	The powers which the Board has reserved to itself within these SOs may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board in public session for formal ratification the powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive.
6.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
6.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”.
7.4	THE BOARD	The NHS Code of Accountability requires Board Members to declare interests which are relevant and material to the business of the Board.
8.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
9.6	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
10.1	CHIEF EXECUTIVE	Keep custody of trust seal in safe place and maintain a register of sealing.

10.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

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SECTION 5

STANDING FINANCIAL INSTRUCTIONS DELEGATION

Introduction	CHIEF FINANCIAL OFFICER	Approval of all financial procedures.
Introduction	CHIEF FINANCIAL OFFICER	Advice on interpretation or application of SFIs.
Introduction Authority and Compliance	ALL MEMBERS OF THE BOARD & EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.
Introduction	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and
Introduction	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
Introduction	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.

Introduction	CHIEF FINANCIAL OFFICER	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Design & implement systems for internal financial control. f) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
Introduction	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
Introduction	CHIEF EXECUTIVE	Ensure that any contractors or employees of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
STANDING FINANCIAL INSTRUCTION NO. 1 AUDIT AND COUNTER FRAUD SERVICES		
1.1 /1.1.4	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.

1.1.2	AUDIT COMMITTEE CHAIR	Where Audit Committee considers there is evidence of ultra vires transactions or improper acts the matter shall be raised at the next Board meeting.
1.1.3	CHIEF FINANCIAL OFFICER AND TRUST SECRETARY	Inform audit committee of activities of other Board sub committees
1.1.5	CHIEF FINANCIAL OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
1.4.3	CHIEF FINANCIAL OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not Involving fraud or corruption.
1.2	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
1.4.1	CHIEF EXECUTIVE & CHIEF FINANACIAL OFFICER	Monitor and ensure compliance with Secretary of State's Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
1.5.1	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.

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STANDING FINANCIAL INSTRUCTION NO. 2 ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING		
2.1.1	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Compile and submit to the Board an annual plan which takes into account relevant financial and non financial targets.
2.1.2	CHIEF FINANCIAL OFFICER	Prepare and submit revenue and capital budgets to the Board in accordance with the Trust's plan; Facilitating budget holders to agree and sign up to their allocated budgets at the commencement of each year.
2.1.3	CHIEF FINANCIAL OFFICER	During the year monitor and challenge financial performance against budget and plan and report to the Board.
2.1.4	CHIEF FINANCIAL OFFICER	Ensure adequate on-going budget holder training
2.2	ALL EMPLOYEES	Ensure income and expenditure is contained within budgets as delegated by the Chief Executive and in accordance with the system devised by the Chief Financial Officer.
2.2.7	TRUST EXECUTIVE	Recommend to the Board and enact approved cost improvement, cost savings and income generation initiatives in accordance with the Annual Plan.
2.3	CHIEF FINANCIAL OFFICER	Ensure the Trust does not breach its External Financing Limit and all external borrowing is authorised By the Board.

2.4	CHIEF EXECUTIVE	Ensure all monitoring forms that the Trust is required to provide to external organisations are provided on a timelybasis
STANDING FINANCIAL INSTRUCTION NO. 3 ANNUAL ACCOUNTS AND REPORTS		
3.1	CHIEF FINANCIAL OFFICER	On behalf of the Trust ensure Annual accounts are prepared and audited in accordance with Department of Health and Social Care's timetable and adopted audit and accounting standards.
3.2	CHIEF EXECUTIVE	Publish an Annual Report that will include the Trust's Annual Accounts and be in accordance with relevant legislation and present it at a public meeting.
STANDING FINANCIAL INSTRUCTION NO. 4 BANK AND GOVERNMENT BANKING SERVICE AND EXTERNAL BORROWING		
4.1 to 4.4	CHIEF FINANCIAL OFFICER	Prepare and operate banking arrangements approved by the Board
4.5	CHIEF FINANCIAL OFFICER	Periodically report to the Board in respect of external borrowing.
4.5.3	BOARD	Approve all external borrowing
STANDING FINANCIAL INSTRUCTION NO. 5 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS		
5.1	CHIEF FINANCIAL OFFICER	Prepare and operate systems for recording, invoicing, collecting and coding of all income and ensure Prompt banking of all monies received.

5.2.1	CHIEF FINANCIAL OFFICER	Approve and regularly review the Trust's level of fees and charges.
5.2.2 / 5.2.3	ALL EMPLOYEES	Inform the Chief Financial Officer promptly of money due arising from any transaction initiated and only Initiate transactions within the boundaries of delegated responsibility.
5.3	CHIEF FINANCIAL OFFICER	Take action to recover outstanding debt and manage bad debt in accordance with losses and compensation procedure.
5.4	CHIEF FINANCIAL OFFICER	Ensure the Trust operates secure procedures for cash and other negotiable instruments.
STANDING FINANCIAL INSTRUCTION NO. 6 CONTRACTS FOR THE PROVISION OF HEALTHCARE SERVICES		
6	CHIEF EXECUTIVE	Ensure the Trust enters into suitable contracts with its Commissioners
6.4	CHIEF FINANCIAL OFFICER	Ensure a summary of the Trust's agreed contracts are reported annually to the Board
STANDING FINANCIAL INSTRUCTION NO. 7 PAYMENT AND TERMS OF SERVICE OF DIRECTORS AND EMPLOYEES		
7.1.1	BOARD	Determine the terms of reference of the remuneration committee
7.2 / 7.3	ALL BUDGET HOLDERS	Ensure staffing levels do not exceed funded establishment as determined by the budgets delegated under SFI No. 2

7.4	CHIEF FINANCIAL OFFICER	Issue instructions for the processing of pay
7.4.3	ALL BUDGET HOLDERS	Ensure times records, starter and leaver and other pay related information is passed to the Chief Financial Officer promptly.
7.5	DIRECTOR OF HUMAN RESOURCES	Ensuring all employees are issued with a contract of employment / variations / terminations in accordance with the Trust's SFIs,
7.6	CHIEF FINANCIAL OFFICER	Establish and operate the Trust's procedure for staff expenses
STANDING FINANCIAL INSTRUCTION NO. 8 NON – PAY EXPENDITURE		
8.1	CHIEF EXECUTIVE	Determine, and set out the level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to order, and the system for authorisation above that level.
8.1.1 and 8.3	ALL EMPLOYEES	Only commit or authorise expenditure where delegated to do so.
8.1.9	CHIEF FINANCIAL OFFICER	Maintain a list of employees authorised to commit the Trust to an order and/or authorise the payment of an invoice
8.2.1	BUDGET HOLDER	In choosing the item to be supplied (or the service to be performed) seek the advice of the Head of Procurement (HSMC)

8.3.2	CHIEF FINANCIAL OFFICER	Shall be responsible for the prompt payment of accounts and claims.
8.3.5	BUDGET HOLDER	Only commit the Trust to prepayments if approved by the Chief Financial Officer
8.4	CHIEF FINANCIAL OFFICER	Ensure and operate appropriate procedures in respect of petty cash.
8.4	ALL EMPLOYEES	Only seek reimbursement from petty cash in accordance with the restricted values set out in the SFIs
STANDING FINANCIAL INSTRUCTION NO. 9 TENDERING AND CONTRACTING FOR NON PAY EXPENDITURE		
9	HEAD OF PROCUREMENT (HSMC) AND DELEGATED MANAGERS OTHER	On behalf of the Chief Executive obtain quotations and where appropriate undertake tendering procedures in accordance with the Trust's SOs and SFIs. Evaluate and award contracts in accordance with the SFIs
9.4.3	CHIEF FINANCIAL OFFICER / MEDICAL DIRECTOR	Ensure that appropriate checks are carried out as to the financial standing and financial capability of those firms that are invited to tender and where appropriate clinical governance checks should be carried out.
9.9	CHIEF EXECUTIVE	Ensure all in-house services provide best value for money.

9.10	CHIEF FINANCIAL OFFICER	Ensure charitable funds are managed in accordance with the Trust's SOs/SFIs and charity commission regulations. That each trust fund is managed appropriately with regard to its purpose and its requirements.
STANDING FINANCIAL INSTRUCTION NO. 10 EMPLOYMENT OF TEMPORARY STAFF		
10.1	ALL BUDGET HOLDERS	Only obtain temporary personnel (in the first instance) from the Trust's Staff Bank or approved agencies within delegated responsibility and budget constraints
10.1	ALL BUDGET HOLDERS	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
STANDING FINANCIAL INSTRUCTION NO. 11 CAPITAL INVESTMENT, PRIVATE FINANCING AND LEASING		
11.1.1	CHIEF EXECUTIVE	Ensure appropriate appraisal and approval of capital investment and that each scheme has a Nominated officer to manage it.
11.1.2	CHIEF EXECUTIVE	Ensure appropriate investment appraisal documentation is prepared and evaluated. That the pay back period is assessed and revenue consequences of any capital investment is agreed prior to
11.1.4	CHIEF FINANCIAL OFFICER	Operate of the construction of industry taxation deduction scheme in accordance with HMRC guidance.
11.1.5	CHIEF FINANCIAL OFFICER	Report expenditure and commitment against authorised capital investment.

11.3.1	CHIEF FINANCIAL OFFICER	On behalf of the Chief Executive issue the authority to commit capital expenditure Expenditure. Subsequent invoices to be approved within delegated limits set out in SFI No. 11
11.2.3	BOARD	All PFI proposals must be agreed by the Board.
STANDING FINANCIAL INSTRUCTION NO. 12 PROPERTY, PLANT AND EQUIPMENT and INTANTIGIBLE ASSET REGISTERS, AND SECURITY		
12.1	CHIEF FINANCIAL OFFICER	Operate the Trust's asset register of plant, property and equipment in accordance with the Trust's SFIs
12.1.7	CHIEF FINANCIAL OFFICER	Calculate and pay capital charges in accordance with Department of Health and Social Care requirements.
12.2.1	CHIEF EXECUTIVE	Take overall responsibility for all assets.
12.2.2	CHIEF FINANCIAL OFFICER	Approval of fixed asset control procedures.
12.2.4 to 12.2.6	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to the Chief Financial Officer and reporting losses in accordance with SFI No.14. Where practical marking assets as Trust property.

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STANDING FINANCIAL INSTRUCTION NO. 13 MANAGEMENT OF INVENTORIES (including stores and stocks)		
13.1	STORES MANAGER	Delegated responsibility for control of stores (subject to CFO responsibility for systems of control).
13.1.2	CHIEF FINANCIAL OFFICER	Responsible for systems of control over stores and receipt of goods.
13.1.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
13.1.4	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores.
13.2.1	CHIEF FINANCIAL OFFICER	Agree stocktaking arrangements.
13.2.2	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.

13.2.3	CHIEF FINANCIAL OFFICER AND RELEVANT MANAGER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items. and report to CFO evidence of significant overstocking.
STANDING FINANCIAL INSTRUCTION NO. 14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS		
14.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures in accordance with SFIs for disposal of assets including Condemnations and ensure that these are notified to managers.
14.2.1	CHIEF FINANCIAL OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
14.2.2	ALL EMPLOYEES	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Chief Financial Officer.
14.2.2	CHIEF FINANCIAL OFFICER	Where a criminal offence is suspected, CFO must inform the police if theft or arson is involved. In cases of fraud and corruption CFO must inform the relevant LCFS and NHS Protect.
14.2.3	CHIEF FINANCIAL OFFICER	Notify LCFS and External Audit of all frauds.

14.2.4	CHIEF FINANCIAL OFFICER	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
14.2.5	BOARD AND DELEGATED MANAGERS	Approve write off of losses in accordance with delegated limits set out in SFI No. 14.
14.2.7	CHIEF FINANCIAL OFFICER	Consider whether any insurance claim can be made.
14.2.8	CHIEF FINANCIAL OFFICER	Maintain losses and special payments register.
14.2.10	CHIEF FINANCIAL OFFICER	Report all losses and special payments to the audit committee
STANDING FINANCIAL INSTRUCTION NO. 15 COMPUTERISED SYSTEMS AND FREEDOM OF INFORMATION		
15.1	CHIEF FINANCIAL OFFICER	Responsible for accuracy and security of computerised financial data.
15.1.2	CHIEF FINANCIAL OFFICER	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.

15.1.4 and 15.1.	CHIEF FINANCIAL OFFICER	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness, timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation
15.2	CHIEF EXECUTIVE	Ensure each System across the Trust has a designated manager responsible for it and that the systems contains as far as possible only necessary information that is accurate and up to date. There are disaster recovery procedures in place.
15.3	DIRECTOR OF COMMUNICATIONS	Shall publish and maintain a Freedom of Information Scheme (FOI).
STANDING FINANCIAL INSTRUCTION NO. 16 PATIENTS' PROPERTY		
16.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
16.3	CHIEF FINANCIAL OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises).
16.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.

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STANDING FINANCIAL INSTRUCTION NO. 17 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT		
17.1	CHIEF FINANCIAL OFFICER	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind.
17.6	TRUST SECRETARY	Maintain a register of all gifts and hospitality both accepted and rejected
STANDING FINANCIAL INSTRUCTION NO. 18 RETENTION OF RECORDS		
18.1	CHIEF EXECUTIVE	Retention of document procedures in accordance with Department of Health and Social Care guidelines
18.2 and 18.3	CHIEF EXECUTIVE	Ensure archived records may be retrieved only by authorised persons and authorise destruction of Records as appropriate when the request is outside that of Department of Health and Social Care guidelines.
18.4	CHIEF FINANCIAL OFFICER	Advise on the retention of financial records
STANDING FINANCIAL INSTRUCTION NO. 19 RISK MANAGEMENT AND INSURANCE		
19.1	CHIEF EXECUTIVE	Ensure the Trust has a programme of risk management in line with the Trust's SFI.

19.1	BOARD	Approve and monitor risk management programme.
19.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
19.3	CHIEFFINANCIAL OFFICER	Ensure commercial insurance is in place per the Trust's SFIs and in all other circumstances consult with the Department of Health and Social Care on the use of commercial insurance before committing the Trust
19.4	CHIEF FINANCIAL OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution, the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements. result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed
19.4.3	CHIEF FINANCIAL OFFICER	Ensure documented procedures cover the accounting treatment of amounts not recovered through risk pooling arrangements.

Trust Board Meeting
5 November 2020

Title of the paper	Corporate Risk Register Report
Agenda Item	19/84
Presenter	Mike Van der Watt, Chief Medical Officer
Author	Chux Ihekwereme, Risk Lead
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 12 October 2020. Data for this report was extracted from Datix on 01 October 2020 following updates made at the RRG meeting; a total of 22 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 29 October 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 12 October 2020 • Quality Committee on 29 October 2020
Action required	The Trust Board is asked to review the corporate risk register and endorse the changes to the CRR.

Agenda Item: 19/84

Trust Board Meeting – 5 November 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 12 October 2020. Data for this report was extracted on 01 October 2020 with some updates made following the RRG; a total of 22 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 12 October 2020 is provided in Appendix 1.

3.3 Risk activity

The following provides an overview of risk activity as discussed at the Risk Review Group on 12 October 2020:

3.4. New/Escalated risks (1)

One risk was presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR) and was **accepted**:

ID	Division	Current Risk Rating	Risk title	Rationale	Exec Lead
4325	Clinical Support	15	Risk of serious patient harm as a result of delayed reporting in acute and outpatient settings due to corrupted Voice Recognition	Corrupted Voice Recognition (VR) profiles since the Dragon 13 upgrade. 1. Individual consultants are unable to report scans and/or have to trial multiple reporting workstations before being able to work, losing hours of activity on a regular basis. 2. Many consultants are unable to work at all in the acute reporting suite. 3. Many consultants cannot work across all sites. 4. Affected individuals are forced into working in SPA and out-of-trust time to try and keep abreast of reporting and vetting examinations. 5. Insufficient IT support to resolve corrupted profiles. 6. Risk to patient safety is exacerbated by other IT failures e.g. PACS, network downtime as and when they arise	SD

3.5 De-escalated risks (0)

No risk was considered for de-escalation at the RRG meeting.

3.6 Closed Risk (0)

No risk on the CRR was tabled for closure at the RRG meeting:

3.7 Reduced risk score (0)

No risk was considered for reduction in current risk rating at the RRG meeting.

3.8 Increased risk score (0)

No risk was considered for increase in current risk rating at the RRG meeting.

3.9 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
November 2020

Appendix 1

Corporate Risk Register – Data extracted from Datix on 01 October 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	2765	11/08/2011	Lack of Interventional Radiology Suite at WGH.	12	The RRG approved the increase in risk score to 15 on 15/9/20.	15	Mike Van der Watt
No	4325	23/09/2020	Risk of serious patient harm as a result of delayed reporting in acute and outpatient settings due to corrupted Voice Recognition	15		15	Mike Van der Watt
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 Hennessey
Clinical Informatics (5)							
No	4283	20/05/2020	Vulnerabilities causing a cyber security incident	15	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.	15	Paul Bannister
No	4116	23/11/2018	Delivery of the Trust's Digital transformation programme	16	Discussed at the RRG in September 2020. Full Business Case is going to Board in October	16	Paul Bannister
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	Paul Bannister
No	3894	12/06/2017	ICT Data Networks 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	Paul Bannister

No	3896	12/06/2017	ICT Data Networks reduced availability, poor reliability & performance	20	WGH is planned to complete this coming weekend (19 & 20/09/20) There will then be a review and lessons learnt captured. Project will then go through the usual closure activities.	16	Paul Bannister
No	3899	12/06/2017	ICT Trust Bleep System	20	Work on going to get the infrastructure ready so that the bleeps can be used. Delivery anticipated for Oct 2020	20	Paul Bannister
Corporate Services (7)							
No	4191	10/07/2019	Risk of a financial liability to Trust following outcome of legal case 'Flowers'	20	We are still awaiting outcome of the legal case - no change	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	Several meetings with a broad demographic of backgrounds have now fed into the action plan which is close to being finalised. The consultation has also ensured the causation of our WRES performance is properly analysed and scrutinised in order to identify the key drivers behind the figures. Black History Month activity planning is also underway and seeks to celebrate our differences as well as promote understand around inclusion. Our external auditors have also provided us with our initial "grades" across six pillars. We are providing our final pieces of evidence in relation to this prior to the "grades" being confirmed. The Trust is also leading on creating a regional diversity dashboard to share and compare best practice with partner organisations.	15	Paul Da Gama

No	4304	28/07/2020	End of Life IT Devices/Systems	15		15	Paul Bannister
No	4207	12/09/2019	Inadequate post in-patient discharge appointment booking processes	20	An escalated outstanding action from the Emergency Medicine Division has now been completed. A meeting is to be arranged to progress the wider ward clerk work.	16	Sally Tucker
Yes	4280	28/04/2020	Workforce Well-Being	16	An ICS business case to support well-being on a system-wide basis has been produced for consideration. Those areas to be included in the ICS offering for well-being are those associated to: • Employee Assistance Programme. • Compassionate Leadership. • Mental Health First Aid Training. • Staff Benefits. • Psychological support. Additional activities are being considered by the Trust to complement the ICS proposal including further resourcing the well-being team, additional rest facilities, additional psychological support. A COVID wellbeing group has been convened and meets fortnightly which reports in to the COVID protected and workforce group.	20	Paul Da Gama
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	This risk was approved for addition to the CRR by the RRG on 15/9/20 with the likelihood of the risk being 5 and consequence 4. It was agreed that the impact of staff being off due to the 14-day self-isolation should be reflected in the risk record. Tanya Marcus and Alison Fuller are to update the risk and reflect on 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

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	Paul Bannister
Yes	3828	09/11/2016	Patients may come to harm and have a poor experience due to long waits for elective care	15	Number of long waits continues to increase Additional control in place to manage patient prioritisation No change to risk score	20	Sally Tucker
Emergency Medicine (1)							
No	3995	06/03/2018	Challenges in Recruitment of Emergency Medicine Medical Workforce	20	A business case is being taken to TMC on 23rd September to ask for approval for a 'recruitment and retention' financial package. This will allow us to match the recent offers made by neighbouring trusts and make us more competitive in the recruitment arena, as well as decreasing the chance of losing current consultants to better offers from neighbouring trusts. We have also recently appointed a locum consultant on a one-year fixed term contract. The Division plans to advertise again for 3 EM consultants as soon as the package is approved by TMC	16	Mike Van der Watt
Environment (3)							

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
No	4154	08/04/2019	Non-compliance with HTM00 (safe systems of work)	16	Risk was reviewed in August, score was discussed and reviewed. Score reduced to a 12 from a 16. Rationale is due to improved monitoring and compliance via statutory compliance meetings and PAM monitoring	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: 20

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**05 November 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 meeting on 23 September

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 23 September

- An update report was received on the restoration of services.
- The outcomes of the 2019 cancer patient survey were discussed and it was noted that overall there had been improvement across a number of questions compared to 2018.
- Status report on Quality Compliance Programme
- The Committee supported the business case on the relocation of HR and Finance staff to the Riverwell site
- The Committee approved the business case for Consultant recruitment and Retention.
- The Committee approved the business case for the direct engagement of agency locum doctors.
- The Committed debated the business case for the enhanced absence management service, though a decision was not reached pending a corporate finance review.
- The BDO team presented the internal audit plan for 2020/21.
- The Committee supported the business case for the accelerated EPR programme.

Risks to refer to the risk register	None
Items to escalate to the Board	None
Attendance	See next page

Summary of the Trust Management Committee

Held on 23 September 2020

Virtual Meeting

Name	Title	Attendance
Allen Christine	Chief Executive	Virtual
Members		
Brown Helen (HB)	Deputy Chief Executive	Virtual
Ball Adrian (Aba)	Divisional Manager, WACS	Apologies
Banks Freddie (FB)	Associate Medical Director, Clinical Strategy	Virtual
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	Apologies
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	Apologies
Gaunt David (DG)	Chief Clinical Information Officer	Virtual
Gertler Fran (FG)	Director of Integrated Care	Virtual
Gilchrist Sean (SG)	Director of Digital Transformation	Virtual
Halfpenny Louise (LH)	Director of Communications	Virtual
Hennessy Patrick (PH)	Director of Environment	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	Apologies
Mason James (JMa)	Head of Emergency Planning & Resilience	Virtual
McKee Jason (JMc)	Divisional Manager, Surgery, Anaesthetics and Cancer	Virtual
Mannion Collette (CM)	Director of Midwifery	Virtual
Miles-Kemp Natalie (NMK)	Head of Programme Delivery Support	Virtual
Moors Esther (EM)	Acute Redevelopment Programme Director	Virtual
Odlum Elaine (EO)	Divisional Manager, Medicine	Virtual
Clare Parker	Director of Integrated Care Partnership Development	Virtual
Pindai Rodney (RP)	Director of Contracts, Efficiency and Commercial Development	Virtual
Richards Don (DR)	Chief Financial Officer (Chair)	Virtual
Reece Ashley	Associate Medical Director for Medical Education	Apologies
Shentall Jane (JS)	Director of Performance	Virtual
Thorpe David (DT)	Deputy Chief Nurse	Virtual
Tucker Sally (ST)	Chief Operating Officer	Apologies
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 (from 1/04/20)	Virtual
While Rod	Trust Secretary	Virtual
Whittle Natalie	Divisional Manager for Clinical Support Services	Virtual
Wood Anna (AWo)	Deputy Medical Director & Associate Medical Director, Clinical Standards & Audit	Virtual
In attendance		
Alderman Julia (JA)	Business Co-ordinator to CEO & Chairman (**note taker**)	Virtual
Clare-Louise Hutchinson	BDO – internal auditor	Virtual
Nemisha Patel	BDO – Internal auditor	Virtual
Michelle Sorley	Macmillan Lead Nurse Cancer & Palliative Care	Virtual

Agenda Item: 21/84

Report to:	Trust Board
Title of Report:	People, Education and Research Committee Assurance Report to Trust Board
Date of meeting:	22 October 2020
Recommendation:	For information and assurance
Chairperson:	Natalie Edwards, Associate Non-Executive Director
Purpose:	The report summarises the assurances received by the People, Education and Research Committee at its meeting on 27 August 2020.
Background:	The Committee meets bi-monthly. During the COVID-19 pandemic met monthly April to August.

It provides assurance on:

- Workforce strategy
- Equality and diversity
- Induction
- Bullying and harassment
- Guardian of safe working
- Job planning
- Occupational health
- National surveys
- Staff health and wellbeing programme
- Revalidation
- Appraisals
- Fit and proper persons
- Whistle-blowing/Freedom to speak up
- Education and training
- Leadership development
- Talent management
- Flu vaccination programme
- Apprenticeships
- Staff engagement
- Relevant external review body reports
- Safe staffing

Key Business Undertaken:

Report on key workforce indicators plus COVID-19 workforce dashboard

The Committee received an overview of key workforce indicators. The key workforce indicators summarise the current workforce metrics against targets, measurement over time, benchmarking where possible, and a supporting narrative.

The Committee noted the challenges facing the Trust's workforce due to the impact of COVID-19. These include:

- Pregnant staff being unable to work in patient facing areas from 28 weeks onwards. The Trust has a young workforce which contributes to this factor.
- Staff having to self-isolate after changes to COVID status of countries.
- The restarting of elective services under COVID-19 social distancing conditions
- General fatigue and low resilience across workforce following the pandemic, but particularly in ITU and ED.
- The staff-side representative highlighted that ITU and ED staff did not consider that the impact of their traumatic experiences during the

pandemic had been sufficiently recognised by the Trust. It was agreed that the Chiefs present at the meeting should meet with those staff in order to understand how the Trust can recognise and support them appropriately.

Workforce Race Equality Standard (WRES) Report 2019-2020
The Committee received the report on the Trust's data and activity from April 2019 – March 2020. The reporting deadline had been extended by NHS England due to COVID-19.

Key points highlighted were:

- The report had been developed in partnership with the Trust's Connect Black, Asian and Minority Ethnic (BAME) staff network.
- Good progress had been made, with visible improvements.
- BAME staff population continues to grow.
- Decreasing, and below national average, reported rates of BAME colleagues:
    - entering formal disciplinary processes;
    - experiencing discrimination from colleagues.
- Closing the gap in relation to BAME applicants success at shortlisting stage

Areas requiring improvement include:

- BAME colleagues are experiencing an increasing and above national average amount of bullying, harassment and abuse from patients, relatives or the public
- The experience of equal opportunities for development and promotion.

A two year action plan has been created on the basis of these findings as well as other research. It was important to see tangible traction of these actions throughout the year and a diversity dashboard would be added to the IPR. The Committee also requested evidence of ownership of the action plan by the Executive team. It was noted that a recommendation had been made to include the action plan as part of divisional performance reviews.

The Committee noted that the report had not been discussed at TMC due to the timing of the meetings. Subject to final review following any recommendations made at TMC, the Committee supported the submission of the report to the Board for approval and subsequent publication on the Trust's website.

Workforce Disability Equality Standard (WDES) Report 2019-2020
The Committee received the report on the Trust's data and activity from April 2019 – March 2020. The metrics are taken from the 2019 staff survey, which received almost 300 responses from colleagues who self-identified as being disabled; around 6% of all employees. Whereas only 1% of staff have formally self-declared themselves via ESR as having have a disability.

Progress has been made in relation to disabled staff in the following metrics:

- experiencing discrimination from colleagues; and

- feeling valued.

Areas requiring improvement in relation to disabled staff in the following metrics:

- experiencing harassment and abuse from patients/public;
- experience of equal opportunities for development and promotion; and
- feeling pressured to come into work despite note feeling well enough to perform their duties.

As above, the Committee noted that the report had not been discussed at TMC due to the timing of the meetings. Subject to final review following any recommendations made at TMC, the Committee supported the submission of the report to the Board for approval and subsequent publication on the Trust's website.

Flu Assurance Paper - Compliance to NHS England Best Practise Management for Healthcare Worker Flu Vaccination

The Committee received assurance that the Trust is fully compliant with the NHS England Best Practise Management checklist and is doing everything possible as an employer to protect patients and staff from seasonal Influenza.

Working Towards Teaching Hospital Status

The Committee received an update on the project which will culminate in an application to the Department of Health and Social Care to change the Trusts' Establishment Order, to become West Hertfordshire Teaching Hospitals NHS Trust. This will have a positive impact on our reputation. In particular this will have a significant impact with our medical staff and those considering West Hertfordshire as a destination to support their medical and/or broader clinical training and development.

Guardian of Safe Working Quarterly Report

The Committee received the report for the quarter 1 May 2020 – 31 July 2020. During this quarter the COVID-19 Pandemic continued and there were ongoing changes in working practices and rotas around the Trust. This led to the redeployment of many junior doctors and the generation of new rotas.

During June and July there was a gradual return to pre-COVID-19 working patterns. The junior doctor workforce has been exceptionally accepting of these rapid changes and has been heavily involved in planning many of them, via a new COVID-19 Junior Doctor Forum set up by the Guardian of Safe Working in response to the pandemic.

Despite the significant changes in work practices and rapidly changing rotas the numbers of exception reports from junior doctors has been low.

There have been no significant exception reports resulting in a Guardian Fine.

Numbers of reports from the medical and surgical specialties have been low and have all related to genuine 'exceptions' rather than any ongoing

worrying trends.

On the basis of exception reports received it is the view of the Guardian of Safe Working that there are no significant issues in regard to the safe working of the junior doctors working on the new TCS at present. The Committee was assured by the report.

Annual Guardian of Safe Working Report
The Committee received the annual summary of doctor rota gaps, shift fill rates, and exception reporting data for the year August 2019 – August 2020.

There have been some rota gaps across the divisions with multiple recruitment attempts which were summarised in the report. Averaged over the year there have been around 22 WTE rota gaps within the Trust. Missing shifts have been filled with bank and agency staff, with an average of 8 unfilled shifts per week across the trust.

There have been 208 exception reports during the year. This is a reduction on 2018-2019. The vast majority were for additional hours worked with most being paid as compensatory pay rather than time off in lieu. This equates to around 0.8 reports per trainee per year. This is similar to other trusts in the region.

The majority of exception reports come from the junior training grades, predominantly foundation doctors. This is reflected elsewhere in the region.

Unlike 2018-2019 there were no episodes of significant breaches in the terms and conditions of the Junior Doctor Contract and no further Guardian Fines were imposed.

Despite the rota gaps and the significant changes to rotas during the year due to COVID-19, on the whole, doctors appear to have been working safely within the terms and conditions of the contract during the year, and where an issue was identified, it has been rectified for subsequent placements.

Further changes to the 2016 Terms and Conditions were agreed in 2019 and these have been implemented during the year in line with the schedule set out by NHS Employers. The most challenging of these was the move towards a maximum in 1 in 3 weekend working throughout all rotas. As of August 2020 there are no rotas planned with an excess of 1 in 3 weekends rostered.

The Committee was assured that the Guardian of Safe Working had no major concerns about the safe working of junior doctors in the Trust, despite significant changes due to the impact of COVID-19.

Health & Well Being Business Case Update
The Committee received an update on the business case to effectively support the well-being of our staff, both as a Trust and plans in partnership with the ICS to enhance that support, and the resources required to enable

the Trust to provide a comprehensive, high quality well-being programme to meet the needs of the WHHT workforce. The key areas of focus were on mental health and psychological support.

The Committee discussed how it is important to understand what staff want as take up of some existing services has been low. The Chief People Officer confirmed that all suggestions for support would be considered within the resources available.

The Committee supported the activities being undertaken and those being proposed to support the well-being of staff.

Talent Management Strategy version 1.1
The Committee were presented with the first Talent Strategy and its accompanying baseline implementation plan. The purpose of the strategy is to set out the high-level approach and initial areas of focus for implementing inclusive, sustainable and effective talent management practices across WHHT over the next 3-5 years. The roll out will be supported by a Talent Management toolkit which is under development.

Further discussion would take place at the Committee once it has been discussed by TMC.

Update on Black History Month activities
The Committee received a verbal update on the activities being undertaken during October for Black History Month. Marsha Jones, Associate Chief Nurse-Quality and Assurance and Connect Chair recommended that there should be an on-going agenda to highlight Black History. The Committee supported this and thanked Marsha for her significant personal impact to move the BAME agenda forward in the Trust.

Research & Development
The Committee received an overview of current research activity at WHHT, including progress with our restart plan to recommence non-COVID-19 activities where feasible, whilst continuing to support COVID-19 research.

The strategy was updated in early 2020, but will now need to be reviewed in the light of COVID-19. All KPIs are currently on target, apart from our desire to have research available alongside standard care in as many specialties as possible. Currently it is difficult to carry out research in many areas due to lack of availability of suitable studies and restrictions put in place by COVID-19.

Staffing in R&D is now a significant risk; new staff have been appointed but will require training to deliver research roles.

The other main risk relates to ATOS and Redcentric; managing the ICT system externally has caused delays in gaining access to eCRF systems for studies and remains unresolved. This issue caused a substantial reduction in portfolio recruitment in 2019/20 as previously reported.

Freedom to Speak Up Activity and Case Update
The Committee received an overview of current Freedom to Speak Up (FtSU) activity being delivered to encourage our staff to speak up; the report also provided a summary of all current FtSU cases from November 2019 to October 2020.

The report summarises the progress of each of the current FtSU cases, by type of case and progress to date. The report also provided a high level summary of the activity from the overall FtSU work plan and the five streams of work, driving the actions:

- Communication and good publicity
- Staff Engagement
- Value and Quality Assurance
- Measurement and Evaluation
- The FtSU team/Champion team

The FtSU Guardian noted that she had found that staff were willing to come forward and that issues raised were dealt with. Areas for improvement were more BAME staff to be encouraged to be FtSU Champions and lack of champions in some of the larger departments.

The Committee was assured by FtSU activity and casework.

Risks to refer to risk register:	None
Key decisions taken:	The following papers were supported for submission approval by the Board: Workforce Race Equality (WRES) Report Workforce Disability Equality (WDES) Report
Issues to escalate:	ITU and ED staff concerns that the impact of their traumatic experiences during the pandemic had not been sufficiently recognised by the Trust.
Challenges and exceptions:	None
Future exceptional items:	None

Present:
Natalie Edwards, Associate Non-Executive Director (Committee Chair)
Paul Cartwright, Non-Executive Director
Tracey Carter, Chief Nurse
Paul da Gama, Chief People Officer
Mike Van Der Watt, Chief Medical Officer

In attendance:
Laura Abel, Assistant Trust Secretary (minutes)
Joanna Bainbridge, Freedom to Speak Up Guardian (for F2SU report only)

Arfan Bhatti, Equality and Diversity Manager
Victoria Houghton, Senior Sister, ITC and staff side representative
Marsha Jones, Associate Chief Nurse-Quality and Assurance
Tania Marcus, Deputy Director of HR, People Services
Andrew McMenemy, Deputy Director of HR, Business Partnering and Learning
Benjamin Sheath, Transfusion Specialist Nurse and staff side representative
Rod While, Trust Secretary

Agenda item: 22/84

Report to:	Trust Board
Title of Report:	Assurance report from Finance and Performance Committee
Date of meeting:	05 November 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 29 October 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 September for ED, referral to treatment (RTT), cancer, diagnostic tests and ambulance handovers.

The Committee also reviewed the Trust's 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.

Elective activity continues to increase. The RTT 18 week performance target, improved from 62.5% in August to 69.7% in September, the highest performance since April, but still well below the 97% standard. The Committee noted that from the latest available benchmarking data, the Trust's performance in July of 51%, was above the national median of 47.1%.

As expected, the number of patients waiting more than 52 weeks continues to increase, with 855 at the end of September compared to 669 in August. The Committee was assured that options to outsource the three specialities with the highest number of waits: oral surgery, ENT and ophthalmology, are being explored, with oral surgery outsourcing planned from October.

Diagnostic testing improved marginally from a performance of 68.4% in August to 69.2%, still well below the 99% standard, which the Trust

consistently achieved pre COVID, but two and half times better than the performance in April. The latest available benchmarking, shows that the Trust's performance of 73.4% was better than the national median of 61.5%.

Five of the eight cancer waiting times achieved the national standard waiting time targets in September, one less than in August, but the reporting period is still not closed for the 62 day referral to first treatment, which currently has a provisional performance of 83.3%, just below the 85% standard. The Committee noted that from the latest available benchmarking data, the Trust's July performance of 76.5% on this 62 day standard was just below the national median of 78.1%.

The Committee was assured that appropriate harm reviews remained in place for all patients with long waiting times, and that a paper updating the harm review process was on the agenda of the October Quality Committee.

The A&E 4 hour waiting time performance improved in September from 83.1% in August to 84.3%, compared to the national standard of 95%. The standard was beaten by the UTCs at Hemel Hempstead and Watford, the CED dropped from 94.4% in August to 88.5%, following a 17.6% increase in attendances, and the flow of Majors remains challenging, with an increase of almost 12% in bed requests compared to August.

Benchmarking based on August shows that the Trust's waiting performance of 83.1% was lower than the national median of 88.9%. The Committee was assured that Trust projects that are underway to increase the capacity and flow in A&E aim to deliver significant improvements in patient experience including waiting times.

The Committee noted an improvement in ambulance waiting times in September of more than 30 minutes, down from 534 to 407 on a similar number of arrivals. This number of delays is still far too high, and the Committee looks forward to the outcome of a review with EEAST of their analysis covering year to date which shows that arrivals at Watford have increased by 5% whilst all other trusts in the region have had reductions.

<u>Elective Activity Recovery Targets</u>

The nationally set Phase 3 recovery targets are aimed at achieving the same levels of activity as the second half of last year, and the Committee reviewed the performance in September, compared with the Trust submitted plans and national targets. The plans cover elective, outpatient and diagnostic activity. In September performance in diagnostics was mixed, with CT scans and endoscopy ahead of plan, but MRI scanning falling below. Outpatients activity was just ahead of plan, and in elective activity, inpatients were above plan and day cases were below.

Planned performances increase significantly in October in a number of areas en route to achieving national targets, and early signs of actual performance in the first two weeks of October suggest that more areas of activity will fall below plan in the month. Actions being taken include discussions with local independent providers to increase capacity, and

selective increase in consultants.

Progress will be reviewed each month by the Committee and Board, and it is recognised that major risks to the plans are the extent of both a second COVID-19 peak and winter pressures.

Integrated Performance Report (IPR)
The Committee received verbal updates from the Chief Medical Officer and the Chief Operating Officer, on their key messages, including COVID-19 activity, which will be presented to the November Board.

Financial Performance

(i) Income and Expenditure

The Committee reviewed revenues and costs for the month, and half year, and the latest forecast for the full year.

In line with national guidelines on reimbursement of costs to manage COVID-19 pressures, the Trust has matched income with expenditure to deliver break even for the half year.

Revenues in September of £36.3m and year to date of £210.1m were matched by pay costs of £23.2m in the month and £134.6m to date, and non-pay costs of £13.1m and £75.5m.

Break even for the half year compares to the pre COVID-19 budget deficit of £2.0m.

The Committee was assured that the Trust is compliant with the national guidelines, including the rules on approval of COVID-19 related spend, which was £13.2m in the half year and matched by revenue reimbursement.

The Committee was also assured that the reimbursement of costs has not led to relaxation of financial controls. Reimbursement is managed centrally, and monthly clinical divisional reviews continue, reviewing costs and revenues generated from activity.

The Committee received an update from the CFO on the latest view of the I&E forecast, following the revised national guidance for the reimbursement structure for the second half year. Following the meeting on 23 October of the ICS with all the CFOs in the region, to agree on the distribution of unallocated revenues, the latest top-down view is that the Trust would generate a deficit of £5.6m for the full year.

The Committee recognises the challenges in forecasting activity levels for the rest of the year, including the rising number of COVID-19 patients, its impact on planned recovery of elective care, all on top of the impact of annual winter pressures.

The Committee was told that a more detailed forecast of activity and costs was underway, and agreed that there should be a presentation to the November Board covering the forecast assumptions, risks, and actions to reduce the deficit, ideally back to break even, but without jeopardising patient care.

(ii) Capital Spend

Capital spend to date is £4.6m plus £1.5m COVID-19 related. The challenging forecast capital spend for the year, excluding COVID-19, is £48m. The Committee noted that the main drivers of the acceleration in the second half year relate to major projects that have been approved, or in the final stages of approval, including EPR, MSCP, A&E expansion and theatres refurbishment.

This still requires significant spend on other projects, mainly providing much needed improvements to patient experience and the estate, and the Committee asked for a status report at the November meeting on approvals, progress and timetables, to seek assurance that the forecast spend is on track.

Business Case Updates

Watford Multi Storey Car Park (MSCP) Full Business Case (FBC)

The schedule is very tight to gain approval of the FBC by the Board and DHSC/NHS by early December, to enable the building contract to be signed by mid-December, and remain on track for completion of the MSCP by March 2022.

The Committee reviewed the latest draft FBC to seek early assurance on progress and that outstanding issues were being addressed.

The enabling works for the MSCP have already been fully approved by the Board and NHS, at a cost of approximately £8m and the FBC will seek further approval of approximately £31m.

The Committee reviewed the draft, covering the strategic, economic, commercial, financial, and management cases, and was assured that it complied with the NHS Comprehensive Investment Appraisal (CIA) model.

The Committee noted that the Trust was working closely with DHSC/NHS to ensure that they were fully briefed on progress and able to provide early guidance on issues.

The Committee was also assured that expert independent reviews had been commissioned and had confirmed that the procurement process was fully compliant, and had concluded a positive value for money assessment for the plan. The Committee was also assured that the draft contractual agreements, were being drawn up with our legal advisers, and would be ready for signing when finalised, following review and approval by the Trust Board, once the FBC has been approved by the Board and NHSI/E.

The Committee recommends that the draft FBC, with any clearly identified updates from the current draft, is presented to the November Board for approval, subject to any outstanding conditions, noting that final contracts between the Trust and LABV can only be entered into following final FBC approval by the Board in December and by DHSC/NHSI&E.

The Committee approved the recommendation to enter into essential pre-construction service agreements, in advance of final FBC approval, subject to a cumulative cap of £500k.

EPR and Pathology
The Committee was given verbal updates on the progress of both business cases, and recommends latest updates are also given to the November Board.

Corporate Risk Register (CRR) and Board Assurance Framework (BAF)
The Committee reviewed and approved the latest risk ratings and mitigating actions on the risks for which it is the primary assurance Committee. There is one area of risk on the CRR and BAF for which the Committee is the secondary assurance Committee. This covers the impact of long patient waiting times, which was missing from the reports and the Committee asked for them to be included in all future reports.

Risks to refer to risk register

See above

Issues to escalate

The Committee recommends the following to the November Board

For information and discussion:
- The I&E forecast for the year.

For approval:
- Submission of the Draft MSCP FBC to DHSC/NHSI&E for further feedback

Attendance record

Present
John Brougham, Non-Executive Director (Committee Chair)
Mike Van Der Watt – Chief Medical Officer
Don Richards, Chief Financial Officer
Phil Townsend, Trust Chair
Sally Tucker, Chief Operating Officer
Jane Shentall, Director of Performance
Simon West, Divisional Director Surgery, Anaesthetics and Cancer

Apologies
Christine Allen, Chief Executive Officer
Tracey Carter, Chief Nurse and Director of Infection Prevention and Control

In attendance
Tom Drabble, Patient Representative
Stephen Dunham, Associate Director of Risk, Efficiency
Rodney Pindai, Director of Contracting, Efficiency & Commercial Development
Soheb Rafiq, Associate Director, Financial Management
Rod While, Trust Secretary

Minutes
Laura Abel, Assistant Trust Secretary

Agenda Item: 24/84

Report to:	The Trust Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	05 November 2020
Recommendation:	For assurance
Chairperson:	Paul Cartwright, Non-Executive Director
Purpose	The report summarises the assurances received by the Audit Committee at the meeting held on 09 October 2020.

Background

The Committee meets four times a year for regular business and has two additional meetings in relation to the year-end sign off process. It provides assurance to the Board:

- on all aspects of internal audit and those aspects of external audit not reserved to the Audit Panel. The Audit Panel deals with the appointment and removal of the external auditor.
- on the appointment of the internal auditor
- that effective assurance controls, structures, systems and processes for integrated governance, risk management and internal controls are in place

Business undertaken

- Discussed briefly how and when WHHT finance systems, performance reporting, analysis (and behaviours) will need to adjust from the old tariff based system and methodology to the new ICS Accountable Care finance ideology. Audit and Finance Committees will need to return to this in a consistent manner at regular intervals as the ICS protocols develop over the next few weeks and months.
- Great Place Committee and Governance structure appear soundly constructed at this stage of the timetable. Appears appropriate to keep the IT and Building Programmes separately constituted particularly as that is how the broader NHS management will view them. The first meeting of the Committee was successful.
- Committee received a well written and interesting Clinical Audit Report that suggests that Clinical Audit is positioned and managed well. Further evidence to be provided to the next meeting that we are doing the most appropriate nature, mix amount of local and national audits and that the level and nature of resource allocated by the Trust is appropriate
- Internal Audit is starting as well as can be expected during

Covid and the current plan still seems appropriate in the light of changes wrought by Covid. Some effort is required before the next Audit Meeting in February to complete the important outstanding actions from RSM days particularly those in relation to medical devices and the CFO will ensure that they are addressed correctly prior to the next Audit Committee.

- Counterfraud appears in reasonable state. Current and Emerging Counterfraud risks were discussed and felt to be correctly reflected in the Trust's Risk Register. The Committee continues to be disappointed with the continued desultory progress by the central team and the CPS in concluding Project Alpha.
- WHHT is a clear outlier in the very interesting Counterfraud report benchmarking active WHHT referrals against other Trusts and more work needs to be done (prior to the next Audit Committee) to interpret the results; Is referring less than others a good or a bad thing? What – if anything - needs to be done?
- Standing Financial Instructions, Standing Orders and Scheme of delegation have changed little during the year and are deemed to remain appropriate at this stage of the move to the ICS/ICP regime. So far, the CFO confirmed that the Trust has not been asked to do anything that would fall foul of our standing instructions. The Standing instructions copious reference to EU regulation continues to be correct until we are told otherwise. The Great Place Committee needs to be added to the Standing Orders and Scheme of Delegation.
- The Committee looked closely at The Losses and Compensation register where things are broadly no worse or better than a year ago and - after conversation with our 3 professional firms on the committee – very consistent with the experience of our peer group. The Committee again expressed its slight disquiet at an NHS accounting convention that seems to discourage appropriate action in addressing losses from overseas visitors.

Risks to refer to risk register None

Issues to escalate None

Attendance record

<u>Attendees</u>

Paul Cartwright, Non-Executive Director (Chair)
John Brougham, Non-Executive Director
Don Richards, Chief Financial Officer
Rod While, Trust Secretary
Stephen Dunham, Associate Director Efficiency, Costing and Financial Risk
Onali Mohamedali, Financial Controller
Greg Rubens BDO
Ciaran McLaughlin Grant Thornton
Ade Oyerinde Grant Thornton

<u>In attendance for specific items</u>
Helen Brown, Deputy Chief Executive