TRUST BOARD
MEETING IN PUBLIC
AGENDA

2 December 2021 at 09.30 – 12.00
Via zoom only

Apologies should be conveyed to the Trust Secretary, Barbara Anthony on
barbara.anthony@nhs.net
or call 01923 436361

Time	Item ref	Title	Subcommittee / Purpose	Accountable officer	Paper or verbal
Standing items					
9.30	1	**Opening and welcome**	Information	Chair	Oral
9.35	2	**Patient story**	Information	Chair	Oral
9.45	3	**EPR status**	Information and assurance	Chief Information Officer	Oral
9.55	4	**Apologies for absence**	Information	Chair	Oral
	5	**Declarations of interest**	Information	Chair	Paper
	6	**Minutes of previous meeting on 4 November 2021**	Approval	Chair	Paper
	7	**Board decision log**	Information	Chair	Paper
	8	**Board action log**	Approval	Chair	Paper
	9	**Board workplan**	Approval	Chair	Paper
10.00	10	**Chair's report**	Information	Chair	Paper
10.05	11	**Chief Executive's report**	Information	CEO	Paper
Performance & Committee updates					
10.10	12	**Board Assurance Framework**	QC/ FPC Approval	CEO	Paper
10.15	13	**Trust Management Committee**	Information and assurance	CEO	Paper
	14	**Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
	15	**Quality Committee** – written report from October 21	Information and assurance	Chair of Committee/Chief Nurse	Paper
	16	**PERC** – written report from October 21.	Information and assurance	Chair of Committee/Chief People Officer	Paper
	16.1	**GPC** – written report from November 21.	Information and assurance	Chair of Committee/ Deputy CEO	Paper
10.25	17	**Integrated performance report**	Information and assurance	Chief Information	Paper

				Officer	
Aim 1: Best Care					
10.40	18	**West Hertfordshire Operational Resilience and Winter Plan 2021/22**	TMC/ Information and assurance	Chief Operating Officer	Paper
10.45	19	**Mandatory vaccination for NHS staff**	Information and assurance	Chief Nurse	Presentation
10.50	20	**Learning from deaths report**	QC/ Information and assurance	Chief Medical Officer	Paper
10.55	21	**Complaints and PALS Annual Report**	QC/ Information and assurance	Chief Nurse	Paper
11.00	22	**Litigation and Claims Annual Report**	QC/ Information and assurance	Chief Nurse	Paper
Aim 2: Best Value					
11.05	23	**Finance update**	FPC / Information and assurance	Chief Financial Officer	Paper
Aim 4: Great Place					
11.20	24	**Strategic Priorities update**	Information and assurance	Deputy CEO	Paper
11.30	25	**Progress update – 5 year change programme**	Information and assurance	Deputy CEO	Paper
11.40	26	**Summary of Clinical Strategy**	Information and assurance	Deputy CEO	Paper
Risk and Governance					
11.45	27	**Corporate Risk Register**	QC / Approval	Chief Medical Officer	Paper
11.50	28	**Items considered in November Private Trust Board**	Information and assurance	Trust Secretary	Paper
11.50	29	**Audit Committee Annual Report**	Information and assurance	Committee Chair	Paper
Closing Items					
12.15	30	**Any other business previously notified to the chair**	N/A	Chair	Oral
	31	**Questions from Healthwatch Hertfordshire**	N/A	Chair	Oral
	32	**Questions from our patients and members of the public**	N/A	Chair	Oral
	33	**Date of the next board meeting:** **2 February 2022** **Executive Meeting Room, Watford General Hospital and via zoom**	Information	Chair	Oral

Here is a story of how charitable support brings strategic change to patient care

Dr Narayanan

Samantha Sherratt

raise
West Hertfordshire Hospitals Charity

NHS
West Hertfordshire Hospitals NHS Trust

Woodland neonatal unit

- Level 2 (local neonatal unit)
- Part of East of England ODN
- > average no of births, complex case load
- Limited funding for innovation and improvement

Charitable funding can transform care

- Vision and strategy
- Commitment at corporate and ward level
- Sustainability
- Patient/parent centered
- Links and networks

The Echo machine – how it strategically improved our service

- 1200 / year referrals
- 300 - 500 inpatient requests
- Bottleneck – one scanner that served neonatal unit and outpatients

- 500 referrals from St Albans/ Hemel area

- Expansion of clinics to Hemel – one stop, at least 500 patients benefitted

Did you know that Raise has supported babies and families by helping us purchase …

Latest technologies

- Paediatric ultrasound scanner
- Video laryngoscope
- BiliLux machines (LED phototherapy light system)
- Baby LifeStart machine (neonatal bedside resuscitation unit) – agreed in principle

And also these things…

Patient comforts

- Kangaroo care chairs
- Electronic breast pumps
- Pillows for breastfeeding

Why the Raise and neonatal partnership works…

Harnessing the power of grateful patients

- Grant requests are strategic
- Raise is widely promoted to staff
- The team leads from the front

What next?

raise
West Hertfordshire Hospitals Charity

- We are developing our new strategic plan, with ‘grateful patient’ fundraising at its heart
- The partnership between the neonatal team and Raise shows how charitable funding can really transform patient care
- Let’s repeat this success!

Declarations of board members and attendees' interests

2 December 2021

Agenda item: 5

Name	Role	Description of interest
Phil Townsend	Chairman	None
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
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
Helen Davis	Associate Non-Executive Director	• Director and shareholder at Brierley Advisory LLP, currently seconded to NHP on a part time basis on behalf of a client. • Partner is senior civil servant at DHSC
Ginny Edwards	Non-Executive Director	• Director of Edwards Consulting Limited • Trustee of *Raise*, West Hertfordshire Hospitals NHS Trust Charity • Trustee Infection Prevention Society • NHS Professionals Bank • Interim Chair of the Infection Prevention Society • Community Ambassador for Peace Hospice Care • Husband is CEO of The Nuffield Trust; Director of Edwards Consulting Ltd; and a non-remunerated member of the Strategy Committee of

Last updated: November 2021

Name	Role	Description of interest
		Guy's and St Thomas's Charitable Trust
Natalie Edwards	Non-Executive Director	None
William Forson	Divisional Director of WACS	None
Louise Halfpenny	Director of Communications	None
Edwin Josephs	Non-Executive Director	• Member of the Vine House Health Centre Patient Participation Group
Jonathan Rennison	Non-Executive Director	Financial Interests • Edgecumbe Consulting – Associate • Director of The Yellow Chair Ltd Relevant Consultancy Contracts Held by The Yellow Chair Ltd (Financial Interests): o Kings College London – OD & Learning & Development Activities o In Touch Networks – Coaching Consultant o Government Commercial Function: Role – Subject Matter Expert (SME) delivering training and facilitation Professional Interests: • West Hertfordshire Hospitals Trust Charity Committee Chair • Trustee of Rising Tides Ltd
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
Mr Simon West	Divisional Director of Surgery, Anaesthetics and Cancer	• Director Northampton Hip and Knee
Dr Anna Wood	Director of Clinical Governance	None
Andrew McMenemy	Chief People Officer	None
Barbara Anthony	Trust Secretary	None
Clare Parker	Director of Strategy and Integration	None
Simon Vaughan	Director of ICT	None

Last updated: November 2021

Name	Role	Description of interest
Mark Landau	Head of Business Intelligence	None

Last updated: November 2021

TRUST BOARD MEETING IN PUBLIC
4 November 2021 from 09:30 – 12:00
via Zoom

Chair	Title	Attendance
Phil Townsend	Chairman	Yes
Voting members		
Christine Allen	Chief Executive	Yes
Helen Brown	Deputy Chief Executive	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Don Richards	Chief Financial Officer	Yes
Dr Mike van der Watt	Chief Medical Officer	Yes
Ginny Edwards	Non-Executive Director (Vice-Chair)	Yes
Jonathan Rennison	Non-Executive Director (Senior Independent Director)	Yes
Edwin Josephs	Non-Executive Director	Yes
Paul Cartwright	Non-Executive Director	Yes
Natalie Edwards	Non-Executive Director	Yes
Non-voting members		
Paul Bannister	Chief Information Officer	Yes
Sally Tucker	Chief Operating Officer	Yes
Andrew McMenemy	Chief People Officer	Yes
Helen Davis	Associate Non-Executive Director	Yes
Dr Andy Barlow	Divisional Director for Medicine	Yes
Dr Rachel Hoey	Divisional Director for Emergency Medicine	No
Dr Anna Wood	Director of Clinical Governance	Yes
Mr Simon West	Divisional Director for Surgery, Anaesthetics and Cancer	Yes
Mr William Forson	Divisional Director for Women's and Children	Yes
In attendance		
Barbara Anthony	Trust Secretary	Yes
Louise Halfpenny	Director of Communications	Yes
Meg Carter	Hertfordshire Healthwatch	Yes
Bennie Agbagwara-Osuji	Deputy Director of Midwifery	Yes

There were no members of the public in attendance.

MEETING NOTES

Standing items	
1	**Opening and welcome**
1.1	The Chair welcomed everyone to the meeting which was being held virtually due to the Exec Meeting Room being used for EPR training. He thanked Andrew McMenemy, Chief People Officer, for organising a successful staff recognition week as well as the Star of Herts award ceremony.
2	**Apologies for absence**
2.1	Apologies were received from Rachel Hoey, Divisional Director for Emergency Medicine.
3	**Patient story**
3.1	David Thorpe, Deputy Chief Nurse, Amanda Budd, Lead Nurse for Patient Experience and Geoff Brown from Healthwatch gave a presentation on patient co-production.
3.2	The Deputy Chief Nurse highlighted the Trust's engagement projects which worked with "hard to hear" groups to understand how services should be improved for the benefit of patients. A recent highlight had been engagement work with LD patients, carers and their families which showed where improvements could be made to make the service more accessible. The engagement work was fully supported by Healthwatch which valued the Trust's commitment to hearing patients and focusing on deliverable practicable projects.
3.3	Ginny Edwards asked how the Trust was measuring the impact of each project and heard from the Deputy Chief Nurse that a patient experience dashboard was in development as well as considering use of experience based design projects. Jonathan Rennison asked how the Trust was making itself more accessible to patient groups. He heard that the Trust operated an admissions register which alerted the safeguarding and acute liaison team if a vulnerable patient had been admitted. The alert required the teams to visit the patient daily and feedback was also being received about which tech would facilitate better interaction. Edwin Josephs noted that patient learning experience should be applied to all groups to make the Trust accessible to everyone.
4	**Declarations of interest**
4.1	Jonathan Rennison noted he had recently updated his declaration following his appointment as a subject matter specialist within the government commercial function.
5	**Minutes of previous meeting on 7 October 2021**
5.1	The following amendments were noted: 5.13 – Add "or otherwise" at the end. 22.3 – change to "alleviate unemployment" rather than providing employment.
5.2	**RESOLUTION: The Board approved the minutes of the previous meeting as a true and accurate record, subject to the above amendments.**
6	**Board decision log**
6.1	No amendments were required.
7	**Board action log**
7.1	Actions 1 and 2 were complete and could be closed. Action 3 was on the agenda and would be closed.
8	**Board work plan**
8.1	No amendments were required.

9	**Chair's report**
9.1	The Chair congratulated Ginny Edwards and Jonathan Rennison on their reappointment as non-executive directors for a further 2-year term until January 2024. He congratulated the Trust's charity, Raise for funding the upgrade to staff facilities on Level 5, PMOK.
9.2	The Chair confirmed to Paul Cartwright that at his recent meeting with local MPs he updated them about the Trust's plans and performance as well as discussions around the redevelopment. The board will be updated once a meeting has been arranged with Mike Penning, MP.
10	**Chief Executive's Report**
10.1	The CEO highlighted the recent rise in Covid-19 numbers. The Trust was presently managing 35-40 Covid -19 positive patients and this rise in patients made it difficult for teams to segregate patients in ward environments and the Emergency Department. She thanked staff for doing an incredible job.
10.2	November 2021 would be a big month for the Trust with the anticipated go-live of the EPR system, which would be the biggest project that the Trust had undertaken in a decade.
10.3	The Chief Medical Officer updated the Board that the government had launched a consultation on the audit requirements for the 7 day self-assessment process and an update would follow. The Chief Nurse reported the CQC's recent visit to review the Trust's maternity services where they considered the domains of safe, effective and well led. The report was expected at the end of November 2021 for factual accuracy.
PERFORMANCE & COMMITTEE REPORTS	
11	**Board Assurance Framework (BAF)**
11.1	The CEO presented the report which summarised the assurance framework around the Trust's objectives and the risks to their delivery. The BAF had been reviewed at a recent board development session. Revisions to the objectives around access, performance and safe care were required and would be presented to the December Board. Changes to the current BAF were highlighted in red.
	RESOLUTION: The Board approved the Board Assurance Framework in its current form.
12	**Trust Management Committee**
12.1	The CEO highlighted the number of business cases received by TMC and recommended for approval to the Board. The committee had also considered the revised IPR and recognised that it was a work in progress welcomed by committee, recognising still work in progress.
13	**Finance and Performance Committee**
13.1	Paul Cartwright, Committee Chair, reported that FPC had received good assurance from the new IPR and the committee looked forward to embedding it over the next few months. It discussed how unreachable targets could be resolved, as well as how the Executives would report into Board each month, as these reports helped the NEDs with their understanding.
13.2	The committee recommended the ED business case to the Board for approval and noted the excellent presentation from the Clinical Support Division and looked forward to an updating report in 6 months time.
14	**Quality Committee**
14.1	Jonathan Rennison, Committee Chair, noted the high levels of assurance in relation to the IPC BAF audit report, bi-annual report on IPC and the internal audit report on risk maturity levels.
14.2	The Maternity Safety Champions report demonstrated good progress and quality

14.3	improvement to the service over the past year. The committee noted that the role was adding value to the maternity service. The new dashboard and oversight metrics for the perinatal quality surveillance tool provided positive assurance on implementation and compliance and identified areas for future work and action. The committee noted high levels of assurance from the Medicines Management Annual Report and the Cervical Screening Bi-annual Report.
15	**PERC**
15.1	Natalie Edwards, Committee Chair, noted that good assurance was provided for the workforce strategy and National People Plan. It received a positive update around the vaccination programme, staff survey and All Stars event as well as the corporate workforce risks, guardian of safe working report, WRES report and FTSU report.
15.2	The committee noted that engagement from WACS for EPR training was being monitored. Turnover rates required further monitoring. A deep dive of the trends affecting staff retention had been undertaken which highlighted that relationship management and staff development/career progression were relevant themes and were addressed in the workforce strategy.
15.3	The CPO confirmed to Paul Cartwright that Covid-19 vaccination rates (validated) were over 91% with flu vaccination rates at 35%. The Trust was sitting in the middle of its peers in terms of benchmarking for flu.
16	**Integrated Performance report**
16.1	The CIO presented the new IPR which would need fine tuning over the next few months.
16.2	He focused on the interpretation of the exception reporting which would be accompanied by a narrative explanation. Where this was not possible, the exception would be explored within a board sub-committee or analysed further to understand the trend and its anticipated future impact.
16.3	Ginny Edwards queried how unachievable targets would be dealt with and how the board could monitor improvement and assure them that patients were receiving good, safe, quality care. She queried if other targets could be included to give assurance. The CIO outlined the available options and the Chair elected for board sub-committees to undertake deep dives on a periodic basis and highlight reports on specific areas of interest, outlining the cause, effect, actions and predicting the impact. This work could be summarised to the Board who would be assured that the committees were doing the work.
16.4	Helen Davis asked if there was learning for the Stroke Unit from E&NH as the latter was maintaining their 4 hour target. The COO confirmed that she would make enquiries, however the Trust could not move patients into the unit without knowing their covid status, and we have limited sideroom capacity. She referred to CNO & DIPC who agreed to ask E&NH how they managed their stroke pathway for admission.
16.5	Paul Cartwright queried how medically optimised patients were reflected within the IPR given the CMO's recent reflection that a number of patients should not be in hospital. The CIO confirmed that other metrics could be used internally to give indicator of quality or efficiency. The CEO added that data should only be included if it illustrated a point. The Board resolved that each committee should consider the metrics that were best for their reports.
16.6	Jonathan Rennison queried how the board would ensure that patients were not adversely affected by patient flow issues and would receive safe care particularly when the target could not be achieved.
16.7	The IPR will identify which committee, Executive and Divisional Director has responsibility for a particular metric. Committees would be asked to monitor the metrics and their outcomes. The Chair and CEO would further consider how to engage the Executives and Divisional Directors in the process.

16.8	**The COO would liaise with E&NH about their IPC pathways.**
17	**Ambulance Handover**
17.1	The COO presented the report which had been prepared in light of formal communication received on 26 October 2021 from NHSE. East of England Ambulance Service (EoEAS) had seen an increase in demand and delays set against a 23.3% rise in ambulance conveyances compared to 19/20 data. The Trust was required to report the actions that it was taking to prevents delays and to inform the board of the actions that were being taken at a local level.
17.2	September data showed an improving position following a number of initiatives enacted to ensure the safety of patients and to allow crews to be released promptly. The COO reported good joint working with EoEAS for finding workable solutions including the opportunity to bid for ambulance support workers who would enable crews to be released.
17.3	The Chair asked if there should be a focus on any particular measure to ensure success. The COO reported that all measures had been developed over a number of months. The bid for ambulance support workers had just started and would be dependant on the ability to recruit suitable staff.
17.4	Jonathan Rennison queried if the impact of the initiatives could be quantified and what the remaining gap would be. The COO explained that the issue was the pattern of arrivals i.e. everyone arriving at once. Good dialogue was taking place with EoEAS and the Trust was helped by the layout of its department. The CEO commented that the system was discussing how to respond to ambulance challenges and winter pressures with both national and local solutions. A peer review would take place across the system and the focus would remain on patient safety across system.
17.5	The COO would discuss with the CIO whether the matter should return to Board and would also be included in the Chief's section of the CEO report.
Aim 1: Best care	
18	**End of Life Care Annual Report**
18.1	The Chief Nurse noted that the report had been received by the Quality Committee which was assured by the evidence outlined in the report. She referred the Board to the key achievements, measures of success and risks contained within the report. The Board noted the report for information and assurance on how end of life care was managed during the pandemic and the progress made with the development of the strategy.
19	**Perinatal quality surveillance – maternity minimum dataset**
19.1	The report had been received by the Quality Committee. The Chief Nurse drew the Board's attention to appendix 1.
19.2	The Deputy Director of Midwifery updated the Board on staff/patient feedback for workforce. The service had maintained its consultant cover and had recruited 5 new consultants to support junior staff. It was challenged on its fill rate, which was at 85% due to vacancy factors and illness. These were known national issues. To maintain safety, the service had reviewed their specialist midwives and deployed them to work clinically. The service had closed the loop on patient leaflets with all interpreted information centralised in one area which had affected patient's choice and place of birth. In the past month, the service had recruited 17 new midwives which would improve the staff fill rate. Work was continuing with NHSE to recruit international midwifes.
19.3	Patient feedback had been received from the maternity voices partnership at its monthly meeting. Most complaints were about the visiting restrictions which had been resolved by increasing visiting from 2hrs to 4hrs on maternity wards. The "message of week" had been used to highlight this feedback. Actions from the maternity safety champion staff feedback had been captured and completed. Staff had report that there was no IT within triage and this had been resolved.

19.4	The Chief Nurse underlined that the impact of workforce issues on maternity services could not be underestimated with both national and local challenges affecting the service which the Chair noted would be discussed in Part 2.
Aim 2: Best Value	
20	**Finance update**
20.1	The CFO presented the update and summarised that the Trust was facing the new challenge of reducing waiting times whilst protecting capacity for unforeseen circumstances. The Trust had received a large amount of capital investment over the past few years and needed to focus on getting the benefits from those investments going forward, as well as making the best use of data to support decision making. The underlying challenge was the need to treat more elective patients within existing capacity.
20.2	The CFO summarised the accounts and highlighted that the year end forecast could be materially affected by a higher covid spend, the estimated £1m legionella spend, efficiencies or the effect of charges on capital spend. Presently, the year end deficit for unfunded legionella costs was projected to be £1.5m but there was now a possibility that the ICS would make dedicated funds available such that the Trust would break even.
20.3	The Chair noted the Board's support for the capital investment programme as it created opportunities. Edwin Josephs queried the Trust's loan figure and its options if it could not secure funding from the targeted investment fund. The CFO explained the loan arrangements with Watford Borough Council for the health campus development. The Trust was relying on £6.95m funding from the targeted investment fund which had yet to be agreed. Positive discussions were taking place and there was also the possibility of benefiting from underspends elsewhere and slippage in the capital programme. The CFO confirmed that the issue would not hold back the Trust's capital projects and the Trust was moving ahead with the EPR programme and theatres project.
21	**ED Business case**
21.1	The Deputy CEO presented the case which had been received and supported by TMC and FPC. She thanked her team for their hard work. In summary, the case represented the right option and would deliver significant benefits with minimal disruption to the service. It represented a sensible investment for the medium term but would need to be reviewed if redevelopment did not go ahead.
21.2	The Chair acknowledged the consultant support for the case. The Deputy CEO confirmed to the Ginny Edwards that there was a high level of staff engagement but no direct patient engagement. The business case was well informed by the ED team's understanding of what would make the most difference for its patients and be the best clinical solution.
21.3	The Board noted that the case had been submitted to the regulator with a letter of support from the ICS. The Deputy CEO would confirm the board's approval after the meeting who would make a decision within 3 months.
21.4	**The Board approved the ED business case.**
Aim 3: Great Team	
22	**Research and Development update**
22.1	The Chief Medical Officer presented the report which highlighted a sustained increase in number of studies and an increase in non-covid research projects. Recruitment had increased and the department was on target to meet all of its objectives and KPIs.
22.2	The Chair recognised that it was important for staff recruitment for the Trust to offer good research facilities. In response to Jonathan Rennison's query about the performance of ICT systems, he confirmed that the systems had been challenged that month but progress had been made with software to support endoscopy. PERC would monitor this action.

22.3	The Divisional Director for Medicine queried if the new team structure would in place in readiness for the new hospital. The Chief Medical Officer and Deputy Medical Officer confirmed that this was under review and would be progressed over the Christmas period in readiness for next year. The Deputy CEO recommended that the charity's strategy should consider adopting research and innovation as a theme to support and development.
23	**Education and learning update**
23.1	The CPO presented the report on the MSc healthcare leadership programme which had been discontinued due to the grant being withdrawn from HEE. The Trust had continued with the RISE programme which was equivalent to a master's qualification. It was hoping to revert to an MSc in future. The evaluation of the leadership development programmes had been paused due the pandemic. Once completed, the evaluation would be reviewed by PERC.
23.2	Paul Cartwright asked if the MSc accreditation could return. The CPO confirmed it would return once the course had been linked with the apprenticeship levy which needed to happen at a national level.
23.3	In response to Jonathan Rennison's query about supporting staff to learn in the workplace, the CPO confirmed the Trust was creating an alumni programme with the divisions which would map a staff member's location, their benefits and career progression. There would be increased support via divisional management teams for staff to apply and use their learning and ensuring that managers made the most of their team's skills.
24	**Annual NHS workforce race equality standard report**
24.1	The CPO presented the report and highlighted the focus on career progression for BAME members of staff. He was leading a review of values based recruitment which should increase the cohort of BAME representation within local, regional and national development programmes. The KPI's for non-mandatory training would be monitored to ensure oversight of diversity and participation. He confirmed to the Chair that these actions were in place and were being monitored by PERC.
24.2	Jonathan Rennison noted the statistics about the levels of bullying and harassment from staff and the public. The CPO agreed that these levels were unacceptable and noted that the Trust's work with its recently developed Connect networks gave it more insight about these issues and how it should engage with the workforce to tackle them.
25	**Annual freedom to speak up/whistleblowing report**
25.1	The CPO presented the report and highlighted that there had been a rise in cases from August to September 21 of which 62% related to bullying and harassment. 5 cases concerned elements of patient safety. The divisions with the most cases were WACS, Surgery and Clinical Support Services and reflected a positive speaking up culture. The CPO commended the FTSU guardian for her work and the changes that she had made.
25.2	Ginny Edwards concurred and heard from the CPO that he was confident on the Trust being compliant with the CQC's requirements. However, there remained a lot of work to do with bullying and harassment being a particular focus. The CEO was pleased that the FTSU guardian had built on the work previously undertaken by Ginny Edwards and noted the positive growth in freedom to speak up champions which was making a significant difference.
Aim 4: Great Place	
26	**Strategic Priorities Update**
26.1	The Deputy CEO highlighted that the health records programme had successfully completed and would not feature in future reports. The cath lab works had completed and an opening event would be scheduled.
26.2	The construction of the car park was on track with work starting on preparing it for use. Car parking options for management, finances and charging policies across all 3 sites were being

26.3	considered. A decision was anticipated within the next few months. The Trust's Green plan would be developed for submission to GPC by January 2022 and February Board. The Deputy CEO was the lead for environment impact for health services.
26.4	The CFO confirmed to the Chair that the issue of the BAFO for the pathology lab was delayed due to advisors refining the contract structure. However, the delay was not expected to impact the wider redevelopment timetable due to the change in timetable from NHP. The Deputy CEO confirmed that she was working on a combined report to reflect the capital elements of the Trust's projects which would come to Board in due course.
27	**South and West Herts Health and Care Partnership – Interim Strategy and Partnership Agreement**
27.1	The Deputy CEO presented the interim strategy and partnership agreement which had been produced by the Health and Care Partnership Board.
27.2	It set out the framework and current priorities and would allow for further engagement with communities and other stakeholders. It also set out how organisations within the HCP would work together during the shadow period. The document had been approved by HCP partners and would need approval from the statutory boards. TMC and reviewed and fully supported the document which ensured that both the physical and mental health needs of patients had be given appropriate focus by aligning the clinical strategies of all partners. The Deputy CEO confirmed to the Chair that the partnership agreement was not a legal document but set out how partners would interact and conduct business with each other. The CEO confirmed that the finance directors within the ICS continued to work on the legal framework.
27.3	Ginny Edwards commented that the document was easy to understand and clear on what it needed to deliver. She recommended the document should be summarised for the public to understand.
27.4	The Board noted its support for the Interim Strategy and Partnership Agreement.
28	**EPR update**
28.1	The CIO highlighted that there were only 16 working days until go-live with this meeting also being the last board meeting before go-live. Dress rehearsals were taking place along with the testing of workflow and hardware and meetings with the Execs and Senior Leadership Team to test operational readiness.
28.2	The Trust was ready to go-live technically. The two areas of greatest challenge were the pathology service and training. Testing was ongoing for pathology and a decision would be taken the following week on whether the pathology service would be included in the go-live date at the end of November 2021
28.3	Training was progressing and most staff had attended their classroom sessions. On-line training rates were less positive at 20% and there would be a focus on this over the next 3 weeks. Overall, the Trust was in a reasonably good place. The decision making process for taking the go/no go decision was set out in the paper and would culminate with a special executive meeting on 24 November 2021.
28.4	The Board discussed approving the delegation of the decision to the Executives. The COO confirmed that operational teams were working closely with the EPR team and system partners run a "perfect week" from 22nd November to enable as many patients to be discharged as possible. The EPR team was also working closely with the Emergency Planning & Resilience lead on business continuity during the go-live period.
28.5	The CIO confirmed to Edwin Josephs that he thought staff did have the capacity to undertake training but surgery and theatres were in a challenging position due to existing capacity issues. The Divisional Director for Surgery confirmed the division were engaged in the project but were addressing working through the challenge of releasing staff to do classroom training.

	The Board confirmed their approval for the delegation of the go-live decision.
28.6	**The Board approved the delegation of the decision for go live to the Executive team.**
Risk and Governance	
29	**Corporate Risk Register report**
29.1	The Chief Medical Officer presented the report which was discussed at both the Risk Review Group (RRG) and the Quality Committee.
29.2	There were 27 open risks and 2 new risks concerning MRI wait times and the admission of patients to AAU with mental health problems. 7 of the open risk related to covid and there were no changes to any of the risks.
29.3	**The Board approved the Corporate Risk Register**
30	**Items considered in October Private Trust Board**
30.1	The report was noted.
Closing Items	
31	**Any other business previously notified to the Chair**
31.1	There was no other business for consideration.
32	**Questions from Hertfordshire Healthwatch**
32.1	Meg Carter asked how the Trust would help the public understand the new IPR format. The CEO responded that the IPR summary would be the most appropriate place to include a summary for the public whilst balancing it with operational needs. She and the Chair would consider the issue further. Meg Carter asked for the Trust to make sure that all of the board papers had been loaded onto the Trust website as she could not locate the ambulance handover paper.
33	**Questions from our patients and members of the public**
33.1	None
34	**Date of the next Board meeting**
34.1	The next Board meeting would be held on 2 December 2021, venue to be confirmed.

BOARD AND CORPORATE TRUSTEE DECISION LOG 2020-2021			
Board meeting/ decision date	**Decision reference (from minutes)**	**Item presented to Board for action**	**Comments/outcome**
##########	13.03/80	**2019 annual gender gap report**	The Board approved the 2019 annual gender gap report.
##########	14.03/80	**2019 annual equality report**	The Board approved the 2019 annual equality report for publication.
##########	15.02/80	**2018/19 medical appraisal annual audit report**	The Board approved the 2018/19 medical appraisal annual audit report for submission
##########	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
##########	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.
##########	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.
##########	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.
##########	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
##########	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.
##########	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
##########	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
##########	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
##########	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.
##########	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.
##########	16.03/83	**Capital expenditure programme**	The Board approved the capital expenditure programme for 2020/21
##########	19.07/83	**Board self assessment of effectiveness**	The Board approved the assessment of effectiveness subject to a small number of ammendments
##########	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
##########	19.01/81 (part 1)	**Charity funding requests**	The Corporate Trustee ratified the funding requests of over £25k as listed in the assurance report
##########	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*
##########	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
##########	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
##########	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
##########	16.03/82	**Great Place Committee Terms of Reference**	The Board approved the Terms of Reverence for the Great Place Committee
##########	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
##########	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.
##########	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
##########	21.02/84	**The current charity investment strategy**	The Corporate Trustee supported the current investment strategy be continued
##########	21.02/84	**Outsourced charity finance function**	The Corporate Trustee supported the move to an outsourced finance function
##########	21.03/84	**£10k contribution to an endoscopy simulator**	The Corporate Trustee approved a £10k contribution to an endoscopy simulator
##########	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
##########	09.06/87 (Part 2)	**Full Business Case for Electronic Patient Record**	The Board approved the Full Business Case for EPR
##########	09.07/87 (Part 2)	**Electronic Patient Record**	The Board delegated authority to the Chairman, The Chief Executive and two NEDS to approve the contract for the interim solution
##########	15.02/85	**Revised Standing Financial Instructions, Standing Orders and Scheme of Delegation**	The Board approved the revised Standing Financial Instructions, Standing Orders and Scheme of Delegation
##########	13.03/86	**Digital Strategy**	The Board approved the Digital Strategy
##########	23.03/86	**Charity Annual Report**	The Corporate Trustee approved the Annual Report
##########	13.04/87	**Ockenden review**	The Board approved the assessment tool within the report.
##########	15.05/87	**Clinical Strategy**	The Board approved the Clinical Strategy.
##########	16.03/87	**Clinical Engagement Plan**	The Board approved Appendix A (Clinical Engagement plan).
##########	25.02/87	**Assurance Report from the Charity Committee**	The Corporate Trustee approved the 3 applications for funding.
##########	18.5/89	**Trust Strategic Ambitions – Breakthrough Objectives for 2021/22**	The Board approved the breakthrough objectives.
##########	19.5/89	**Terms of Reference and work plan for 2021/22**	The Board approved the terms of reference and work plan.
##########	24/89	**Charitable Funds Committee**	The Corporate Trustee approved the 2 applications for funding.

BOARD AND CORPORATE TRUSTEE DECISION LOG 2021-2022			
Board meeting decision date	**Decision reference (from minutes)**	**Item presented to Board for action**	**Comments/outcome**
################	18.5/89	**Trust Strategic Ambitions – Breakthrough Objectives for 2021/22**	The Board approved the breakthrough objectives.
################	19.5/89	**Terms of Reference and work plan for 2021/22**	The Board approved the terms of reference and work plan.
################	24/89	**Charitable Funds Committee**	The Corporate Trustee approved the 2 applications for funding.
################	10.18/90	**Inclusion of Covid-19 snapshot in Trust Board meeting pack**	The Board resolved that the snapshot no longer needs to be included in the pack.
################	18.4/90	**Annual statement of actions to prevent human trafficking 2020-2021**	The Board approved the statement and approved its publication on the Trust's website
################	19.3/90	**NHS License Provider Self-Certification forms (G6 Declaration and FT4(8) Declaration**	The Chair and the Chief Executive signed the G6 and FT4(8) Declarations (annual self-certification process).
################	10.17/91	**(Suspended) Safety Thermometer to be removed from the IPR Dashboard.**	The Board resolved that the Safety Thermometer does not need to be included in the IPR dashboard going forward.
################	14.2/91	**Trust's Business Plan for 2021/22**	The Board approved the business plan.
################	15.4/91	**Teaching hospital status/name change application to go before the relevant ministers before Parliamentary recess (July 2021).**	The Board approved the application pack for teaching hospital status.
################	22.5/91	**Committees' Terms of Reference and work plans for the year 2021/22**	The Board approved the Terms of references and work plans.
################	13.3/92	**NHSR Maternity Incentive Scheme**	The Board gave permission to the CEO to sign the board declaration form; the Trust Board was satisfied that the evidence provided to demonstrate achievement of the 10 maternity safety actions met the required safety actions' sub-requirements as set out in the safety actions and technical guidance doc.
################	15.2/92	**Request for delegated authority for Continuity of Carer roll out plan**	The Board approved the Quality Committee's request for delegated authority on the Continuity of Carer roll out plan.
################	21.4/92	**Vascular OBC**	The Board approved the Vascular OBC.
################	20	**Clinical Brief and Clinical Strategy**	The Board approved the Clinical Brief and Clinical Strategy
################	24	**Amendment to Terms of Reference**	The Board approved the amendment to the terms of reference and use of SO 6.2.1 in July 21.
################	19.2	**Emergency Preparedness, Resilience and Response**	The Board approved the EPRR.
################	23.3	**Vascular Business Case**	The Board approved the Vascular Business Case
################	24.4	**Enabling Works Business Case**	The Board approved the Enabling Works Business Case
################	34.2	**Charitable Funds Committee**	The Board approved the requests for funding.
################	21.4	**Emergency department Business Case**	The Board approved the ED business case
################	27.4	**South and West Herts Health and Care Partnership – Interim Strategy and Partnership Agreement**	The Board confirmed its support for the Interim Strategy and Partnership Agreement.
################	28.6	**EPR go-live decision**	The Board approved the delegation of the decision for go live to the Executive team.

Agenda item: 8

Action log (updated following 4 November 2021)

No.	Date of meeting	Minute ref	Action	Lead for completing the action	Date to be completed	Update
1	4 November 2021	16.8	The COO would liaise with E&NH about their IPC pathways.	ST	December 2021	Action allocated to the Chief Nurse as it relates to a clinical pathway. Chief Nurse has liaised with E&N Herts and obtained their SOP. This has been shared with the medical division to enable them to review and consider if there are any opportunities to learn and adapt the current clinical pathways.
2	4 November 2021	32.1	The Chair and CEO would consider how the Trust could help the public understand the new IPR format.	CA/PT	December 2021	

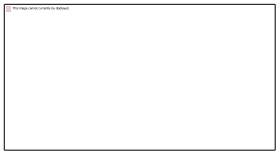
TRUST BOARD WORK PLAN 2021-22: Part 1	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Service presentation/patient story	✓	✓	✓	✓	✓	✓
Trust Chair and Chief Executive's report	✓	✓	✓	✓	✓	✓
Performance						
Integrated Performance Report	✓	✓	✓	✓	✓	✓
Access Standards Performance update	✓	✓	✓	✓	✓	✓
Activity Restoration and Recovery	✓	✓	✓	✓	✓	✓
Aim 1: Best Care						
Seven day services – board assurance framework		✓				
Bi-annual establishment review – maternity					✓	
Bi-annual establishment review report – adult inpatient wards	✓					✓
Annual establishment review report – Paediatrics				✓		
Maternity safety strategy actions and CNST incentive scheme (as required)						
Annual report: infection prevention and control		✓				
Annual report: safeguarding	✓					
Outcome of national patient surveys/progress reports	Reports aligned with the publication of results					
Report on the quality account						
Annual report: end of life care			✓			
Annual report: complaints and patient advice and liaison			✓			
Annual report: serious incidents and never events	✓					
Quarterly learning from deaths report	✓			✓		
Annual assurance report: emergency preparedness, resilience and response						
Patient Safety Specialist update		✓				
annual report: legal services						
Aim 2: Best Value						
Outline and final business cases for capital investment more than £1m (as required)	As required					
Ratify proposals for acquisitions, disposals or changes of use and/or buildings (as required)	As required					
Approval to open bank accounts (as required)	As required					
Finance update	✓	✓	✓	✓	✓	✓
Aim 3: Great Team						
Research and development update		✓				
Public sector equality duty report 2020-21						✓
Gender pay gap report 2020-21						✓
Outcome of national staff survey/progress report						
Annual medical appraisal report and statement of compliance						
Annual NHS disability equality standard report				✓		

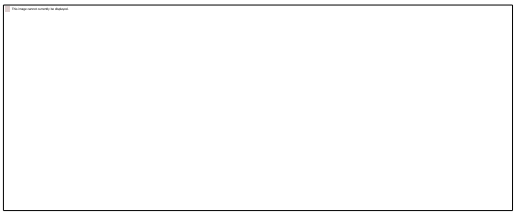
Annual NHS workforce race equality standard report		✓				
Bi-annual workforce and development strategy update			✓			
Bi-annual freedom to speak up/whistle blowing report		✓				✓
People Strategy annual review		✓				
Guardian of Safe Working Annual Report						✓
Aim 4: Great Place						
Strategy update	✓	✓	✓	✓	✓	✓
Updated Trust strategy			✓			
Replacement of existing cardiac catheter labs						
Redevelopment OBC preferred option decision						
Development of integrated care partnership update report		✓				
ICS governance proposals						
Progress update on major capital projects (outline business cases/full business cases)	As required					
Risk and governance						
Approval of the corporate aims and objectives					✓	
Board assurance framework report	✓	✓	✓	✓	✓	✓
Corporate risk register report	✓	✓	✓	✓	✓	✓
Board and committee terms of reference and work plans review						✓
Annual review of Board and committee effectiveness						✓
Annual review of corporate governance structure						
Board engagement report					✓	
Board and committee meeting schedule						
Regulatory						
Audit Committee annual report						
Annual statement of actions taken to prevent slavery and human trafficking						
Annual self-certification process						
Use of the Trust Seal (*via Audit Committee assurance report)*		✓				✓
Report on standing financial instructions, standing orders and scheme of delegation (*via Audit Committee assurance report)*						
Approval of annual report, annual accounts, annual governance statement and quality account (*via Audit Committee assurance report*)						
Assurance reports from committees						
People, Education and Research Committee	✓		✓		✓	
Audit Committee		✓				✓
Finance and Performance Committee	✓	✓	✓	✓	✓	✓
Quality Committee	✓	✓	✓	✓	✓	✓

Trust Management Committee	✓	✓	✓	✓	✓	✓
Great Place Committee	✓	✓		✓		✓
Charity Committee	✓		✓			✓
Charity Committee annual report and accounts	✓					
Questions						
Questions from Hertfordshire Healthwatch	✓	✓	✓	✓	✓	✓
Questions from the public	✓	✓	✓	✓	✓	✓

Trust Board Meeting
2 December 2021

Title of the paper	**Chair's Report**
Agenda Item	**10**
Presenter	**Phil Townsend, Trust Chair**
Author(s)	**Barbara Anthony, Trust Secretary**
Purpose	**For approval**: **For discussion**: **For information**: ✓
Executive Summary	This paper provides 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 care – *Objectives 1-4* – ✓ Aim 2 Great team – *Objectives 5-8* – ✓ Aim 3 Best value – *Objective 9* – ✓ Aim 4 Great team – *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: 10

Trust Board Meeting – 2 December 2021

Chair's report

Presented by: Phil Townsend, Trust Chair

1 PURPOSE

1.1 The aim of this paper is to provide an update on items of national and local interest/ relevance to the Board.

2 NEWS AND DEVELOPMENTS

West Herts' Chief Nurse, Tracey Carter honoured with an MBE:

2.1 We offer our congratulations and warmest wishes to Chief Nurse, Tracey Carter, who received her MBE from the Princess Royal at a ceremony at Windsor Castle on 17 November. Tracey was honoured for her leadership, empathy, and passion. We are extremely proud of her.

Nursing Times Workforce Awards:

2.2 Our congratulations also go to the winners and finalists honoured at the Nursing Times Workforce Summit and Workforce Awards on 17 November.

West Herts brought home the award for 'Best Workplace for Learning and Development – Under 1,500 Nursing Staff'. This was for the retiree workforce pilot initiative. Davinia Rodgers, Deirdre McCarthy and Jo Prytherch from the preceptorship team launched the initiative to offer retired nurses the opportunity to return in educator roles.

Deputy Chief Nurse, David Thorpe and NHS Elect were also finalists in the 'Best Wellbeing and Staff Engagement Initiative' category, for their work developing a programme for personal and professional development though clinical supervision.

We congratulate all the worthy winners and finalists.

HSJ Awards 2021:

2.3 Congratulations go to all colleagues on the teams shortlisted as finalists in two categories at the Health Service Journal (HSJ) awards ceremony on 18 November.

The Connect BAME group – our Black, Asian and minority ethnic (BAME) staff network – were finalists in the '*Staff Engagement Award'* category for their inspiring work supporting the BAME workforce during the pandemic.

We were also finalists and were 'highly commended' in the '*Driving Efficiency through Technology Award'* category for setting up an orthopaedics virtual fracture clinic.

Thanks and warm wishes go to both groups of finalists for their inspiring support for our patients and staff during the pandemic.

Star of Herts Awards winners:

2.4 We warmly congratulate our monthly Stars of Herts winners for August/September. The team award went to De La Mare and Beckett ward at St Albans for 'always keeping a smile on their faces and doing their best to provide excellent care despite the difficult circumstances'. The individual award winner was Asma Suleman, a freelance interpreter and translator in the patient, advisory and liaison service, nominated for her excellent work throughout the pandemic.

Freedom to Speak Up:

2.5 October saw the annual celebration across the NHS, of Freedom to Speak Up month. We reinforced the message to staff that at West Herts, we are committed to making every day a Freedom to Speak Up day. Our Freedom to Speak Up Guardian, Joanna Bainbridge continued her work across all hospital sites, talking to staff on wards and in departments.

Our Freedom to Speak Up Champions continued to share examples of good practice and learning from concerns raised over the past year. We also put out a call for more staff to come forward for the role of Speak Up Champion.

3 COMMUNITY NEWS

Remembrance Day:

3.1 The Trust held its annual service of remembrance on Sunday 21 November at Watford Football Club, to pay tribute to friends, families and loved ones who have passed away over the last year. Music was provided by the Watford Rock Choir, while readings were given by volunteers, the pastoral care team and the Chief Nurse, Tracey Carter.

4 BOARD NEWS

Board visit programme:

4.1 As part of the monthly Board visit programme, in November 2021 the Board visited the following at Watford General Hospital:

- Tudor ward
- Breast clinic
- Community midwife team
- Paediatrics.

Trust Chair's meetings:

4.2 The Trust Chair has attended the following since the report to the last Board meeting:

- Star of Herts presentation at SACH
- Herts Quarterly Chairs' meeting
- Pre-interview Consultant discussions

- HWE ICS Partnership Board attendance
- Chaired South & West Herts HCP Chairs' Group
- Governance discussions
- Attendance at NHS Providers Virtual Conference 2021
- HWE ICS Chairs' Informal Meeting
- Great Place Committee
- Finance & Performance Committee attendance
- Hosted Herts County Councillors meeting – Richard Roberts/Owen Mapley
- Consultant Interviewing
- Public Inquiry Training
- Hosted WHHT Tour with Chair of PAH
- Meeting with Cabinet Member Adult Care, Health & Wellbeing
- Hosted WHHT Tour / meeting with Independent Chair - Hertfordshire and West Essex ICS & Chair Designate, Integrated Care Board
- Started the search for a Teaching NED for our forthcoming Hospital status change

5 RECOMMENDATION

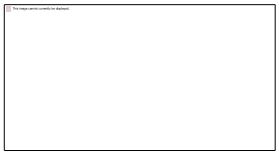
5.1 The Board is asked to receive the report for information.

Phil Townsend
Trust Chair

December 2021

Trust Board Meeting
2 December 2021

Title of the paper	**Chief Executive's Report**
Agenda Item	**11**
Presenter	**Christine Allen, Chief Executive**
Author(s)	**Barbara Anthony, 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 since the last meeting. The information in the report is drawn from a variety of sources, including information published by NHS England/Improvement, DHSE, NHS Providers and the CQC.
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 team – *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.



West Hertfordshire Hospitals NHS Trust

Agenda Item: 11

Trust Board Meeting – 2 December 2021

Chief Executive's report

Presented by: Christine Allen

1 PURPOSE

1.1 The aim of this paper is to provide an update on items of national and local interest/ relevance to the Board.

2 KEY ISSUES

Winter pressures

2.1 The NHS Providers issued their report "*State of the Provider Sector"* on 16 November 2021 which highlighted the national picture that all providers are under immense pressure as the winter season approaches. It highlighted the use of strategies, such as staff recruitment, capacity management and expansion, promotion of vaccination programmes, and working collaboratively across systems which many providers will be deploying in an effort to ease the effect of winter pressures on their respective organisations.

2.2 This Trust has seen an increase in activity over the past month from both covid and non-covid patients through our emergency and elective pathways. We remain extremely thankful to our staff for their hard work and dedication and acknowledge the pressure that our staff will be under as we enter this winter period. The organisation is focused on recruiting extra staff, retaining current staff and working collaboratively with our system partners to provide the best service that we can to our patients.

Covid-19

2.3 On 9 November 2021, the Department of Health and Social Care (DHSC) announced that a Covid-19 vaccination would become a condition of deployment for all frontline health and social care workers. The requirement is already in force for social care staff and will come into force in April 2022. We are currently waiting for further guidance to be issued by DHSC and will update our staff as soon as information is received.

2.4 On 15 November 2021, DHSC announced that boosters can be administered to those aged over 40 and a second dose offered to 16 and 17 year olds. There remains a continued need for as many people as possible to be vaccinated in order to reduce hospital admissions over the winter period. Within the Trust, we have noted a rise in admissions of patients with Covid-19 and this also appears to be the case for our system partners. The ICS's recent board papers note an increase in admissions for patients over 65 with actions to provide as many boosters and vaccines as possible to the population and care home residents in particular. We continue to ask staff to keep up to date with the latest Covid-19 infection, prevention and control guidance on the Covid-19 hub intranet page.

3 NATIONAL GUIDANCE

Government announces support for rough sleepers over winter

3.1 On 27 October 2021, the Department for Levelling Up, Housing and Communities announced that rough sleepers would be helped into safe and warm accommodation and treatment services for drug and alcohol dependency over the winter, supported by an extra £66 million of funding.

3.2 Building on the success of the Everyone In initiative, which supported 37,000 vulnerable people into longer term accommodation during the pandemic, this support will continue to help rough sleepers off the streets at a time of year when they face falling temperatures and give them an opportunity to turn their lives around by ending the cycle of addiction and preventing hospital admissions.

Adult social care campaign to build bigger and better workforce

3.3 On 3 November 2021, DHSC announced a new recruitment campaign to encourage people to apply for roles in the adult social care sector with £5.4 billion of additional funding to reform social care over the next 3 years including £500 million to support staff training and career development for the workforce. It is anticipated that the campaign will enable a smoother discharge of patients from acute care to social care settings.

Review launched into the health impact of potential bias in medical devices

3.4 DHSC has announced an independent review that will look at potential bias in medical devices and the impact on patients from different ethnic groups following concerns that the way medical devices and technologies are designed and used could mean a patient's diagnosis and treatment is affected by their gender or ethnic background, exacerbating existing inequalities in healthcare.

3.5 The coronavirus (COVID-19) pandemic has exposed health disparities across the country as the virus had a greater impact on those whose underlying health was poorer and death rates have been higher among people from ethnic minority communities. While current UK regulations set out clear expectations, they do not currently include provisions to ensure that medical devices are equally effective regardless of demographic factors, such as ethnicity. The review's initial findings are expected to be published in late January 2022.

£250 million in NHS technology to modernise diagnostics

3.6 On 8 November 2021, DHSC announced funding of £248 million to modernise diagnostics and help tackle patient waiting lists. The funding will allow hospital labs to share patient results, tests and scans more easily and quickly between different hospitals and doctors, reducing the time it takes to diagnose a health problem. It aims to drive up efficiency by saving staff time, and comes as part of the government's ambition to tackle waiting lists and speed up routine treatment for patients.

£3 million more to reduce brain injuries at birth

3.7 On 5 November 2021, the Patient Safety Minister, Maria Caulfield, announced £3 million for the second phase of a programme to improve maternity safety and reduce brain injuries at birth.

3.8 The Royal College of Obstetricians and Gynaecologists (RCOG) in collaboration with the Royal College of Midwives (RCM) and The Healthcare Improvement Studies Institute at the University of Cambridge (THIS Institute) will lead the second phase to roll out tools and training across the NHS. The programme will help achieve DHSC's ambition to halve the rate of brain injury during or soon after birth by 2025.

Major reforms to NHS workforce planning and tech agenda

3.9 On 23 November 2021, the Secretary of State for Health and Social Care announced that HEE and NHSX would be merged into NHS England and Improvement. The plans will aim to see more patients benefit from the best possible care, with the right staff in place to meet patients' needs. The plans will sit alongside the strategic NHS workforce framework ministers previously commissioned to report in spring, looking at what the workforce of the future should look like. The changes will better support the recovery of NHS services, address waiting list backlogs, and support hardworking staff, all while driving forwards an ambitious agenda of digital transformation and progress.

4 SYSTEM AND REGULATORY MATTERS

System Winter Planning

4.1 The ICS is working collaboratively to ease operational pressures across urgent and emergency care. Bed occupancy is high across the system and 4-hour performance has deteriorated month on month since April across all Trusts. Local system leaders recognise that the standard mitigations may be insufficient to manage anticipated capacity pressures safely and sustainably this winter.

4.2 System leaders are therefore working with NHSE on developing additional responses to ensure the system meets increasing pressures whilst maintaining patient safety and protecting capacity for elective activity and recovery. This may include the via daily escalation calls to respond rapidly to emerging pressures, use of mutual aid, increasing voluntary sector support in hospital discharges, working with key link workers and social prescribers to support decision making.

5 NEWS AND DEVELOPMENTS

Flu update

5.1 Walk-in flu clinics for clinical and non-clinical staff continued throughout November at each hospital site. Morning flu clinics for our night shift staff were organised across dates in November 21 and opened from 7am to 9am.

Disability workforce standards

5.2 Staff were invited to contribute ideas for the Trust's disability workforce standards and action plan for the next 12 months, by joining one of a series of Teams meetings across dates in October and November.

Black History Month

5.3 Our thanks and appreciation go to all who contributed to the fantastic range of events delivered to mark Black History Month. Unfortunately, the movie night planned for 28 October mentioned in the Chief Executive's report to last month's Board meeting was unable to go ahead.

National Safeguarding Adults Week 2021

5.4 The Trust marked National Safeguarding Adults Week 15 -21 November with this year's theme of creating 'safer cultures'. Resources on how to keep ourselves and each other safe were shared, such as availability of Safe and Well home safety visits from the Fire and

Rescue Service to check smoke detectors and the Keeping Caring Safe leaflet on advice for carers about where to get advice, help and support.

Switchboard and outpatient phone services

5.5 The switchboards at Watford General and St Albans went live in November with a new telephone system that will improve the experience of callers to the Trust. The new system will allow callers to reach the correct department more quickly.

New voluntary service lead

5.6 In October the Trust welcomed Aga Dychton into her new role as voluntary service lead. Aga aims to focus on creating an effective and sustainable service, with people and the community at its centre. Aga will be collaborating with community groups, to show the positive impact of volunteering.

Healthwatch survey

5.7 Healthwatch Hertfordshire (HwH) is running a new survey asking for the views of people from Black, Asian or Arab communities to help improve the equality and inclusiveness of the health and care services provided locally.

5.8 Ethnic health inequalities has come into sharp focus during the pandemic meaning some people have faced even more difficulty accessing and using health services. The views gathered in this survey will help build the local picture about people's experiences.

5.9 The survey, which is open until 10 March, can be accessed in a variety of languages through the HwH website and takes approximately five-10 minutes to complete.

6 CHIEFS' UPDATES

Chief Operating Officer

6.1 A mobile MRI scanner has been safely delivered to Hemel Hempstead and is now staffed and operational. The scanner will help reduce the waiting list for our patients.

Deputy Chief Executive

Acute redevelopment

6.2 The Trust has continued to develop its acute redevelopment outline business case, with a recent focus on confirming the detail of the estate options of each of our three hospital sites. The Trust's ambition is to secure sufficient funding to replace the main acute care clinical block at Watford General Hospital, the Princess Michael of Kent building (PMoK), with new build clinical facilities, as well as new build women's and children's facilities. The outline business case process requires us to fully appraise a range of options including retention and refurbishment of some or all of the existing buildings on the site. The redevelopment programme team has reviewed future options for PMoK with a view to detailing a clear 'retain PMoK' option. Work is also progressing to finalise the options for Hemel Hempstead and St Albans Hospital, in line with our three-site clinical model.

6.3 We had hoped to complete the full costs benefits appraisal of all options early in 2022, enabling a formal preferred option for each site to be confirmed and the final elements of the outline business case to be completed. This is now not possible due to national issues within the New Hospital Programme, including a lack of confirmed development funding to support further work on the business case in this financial year. It is currently therefore

anticipated that the option appraisal will be completed by June and the outline business case towards the end of 2022, subject to approval to proceed and confirmation of funding from the New Hospital Programme to enable this timeline to be met.

6.4 The Trust issues a monthly newsletter regarding the redevelopment (Blueprint) to keep stakeholders informed of progress. An A to Z of information regarding the redevelopment has also been published on our website and will be regularly updated in response to feedback and questions received.

Travel and Access

6.5 Our patients and stakeholder groups have told us that getting to our hospitals can be difficult and stressful at times. We held our first travel and access steering group at the end of October 2021. We heard about the plans that Hertfordshire County Council, Watford Borough Council and Dacorum and St Albans City District Councils have to improve transport links in Hertfordshire and discussed opportunities to work together to improve access to our hospitals in both the short, medium and longer term.

6.6 In November we held our first patient travel and access reference group. A number of people attended and shared their experience of travelling to our hospitals and their ideas for improving patient and visitor experience of getting to our hospitals, as well as a range of wider factors than can impact on their experience of care. We have identified some immediate steps that we can take to make improvements in the short term, as well as some areas for joint work that will support improvements in the longer term. Further information will be published on our website redevelopment pages in the next few weeks.

Green Plan

6.7 In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, in response to the profound and growing threat to health posed by climate change. The "Delivering a Net Zero Health Service" report sets out a clear ambition and two evidence-based targets for the NHS:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045

Greener NHS » Delivering a 'Net Zero' National Health Service (england.nhs.uk)

6.8 The Trust is developing a Green Plan setting out the steps we will take over the next three years to work towards more environmentally sustainable hospital services and start our journey to become a 'net zero' organisation.

6.9 During COP26 we ran a communications and engagement campaign to raise awareness of environmental issues and the part that all our staff can play in reducing our carbon footprint. We had a fantastic response with more than 70 staff from across the organisation volunteering to become 'Green Champions' to help us take forward this important work.

6.10 A draft Green Plan will be brought to the Board for formal review and approval in February 2022 and will set out the steps we will take over the next three years to embed environmental sustainability in every aspect of our work.

7 RECOMMENDATION

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

Christine Allen
Chief Executive

December 2021

Trust Board Meeting

2 December 2021

Title of the paper	**Board Assurance Framework report**
Agenda Item	**12**
Presenter	**Christine Allen, Chief Executive**
Author	**Barbara Anthony, Trust Secretary**
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	This report is to provide the Board with assurance that risks to achieving the Trust's strategic objectives are being appropriately mitigated, to consider those elements that report direct to Board and any recommendations of changes from assurance committees. Elements of the update BAF were reviewed on 25 November 2021 by the Quality Committee and FPC. Updates to the BAF template have been marked in red.
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	• Finance and Performance Committee – 25 November 2021 • Quality Committee – 25 November 2021
Action required	The Board is asked to consider and approve the latest version of the BAF.

Agenda Item: 12

Trust Board meeting – 2 December 2021

Board Assurance Framework report

Presented by: Christine Allen, Chief Executive

1. Purpose

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

2. Background

2.1 All NHS Trusts are required to use a Board Assurance Framework (BAF), not least because it has been proven good practice for many years in both healthcare and a whole range of complicated high-risk organisations. The BAF is a 'live' document that changes over time, and 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 10 underpinning strategic objectives
- A headline summary of all the issues (risks) that might get in the way of achieving those objectives.
- A headline summary of what the Trust is doing about those issues, along with a concise description of how the Board can be assured that what is being doing is working.

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

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

Reassurance **Assurance**

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

2.5 The risk appetite statement and threshold matrix are attached for Board reference (appendix 1). These are both dynamic documents and are used by the Board and assurance committees to influence decision making at an individual risk level.

3. Monthly review

3.1 The refreshed BAF can be found in appendix 2 with a risk summary sheet at appendix 1. The description, controls, assurances, and actions to address gaps in controls and assurances were reviewed and updated by executive leads in November 2021.

3.2 Elements of the BAF were reviewed on 25 November 2021 by the Quality Committee and Finance Committee. Changes made have been marked in red.

3.3 There are no areas of extreme risk (red) identified on the BAF. 12 risks are now assessed as high (amber) for which only limited assurance can be gained by the Board.

3.4 The risk level for weekday/weekend mortality is undergoing a review as the data suggests the Trust's performance has improved. Following a board development session in October 21, the strategic objective relating to access standards has been updated to reflect the national position. Work is on-going to update the risks (3A-C) which sit underneath that objective. The risks relating to avoidable harm have been updated to include Covid-19 controls.

3.5 Risk 8C (Delays with out partner's EPR timetable could impact our go-live date) will be closed as RFL have gone-live with their EPR project. The risk has been fully mitigated.

3.6 The timescales for the risks relating to the ICS wide pathology outsourcing programme have been extended due to the further work required on the contract drafting.

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 consider the latest version of the BAF.

Christine Allen
Chief Executive

November 2021

Appendix 1. Risk summary sheet and risk appetite statement and threshold matrix
Appendix 2. Board Assurance Framework detailed template.

Appendix 2: Board – Detailed BAF template

AIM 1 : BEST CARE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Mortality (SHMI & HSMR): 'as expected' or 'better than expected' for HSMR and for SHMI.	Reduce the gap between weekend and weekday mortality

Breakthrough Measures

1. Sustained improvement in the gap between weekday and weekend mortality

No	**Risk identified (What could prevent us from meeting this objective?)**	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
1A	Excess mortality due to COVID-19 and non-COVID-19 patients	CMO	QUALITY	4272	CQC	HIGH	LOW
1B	Failure to reduce the gap between weekend and weekday mortality	CMO	QUALITY	4272	CQC	HIGH	LOW

Risk 1A - Excess mortality due to Covid-19 and non-Covid-19 patients

Risk 1A	Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence	
	1. Morbidity and mortality meetings 2. Structured judgement review process fully embedded 3. Divisional Governance meetings 4. Consultant coders and medical examiners fully established. 5. Quality, Mortality review group 6. Quality Committee reports 7. Dr Foster Mortality reports	The Office for National Statistics estimates that excess deaths have increased by 40% in non-Covid-19 deaths, largely due to patients not accessing A&E. Patients are presenting late to both primary and secondary care facilities.	1) Divisional governance meeting, 2) Quality Committee 3) Dr Foster 4) Trust wide harm review processes in place. To date, no confirmed patient has come to severe harm due to delayed procedures.	As Covid-19 is a new disease, the medium-term effects are unknown. The significant increase in patients waiting more than 18 weeks for procedures means that there is a risk that severe harm might occur despite the harm reviews.	
	Actions to address controls and assurance gaps			Exec Lead	Timescale

	1. CAG to discuss need for oversight panels and frequency to provide quality oversight of divisional harm reviews.	CMO	Completed
	Update The Harm Review Panel continues to meet, and most departments are meeting trust target. If harm is perceived to have occurred, the patient will be discussed at M&M meeting, and then escalated if required. HSMR and SHMI are both "as expected", and if Covid deaths are excluded, SMR is now "below expected"		

Risk 1B - Failure to reduce the gap between weekend and weekday mortality.

Risk 1B

Key Controls	Control Gaps	Identified assurance	Assurance gaps
1. Adherence with 7 day working standards, 2. Improved patient flow. 3. VSmart project is currently redesigned in keeping with Royal College guidelines. 4. Clinical Outreach service. 5. Sepsis screening.	The Trust has insufficient medical staff to provide the same level of patient scrutiny at weekends compared to weekdays, although patients identified as being unstable do receive a daily consultant review.	1) Divisional governance meeting 2) Divisional performance reviews 3) Quality Committee 4) Dr Foster	Currently, Respiratory and ITU consultant workforce has several vacancies where recruitment is difficult. There are 4 vacancies in Respiratory Medicine. Active recruiting is on-going, but efforts are hampered due to staff leaving, long-term sick levels, long covid and PTSD.

Actions to address controls and assurance gaps	Exec Lead	Timescale
1. Medical staffing on weekends is being actively reviewed with the aim of increasing junior doctors by 6 at the weekend. 2. Divisional Director of Medicine and Divisional Manager for Medicine are creating proposals for more hands-on review of patients.	CMO supported by CPO CMO	February 2022

Update

The medical take structure is currently under active review by the Deputy CMO who has completed the scoping work. The Deputy CMO has met with all CLs / CDs. An options appraisal for future pathways (SDEC/SMART) and comparison with other organisations is ongoing and an update will be provided in November 21.

	The risk level will be reviewed by the Trust Mortality Review Group and then by the Quality Committee in November 2021. The outcome of the review will be reported to Board in February 2022.

AIM 1: BEST CARE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Avoidable Harm (harm free care): Continuous improvement and better than national average for new pressure ulcers, falls with harm, new venous thromboembolism, urinary tract infections (in patients with a catheter) and healthcare associated gram-negative blood stream infections (GNBSI)	To reduce nosocomial infections and implement IPC BAF
Breakthrough Measures	
1. To prevent Covid-19 outbreaks in a hospital setting	2. Achieve a 10% reduction in GNBSI 2021/2022
3. Achieve a 20% reduction in e-coli infections	4. 60% reduction in device related pressure ulcers (recover to 2019/2020 performance levels) (Covid-19 recovery from 2019 performance)

No	**Risk identified (What could prevent us from meeting this objective?)**	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
2A	Failure to implement the IP&C Board Assurance Framework leading to the risk of nosocomial infection (including covid infections)	TC	Quality	-	CQC	Medium	Low
2B	Failure to reduce e.coli in line with agreed trajectory	TC	Quality	4359	National HCAI	Medium	Low
2C	Failure to deliver harm free care	TC	Quality	4238 4394 4451 4335 4283 4197 3899 4427		Medium	Low

Risk 2A - Failure to implement the IP&C Board Assurance Framework leading to the risk of nosocomial infection (including covid)

Risk 2A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
1. Infection & Prevention control panel. 2. Recovery Governance Framework. 3. IMT. 4. Enhanced cleaning. 5. System peer reviews 6. Code of Practice audits across the 7-day period. 7. Ventilation risk assessments 8. National vaccination programme including front line staff. 9. Evidence to support hierarchy of controls. 10. Robust screening and assessment process. 11. Encouraging staff to LFT and point prevalence PCR testing for covid. 12. Regular review of clinical and operational pathways relating to covid and flexed depending on community prevalence.	Continually changing national guidance based on increasing evidence as we move through the pandemic. Differing levels of community prevalence for covid. Individual vaccination status of patients. Unknown new variants affecting transmission rates and immunity. Higher rates of hospital associated C.*difficile* due to environmental and clinical demands.	1. Gap analysis. 2. Quality Committee reporting 3. CCG review/nosocomial reporting. 4. External review with PHE, CCG and regional IPC teams. 5. Board IPR 6. Staff and patient testing programme. 7. Internal audit report o IPC BAF provided assurance and no further recommendations. 8. Benchmarking against community rates.	As Covid-19 is a new disease, the medium to long term effects are unknown. Winter viruses including flu, norovirus impacting patient placement and management alongside existing covid. Further assurance required regarding consistency in standards and processes of cleaning.

Actions to address controls and assurance gaps	Exec Lead	Timescale
1. Updating practice, education as evidence available. ~~2. Introduction of RCA process for all cases with a COVID positive result at 7 days and over with thematic review. Themes reported back via divisional governance meetings and IPC ward-based sessions (board round).~~ Complete ~~3. Formal IPC BAF updated June 21 (v1.6) by NHSE.~~ Complete and embedded as BAU, confirmed by internal audit. ~~4. Bi-Monthly reporting on compliance to BAF in place.~~ Complete and embedded as BAU. 5. Practice audits embedded as BAU. Inconsistent standards of cleaning highlighted. Further assurance required. Weekly Director led meetings with contractor to provide further assurance and actions around cleaning standards. ~~6. Review of risks and gaps in the IPC BAF with internal audit in progress.~~ Complete and embedded in practice.	CNO	February 2022

	7. Continued review of algorithms according to new guidance and evidence to support patient management. Ongoing – reviewed as and when new guidance comes out. 8. Robust review including epidemiology has highlighted high risk areas resulting in action plan to be shared with planned external review in November 21. Continued surveillance (50% reduction in cases in October)		
	Update 1. Actions completed and in place. IPC BAF is fully implemented and reporting is part of QC workplan and repository in place on PM3 now on formal spreadsheet system with evidence uploaded. NHSE has recently updated the IPC BAF guidelines (v1.6) which now contain a hierarchy of controls. 2. RCA's completed for Covid cases over 7 days = Thematic reviews undertaken. Process for feeding back lessons learnt and actions embedded - COMPLETE ~~3. Staff & Pt testing in place and business cases developed and approved. Further monitoring in place and to review further actions with new IP&C guidance.~~ 1) ~~Ventilation review 2) Monitor IPC BAF and Covid risks 3) Assessments for Covid protection and social distancing.~~ Embedded, now undertaken as BAU. COMPLETE 4. Gaps in controls reported and updated at quality committee and risks logged and discussed in the ICS IPC meetings and at regional level. The risk level was reduced from High to Medium and an internal audit of the IPC BAF is underway. Risk level will be reviewed in November 21 once the results of the audit are known. 5. Variant testing in place 6. All SI's having a thematic review to identify actions and learning.		

Risk 2B - Failure to reduce E. coli in line with agreed trajectory

Risk 2B

Key Controls	Control Gaps	Identified assurance	Assurance gaps
1. RCA process for all cases 2. Catheter passport 3. Review of all patients admitted with a catheter. 4. Work with CCG to manage those patients discharged with urinary. catheters to facilitate removal at earliest opportunity. 5. Review of RCA to review all gram negative infections in line with national trajectory.	Oversight and management of catheter insertion across the trust	E.coli working group with the CCG	Reporting of all catheter insertion and use of passports, monitoring of removal. Hospital reported cases now include cases where patient has been discharged from WHHT in the last 28 days – system work to address community infections – primary care.

Actions to address controls and assurance gaps	Exec Lead	Timescale
1. QI hydration project. – complete in July 2019, roll out delayed due to covid. Roll out under consideration. 2. Audit catheter usage and trial catheter restriction programme. IPC working closely with harm free care team and IPC. 3. Review and update catheter care plan. – Same as above	CNO	February 22

	Update This work has been delayed and has been included in the IPC forward plan and will be reviewed in July 21. Reduction of E-coli post 48-hour samples by 20 cases in year 2020/21 against previous year meeting reduction required. Work will continue as part of overall IPC strategy. The CCG have set up a working group but progress has been impacted by the pandemic. The group is reviewing data on urinary catheters and infection rates. Catheter passports are key to managing community infections and a workshop will be working to standardise IPC practices. The risk level remains unchanged. The Trust has just received the national requirements for KPIs for C Diff, Gram negative which need to be reviewed and included in the IPR indicators. These will be reviewed as part of IPC System going forwards. Currently on target to meet trajectory for e coli. Other gram negatives infections currently in range but if rates continue, likely to exceed. Actions – reviewed RCA, looking for themes, monitoring antibiotic prescribing and relaunch of clinical practice regarding aseptic technique. System working to address community acquired infections.

Risk 2C – Failure to deliver harm free care

	Key Controls	Control Gaps	Identified assurance	Assurance gaps
Risk 2C	1. Bi-daily ward safety huddles 2. Weekly harm review meetings 3. Monthly Divisional Quality Nurse Summit meetings 4. Divisional Integrated Performance reviews. 5. Harm Free Care Specialist nursing and AHP team 6. Specialised training for all areas 7. Ward managers supervisory time to support staff development. 8. Test Your Care monthly audits. 9. 'Back to the floor' senior team that focus on harm free care and being visible.	The Registered staff consistency in the delivery of harm free care	1. Quality Committee reporting 2. Board IPR 3. Divisional Integrated Performance reviews 4. Annual reports for falls and Tissue Viability	The Registered staff consistency in the assessment of tissue viability.

	Actions to address controls and assurance gaps			Exec Lead	Timescale
	Introduction of the Commitment to Care and Quality – harm free care model.			CNO	12 months March 2022
	Update We are constantly trying to innovate and embed the work we've done to provide the very best care for every patient, this includes coproduction and shared professional decision making and QI work. The commitment to care and quality – harm free care model programme will commence early June. This will be a phased approach over the next year. This model has been developed to drive a sustainable model of harm free care and provide best care with continuous quality improvement across our services. The launch of the harm free care model took place in June by the CNO.				

AIM 1 : BEST CARE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Access to care (national waiting time standards): eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer; hold or where possible reduce the number of patients waiting over 52 weeks; stabilise RTT waiting lists around the level seen at the end of September 2021. Return the number of people on cancer pathways waiting for longer than 62 days to the February 2020 level by March 2022; meet the Faster Diagnosis Standard (FDS) from Q3, ensuring at least 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing. A further wave of Covid-19 or other infectious disease will impact our ability to meet access to care standards. High Low 3288 – Patients may come to harm and have a poor experience due to long waits for elective care 4279 - Increased Staff unavailability through sickness absence or Covid isolation/symptoms etc 4419 - Long term sickness & vacancies within theatres resulting in reduced capacity available for emergency & elective theatre lists 20 20 16 3B If target activity through UTC is not met this could have an impact on performance Medium Low 3C High Low 4019 - Ambulance handover delays affecting patient pathway and escalation 16 Reduce the number and duration of ambulance to hospital handover delays; eliminate 12-hour waits in A&E. Roll out the new clinical standards for ED, with shadow reporting until thresholds are announced and national reporting established.	1. Work with HVCCG to confirm and implement urgent care model for St Albans and Harpenden (may not be a Trust provided service in future) 2. Deliver agreed improvement trajectories for key standards. 3. Consistent compliance with cancer waiting times (CWT) standards. 4. Reduce the number of very long waits (52+ weeks).

Breakthrough Measures

1. Work with HVCCG to confirm and implement urgent care model for St Albans and Harpenden (may not be a Trust provided service in future)
2. % of patients seen in primary care led UTC model and performance against agreed contract KPI's
3. Task and finish groups in place to support improvement in the more challenged tumour types (e.g., LGI, Urology, Lung).
4. Incremental percentage reductions of 52+ weeks, underpinned by a commitment to have no patient waiting over 104 weeks at any point in time.

No	Risk identified (What could prevent us from meeting this objective?)	Executive	Sub-	Corporate	Link to	Current risk	Target level

		Lead	committee	Risk Register	Standards	level	(Risk appetite)
3A	The planned implementation date of April 2022 will not be met if: 1 – The CCG led engagement and decision-making process is delayed; and/or 2 – There is a lack of market interest in delivering the service.	HB	Quality	3288 4279 4419		Medium	Low
3B	If target activity through UTC is not met this could have an impact on performance	ST			CQC	Medium	Low
3C	A further wave of Covid-19 or other infectious disease will impact our ability to meet access to care standards.			4019 4444 4068		High	Low

Risk 3A - The planned implementation date of April 2022 will not be met if there is CCG delay or lack of market interest.

Risk 3A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
Programme plan, task & finish group, WHHT senior lead to ensure appropriate input.	None identified	Joint Urgent Care Programme Board.	None identified.

Actions to address controls and assurance gaps	Exec lead	Timescale
CCG to test market interest and secure specialist procurement support to maximise likelihood of success. December timescale.	HB	Ongoing

Update

This is a HVCCG lead project, however the Trust has aligned senior lead to support. Engagement on options due to be undertaken June / July. CCG leading dialogue with primary care providers to test appetite to deliver. Procurement options under review.

HVCCG lead the project and engagement on options has now completed. The CCG are finalising bus case for approval in October or November and the procurement strategy is being finalised to commence in Nov 21 with service go-live targeted for Q1 2022. There is a risk that the CCG cannot secure a provider for the service.

	CCG procurement advisors are supporting the procurement and undertaking market engagement to stimulate market interest. Risk was reviewed in October 21. No changes were made and a further review will take place in December 21. It is anticipated that this risk will be moved to align with a different strategic objective.

Risk 3B - If target activity through UTC is not met this could have an impact on performance.

Risk 3B

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
Daily review of data against KPI's (including patients referred from UTC to ED, specialty referrals)	No sustained period for comparison pre pandemic.	Weekly joint meeting between service provider and West Herts with monthly joint governance meetings which will feed into divisional governance and QSG. Review of activity levels as part of the Contract Quality Review meeting held on a monthly basis.	The establishment of accurate data and embedding of process.

Actions to address controls and assurance gaps	Exec lead	Timescale
None identified	ST	December 21

Update

Risk was reviewed in October 21. No changes were made and a further review will take place in December 21. It is anticipated that this risk will be moved to align with a different strategic objective.

Risk 3C - A further wave of Covid-19 or other infectious disease will impact our ability to meet access to care standards.

Risk 3C

Key Controls	Control Gaps	Identified assurance	Assurance gaps
1. Patient harm reviews. 2. Use of external contracts with	Insufficient capacity available to deliver required levels of activity to reduce	1. Oversight of harm reviews and outcomes discussed at divisional	1. Capacity constraints will limit the

	other providers. 3. Introduction of scheduling using the P categories to inform treatment dates, ensuring urgent, time critical and cancer cases are prioritised. 4. Development of an independent sector provider (ISP) activity plan for 2021/22 in conjunction with commissioners and the wider ICS.	backlog as IPC measures and social distancing result in lower throughput. Limited control on access to independent sector capacity, utilisation and booking practices despite weekly meetings and patient tracking. The categorisation of patients waiting using the P codes has implications for the most routine (P4) cases, in that higher priority work leaves no capacity for these patients.	governance meetings, Quality Committee and Board, with supporting papers that include updated summaries of reviews undertaken and outcomes. 2. Weekly performance reports. 3. Weekly Access meeting now includes review of P1/P2 (the most urgent) categories to ensure progression to timely treatment, with additional review of any waiting list entry without a P category. 4. Divisional IPRs & performance reviews TMC, Finance & Performance Committee & Board oversight through papers and IPRs. 5. Outsourcing Oversight Group - multi-divisional, chaired by DD for Surgery, Anaesthetics & Cancer, with oversight of contracts & finance, activity and quality/safety 6. ICS Planned Care task and finish group. 7. CCG Contract & Quality Review Group. 8. NHSEI performance review meetings (OSM)	pace of recovery.
	Actions to address controls and assurance gaps			Exec Lead / Timescale
	Outpatient transformation work, led by Director of Integrated Care (implementation Patient initiated follow up (PIFU), virtual consultations etc)			HB/PB / December 21
	Update Strategic Priorities paper contains an update on the outpatient transformation work. Priority areas for transformation have been jointly agreed between WHHT & Herts Valleys CCG (HVCCG). Patient Initiated Follow Up (PIFU) a strand of personalised care and a key driver in the recovery plan is now live in seven services. A further review will take place in December 21. It is anticipated that this risk will be moved to align with a different strategic objective.			

AIM 1 : BEST CARE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Patient Experience: Improve our scores on the Friends and Family Test and national patient survey results to better than national average	1. Improve communication with our patients and carers. 2. Develop best practice induction of labour pathway as part of the CPG programme using a co-production approach. To develop best practice through CPG programme using co-production approach. 3. Increase engagement in Maternity Voices Partnership, with increased representation from Black, Asian and ethnic minority communities. 4. Establish outpatient transformation programme to improve patient experience, implement new models and improve efficiency

Breakthrough Measures

1. 25 selected questions from 9 of the 12 sections from inpatient survey.
2. Number of mothers involved in development of new pathway.
3. Number of mothers engaged in MVP/% from Black, Asian and ethnic minority communities.
4. Improved patient experience of booking.
5. Roll out patient initiated follow ups (PIFU).
6. Increase use of advice and guidance models.
7. Sustain improved dropped call rate.

No	**Risk identified (What could prevent us from meeting this objective?)**	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
4A	COVID-19 outbreak negatively impacts on patient experience.	TC	Quality	-	CQC	Medium	Low
4B	Failure to communicate effectively with our patients and carers and improve the experience of discharge			4207		Medium	Low
4C	Induction of labour pathway not being developed in partnership with women to improve experience of the service.					High	Low

4D	Low levels of staff/division/management engagement will impede the implementation and progress of the transformation plan.	PB		3120		High	Medium

Risk 4A - COVID-19 outbreak negatively impacts on patient experience

Risk 4A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
1. Patient Experience Group 2. Family Liaison line introduced as an extension of PALS. 3. Visitor's 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 8.All inpatient wards can have visiting via booking system and risk assessment. A phased visiting framework has been adopted due to additional national outbreaks, the phased approach remains at phase 1 where inpatients are allowed visiting through booking system and risk assessment. All patients who are end of life, mental health, dementia, learning disability have always been accommodated.	The national and local visiting policy has the potential to have negative impact with no or reduced visiting.	1. Divisional Governance meeting 2. Patient Experience Group 3. Quality Committee 4. National inpatient surveys 5. Healthwatch report 6. Co-production Board FFT was re-established in Feb 21 with a new emphasis on responding to comments rather than targets. National survey programme has recommenced.	

Actions to address controls and assurance gaps	Exec lead	Timescale

	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 with Healthwatch and reporting to PEG and QC 4a extraordinary meeting of co-production board to discuss projects more aligned to the community which will improve our engagement with the community including seldom heard groups	TC	Next review due in February 22.
	Update Continue to review complaints and PALS to enable themes to be monitored. Call back "compassionate conversation" service continues to operate with no major themes emerging 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. Friends and Family Test recommenced and feeding back to all wards. Family Liaison line supporting information sharing and patient and family experience. Full Maternity visitation recommenced on the 12th of April with agreed processes and lateral flow test in operation. Inpatient visitation phased approach commenced in May 21 with weekly oversight by IMT and fortnightly review from the visitation panel. We have a close working relationship with Healthwatch Hertfordshire and receive and monitor feedback from their members regarding emerging themes and improvements. Overall risk is in the process of being reviewed with the overall strategic objective being refreshed in April 2022. The current focus will look at whether patients and their families have engaged and been involved in the quality of their care. Patient experience dashboards are being developed and the use of experience based design models in being explored with NHS Elect.		

Risk 4B - Failure **to communicate effectively with our patients and carers and improve the experience of discharge**

	Key Controls	Control Gaps	Identified assurance	Assurance gaps
Risk 4B	1. Hospital Efficiency 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 established. 7. The monitoring of medically optimised patients	2. 1. National PPE policy and the challenges that it brings with effective communication 2. Due to visiting restrictions reduced MDT communication with family. Family liaison line discusses patient plans with family members.	1. Hospital Efficiency Group 2. Patient Experience Group 3. Quality Committee 4. Trust management Committee 5. Healthwatch reports	None identified

	Actions to address controls and assurance gaps	Exec lead	Timescale
	1. Communication bundle available to all areas to support collaborative planning of care and goal setting. 2. The coproduction board will reach out to members to enable engagement and involvement and codesign work to support planning and evaluation	TC	Next review due February 22

Update

Implementing our phased approach to visitation. Family liaison line – staff engage with all wards and work well with families and all carers FLL staff engaged with all wards and working well in communicating to families/carers of our patients. ~~ITU visitation was re-evaluated and returned to previous process due to wave 2 pressures~~. New co-design projects accepted and progressing with oversight at co-production board. Compassionate conversation supports patients and families in this post discharge conversation to clarify issues or signpost on for additional support. Hospital Efficiency Group monitors progress on discharge. Criteria led discharge is progressing within divisions and being monitored at the Hospital Efficiency Group. Visiting within Maternity continues which recommenced on 12 April with agreed processes and LFT.

24/7 interpreter services remain. This now includes British sign language. Future projects will develop a more digitalised service.

Implemented our phased approach to visitation. Visiting remains in phase 1 which is all inpatient wards. ICU visiting has been reviewed and amended. Maternity remains the same. There is going to be a focused week which will incorporate patient discharge.

Risk 4C – Induction of labour pathway not being developed in partnership with women to improve experience of the service.

Risk 4C

Key Controls	Control Gaps	Identified assurance	Assurance gaps
• Maternity voices partnership (MVP) plan in place to develop coproduction of pathways. • Multiple forums for mothers to provide feedback on their experience.	Representation from women from diverse ethnic groups.	CPG pathways programme NICE guidance for induction of labour guidelines based on user involvement. Maternity surveys of women's experience and demographic data Maternity voices partnership meetings taking place monthly with maternity team and Executive safety champions.	

Actions to address controls and assurance gaps	Exec lead	Timescale
Coproduction with maternity services with stakeholder events being progressed. Communication campaign to support increased diversity in the maternity voices partnership from women in the local community.	TC	February 2022

	Update Social media campaign underway and the local maternity system has brought together all 3 MVP's to coproduce posters and films with a multilingual padlet reconfigured for use across the LMS. Progress is being made but is slow due to Covid-19. Risk level remains unchanged. Work with MVP on induction of labour pathway is progressing well. MVP meets monthly and receives feedback about complaints. MVP asked for visiting hours to be extended which has been facilitated and fed back to patients via the "message of the week".

Risk 4D - New outpatient model fails to improve patient experience.

Risk 4D

Key Controls	Control Gaps	Identified assurance	Assurance gaps
1. An integrated outpatient transformation programme plan is being developed which will align with a clear clinical strategy for outpatient services 2. The digitisation and standardisation of outpatient administration processes will continue around our EPR implementation 3. A new governance process will be implemented to monitor progress against the plan. administration teams to ensure alignment in activities.	1. The controls will be re-stated once the outpatient transformation plan has been produced but the key limiting factor might be securing the required amount of resource for effective management of a significant change programme plus the completion of the digitisation of our communication channels	1. Outpatient Transformation Group. 2. Trust Management Committee 3. Patient surveys	None identified

Actions to address controls and assurance gaps	Exec lead	Timescale
1. Production of an integrated outpatient transformation plan which will include widespread standardisation of outpatient processes and further digitisation of patient communication channels to be produced. 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	PB TC/MVDW	Jan 22 To be updated once the Project initiation document (PID) is

	support planning and evaluation	TC	approved at TMC
	Update Consultancy firm Attain were asked to independently review our outpatient services. They produced a report with several recommendations, foremost of which was to bring the leadership of the outpatient transformation programme together with the management of day-to-day outpatient services and produce an integrated transformation plan with clear accountability, governance, and targets. This report was considered (and broadly agreed to) by a small steering group on the 5th of March with the agreement that the CIO would produce a PID for the integrated transformation plan with a subsequent paper going to TMC for more formal consideration. The draft PID is complete and in the process of being reviewed for presentation at TMC in January 22 (slippage from July 21). Work on the clinical plan and coproduction will follow once TMC has approved the PID. There has been timetable slippage due to the pressures of the EPR and Medical Records projects.		

AIM 2 : BEST VALUE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Deliver our annual control totals and reach breakeven by 2023.	Ensure that revenue income balances with revenue for each of the next two years.
Breakthrough Measures	
2. Deliver financial plan and ensure that all clinical divisions can demonstrate costs are within 2021/22 budget or an improvement in patient care productivity.	

No	**Risk identified (What could prevent us from meeting this objective?)**	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
5A	Change in the financial regime, with (a) all patient care resources block funded and (b) the creation of the ICS could change the way that	DR	FPC	2833	Financial break-even	Medium	Medium

	finances are allocated which could impact our ability to break even.				duty		
5B	Top up funding/recovery funding is not made recurrently available during the period.				Financial break-even duty	Medium	Medium
5C	An unknown change in patient care productivity arising in the post pandemic period.				Financial break-even duty	High	Low

Risk 5A - Changes in the financial regime, with the creation of the ICS and the ICP, could change the way that finances are allocated which could impact our ability to break even.

Risk 5A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
• Financial plan for the Trust consistent with ICS financial plan. • Monthly financial forecasts	• ICS financial regime is in its early stages.	• ICS agreement to draft financial plan.	• Full definition of ICP financial governance

Actions to address controls and assurance gaps	Exec lead	Timescale
• Development of ICP financial governance	Chief Financial Officer/ Director of Strategy.	Next review due Feb 22.

Update

- Reimbursement mechanism through the ICS largely based on fixed payments continues.
- Control focus shift more toward demand management.

	• Demand management focus creates some tension with the elective recovery effort. However, the Elective Recovery fund eases this tension. The trust has submitted proposed Covid-19 costs for the first half of 2021/22, and these are being considered as part of the ICS system plan. • The HCP financial governance development continues to progress in readiness for April 2022. An operating financial framework is being developed with all HCP stakeholders and discussions ongoing on agreeing investment principles, financial risk management and measuring return on investment. • Alongside the HCP development, the Trust is awaiting the national NHS H2 operational and financial planning guidance to determine the exact H2 financial envelope. Indicative high-level workings indicate a likely financial gap of £1.5m at the end of the financial year. This analysis will be updated in due course upon the national guidance being released. • Financial planning guidance expected December 2021.

Risk 5B – Top up funding/recovery funding is not made recurrently available during the period.

Risk 5B

Key Controls	Control Gaps	Identified assurance	Assurance gaps
• Continued dialogue with NHSEI. • Continued dialogue within ICS and agreement to manage the financial health of the whole System such that single organisation failure is unlikely if the System as a whole succeeds. • Block funding agreed for H1.	• Financial regime for H2 not yet published.	• Business cases for EPR and MSCP included assumptions for top up/FRF funding for the next 10 years. Business cases approved on this basis. • Expenditure forecast compared to assumptions for H2 funding envelope	• Assurance on likely performance for H2 21/22 and beyond not yet possible without clarity on financial regime.

Actions to address controls and assurance gaps	Exec lead	Timescale
• Confirmation of Financial Regime for H2 2021/22 • Confirmation of continuation of top up / FRF funding. • Assurance that financial balance can be maintained within the notified regime and with the agreed top up funding.	Chief Financial Officer	Next review due February 22.

Update

Top up for H2 has been confirmed and supports the Trust achieving break even.

Financial information for 22/23 will be published in December 21.

Risk 5C – An unknown change in patient care productivity arising in the post pandemic period.

Ri

Key Controls	Control Gaps	Identified assurance	Assurance gaps

• Hospital Efficiency Group • Trust Efficiency Programme • Theatre efficiency group • Benefits realisation process for business cases • Divisional Performance Reviews	• Targeted KPIs	• Internal Audit reports on financial controls and efficiency programmes. • Monthly efficiency reports. • Introduction of Chief Officer reviewed through cross cutting meetings	• Independent assurance of output from Hospital Efficiency Group. • Benefits realisation reports • Targeted KPIs to monitor productivity changes. • Restoration of intensive efficiency reviews.

Actions to address controls and assurance gaps	Exec lead	Timescale
• Publication of Hospital Efficiency Group (HEG) baselines • Publication of HEG aims and objectives. • Publication of expected financial outcomes from HEG objectives. • Publication of theatre efficiency baselines and targets • Restoration of intensive efficiency reviews	Chief Medical Officer (HEG actions) Chief Operating Officer (Theatre productivity actions) Chief Financial Officer (efficiency reviews)	Next review due in Feb 22

Update

Productivity baselines drafted. To be formally signed off by groups. Risk to 21/22 breakeven is mitigated by the block funding regime. Risks to ongoing financial balance will become clearer after the publication of the financial regime in December 21.

Surgery division capacity and productivity workshop held in November 21 to address capacity issues.

AIM 3 : GREAT TEAM	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Staff Engagement: 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	1. Ensure that our staff feel engaged and included (equality, diversity, and inclusion) 2. Reduce vacancy rates in hard to recruit "hotspots"

Breakthrough Measures

1. Equality, diversity, and inclusion domain of the staff survey show improvement to above national median.

2. 30% reduction in vacancies in these areas:

   - Midwifery band 6

   - Theatre Nursing Band 5

   - Operating Department Practitioners band 5&6

No	**Risk identified (What could prevent us from meeting this objective?)**	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
7A	Staff wellbeing and engagement , ~~mental health and staff retention~~ will be affected by the long-term impact of the pandemic.	AM	PERC	Yes (aligned to risk 4280)		High	Moderate
7B	Sustainable staffing and improved levels of retention will be affected if we do not invest internally in staff development and externally in local candidate opportunities.	AM	PERC	No		Medium	Moderate

Risk 7A - Staff engagement, mental health and staff retention will be affected by the long-term impact of the pandemic.

	Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
Risk 7A	1.Staff wellbeing and engagement ~~and inclusion~~ identified as priority area in revised People Strategy. "~~Big 5" intitiative.~~ 2. Leadership development programmes focusing on behaviours, impact and compassionate leadership principles. 3. Implementation of Connect, Diversibility and LGBT groups to enhance inclusion and engagement. ~~Career coaching and enhanced staff development opportunities.~~ 4. Implementation of Well-Being strategy ~~for staff that provides clear support~~ to include psychological support ~~as well~~ and supporting physical well-being and improvements to the working environment aligned to wider system strategy. 5. Implementation of peer to peer support aligned to the wellbeing strategies including Mental health First Aiders, and Clinical Supervision. ~~Workforce modelling plans to support sustainable workforce over the next 5 –~~	1. Further review of leadership development programme and alignment across the ICS. ~~Implementation of career and development pathways embedded within the organisation.~~ 2. Implementation of Inclusion and Diversity Group to develop improved inclusion and outcomes across all protected characteristics. 3. Fully embedded peer to peer support programme following the funding identified for 2022. ~~Further support to enhance skills around workforce modelling~~ .	1, Divisional Performance Meetings. 2.TMC / PERC 3. Staff survey (including new quarterly pulse surveys)	It is still unclear as to the precise long-term impact of COVID19 upon our staff and how this may affect certain staff groups. ~~There are gaps in assurance regarding the opportunities for staff development and the impact of measures being introduced.~~

	~~10 years.~~			
	Actions to address controls and assurance gaps		Exec Lead	Timescale
	1. Actions developed from feedback of annual staff survey and quarterly staff pulse survey. ~~Big 5 workstream associated directly to inclusion as a priority area.~~. 2. Compassionate leadership and revision of overall leadership programme being undertaken. 3. Annual plan finalised and being implemented regarding well-being priorities including peer to peer support and clinical supervision. 4. Revised People Strategy with engagement and wellbeing prioritised to be published early 2022. ~~Career coaching being piloted with further implementation from October 2021~~ 5. ~~Workforce plans developed to support NHE/I submission alongside 5 year plans to support OBC for Acute redevelopment.~~		AM	March 2022
	Update There continues to be a focus on sustaining and enhancing staff well-being with the recognition week taking place in October 2021 alongside ongoing support associated to psychological and physical well-being. The work around developing a culture of development with staff has extended with the introduction of career coaching. This will develop further with initiatives to bring in future talent based on enhanced work experience and better utilisation of the apprenticeship levy. This will be linked to the workforce modelling plans to ensure our interventions are aligned to future workforce and skill needs.			
Risk 7B - Sustainable staffing and improved levels of retention will be affected if we do not invest internally in staff development and externally in local candidate opportunities.				
Risk 7B	Key Controls	Control Gaps	Identified assurance	Assurance gaps
	Recruitment plans in place that include continued support for International recruitment alongside plans to develop an ICS 'grow your own' nursing	1. Effective retention and engagement strategy to support continue levels of low turnover. 2. Implement the 'grow you own'	1. Divisional performance Reviews 2. TMC/PERC 3. ELLG.	There are gaps in assurance regarding the opportunities for staff development. The ICS initiative associated to Nursing

	programme. Career coaching and enhanced staff development opportunities within Divisional development plans. Workforce modelling plans to support sustainable workforce over the next 5 years. Links developed with local education providers to promote healthcare career opportunities. Developing opportunities for local employment with ~~Plans to develop an ICS "grown your own" nursing programme with better~~ improved utilisation of the apprenticeship levy and implementation of a work experience programme.~~for Nurse Associate and Nurse Degree programmes~~ . Launch of quarterly recruitment events to support hard to fill clinical areas.	strategy to sit alongside ~~support~~ the successful international recruitment. 3. Learning and Development strategy to support staff development and career and succession planning. 4. Further support to enhance skills around workforce modelling.		Associate and Degree Programme requires further focus to realise potential. Embedded links with local education providers alongside the launch of the new work experience programme.

Actions to address controls and assurance gaps	Exec Lead	Timescale
Supporting workforce plans to cover the next 5 years that allow us to set out the short-, medium- and long-term strategies for better retention, development of staff and effective recruitment to support sustainability.	AM	~~August 2021~~ March 2022

Update

Operational Plans have been developed alongside financial and operational activity and assumptions. This is concentrated on the next 12 months whereas the Trust workforce plans being developed are looking at the next 5 years.

In addition, progress has been made with hotspot staff groups where high vacancy rates have been identified for specific focus.

~~The "Big 5" campaign alongside~~ More effective engagement with Connect is demonstrating good progress to support equality and Diversity initiatives. This includes

	the introduction of new recruitment and selection procedures as well as the introduction of targeted career coaching for staff.

AIM 4 : GREAT PLACE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
Paper light Hospital by 2025	1. Improve the remainder of our application estate (designed to work with our infrastructure) 2. EPR Go live Nov 21

Breakthrough Measures

8. Understand all the paper processes that are currently used in the hospital
9. Identify the paper processes that can be digitised or automated (ensuring they are more effective
10. Upgrading our applications so they all work in a W10 environment (detailed programme subject to confirmation of capital funding)
11. Hit the EPR go-live date and end user feedback of go-live
12. Complete the first stage of the Health Records Transformation (movement of paper records off site)

No	**Risk identified (What could prevent us from meeting this objective?)**	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
8A	Low levels of staff support will impede progress with the paper light aim.	PB	GPC	-	CQC	High	Low
8B	Insufficient funding will prevent plans from coming to fruition.					Med	High
8C	Delays with our partner's EPR timetable could impact our go-live date.					Med	Moderate

8A - Low levels of staff support will impede progress with the paper light aim.

Risk 8A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
1. Chief's meetings – issues raised for escalation. 2. Oversight groups developed for specific projects. 3. Business cases approved for medical records and managed print services.	1. Need to ascertain baseline data e.g. Volume of paper used.	1. Specific monthly project reports to Chief's meetings e.g. EPR status report. 2. Specific project risk register. 3. Great Place Committee reports 4. Monthly Board report	

Actions to address controls and assurance gaps	Exec lead	Timescale
Work has begun to assess all the paper processes across the organisation (that are not part of the EPR programme). Once this baselining has been completed, we will present a plan of action to Exec and TMC where the appetite for further digital change will be assessed and the plan iterated as appropriate	PB	Jan 2022

Update

See above, the focus at the moment is on the paper processes that are being replaced by the EPR and Medical Records Transformation. The work to review other paper processes has only just begun

Risk 8B – Insufficient funding will prevent plans from coming to fruition.

Risk 8B

Key Controls	Control Gaps	Identified assurance	Assurance gaps
1. The NHP will expect the WHHT OBC to describe a modern fully digitised hospital	3. Inability to have an effective conversation on internal commitment to technology funding. 4. Lack of certainty around national digital requirements for new hospital programme.	1. Deputy Chief Executive working with CIO and CFO to steer the OBC conversation to the correct outcome. 2. Regular feedback to Exec and GPC on the level of digital investment in the OBC	

Actions to address controls and assurance gaps	Exec lead	Timescale
The funding required to implement the digital strategy that supports the Trust's longer term ambitions has not been identified. An on-going commitment to digital investment is required. We have agreed to fund the "digital imperatives" for	PB	February 2022

	the new hospital in the acute redevelopment OBC, conversations continue around how we secure the remaining funding.		
	Update SG has fully aligned our recommended digital investment with the national digital blueprint for new hospitals and is currently writing a brief for each recommended piece of functionality that explains the benefit drivers and calculations. Meetings are progressing with whole of executive to go through the rationale for each of the most significant digital benefits commencing with the digital command centre on 21 June 2021. The Digital Programme is funded to the end of March 2022. Digital funding will be clarified by the next round of financial planning or via an update from NHP.		

~~Risk 8C - Delays with our partner's EPR timetable could impact our go-live date.~~

Risk 8C

Key Controls	Control Gaps	Identified assurance	Assurance gaps
~~1. Monthly EPR status report to Chiefs.~~ ~~2. Shared RFL & WHHT EPR programme board meetings~~ 3. ~~Joint RFL& WHHT Partnership board meetings~~	~~1. WHHT will not have a vote in the RFL go live decision~~	~~1. Trust Management Committee~~ ~~2. Great Place Committee~~ 3. ~~External assurance from technology partners, Atos, Cerner~~	

Actions to address controls and assurance gaps	Exec lead	Timescale
~~WHHT leadership are maintaining effective and supportive relationships with colleagues, ensuring decisions are taken when required and influencing progress wherever possible~~	~~PB~~	~~Sep 2021~~
Update ~~The last joint programme board was held on 13th May. At present both organisations remain committed to the original go-live dates. Joint EPR programme board was held on 10 June with RFL Exec meeting on 11 June. Productive discussions were had in both meetings.~~ RFL have gone live. This risk has been fully mitigated and will be closed.		

AIM 4: GREAT PLACE	
Strategic Objective	**Breakthrough Objective** (Priority areas of focus for 2021/22)
New hospital facilities – building work to commence 2023	ICS wide pathology outsourcing programme

Breakthrough Measures

Key milestones:

- Appoint preferred bidder (Sept 2021)
- Approve Full Business Case (Oct 2021)
- Contract signature (Nov 2021) (For pathology)

No	Risk identified (What could prevent us from meeting this objective?)	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
9A	Agreement to invitation, best and final offer is delayed. *Path*	DR	FPC	-		Medium	Low
9B	Offer made by the bidders is not economically viable.					Medium	Low
9C	Contractual agreement with the preferred bidder and/ or agreement to full business case delayed					High	Low
9D	Clearance of WGH pathology building delayed due to delays in completion of interim hot lab					Medium	Low
9E	Clearance of WGH pathology building delayed due to delays in preferred bidder implementing target operating model.					High	Low

9F	Changing regulatory environment and requirements could mean delay to the completion of the OBC. This risk has materialised. Assurance report from GPC sets out delays to NHP at a national level are impacting our OBC timeline.	HB	GPC	4332 2795 4438/4439		High	Moderate
9G	Delay to confirmation of funding by NHSE&I will delay the enabling works programme.					Medium	Moderate

9A - Agreement to invitation for best and final offer is delayed

Risk 9A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
• ICS wide programme Board • Externally sourced project management. • Dialogue sessions with bidders to minimise risk of bids being uneconomical. • Additional focus from redevelopment programme.			Assurance regarding clinical solution.

Actions to address controls and assurance gaps	Exec lead	Timescale
Full clinical assurance to be gained from final evaluation of BAFO		Feb 2022

Update

Pathology BAFO substantively agreed by organisations. Finer draft contract consistency details being completed by lawyers.

Completion of those final contract details remains delayed.

9B - Offer made by the bidders is not economically viable.

Risk 9B	Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence	
	• Construction of a full financial model. Financial evaluation team in place	Receipt of affordable BAFOs		Analysis of affordable BAFOs	
	Actions to address controls and assurance gaps			Exec lead	Timescale
	None identified			Chief Financial Officer	February 2022
	Update Issue of Pathology BAFO delayed to allow finer draft contract inconsistencies to be ironed out. Work continues in developing the pathology business unit.				

9C - Contractual agreement with the preferred bidder and/ or agreement to full business case delayed

Risk 9C	Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence	
	Project structure in place. Legal advisors in place. 3rd party project managers in place.	Inability to control bidder disputed items.	ICS wide project board and individual organisations boards		
	Actions to address controls and assurance gaps			Exec lead	Timescale
	• Complete enabling works business case and secure approval. • Secure BAFOs and preferred bidder for pathology outsourcing			Chief Financial Officer	Feb 2022
	Update				

	Issue of Pathology BAFO delayed to allow finer draft contract inconsistencies to be ironed out. Enabling work business case approved by Trust Board in October and submitted to NHP. Awaiting feedback on process for approval from NHP.

9D – Clearance of WGH pathology building delayed due to delays in completion of interim hot lab

Risk-9D

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
Enabling works business case Project team in place to undertake and surge wards and pathology hot lab.	Business case and funding need approval	Reports to GPPB.	Approval of enabling works business case. BAFOs from bidders that are consistent with interim hot lab plans.

Actions to address controls and assurance gaps	Exec lead	Timescale
• Complete enabling works business case and secure approval. • Secure BAFOs and preferred bidder for pathology outsourcing	CFO	February 22.

Update

We are at the initial stages of developing the business case. The BAFO has been approved by TMC in September 21 and business case for the interim hot lab was approved by the Board in October 21. The enabling works business was approved by Board in October 21 and now awaits NHP's approval which should take 3 months.

9E - Clearance of WGH pathology building delayed due to delays in preferred bidder implementing target operating model.

Risk 9E

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
Contractual agreement with preferred bidder	Contract not yet in place	Project progress reported via GPPB	None identified

Actions to address controls and assurance gaps	Exec lead	Timescale

	Get the contract with the preferred bidder by December 2021.	CFO	Feb 2022
	Update Face to face dialogue is coming to and end with a view to invitation to BAFO expected to be issued shortly one contract issues have been resolved.		

9F - Changing regulatory environment and requirements could mean delay to the completion of the OBC.

	Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence	
Risk 9F	Programme Director / team in place. Regular liaison with NHP and NHS E and responsive to all requests for information and ensure sighted on key requirements as they emerge. Stakeholder mapping and plan has identified key influencers and WHHT link. Use of networks – NHS providers, RFL PS, PA Consulting	None identified	Great Place Programme Board meets monthly. Great Place sub-committee meets bi-monthly / as required.	None identified	
	Actions to address controls and assurance gaps			Exec lead	Timescale
	None identified.			HB	December 21
	Update Programme plan for outline business case being re-worked and will remain dynamic until NHP have confirmed key dependencies. Current risk level has increased to High. Target level (risk appetite) remains the same.				

9G - Delay to confirmation of funding by NHSE&I will delay the enabling works programme.

AIM 4: GREAT PLACE

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence	
Programme Director / team in place. Regular liaison with NHP and NHS E and responsive to all requests for information and ensure sighted on key requirements as they emerge.	Enabling works business case in development.	Great Place Programme Board meets monthly. Great Place sub-committee meets bi-monthly / as required.		
Actions to address controls and assurance gaps			Exec lead	Timescale
Enabling works business case to be finalised.			HB	January 2022

Update

~~Awaiting template / guidance from NHP. Initial meeting held to discuss requirements. Broadly positive but some challenge re requirement to re-provide surge wards. Short time-period for depreciation has potential to create short term cost pressure which requires discussion with system partners / CCG.~~

Enabling business case approved at October 21 Board. NHP will progress approval within 3 months period.

Strategic Objective	Breakthrough Objective (Priority areas of focus for 2021/22)
MSCP	MSCP – construction completed and in use by 26 March 22, allowing Cardiff Road staff car park to be handed back to Watford Borough Council

Breakthrough Measures

Key milestones:

-MSCP main build contract signed by 1 April 2021

- MSCP access road completed by 31 August 2021

- MSCP main build completed by 26 March 2022.

No	Risk identified (What could prevent us from meeting this objective?)	Executive Lead	Sub-committee	Corporate Risk Register	Link to Standards	Current risk level	Target level (Risk appetite)
10A	Progress with the construction is delayed by collapse of contractor.	DR	FPC	-	CQC	High	Low

10 A- Progress with the construction is delayed by collapse of contractor.

Risk 10A

Key Controls What controls have been put in place to mitigate the risk	Control Gaps What are the key gaps in controls	Identified assurance	Assurance gaps Where we are not gaining effective evidence
Regular dialogue with Contractor. Parent Company Guarantees and step in rights. MSCP project group	No monitoring process of the Contractor's financial health.	Contractual due diligence process regarding contractor's capacity.	We are not privy to the Contractor's up to date financial provision.

Actions to address controls and assurance gaps	Exec lead	Timescale
None identified	DR	December 21

	Update The project is on track for completion by March 2022 with governance, approval and legal steps completed. The project has now gone into the construction and operational readiness phase. The ITT to be issued in October/November 21 for the car park operator.

Board BAF risk summary sheet 2021/22

Appendix 1

Risk ref	Objective	Risk detail	Risk level	Risk appetite
1A	Mortality (SHMI & HSMR): 'as expected' or 'better than expected' for HSMR and for SHMI.	Excess mortality due to COVID-19 and non-COVID-19 patients	High	Low
1B		Failure to reduce the gap between weekend and weekday mortality.	High	Low
2A	Avoidable Harm (harm free care): Continuous improvement and better than national average for new pressure ulcers, falls with harm, new venous thromboembolism, urinary tract infections (in patients with a catheter) and healthcare associated gram-negative blood stream infections (GNBSI)	Failure to implement the IP&C Board Assurance Framework leading to the risk of nosocomial infection	Medium	Low
2B		Failure to reduce e.coli in line with agreed trajectory	Medium	Low
2C		Failure to deliver harm free care	Medium	Low
3A	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 waits, 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).	The planned implementation date of April 2022 will not be met if: 1 – The CCG led engagement and decision-making process is delayed; and/or 2 – There is a lack of market interest in delivering the service.	Medium	Low
3B		If target activity through UTC is not met this could have an impact on performance	Medium	Low
3C		A further wave of Covid-19 or other infectious disease will impact our ability to meet access to care standards.	High	Low
4A	Patient Experience: Improve our scores on the Friends and Family Test and national patient survey results to better than national average	COVID-19 outbreak negatively impacts on patient experience	Medium	Low
4B		Failure to communicate effectively with our patients and carers and improve the experience of discharge	Medium	Low
4C		Induction of labour pathway not being developed in partnership with women to improve experience of the service.	High	Low
4D		Low levels of staff/division/management engagement will impede the implementation and progress of the transformation plan.	High	Medium

Risk ref	Objective	Risk detail	Risk level	Risk appetite
5A	Deliver our annual control totals and reach breakeven by 2023.	Change in the financial regime, with (a) all patient care resources block funded and (b) the creation of the ICS could change the way that finances are allocated which could impact our ability to break even.	Medium	Medium
5B		Top up funding/recovery funding is not made recurrently available during the period.	Medium	Medium
5C		An unknown change in patient care productivity arising in the post pandemic period.	High	Low
6	Achieve a "cost per weighted activity unit"	Suspended	Suspended	Suspended
7A	Staff Engagement: We want to be one of the best hospitals in England for staff engagement and in top 20% of acute hospital Trusts in the country for NHS national staff survey results	Staff engagement, mental health and staff retention will be affected by the long-term impact of the pandemic.	High	Low
7B		Sustainable staffing and improved levels of retention will be affected if we do not invest internally in staff development and externally in local candidate opportunities.	Medium	Low
8A	Paper light Hospital by 2025	Low levels of staff support will impede progress with the paper light aim.	High	Low
8B		Insufficient funding will prevent plans from coming to fruition.	Medium	High
8C		Delays with our partner's EPR timetable could impact our go-live date.	Medium	Medium
9A	New hospital facilities – building work to commence 2023	Agreement to invitation, best and final offer is delayed.	Medium	Low
9B		Offer made by the bidders is not economically viable.	Medium	Low
9C		Contractual agreement with the preferred bidder and/ or agreement to full business case delayed	High	Low
9D		Clearance of WGH pathology building delayed due to delays in completion of interim hot lab	Medium	Low
9E		Clearance of WGH pathology building delayed due to delays in preferred bidder implementing target operating model.	High	Low
9F		Changing regulatory environment and requirements could mean delay to the completion of the OBC.	High	Moderate
9G		Delay to confirmation of funding by NHSE&I will delay the enabling works programme.	Medium	Moderate
10A	Progress with the construction is delayed by collapse of contractor.	Progress with the construction is delayed by collapse of contractor.	High	Low

Risk appetite statement

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

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

The Threshold Matrix explains the level of risk appetite that the Board is prepared to accept for each category.

Threshold Matrix

Risk appetite	**What this means**	
Very low	The Board is not prepared to accept uncertainty of outcomes for this type of risk.	
Low	The Board accepts that a level of uncertainty exists but expects that risks are managed to a level that may not substantially impede the ability to achieve objectives.	
Moderate	The Board accepts a moderate level of uncertainty but expects that risks are managed to a level that may only delay or disrupt the achievement of objectives but will not stop their progress.	
High	The Board accepts a high level of uncertainty and expects that risks may only be managed to a level that may significantly impede the ability to achieve objectives.	
Category	**Risk Appetite**	**Risk Appetite Score**
Quality safety	VERY LOW risk appetite for risks that may compromise safety such as patient harm, infection control, pressure sores and learning lessons.	1 - 5
Affordability	VERY LOW risk appetite for unaffordable items which would affect the financial sustainability of the organisation.	1-5
Quality effectiveness	LOW risk appetite for risks that may compromise the delivery of outcomes for service users such as outcomes, delays, cancellations or operational targets and performance.	6 - 9
Statutory compliance	LOW risk appetite for risks that may affect statutory compliance such as Information Commissioner, CQC, H&S, professional standards and external certifications.	6 - 9
VFM	LOW risk appetite for affordable patient safety items where there is a degree of subjectivity regarding assessment of VFM.	6-9
Workforce recruitment and retention	LOW risk appetite for risks that would affect equal opportunity and diversity and compromise fair recruitment and attractiveness	6-9

	of Trust as employer of choice.	
Clinical innovation	MODERATE risk appetite for clinical innovation that does not compromise quality of care	10 - 12
Compliance/regulatory	MODERATE risk appetite for compliance/regulatory risks ***where there are no risks or compromise in quality safety***	10 - 12
Reputation	MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation	10 - 12
Quality experience	MODERATE risk appetite for risks that may affect the experience of service users	10 - 12
Workforce innovation	MODERATE risk appetite for actions and decisions taken to improve workforce health and wellbeing and future staffing requirements.	10 - 12
Partnerships	HIGH risk appetite for partnerships which may support and benefit the people the Trust serves	15 - 25
Commercial	HIGH risk appetite for commercial gain whilst ensuring quality and sustainability to service users	15 - 25
Digital innovation	HIGH risk appetite for digital innovation that challenges current working practices in support of digital systems that will produce benefits for the organisation.	15 - 25

Agenda item: 13

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Committee meeting:	**27 October 2021**
Quoracy:	**The meetings were quorate.**
Date of Board meeting:	**2 December 2021**
Recommendation:	**For information and assurance**
Chair:	**Christine Allen, Chief Executive Officer**
Purpose:	This report provides an update to the Trust Board on actions and developments since its most recent meetings on 27 October 2021.
Background:	The Committee meets monthly and provides assurance to the Board: • 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
Assurances received and items for update:	**Summary:** Assurance was provided on the monitoring of operational, financial and clinical performance and the development, implementation and monitoring of strategy. **Regular reports received and discussed for assurance:** • Covid-19 update from the Chief Operating Officer. • Finance update from the Chief Financial Officer. • Strategy updates from the Deputy CEO.

Additional reports received and discussed for assurance:

- The presentation on the options for redevelopment
- The Green Travel plan
- The IPR

The Committee approved:

- The Accommodation Manager Post business case
- The South & West Herts ICP Shadow Partnership Agreement and Interim Strategy
- MOU for the Mental Health Collaborative
- The new Rheumatology Consultant business case
- The Emergency Department business case
- The MEC refurbishment business case

Oral reports were received from:

- The Chief Medical Officer with feedback from the Hospital Efficiency Group (HEG) and the Clinical Advisory Group (CAG)
- The Chief Nurse with feedback from the Professional Advisory Council

Any other business:

Risks to refer to risk register:	None.
Issues for the Board to note:	None
Recommendation to the Board:	That this report be taken for information and assurance.

Agenda item:	**14**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Finance and Performance Committee**
Date of Board meeting:	**2 December 2021**
Quorum:	**The meeting was quorate**
Recommendation:	**For information and assurance**
Chairperson:	**Paul Cartwright, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents the approvals of recommendations made to the Finance and Performance Committee at its meeting on 25 November 2021.
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.

Summary:

The committee received reports on the following matters:

Standard reports received and discussed/noted for information and assurance:

- Summary finance risk register including review of corporate risks and Board Assurance Framework;
- Integrated Performance Report;
- Month 7 Finance summary;
- Efficiency Programme update;
- Contracts and Commerce update;
- Capital programme expenditure, planning, capital control schedule and risks update.

Additional reports received and discussed/noted for information and assurance:

Atos Contract Extension:

Business case evaluations:

1. **Enhanced Care Workers**
2. **Acute Respiratory Care Unit**

Assurance received and items of note:

IPR

1. FPC is delighted to see the continued development and refinement of the new IPR and statistical approach through extensive debate and discussion in the various committees and elsewhere. Allocation in IPR to committee and executive works well and the approach to rare events sounds right. The narrative needs more work and FPC was pleased to hear that was already in hand.
2. Other areas required continued reflection including the treatment of activity statistics. Debate needs to take place in the main performance section with the financial consequences (e.g. ERF) then dealt with when discussing the Financial statements.
3. IPR and performance reviews should use the appropriate technical language necessary for deep analysis; separate documentation should be used to communicate with the wider public less familiar with technical language.
4. A number of specific performance items were discussed in more detail including OP appointments, A+E attendance and ambulance handover anomalies, patients medically fit for discharge, RTT and C sections.
5. FPC notes that WHHT continues to be under great pressure in advance of the normal winter peak and that the pressure points and issues are statistically speaking broadly similar to the last period.

Risk

1. FPC noted minor changes to risks and the board assurance framework.

Financial Performance

1. Following discussion, FPC continued to be assured that management of finance under the current block payment was working effectively and with day to day revenue and cash issues understood and addressed appropriately.
2. The £62m Capital expenditure programme is proceeding broadly to plan and with the finance function prepared to deal with any end of year capital opportunities that frequently arise.
3. Performance improvement under the CIPS programme continues to be challenging and FPC noted frustratingly that with the Covid related recovery pressures facing the hospital, WHHT is unlikely to achieve the full £15.9m hoped for at the beginning of the year and that this reduced expectation was allowed for in the forecast.
4. Experimentation with the graphical forms of the new IPR appeared less useful or concise in discussing financial performance. The snappy consistent commentary was good. FPC agreed with the Finance Function that future iterations of the Financial Performance Report should in part revert to more conventional expression, have fewer pages and guide the reader rapidly to issues of note.

IT Infrastructure

1. The ATOS IT contract reached its first review point in September 2022 and agreed preparations for what should happen thereafter need to commence immediately in order to ensure excellent continuity of service without compromising WHHT's commercial position. Following discussion, FPC understands the various technical and commercial issues more clearly and wishes the CIO to confirm - after consulting with the CFO and CEO - the proposed way forward that appropriately balances commercial, technical, legal and economic risk with WHHT business requirements.
2. The CIO will bring to December FPC an options paper with the proposed way forward.

Benefit Appraisal

1. FPC was very pleased to receive the first assessment of benefits achieved from two earlier projects (ARCU and ECW) along with plans for the next year of reviews. The crisp reports were informative and helpful in thinking through what needs to be set at project inception. It was felt that this process should be as simple and non-threatening as possible to not discourage capital/project applications and to encourage the rapid incorporation of learning into future projects. Finance was asked to ensure that large and tricky project/contracts were included in the review process and in particular the MITIE contract.
2. FPC was particularly pleased that benefits review had received extensive discussion at TMC.

Business Cases

1. None

Risks to refer to risk register: None

Items for the Board to note: The approach to the IT infrastructure contract must be determined by the end of this calendar year and, in the absence of a January Board Meeting, a subset of the Board must be given delegated authority to agree the way forward proposed by the CIO.

Recommendations to the Board: None

Agenda item:	**15**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Quality Committee**
Date of Board meeting:	**2 December 2021**
Quorum:	**The meeting was quorate**
Recommendation:	**For information and assurance**
Chairperson:	**Ginny Edwards, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents the approvals of recommendations made to the Quality Committee at its meeting on 28 October 2021.
Background:	The purpose of the Quality Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes are provided by the Trust, and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

Summary:

The committee received reports on the following matters:

Standard reports received and discussed/noted for information and assurance:

- Corporate Risk Register and Board Assurance Framework Report
- Chair's report from Risk Review Group
- Chair's report from Outsourcing Group
- Outsourcing quality contracts/Harm review update

Additional reports received and discussed/noted for information and assurance:

Infection Prevention and Control BAF Internal Audit Report: The committee were assured that the audit found a substantial level of assurance when reviewing procedures and evidence to support the IPC BAF.

The committee were informed about a recent occurrence of Covid cases on Tudor Ward and steps taken both internally and with external partners to manage this, including ward lock-down, identification of cases from discharge and screening, screening of all staff and patients on the ward, increased ventilation, extra cleaning in addition to existing enhanced cleaning, HCP testing, allocation of dedicated toilet facilities to individuals, review of admissions, negative screening of persons entering the ward and daily reviews.
The committee was assured in response to questions, about steps taken to ensure the safety of patients and staff and the speed and thoroughness of response. The committee were assured that notwithstanding constraints in terms of the estate and ventilation, the ward was safe for patient care and had been re-opened only when all control measures were in place.

Infection and Prevention Control (IPR) (6 monthly report): The committee received assurance of compliance with the hygiene code set out in the Health & Social Care Act 2008 (2015).

Risk Maturity Internal Audit Report: The committee received the report of the internal auditors assessing the effectiveness of risk management systems and processes within the Trust, and how risk the management culture within the organisation has been embedded. The committee was assured that no significant concerns were identified and noted areas for improvement.

Maternity

Maternity Safety Champion report: The committee received assurance on the Trust's maternity safety champion work during August to October 2021. The committee received a good level of assurance that the Trust is compliant with standards set out in the CNST year 4 maternity incentive scheme, Safety Action 9 (which requires the Trust to demonstrate that Trust safety champions (obstetrician and midwife and neonatal) are meeting with Board level champions to escalate locally identified issues.

The committee heard key headlines from monthly maternity safety champions' meetings and walkarounds during the reporting period. The Trust had reported 5.9% neonatal term admissions between 1 January to 31st July, which was above the national target of 5%. A deep dive review had shown that a high proportion of these were unavoidable. The committee was assured that the Maternity and Neonatal Safety Champion would continue to monitor the improvement plan to reduce the number of avoidable term admissions to neonatal unit in the interests of keeping mothers and babies together.

A safety action to ensure that MEOWS charts were being completed at all times in the maternity day assessment unit, was being monitored.

Non-executive director, Jonathan Rennison reported his participation in the champions' monthly meetings and the work done to implement action plans. The committee received a high level of assurance that actions were being progressed and that there was a robust process in place for learning and reflection.

The committee heard that the maternity dashboard was under review to change targets that measured total, emergency, and elective c-sections rates to include the Robson criteria for measuring c-section rates more intelligently. The committee asked for an update on this at its November 2021 meeting, to inform discussion on how redeveloped dashboard data would be used to track improvement.

Perinatal Quality Surveillance Tool report: The committee received a report on the revised Perinatal Quality Surveillance Model (January- September 2021) and were assured of implementation of the data set of the revised Perinatal Quality Surveillance Model, as recommended in safety action 9 in the maternity CNST scheme, year 4.

CQC Inspection: The committee received an update on an unannounced inspection and initial feedback given by letter confirming that CQC found:

- The staff team within maternity services worked well and cohesively together despite staffing challenges, and staff cared for women and their families with compassion and took time to answer their questions.
- Staff were open with the inspection team about the challenges of the service. There was a collaborative approach to improve the assessment of risk and incident reviews.

• The recruitment of additional consultants to have consultant presence onsite 24 hours a day, Monday to Friday was positive.

The committee also heard that the following issues were raised at the feedback meeting:

• Although the trust is challenged by the aged estate, areas of the environment could be resolved or monitored such as additional cleaning of window-sills in delivery rooms and formal monitoring of Entonox gas levels within these rooms.
• CQC also had concerns about a number of policy and guideline documents which were behind their review dates.

The committee understood that the next step would be for CQC to send a draft inspection report for factual accuracy checks. The committee were assured that there were no immediate high risks or changes required.

Medicines Management report: The committee received assurance on medicines management and improvement actions taken. The committee noted the forthcoming introduction of Electronic Prescribing and Medicines Administration (EPMA).

Cervical Screening Programme 6 monthly report: The committee received a high level of assurance on the delivery of the cervical screening programme from January to June 2021 and were updated on issues concerning external providers, which the Trust is managing.

RIDDOR report: The committee considered a review of RIDDOR reporting of employees exposed to Covid. The committee received a high level of assurance that all processes had been completed cases and that a robust retrospective review of all cases had taken place.

Co-production update: The committee received an update for information.

Quality Improvement update & Progress update report on clinical practice groups: The committee received assurance on arrangements in place to ensure adequate governance of outsourced work to external providers in the independent sector and the methods and mechanisms in place since formation of the Outsourcing Oversight Group in April 2021. The committee received good assurance on the realisation of benefits to patients and looked forward to further reports of the benefits to patients of digitisation of pathways.

Outsourcing quality contracts/harm review update: The committee were assured that processes and policies were in place and the development of effective relationships was progressing well.

Ambulance Handovers: The committee were updated under AOB about a recent letter from NHSE concerning ambulance handover delays, in relation to which the committee were informed there would be a paper to the Trust Board's 4 November meeting.

Risks to refer to risk register: None

Items for the Board to note: None

Recommendations to the Board: None

Agenda item:	**16**
Report to:	**Trust Board**
Title of Report:	**Assurance report from People, Education and Research Committee**
Date of Board meeting:	**2 December 2021**
Quorum:	**The meeting was quorate**
Chairperson:	**Natalie Edwards, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents approvals of recommendations made by the People, Education and Research Committee at its meeting on 28 October 2021.
Background:	The purpose of the People, Education and Research Committee is to provide the Board with assurance that the Trust is meeting its requirements in relation to basic workforce metrics and obligations, including whistleblowing and freedom to speak up, meeting the key objectives of the People Strategy, that its workforce is fit for purpose, engaged and that it provides a high quality education provision and excellent research and development opportunities.

Summary:

The Committee received reports and had discussions for information and assurance on the following matters:

- **Workforce Strategy:**
  - Chief People Officer Update
    - this included an update of the flu vaccination programme, the staff survey as well as feedback from the recent All Stars and Stars of Herts events.
  - National People Plan implementation – progress report
  - Trust People Strategy – draft
  - Developing Talent.

- **Workforce Governance:**
  - Corporate workforce risks
  - Reports from Guardian of Safe Working
  - WRES Annual Report -this report will also proceed to Board for formal ratification for publication.
  - Internal Audit Report – Local Induction.
  - Freedom to Speak Up - Annual Report - this paper will proceed for Board as part of an annual report.

- **Workforce Performance:**
    - Workforce Performance & Exception Report – this paper highlighted performance based on September 2021. It highlighted 2 main areas of focus being Staff Appraisal rates and Staff turnover. Staff turnover was considered more closely as part of a deep dive report.
- **Research and Development** – Strategy Update Report**.**

Issues to note

The committee received positive assurance on:

- The success of the All Stars week with a summary report to follow at the next meeting.
- The Trust's focus on flexible working and inclusive recruitment which would be developed over the next few months.
- Ongoing work on staff retention and recruitment.
- The proposed review of processes by internal audit regarding the enhancement of local induction.
- The implementation plan for improving the utilisation rate for apprenticeships which will be received by TMC in December 2021.
- The Trust's People Strategy with a review of the first draft.
- Developing talent in the medium to longer term with a focus developing volunteers and engagement work with the local community.
- Management of workforce risks.
- Workforce related key performance indicators, with an emphasis on staff turnover. Workforce performance and the positive data on the number of candidates joining the Trust in the next three months.
- Work being undertaken to ensure recruitment processes and development opportunities are fair and accessible, a reduction of bullying and harassment and embedding the connect network into the governance framework.
- Progress on safer working for junior doctors and the work being undertaken to resolve rota concerns for medicine.
- The work of the FTSU guardian and progress on training levels in relation to speaking up.
- Progress on research and development.

The committee noted concerns on:

- Engagement from WACS for EPR training which was being monitored.
- Performance in relation to turnover rates, for which a deep dive of the trends affecting staff retention had been undertaken. The deep dive highlighted exit interview analysis that focused on relationship management and staff development/career progression which is addressed in the workforce strategy.

Risks to refer to risk register:	None.
Items for the Board to note:	None
Recommendations to	Formal approval for the publication of the Workforce Race Equality Scheme

the Board: (WRES).

Agenda item:	
Report to:	**Trust Board**
Title of Report:	**Assurance report from Great Place Committee**
Date of Board meeting:	**2nd December 2021**
Quorum:	**The meeting was quorate**
Chairperson:	**Helen Davis**
Purpose:	The report summarises the assurances received, and documents approvals of recommendations made by **Great Place Committee** at its meeting on 18th November 2021
Background:	The Committee meets bi-monthly and gains assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and provides senior-level leadership to shape and drive the implementation of these key elements of the Trust's strategy.

Summary:
The Committee received reports and had discussions for information and assurance on the following matters:

- **EPR go live readiness and risks:** the committee received a detailed update from the CIO on readiness for go live at the end of November. Key areas of focus were discussed, including access (smartcards) and training uptake.

  It was noted that a decision had been taken to descope pathology order communications from the November go-live due to insufficient progress on testing and that an implementation plan is being worked up for implementation in Q4. The key risk to implementation in Q4 relates to Clinysys resourcing and laboratory staff capacity and it was noted that this presents a risk of costs being carried forward into the next financial year.

  System partners were thanked for their support, with an agreement to run a multi-agency discharge event (MADE) in the in the run up to EPR go live.

  The EPR programme team and Trust operational and clinical teams were thanked for all their hard work to date, and the hard work still to come over the next period.

  The formal go / no go decision was scheduled for the 24th November, the CIO noted that if good progress continues to be made over the next week then the expectation is for a 'go' decision.

- **Digital Programme Progress report:** It was noted that progress continues to be made on a range of digital priorities. A joint bid has been submitted with ICS partners for a maternity EPR system, with a decision due on 24th December. It was noted that the patient portal variation has not yet been signed off by Cerner and that this has been escalated within Cerner by the CIO for urgent resolution.

- **Acute redevelopment programme.**

    - **New Hospital Programme (NHP) –** a brief update was provided on changes to the leadership team at a national level. The NHP focus is currently on phase 1 (live schemes) and 2 (agile schemes) and on the development of a programme business case for submission to the Treasury. As such work with pathfinders and full follower schemes is receiving less attention and effectively remains on pause. It was noted that approval of the programme business case will provide greater clarity of the likely quantum of funding available for pathfinder schemes but that it is likely to be early summer at the earliest before there is a formal outcome and individual feedback to pathfinders on the implications for their OBCs.
    - **Enabling works business case –** NHP have not yet confirmed the process or timeline for review and approval of the enabling works business case. It appears that there is no flexibility within this year's budget to allow for any funding to be released in this financial year. The earliest realistic start date is therefore April 2022, representing a minimum 2 month delay to planned start date. The ARP team will be working with the NHP team to try to secure approval in this financial year.
    - **Emergency Care options** – the committee received a detailed update on work that has been undertaken to review 'retain PMoK' / option 4 on the WGH site to identify an option that delivers meaningful improvement (in compliance and patient experience) at a lower cost than new build replacement of PMoK (options 5 & 6). Following a detailed appraisal of the options the programme team have recommended an option that would see PMoK refurbished to provide 390 inpatient beds (close to full compliance with Health Building Note requirements) and associated diagnostic facilities with some relatively limited improvements to the core infrastructure (water safety, air quality and temperature control). The committee noted that this option costs almost as much as new build and offers much lower benefits and that our preferred option remains full replacement of PMoK. However it was noted that the business case process requires detailed economic appraisal of a range of viable options and that as such it was agreed that this option should be included within the appraisal.
    - **Planned Care options –** the committee noted that work to define in detail options for Hemel and St Albans hospitals is nearing completion.
    - **Programme Dashboard –** this was received and noted. The delays to the national programme and uncertainty re funding and timelines have resulted in an overall 'red' rating for the programme at this time.
    - **Programme fee draw down –** the CFO updated the committee on this issue. Confirmation of programme funding for this year has not yet been received. We have been advised that a decision should be made and communicated to Trusts by late November / early December. However it was noted that the Trust has already committed significant expenditure at risk (c £2.7m) and that given the overall risk profile within the Trust's capital programme, the Trust is no longer in a position to fund any further discretionary spend on the programme until funding has been confirmed. As such it was noted that all external

advisory support will be stood down with effect 31st December 2021, with steps already being taken to reduce expenditure in November and December. This will inevitably delay the pace of progress on the OBC.

- **Stakeholder engagement and communications –** it was noted that the communications environment remains challenging, however the Trust is actively responding to local media coverage and ensuring that key stakeholders are briefed on the current issues and the Trust's plans. It was noted that internal communications are important at this time and that an all staff communication would be issued.

Risks to refer to risk register:	None.
Items for the Board to note:	An update on EPR go live will be provided at the Trust Board. Detailed definition of options for both emergency care and planned care are close to being finalised to enable the economic appraisal to be completed, subject to programme resources. All discretionary spend on the ARP is being ceased, pending confirmation of draw down funding by the NHP. The overall timeline for OBC completion is significantly delayed and remains uncertain.
Recommendations to the Board:	None.

Trust Board Meeting
02 December 2021

Title of the paper	**Integrated Performance Report** ***(November 2021 reporting period – October 2021 data)***
Agenda Item	**17**
Presenter	**Paul Bannister, Chief Information Officer**
Author(s)	**Paul Bannister, Chief Information Officer** **Mark Landau, Director of Business Intelligence**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓

Executive Summary	**Summary**
	• This cover sheet summarises the contents of the Trust Integrated Performance Report, detailing changes made to the pack and summarising some of the narrative points made and is intended to provide information and assurance to the committee.
	
	New changes to the pack
	• Summary sheets have had three columns added:
	  ○ Whether the target is local or national
	  ○ Which Committee has oversight of the metric
	  ○ Who is the Executive owner
	• The appendix charts have been increased in size in an attempt to make them more readily legible.
	Safe Care & Improving Outcomes - Quality
	• There are three statistically significant indicators identified, all of which were also an exception in the previous month. Mortality indicators (SHMI and HSMR) are both showing as positive exceptions.
	• Changes to this section this month:
	  ○ Targets for Caesarean Section rates removed, following discussion with Chief Nurse.
	  ○ Three new Caesarean Section indicators added - Robson 1 category (single baby at term in spontaneous labour where no previous birth), Robson 2 category (single baby at term with induced labour or C-section where no previous birth) and Robson 5 category (single baby at term with a previous C-section)
	  ○ Whilst not generating an exception (performance is is common cause variation), the Trust's C-Section rate for Robson category 1 and 2 are both higher than the national position
	Safe Care & Improving Outcomes - Safety
	• There are five exception pages generated. The exception pages generated this month were also exceptions last month with the exception of Category 4 Pressure ulcers, which is no longer an exception following the move to a Rare Events tool.
	• Changes to this section this month:
	  ○ Category 4 Pressure ulcers – New (Hospital acquired) plotted on a rare events chart (T chart – looks at the time between rare events) – now no longer expressing an exception
	Caring & Responsive Services – A&E
	• Six Exception pages generated, 5 of which were also exceptions in the previous month. The new exception page is Mean time (minutes) in department (non-admitted), which has triggered due to a run of points above the mean. Regionally WHHT are not showing as an outlier for ambulance handover delays (sitting in the middle of the pack in terms of volume and percentage of handover delays) however the Trust is still very challenged on Type 1 Performance

<table>
<tr><td></td><td>

Changes to this section this month:

A&E 12 Hour Trolley waits has been plotted on a rare events chart (T chart – looks at the time between rare events) – and is now no longer expressing an exception, as it would be if plotted
A&E Admitted 4 hour performance removed as not a helpful/meaningful metric (this was a local metric) following conversations with Director of Performance and Divisional Director of Emergency Medicine

Caring & Responsive Services – RTT, Cancer, Outpatients

Seven Exception pages generated, all of which were also exceptions in the previous month.
Changes to this section this month:

Cancer 31 Day Subsequent Surgery was an exception in the previous month however it is now in common cause variation

Although 62 Day and Faster Diagnosis Standard are not triggering exception pages, the service do want to highlight the challenging nature of performance in these areas. Two week wait performance (which is an exception) is having a knock on effect on the 62 day pathway. Of the 38 breaches, 7 were closed within 1 week of the breach date with 8 closed over 104 days. Faster Diagnosis Standard is still in a compliant position, however the last two data points have been the lowest since April 2020.

Workforce

Three Exception pages generated, all of which were also exceptions in the previous month.

Activity

Five Exception pages generated, four of which were also exceptions in the previous month.
The new exception page is A&E attendance volume which has generated an exception due to a run of 7 data points above the mean, as well as a breach of the upper control limit. The increase in volume is congruous with the challenged A&E 4hr wait performance, as well as the exceptions generated for non-elective admissions – zero LOS, and non-elective admissions - +1 LOS. It is worth noting that the same pattern of exceptions is noted when plotting A&E attendances in England as a whole.

NB: Data correct at the time of reporting
</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></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>

NHS
West Hertfordshire Hospitals
NHS Trust

Integrated Performance Report

November 2021 – October 2021 data

Mark Landau, Director of Business Intelligence
Paul Bannister, Chief Information Officer

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

- Trust Management Committee – 24th November 2021
- Finance & Performance Committee – 25th November 2021
- Trust Board – 2nd December 2021

West Hertfordshire Hospitals NHS Trust

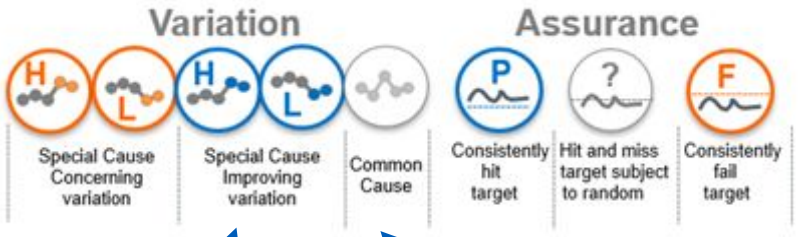
A note on SPC charts

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

West Hertfordshire Hospitals NHS Trust

High Level Key - Variation

Are we improving declining or staying the same



Orange = significant concern or high pressure

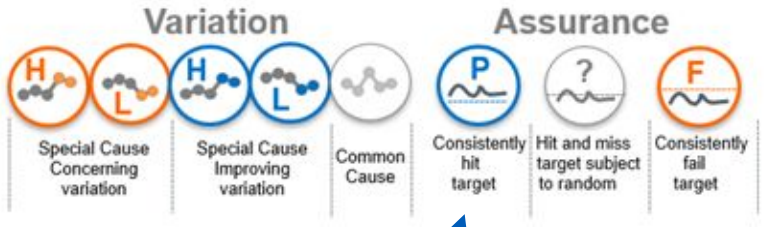
Blue = significant improvement or low pressure

Grey – no significant change

West Hertfordshire Hospitals NHS Trust

High Level Key - Assurance

Can we reliably hit the target



Orange = system change required to hit target

Blue = will reliably hit the target

Hit and miss the target

West Hertfordshire Hospitals NHS Trust

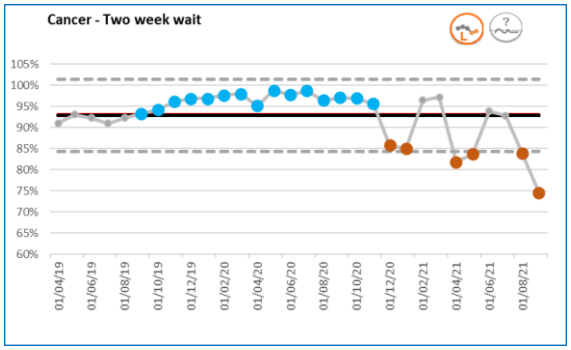
Summary Icon Descriptions

Perform	Assure	*Description*
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or worse performance. However despite deterioration the system is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or worse performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of a concerning nature where the measure is significantly **LOWER**. This occurs where there is deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
		Special cause of a concerning nature where the measure is significantly **LOWER**. This occurs where there is deteriorating performance. However the system is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **LOWER**. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Common cause variation, no significant change. This system is not reliably capable. It will **FAIL** to consistently meet target without system change.
		Common cause variation, no significant change. The system is capable and will consistently **PASS** the target.
		Common cause variation, no significant change. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).

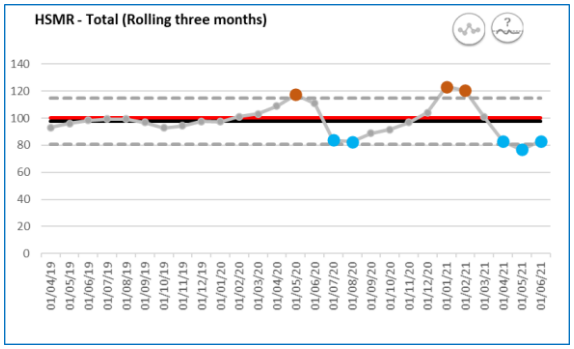
West Hertfordshire Hospitals NHS Trust

SPC rules – Special Cause Variation

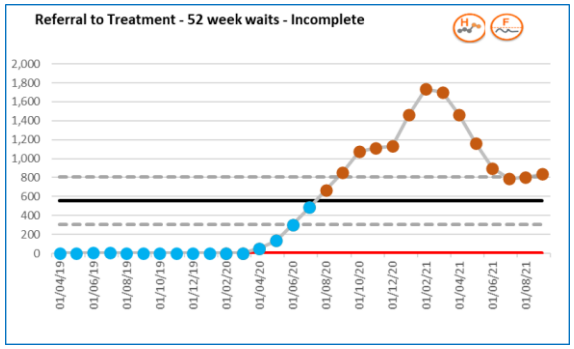
A breach of the upper/lower control limit



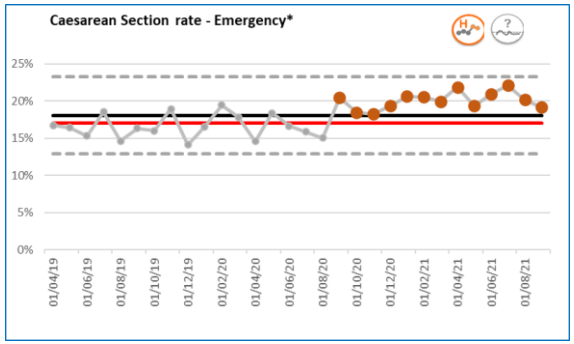
2 out of 3 points close to the control limit



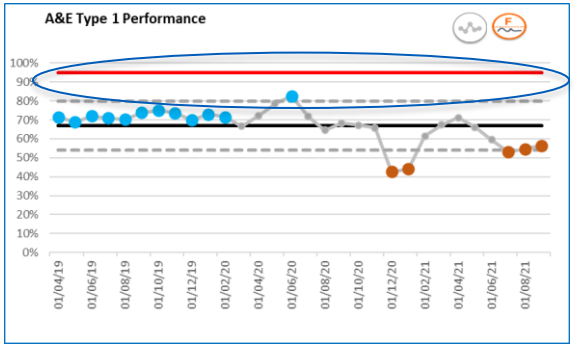
A run of ascending/descending data points



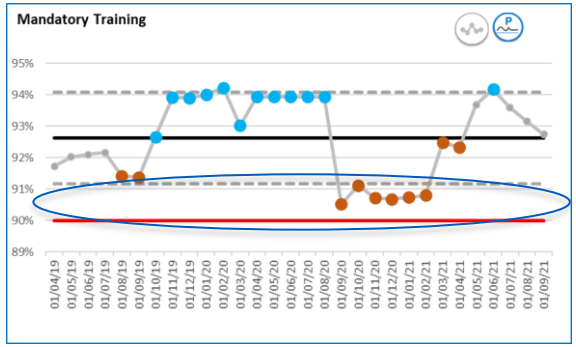
A run of points all one side of the mean



Variation indicating consistently failing the target – target line above upper control limit



Variation indicating consistently passing the target – target line below lower control limit

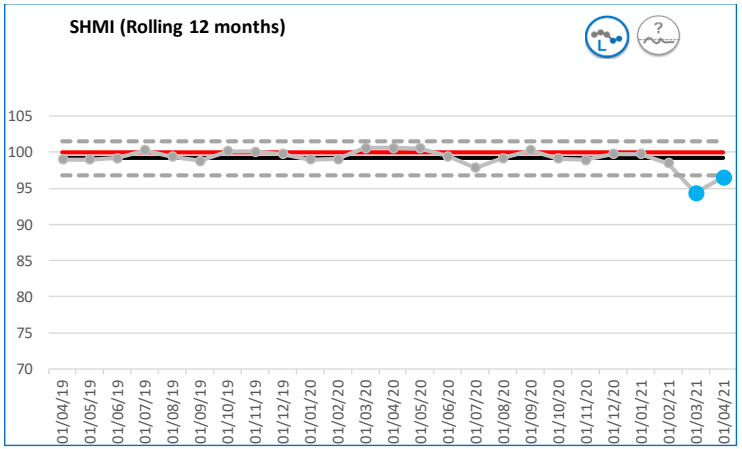


NHS
West Hertfordshire Hospitals
NHS Trust

KPI	Latest month	Measure	Target	Perfomance	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Quality								
Quality of Care: Mortality Indicators								
SHMI (Rolling 12 months)	Apr 21	97	100			National	Quality	CMO
HSMR - Total (Rolling three months)	Jun 21	83	100			National	Quality	CMO
Quality of Care: Infection Control								
Clostridioides Difficile - Hospital associated (Cat 1)	Oct 21	3	none			Local	Quality	CN
Clostridioides Difficile - Healthcare associated (Cat 2)	Oct 21	2	none			Local	Quality	CN
Clostridioides Difficile - Hospital and Healthcare associated Tota	Oct 21	5	3			Local	Quality	CN
Hand Hygiene Compliance	Oct 21	96.3%	95.0%			Local	Quality	CN
Quality of Care: Emergency Readmissions								
30 Day Emergency Readmissions - Elective *	Mar 21	4%	4%			Local	Quality	CMO
30 Day Emergency Readmissions - Emerg *	Mar 21	14.7%	13.1%			Local	Quality	CMO
Quality of Care: Caesarean Section Rates								
Caesarean Section rate - Combined*	Oct 21	37.6%	none			Local	Quality	CMO
Caesarean Section rate - Emergency*	Oct 21	18.4%	none			Local	Quality	CMO
Caesarean Section rate - Elective*	Oct 21	19.2%	none			Local	Quality	CMO
Caesarean Section rate - Robson Category 1	Oct 21	21.5%	none			Local	Quality	CMO
Caesarean Section rate - Robson Category 2	Oct 21	56.6%	none			Local	Quality	CMO
Caesarean Section rate - Robson Category 5	Oct 21	70.7%	none			Local	Quality	CMO

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – SHMI (Rolling 12 Months)



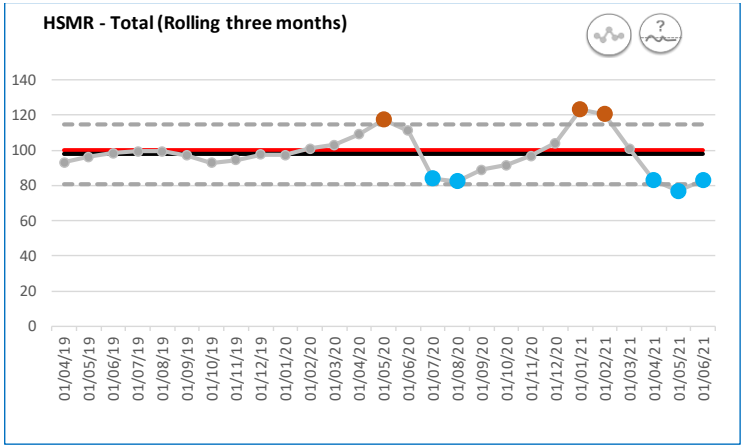
Provider	SHMI
East and North Hertfordshire NHS Trust	86
Cambridge University Hospitals NHS Foundation Trust	90
West Suffolk NHS Foundation Trust	93
West Hertfordshire Hospitals NHS Trust	94
The Princess Alexandra Hospital NHS Trust	97
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	105
Bedfordshire Hospitals NHS Foundation Trust	107
James Paget University Hospitals NHS Foundation Trust	107
East Suffolk and North Essex NHS Foundation Trust	108
Milton Keynes University Hospital NHS Foundation Trust	110
Norfolk and Norwich University Hospitals NHS Foundation Trust	120

***Latest available benchmarking data – Dr Foster – March 2021**

Background	What the Data tells us	Issues	Actions	Mitigations
Caesarean Section Rate - Emergency	Exception triggered due to falling below the lower control limit	Crude mortality has dropped faster than expected mortality reducing the relative risk	The trust are looking into the reasons behind the recent improvement in Mortality rates	

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – HSMR Total (Rolling 3 months)



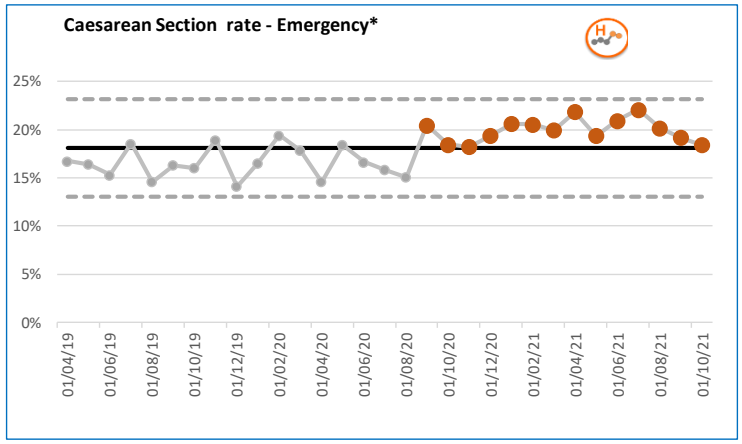
REGION (acute)	Relative risk
WEST SUFFOLK NHS FOUNDATION TRUST	62
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	73
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	81
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**83**
EAST AND NORTH HERTFORDSHIRE NHS TRUST	84
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	86
Regional Average	89
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	92
THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	94
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	95
NORTH WEST ANGLIA NHS FOUNDATION TRUST	97
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	101
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	104
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	117
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	122

***Latest available benchmarking data – Dr Foster – June 2021**

Background	What the Data tells us	Issues	Actions	Mitigations
Caesarean Section Rate - Emergency	Exception triggered due to 2 of 3 points around the lower control limit	Crude mortality has dropped faster than expected mortality reducing the relative risk	The trust are looking into the reasons behind the recent improvement in Mortality rates	

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Caesarean Section Rate - Emergency



MSDS Statistics - August 2021	Percentage of deliveries	
Measure	**West Herts Hospitals Trust**	**Proportion of Deliveries**
Elective caesarean section	15%	13%
Emergency caesarean section	22%	17%
Instrumental	11%	11%
Missing Value/Value outside reporting parameters	-	3%
Other	-	2%
Spontaneous	51%	54%

***Latest available benchmarking data – Maternity Services Data Set – August 2021**

Background	What the Data tells us	Issues	Actions	Mitigations
Caesarean Section Rate - Emergency	Exception triggered due to 7 or more data points above the mean (shift)	Emergency C-sections have been reviewed daily by the incoming teams on call and decision making is reviewed and discussed with the outgoing team. All maternal requests for C-sections are reviewed by the booking team and referred to the birth options team where needed.	Emergency C-sections reviewed daily by the incoming team.	The latest MSDS data available (August 2021) suggests an Emergency C-Section rate nationally of 17%. Latest HES data for 20/21 suggests the national emergency C-section rate has increased by 4% over the last 12 months

West Hertfordshire Hospitals NHS Trust

KPI	Latest month	Measure	Target	Perfomance	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Quality								
Quality of Care: Mortality Indicators								
SHMI (Rolling 12 months)	Apr 21	97	100			National	Quality	CMO
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Quality of Care: Infection Control								
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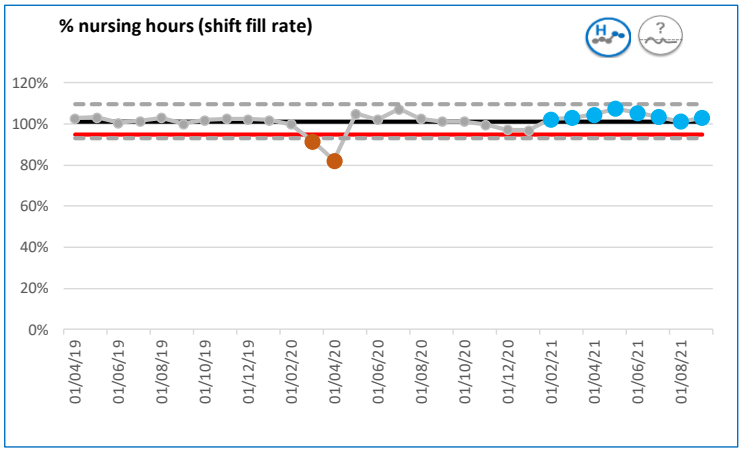
Caesarean Section rate - Robson Category 2	Oct 21	56.6%	none			Local	Quality	CMO
Caesarean Section rate - Robson Category 5	Oct 21	70.7%	none			Local	Quality	CMO

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Nursing Hours (shift fill rate)

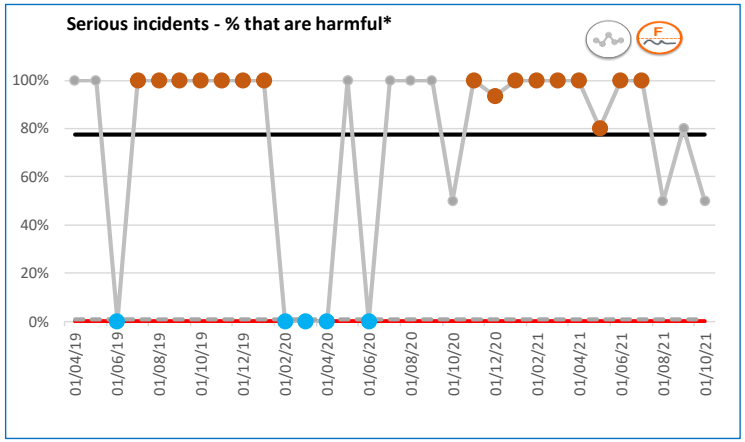


Organisation Name	Reporting Date	Care Hours Per Patient Day	National Quartile	National median
Cambridge University Hospitals	Aug-21	9.2	Quartile 3	8.4
Bedfordshire Hospitals	Aug-21	8.6	Quartile 3	8.4
Mid And South Essex	Aug-21	8.6	Quartile 3	8.4
West Hertfordshire Hospitals	**Aug-21**	**8.4**	**Quartile 3**	**8.4**
James Paget University Hospitals	Aug-21	8.0	Quartile 2	8.4
East And North Hertfordshire	Aug-21	7.6	Quartile 2	8.4
North West Anglia	Aug-21	7.6	Quartile 2	8.4
Queen Elizabeth Hospital King'S Lynn	Aug-21	7.5	Quartile 1	8.4
Norfolk And Norwich University Hospitals	Aug-21	7.5	Quartile 1	8.4
Milton Keynes University Hospital	Aug-21	7.4	Quartile 1	8.4
East Suffolk And North Essex	Aug-21	7.4	Quartile 1	8.4
West Suffolk	Aug-21	7.4	Quartile 1	8.4
Princess Alexandra Hospital	Aug-21	7.4	Quartile 1	8.4
*Model Health System - Care Hours per Patient Day				

Background	What the Data tells us	Reasons	Actions	Mitigations
Nursing Hours (Shift Fill Rate)	Exception triggered due to 7 or more points above the mean	Surge wards/COVID-19 wards running above budget due to COVID-19 response and surge expansion. Enhanced care shifts – staff looking after mental health patients, 1:1 special care patients	Registered below 95% day and Night – supported by redeployments and corporate nursing education team. Maternity Registered 76% Day and Night, delivery suite supported with staff redeployed from ABC. ABC closed the month of October. **CHPPD October 8.2** Monthly tabletop exercise to agree safe staffing levels. Monthly workforce. KPI meetings with all senior staff to review and support improvement	Likely to continue as COVID-19 provision still in place

West Hertfordshire Hospitals NHS Trust

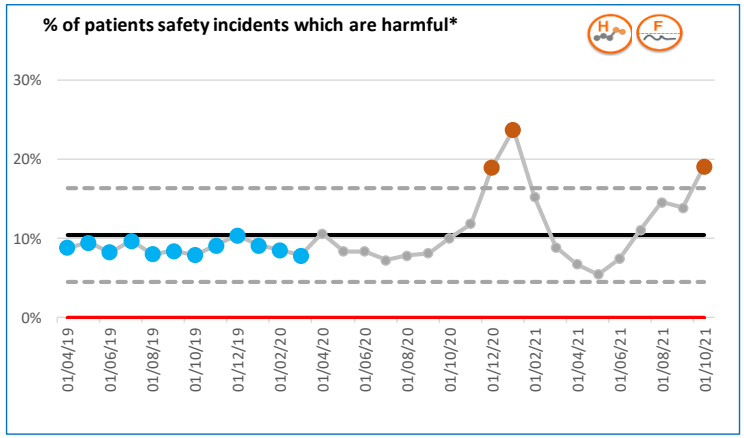
Special Cause Variation – Assurance – Serious Incidents - % that are harmful



Background	What the Data tells us	Issues	Actions	Mitigations
Serious Incidents - % that are harmful. These are graded as moderate, severe or catastrophic.	Exception triggered due to system inability to hit target (target is below lower control limit)	Serious incidents are confirmed following discussion at regular SI panel meetings when the level of harm and level of investigation are confirmed. In Oct 2021, 4 out of 8 Sis declared were assessed as causing severe harm or higher equalling data for previous month.	Regular monitoring are carried out. RCA investigation are carried out and lessons learned are elicited and actions devised to address the recommendations.	Regular monitoring, Trustwide sharing of lessons learned and quality improvement

West Hertfordshire Hospitals NHS Trust

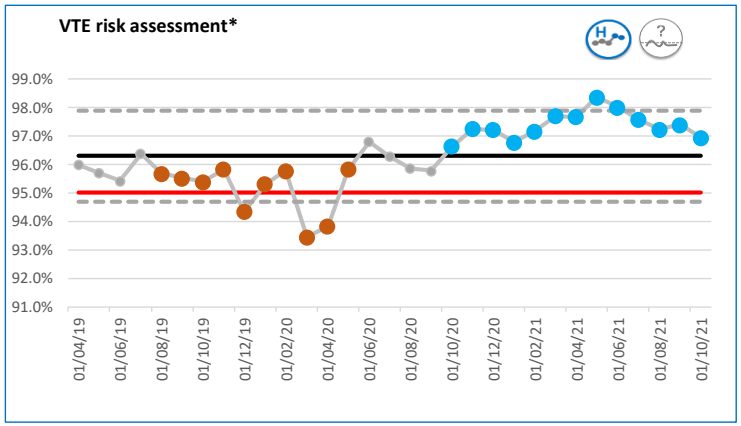
Special Cause Variation – Assurance – % of patient safety incidents which are harmful



Background	What the Data tells us	Issues	Actions	Mitigations
% of patient safety incidents which are harmful	Exception triggered due to system inability to hit target (target is below lower control limit)	This relates to all patient safety incidents reported in the month. Increasing number of harmful incidents are beginning to rise for multi-faceted reasons. There are more cases rated as moderate or higher, i.e. 17% (49) compared with 12% (26) in previous month.	The divisions will continue to support their wards and department and the trend will be reported continually.	Patient safety incident discussions to be held in governance and departmental meetings locally. Training and the sharing of lessons learned

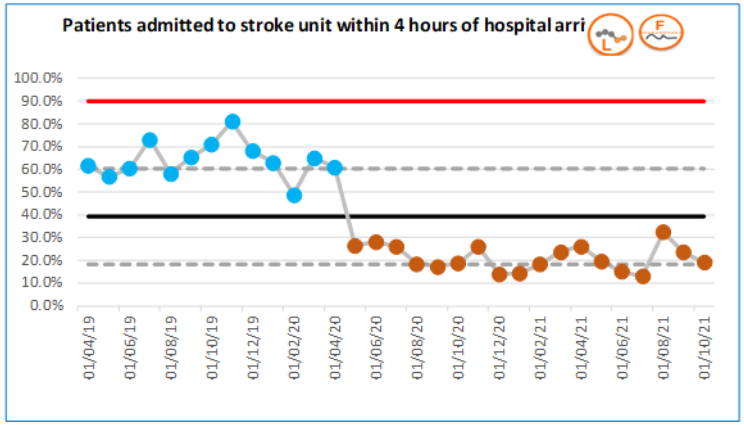
West Hertfordshire Hospitals NHS Trust

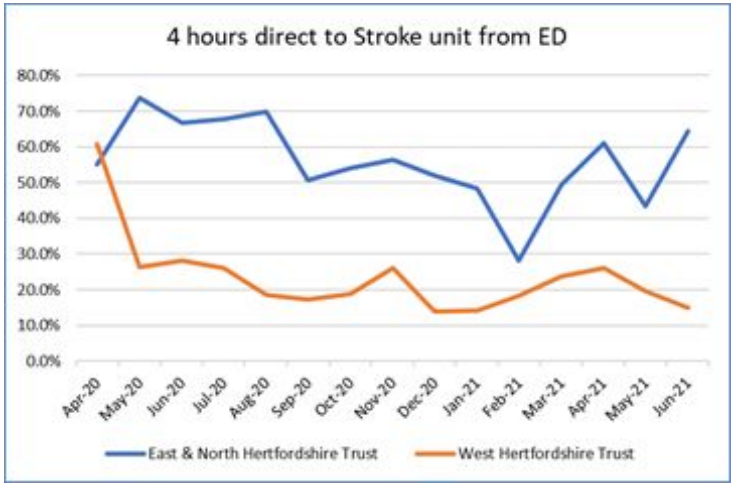
Special Cause Variation – Performance – VTE Risk Assessment



Background	What the Data tells us	Reasons	Actions	Mitigations
VTE Risk Assessment	Exception triggered due to 7+ points above the mean (a shift)	Improvement noted in VTE risk assessments	Regular reporting is being provided to all wards where VTE risk assessments are below threshold Focussed awareness and training sessions in AAU Level 1	VTE preventions specialist nurse to target areas and liaise with senior sisters VTE learning is part of Doctors and nurses mandatory training

Special Cause Variation – Performance/Assurance – Patients admitted to stroke unit within 4 hours of hospital arrival





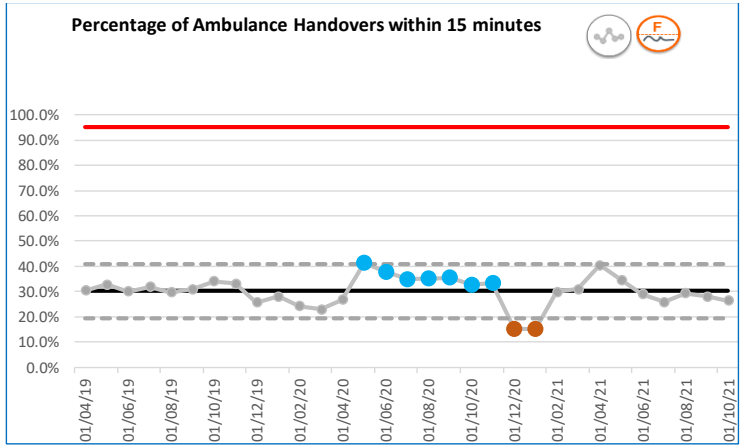
Background	What the Data tells us	Issues	Actions	Mitigations
Patients admitted to stroke unit within 4 hours of hospital arrival	Exception triggered due to 7+ points below the mean (a shift) Exception triggered due to target being outside the upper control limit	Patients admitted to the Trust require COVID swabs prior to any planned ward transfers and therefore wait in a holding ward until the swab results are available, this invariably delays patients accessing the stroke unit within 4 hours	Ring-fenced side room for patients requiring thrombolysis whilst awaiting swab results Arrangements underway for a further side room for patients not requiring thrombolysis whilst awaiting swab results. The service is linking up with E&N Herts with a view of them sharing their model and will learn and apply appropriate adaptations where possible	Patients continue to receive Stroke Consultant input and specific recommendations for their care

West Hertfordshire Hospitals NHS Trust

KPI	Latest month	Measure	Target	Perfomance	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - A&E Metrics								
Percentage of Ambulance Handovers within 15 minutes	Oct 21	26.5%	95.0%		F	National	F&P	COO
Ambulance Turnaround Time between 30 and 60 minutes	Oct 21	387	0		F	National	F&P	COO
Ambulance Turnaround Time >60 minutes	Oct 21	238	0		?	National	F&P	COO
Time to Initial assessment, percentage within 15 minutes	Oct 21	97.4%	95.0%	H	?	National	F&P	COO
Mean time (minutes) in department (non-admitted)	Oct 21	238.2	none	H		National	F&P	COO
Mean time (minutes) in department (admitted)	Oct 21	346.3	none			National	F&P	COO
A&E 12 hour waits (arrival to departure)	Oct 21	216	none			National	F&P	COO
A&E 12 hr trolley waits	Oct 21	0	0		?	National	F&P	COO
ED 4hr waits (Type 1, 2 and 3)	Oct 21	73.6%	95.0%		F	National	F&P	COO
A&E Type 1 Performance	Oct 21	53.1%	95.0%	L	F	Local	F&P	COO
% patients admitted through A&E - 0 LOS	Oct 21	31.0%	none			Local	F&P	COO
Clinically Ready to proceed (to follow)			none			National	F&P	COO
Critical Time Standards			none			National	F&P	COO

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – Percentage of ambulance handovers within 15 minutes



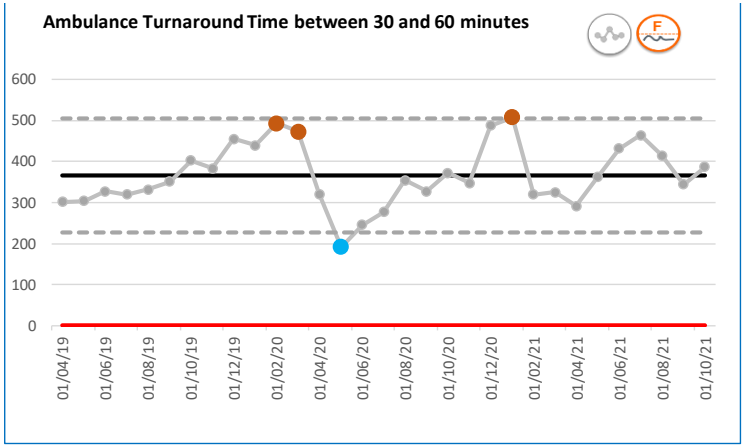
*Latest available benchmarking data – EEAST – October 2021

Hospital	% within 15 minutes
Bedford Hospital South Wing	47.5%
Luton & Dunstable Hospital	44.1%
Basildon & Thurrock Hospital	39.5%
West Suffolk Hospital	38.4%
Ipswich Hospital	31.3%
Broomfield Hospital	29.6%
Queen Elizabeth Hospital	29.3%
Watford General Hospital	**26.5%**
Norfolk & Norwich University Hospital	25.9%
Addenbrookes Hospital	25.1%
James Paget Hospital	17.6%
Colchester General Hospital	15.1%
Southend University Hospital	13.9%
Hinchingbrooke Hospital	12.6%
Princess Alexandra Hospital	12.5%
Peterborough City Hospital	7.5%
Lister Hospital	7.3%
Region	**25.6%**

Background	What the Data tells us	Issues	Actions	Mitigations
Percentage of ambulance handovers within 15 minutes	Exception triggered due to target being outside the upper control limit	Increase in ambulance conveyances - second highest in the region (23.3% increase since 19/20)	Ambulance handover meeting with WHHT, EEAST and CCG. EEAST and CCG focus on alternative pathways & admission avoidance. Performance updates shared with clinical and nursing teams.	Support from EEAST provided with cohort crews utilised to release ambulances back into community. In/out assessment model in use during times of high demand meaning all patients receive a clinical assessment and initial investigations initiated which waiting to offload.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – Ambulance Turnaround Time between 30 and 60 minutes



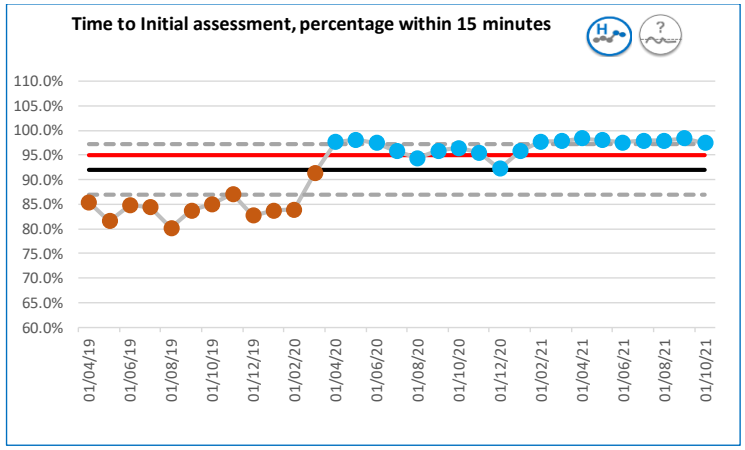
*Latest available benchmarking data – EEAST – October 2021

Hospital	Number over 30 Minutes	% over 30 minutes
Bedford Hospital South Wing	200	13.1%
West Suffolk Hospital	276	15.3%
Luton & Dunstable Hospital	357	14.9%
Basildon & Thurrock Hospital	372	16.6%
Colchester General Hospital	441	15.9%
Ipswich Hospital	526	24.8%
Hinchingbrooke Hospital	532	47.1%
Broomfield Hospital	595	27.7%
Watford General Hospital	**620**	**27.7%**
James Paget Hospital	640	42.9%
Southend University Hospital	669	31.6%
Queen Elizabeth Hospital	754	43.6%
Princess Alexandra Hospital	795	58.2%
Addenbrookes Hospital	818	31.7%
Peterborough City Hospital	882	51.7%
Lister Hospital	932	54.2%
Norfolk & Norwich University Hospital	1175	42.1%
Region	**10,584**	**31.3%**

Background	What the Data tells us	Issues	Actions	Mitigations
Percentage of ambulance handovers within 15 minutes	Exception triggered due to target being outside the upper control limit	Increase in ambulance conveyances - second highest in the region (23.3% increase since 19/20)	Ambulance handover meeting with WHHT, EEAST and CCG. EEAST and CCG focus on alternative pathways & admission avoidance. Performance updates shared with clinical and nursing teams.	Support from EEAST provided with cohort crews utilised to release ambulances back into community. In/out assessment model in use during times of high demand meaning all patients receive a clinical assessment and initial investigations initiated which waiting to offload.

West Hertfordshire Hospitals NHS Trust

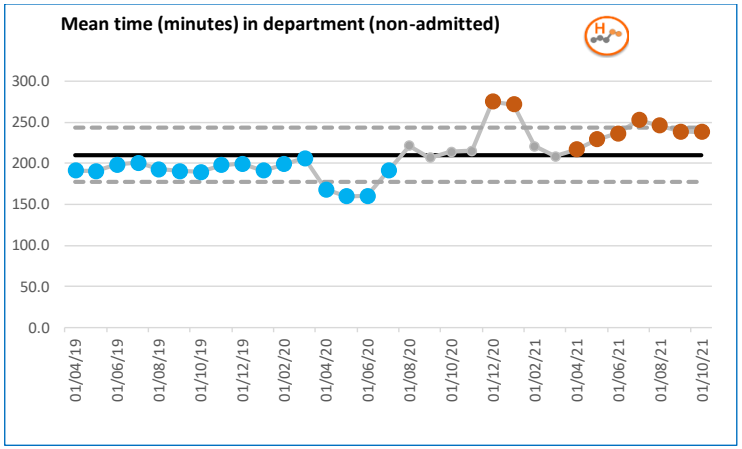
Special Cause Variation – Assurance – Time to initial assessment - Percentage within 15 minutes



Background	What the Data tells us	Issues	Actions	Mitigations
Time to Initial Assessment – Percentage within 15 minutes	Exception triggered due to performance being above upper control limit Exception triggered due to a run of points above the mean (a shift)	None – consistent achievement demonstrated		

West Hertfordshire Hospitals NHS Trust

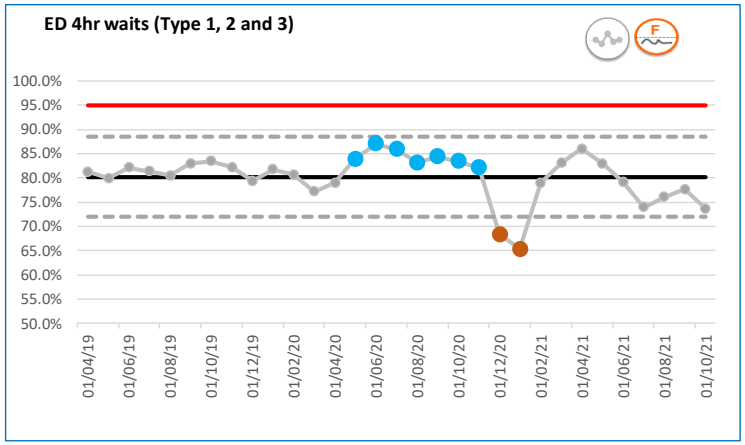
Special Cause Variation – Performance – Mean time (minutes) in department (non-admitted)



Background	What the Data tells us	Issues	Actions	Mitigations
Mean time (minutes) in department (non-admitted	Exception triggered due to 7 consecutive data points above the mean	Demand for UEC services remains higher than seen in previous years. Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. Patient flow out of department to wards impacts on cubicle capacity for all ED patients	Maintenance of assessment space to support flow Senior review/oversight of decisions to admit. Regular ED Access & Performance meetings HEG meetings Optimising patient flow	Patient safety ensured by ED team Patients seen and treated in timely manner Speciality reviews being undertaken within ED. Prompt senior reviews/post taking. Hourly rounding being undertaken on all patients ensuring comfort. If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – ED 4 hour waits – Type 1,2 and 3

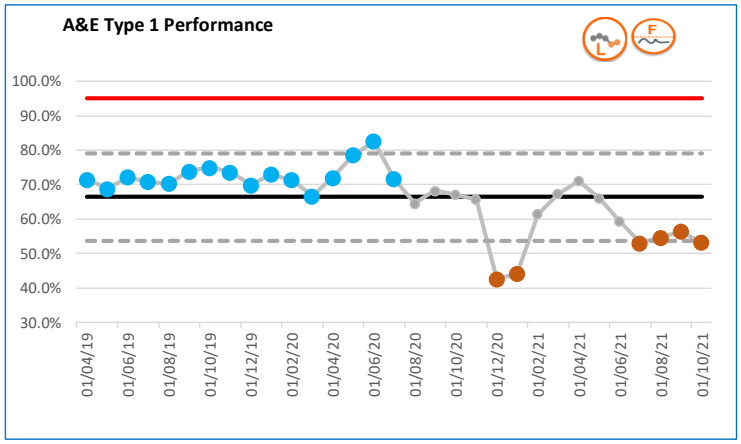


September 2021 - East of England A&E 4hr Wait Performance (Latest Published Data)			
Trust	**Attendances**	**Within 4 hours**	**Performance**
Milton Keynes University Hospital NHS Foundation Trust	14,122	11,396	80.7%
East Suffolk And North Essex NHS Foundation Trust	24,134	18,987	78.7%
Mid And South Essex NHS Foundation Trust	33,604	26,017	77.4%
West Hertfordshire Hospitals NHS Trust	**15,203**	**11,191**	**73.6%**
East And North Hertfordshire NHS Trust	16,591	11,628	70.1%
Norfolk And Norwich University Hospitals NHS Foundation Trust	18,953	12,840	67.7%
James Paget University Hospitals NHS Foundation Trust	7,366	4,867	66.1%
North West Anglia NHS Foundation Trust	17,251	11,207	65.0%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,096	4,418	62.3%
The Princess Alexandra Hospital NHS Trust	10,780	6,587	61.1%

Background	What the Data tells us	Issues	Actions	Mitigations
ED 4 hour waits for Type 1,2 and 3	Exception triggered due to target being outside the upper control limit	Overall performance 73.6%: Type 1 (WGH ED) 53% WGH UTC 94.4% HHGH UTC 95.5% CED 78.3% Significant increase in demand vs previous month: Type 1 attendances up 9% CED attendances up 17.8%	Maintenance of assessment space to support flow Senior review/oversight of decisions to admit. Regular ED Access & Performance meetings HEG meetings Optimising patient flow	Patient safety ensured by ED team & patients seen and treated in timely manner Speciality reviews being undertaken within ED & prompt senior reviews/post taking. Hourly rounding being undertaken on all patients ensuring comfort & patients transferred to beds in the even of prolonged trolley wait

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – A&E Type 1 Performance



September 2021 - East of England A&E 4hr Type 1 Wait Performance (Latest Published Data)			
Trust	**Attendances**	**Within 4 hours**	**Performance**
Mid And South Essex NHS Foundation Trust	31,102	23,600	75.9%
Milton Keynes University Hospital NHS Foundation Trust	8,624	6,047	70.1%
East Suffolk And North Essex NHS Foundation Trust	14,800	9,747	65.9%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,096	4,418	62.3%
James Paget University Hospitals NHS Foundation Trust	6,519	4,026	61.8%
The Princess Alexandra Hospital NHS Trust	10,780	6,587	61.1%
North West Anglia NHS Foundation Trust	12,240	6,697	54.7%
West Hertfordshire Hospitals NHS Trust	**7,764**	**4,126**	**53.1%**
East And North Hertfordshire NHS Trust	10,179	5,229	51.4%
Norfolk And Norwich University Hospitals NHS Foundation Trust	11,136	5,024	45.1%

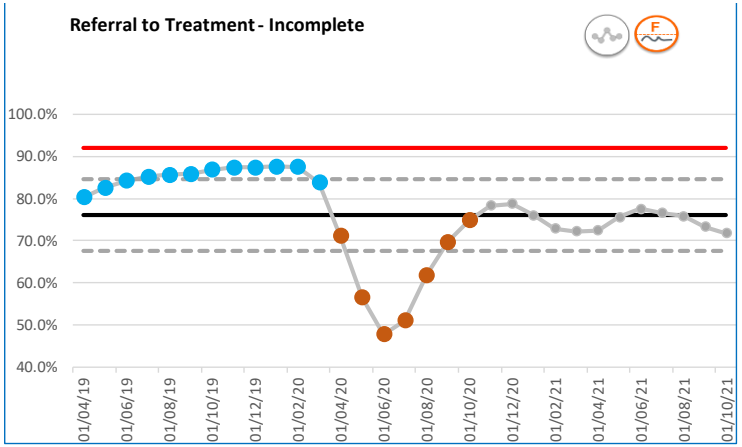
Background	What the Data tells us	Issues	Actions	Mitigations
A&E Type 1 Performance	Exception triggered due to target being outside the upper control limit Exception triggered due to 2 out of 3 points near the control limit	Ongoing high demand, up 9% on previous month's attendances CED demand rose by 18% on previous month with 2169 attendances. Flow is constrained by delays in transfer from department to wards, limiting cubicle space	Senior review/oversight of decisions to admit. Regular ED Access & Performance meetings and HEG meetings Optimising patient flow ICS missed opportunities MDT audit	Patient safety ensured by ED team Patients seen and treated in timely manner Speciality reviews being undertaken within ED. Prompt senior reviews/post taking. Hourly rounding being undertaken on all patients ensuring comfort. If prolonged trolley wait – patients transferred to bed for comfort.

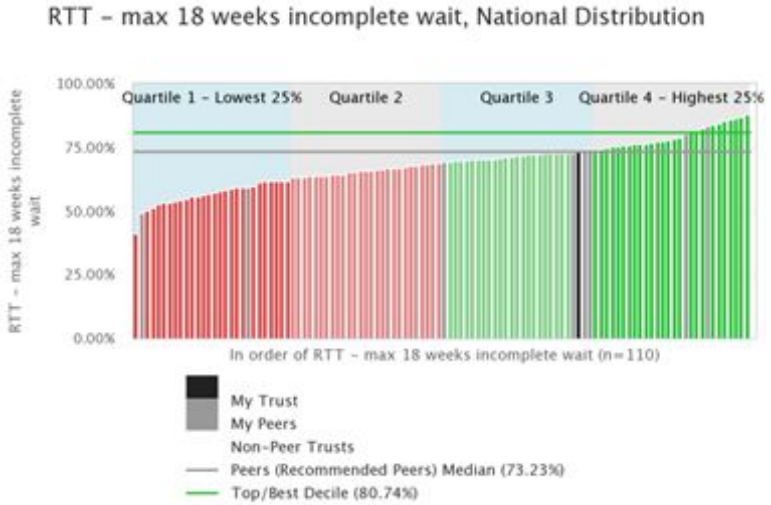
West Hertfordshire Hospitals NHS Trust

KPI	Latest month	Measure	Target	Perfomance	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - RTT, Cancer, Outpatients								
Referral to Treatment - Incomplete	Oct 21	71.8%	92.0%		F	National	F&P	COO
Referral to Treatment - 52 week waits - Incomplete	Oct 21	878	874	H	P	Local	F&P	COO
Referral to Treatment - 104 week waits - Incomplete	Oct 21	38	38	H	P	Local	F&P	COO
Diagnostic (DM01) <6 weeks	Oct 21	75.4%	99.0%		F	National	F&P	COO
Cancer - Two week wait	Oct 21	79.4%	93.0%	L	?	National	F&P	COO
Cancer - Breast Symptomatic two week wait	Oct 21	88.6%	93.0%		?	National	F&P	COO
Cancer - 28 day waits (faster diagnosis standard)	Oct 21	75.7%	75.0%		?	National	F&P	COO
Cancer - 31 Day First	Oct 21	97.5%	96.0%		?	National	F&P	COO
Cancer - 31 day subsequent drug	Oct 21	100.0%	98.0%	H	?	National	F&P	COO
Cancer - 31 day subsequent surgery	Oct 21	92.3%	94.0%		?	National	F&P	COO
Cancer - 62 day	Oct 21	75.4%	85.0%		?	National	F&P	COO
Cancer - 62 day screening	Oct 21	68.8%	90.0%		?	National	F&P	COO
Cancer 104+ day waits	Oct 21	153	none			Local	F&P	COO
Outpatient cancellation rate within 6 weeks	Oct 21	6.0%	5.0%	L	?	Local	F&P	CIO
Outpatient DNA rate	Oct 21	10.3%	8.0%		?	Local	F&P	CIO

Special Cause Variation – Assurance – Referral to Treatment - Incomplete

West Hertfordshire Hospitals NHS Trust



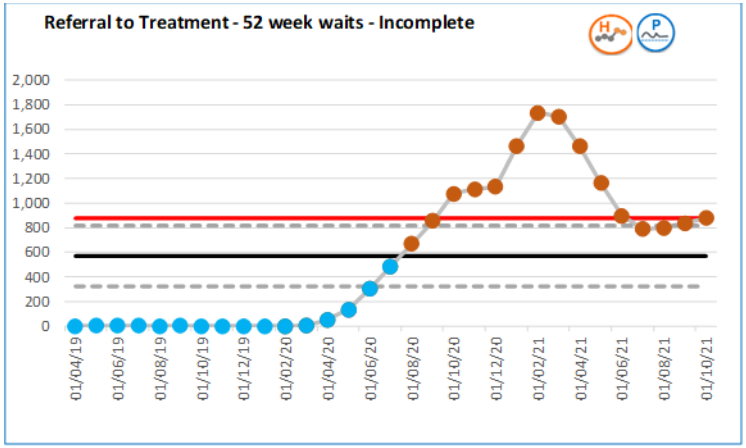


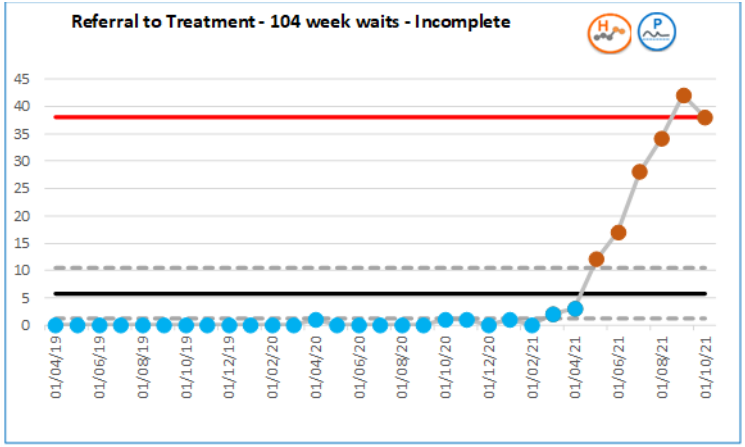
***Latest available benchmarking data – Model Health System – September 2021**

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment - Incomplete	Exception triggered due to target being outside the upper control limit	Response to COVID diverted resources from elective care resulting in increase in backlogs and waiting times Prioritising the most clinically urgent patients results in longer waits for more routine patients Insufficient resources (capacity & workforce) to reduce backlog over a short timescale	Long waits improvement plan includes: • Outsourcing • Additional sessions offered to services • Operational recovery group oversight of activity delivery	External validation of the RTT PTL continues, supporting EPR preparedness, but will also deliver a more accurate PTL which can influence performance. Currently at a confidence level of 98% in the national RTT PTL data quality programme

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Referral to Treatment – 52/104 weeks - Incomplete

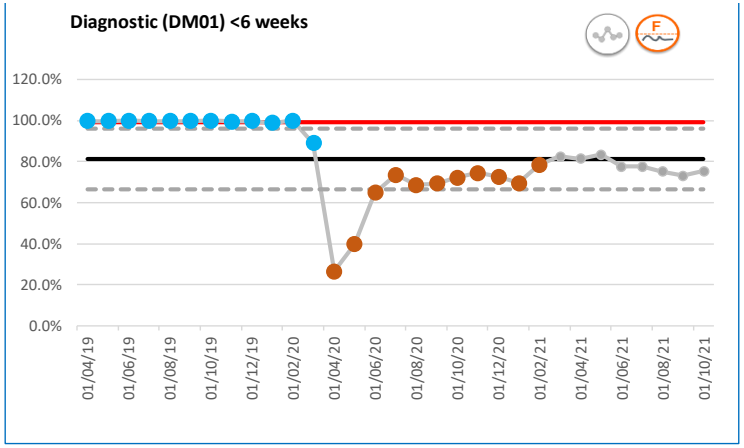


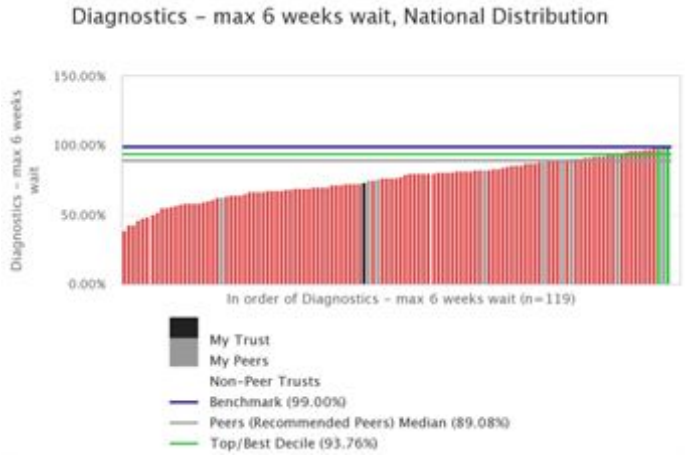


Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment - Incomplete	Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to breach of upper control limit Exception triggered due to target being outside the lower control limit	Response to COVID diverted resources from elective care resulting in increase in backlogs and waiting times Prioritising the most clinically urgent patients results in longer waits for more routine patients Insufficient resources (capacity & workforce) to reduce backlog over a short timescale	Long waits improvement plan includes: • Outsourcing • Additional sessions offered to services • Operational recovery group oversight of activity delivery • Weekly review of long waits with Director of Performance	External validation of the RTT PTL currently underway to support EPR implementation, but will also deliver a more accurate PTL which can influence performance. Currently at a confidence level of 98% in the national RTT PTL data quality programme

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – Diagnostic (DM01) < 6 weeks



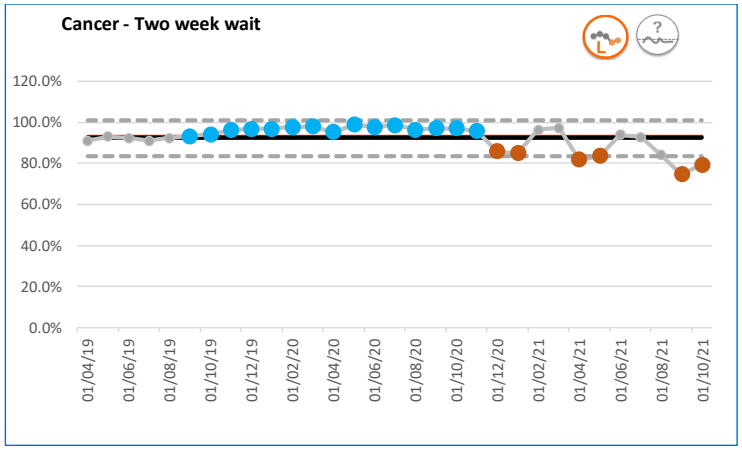


***Latest available benchmarking data – Model Health System – September 2021**

Background	What the Data tells us	Issues	Actions	Mitigations
Diagnostic (DM01) < 6 weeks	Exception triggered due to target being outside the upper control limit	Response to COVID diverted resources from elective care resulting in increase in backlogs and waiting times Prioritising the most clinically urgent patients results in longer waits for more routine patients Insufficient resources (kit, capacity & workforce) to reduce backlog over a short timescale	Long waits improvement plan includes: • Outsourcing • Additional sessions in place • Operational recovery group oversight of activity delivery Planning for a mobile, staffed MRI scanner to go live in late November	Outsourcing Additional in house sessions Additional scanning capacity will come on line in November when mobile unit goes live

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Cancer – Two Week Wait

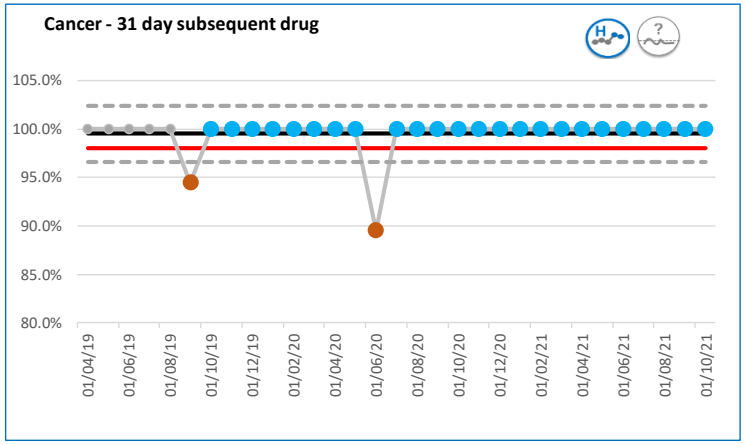


Provider name	Sep 21
EAST AND NORTH HERTFORDSHIRE NHS TRUST	97.5%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	95.7%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	94.0%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	92.1%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	88.5%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	84.5%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**74.8%**
NORTH WEST ANGLIA NHS FOUNDATION TRUST	63.5%
WEST SUFFOLK NHS FOUNDATION TRUST	61.4%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	60.0%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	57.9%

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – Two Week Wait	Exception triggered due to this month's performance being below the lower control limit	Insufficient capacity across many of the services to enable first date seen between 0-14 days.	All services actively seeking ways to increase capacity - provision of adhoc clinics, switching routine OPA slots to 2ww slots, outsourcing where possible. New substantive gastro consultant starting 6 Dec will support the 2ww clinics	All patients are tracked and are safety netted.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Cancer – 31 Day Subsequent Drug

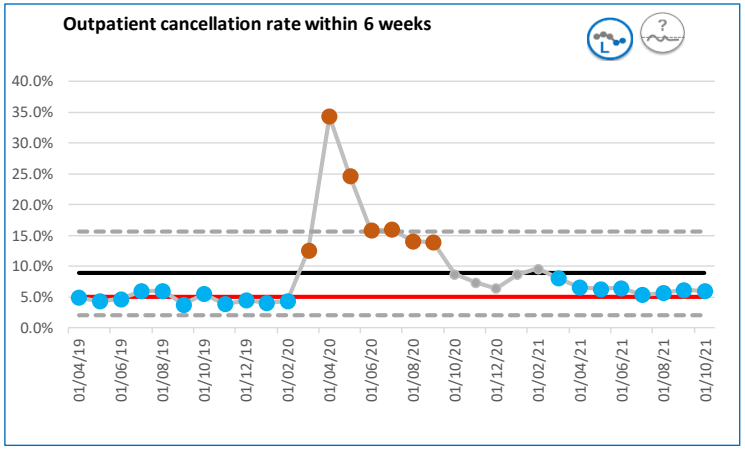


Provider name	Sep 21
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	100.0%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	100.0%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	100.0%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	100.0%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	100.0%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**100.0%**
WEST SUFFOLK NHS FOUNDATION TRUST	100.0%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	99.3%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	98.1%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	93.7%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	92.9%

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 31 Day Subsequent Drug	Exception triggered due to a run of 7+ points above the mean (a shift)	WHHT were compliant with this standard		

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Outpatient cancellation rate within 6 weeks



Background	What the Data tells us	Issues	Actions	Mitigations
Outpatient cancellation rates within 6 weeks	Exception triggered due to a run of 7+ data points below the mean (a shift)	This is positive performance and is the outcome of renewed BAU practises and processes within the cancellation PAS Clinic build team	Continued monitoring to ensure sustained performance	N/A

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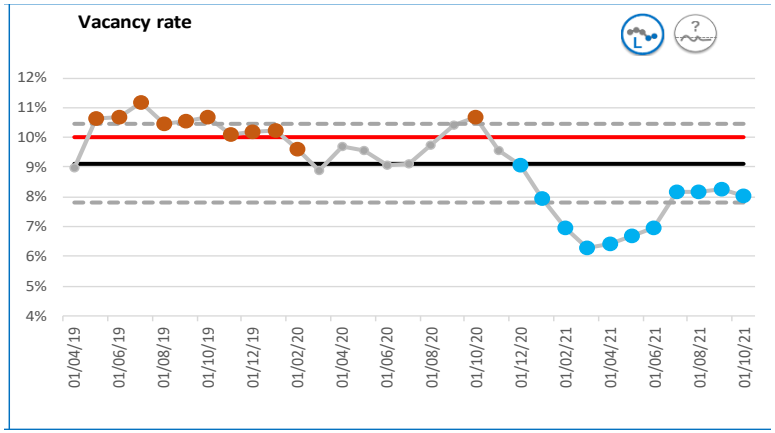
KPI	Latest month	Measure	Target	Perfomance	Assurance	Local or National Metric	Committee	Owner
Well-Led Services - Workforce Metrics								
Staff Turnover rate (Rolling 12 months)	Oct 21	13.7%	13.0%			Local	PerC	CPO
% staff leaving within first year (excluding medics and fixed term contracts)	Oct 21	17.9%	none			Local	PerC	CPO
Vacancy rate	Oct 21	8.0%	10.0%			Local	PerC	CPO
Sickness rate	Oct 21	5.1%	3.5%			Local	PerC	CPO
Appraisal rate (Total)	Oct 21	77.2%	80.0%			Local	PerC	CPO
Mandatory Training	Oct 21	93.1%	90.0%			Local	PerC	CPO
% Bank Pay	Oct 21	12.7%	12.0%			Local	PerC	CPO/CFO
% Agency Pay	Oct 21	5.3%	4.8%			Local	PerC	CPO/CFO

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – Vacancy Rate

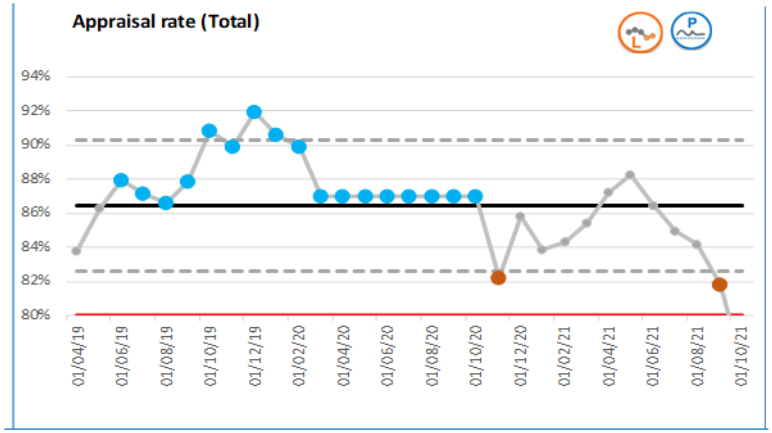


***Latest available benchmarking data – Model Health System – June 2021**

Background	What the Data tells us	Issues	Actions	Mitigations
Vacancy Rate	Exception triggered due to a run of 7+ points falling below the mean (a shift)	Staff in post has increased by 171wte in last 12 months.	The 114 staff waiting to start, and a further 119 awaiting clearance pending a start date will have a positive impact on the vacancy rate. Vacancies are projected to reduce further based on our immediate recruitment pipeline.	Recruitment strategy includes: International recruitment - This has already reduced Band 5 Nursing vacancies to 0, and HCA vacancies to very low levels. Internal recruitment days will reduce vacancies in areas such as Theatres and ITU, while further international recruitment will take place to offset midwifery vacancies.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Appraisal Rate

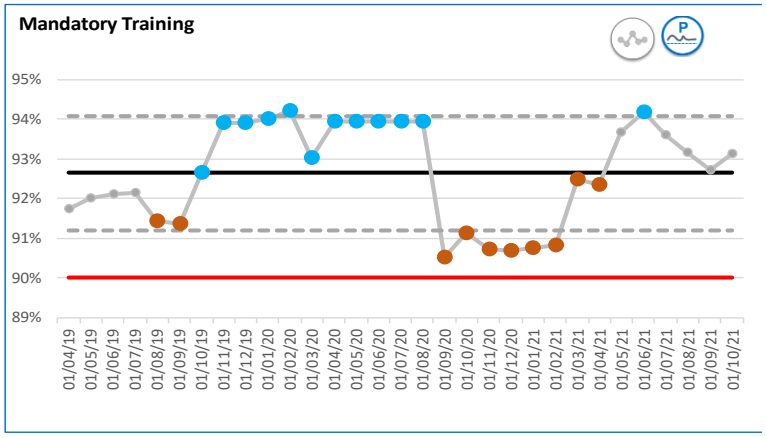


APPRAISAL RATE COMPLIANCE		
Trust	Appraisal Rate Q1 21/22	Q1 21/22 Ranking (current)
Bedford Hospitals	67%	**7**
Herts Community	69%	**6**
West Hertfordshire Hospitals Trust	**86%**	**3**
East & North Herts	63%	**8**
HPFT	89%	**2**
ELF Bedford MH	22%	**11**
ELF Luton MH	23%	**10**
ELF Bedford Community	38%	**9**
Princess Alexandra	83%	**5**
Essex Partnership UT		
Milton Keynes UFT	92%	**1**
Central North West London FT	85%	**4**
Average	**65%**	

Background	What the Data tells us	Issues	Actions	Mitigations
Appraisal Rate	Exception triggered due to this month's performance falling below the lower control limit Exception triggered due to the target falling below the lower control limit	Covid and winter service pressures have meant some staff and managers have had difficulty in maintaining appraisal compliance.	HRBP's agreeing weekly targets with manager. Appraisals are now being reported weekly to monitor performance.	Target for appraisals temporarily changed from 90% to 80%. Shortened paperwork introduced in recognition of the organisational challenges.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – Mandatory Training



MANDATORY TRAINING COMPLIANCE		
Trust	Mandatory Training Rate Q1 21/22	Q1 21/22 Ranking (current)
Bedford Hospitals	77%	**12**
Herts Community	94%	**3**
West Hertfordshire Hospitals Trust	**94%**	**2**
East & North Herts	86%	**9**
HPFT	91%	**5**
ELF Bedford MH	88%	**6**
ELF Luton MH	87%	**8**
ELF Bedford Community	85%	**10**
Princess Alexandra	88%	**6**
Essex Partnership UT	81%	**11**
Milton Keynes UFT	96%	**1**
Central North West London FT	94%	**3**
Average	**88%**	

Background	What the Data tells us	Reasons	Actions	Mitigations
Mandatory Training	Exception triggered due to the target being below the lower control limit	The mandatory training rate consistently achieves 90% with improvement across all staff groups.	Training team and HRBPs to support Divisions maintain compliance across staff groups and subjects.	Continued focus on specific subjects to maintain compliance.

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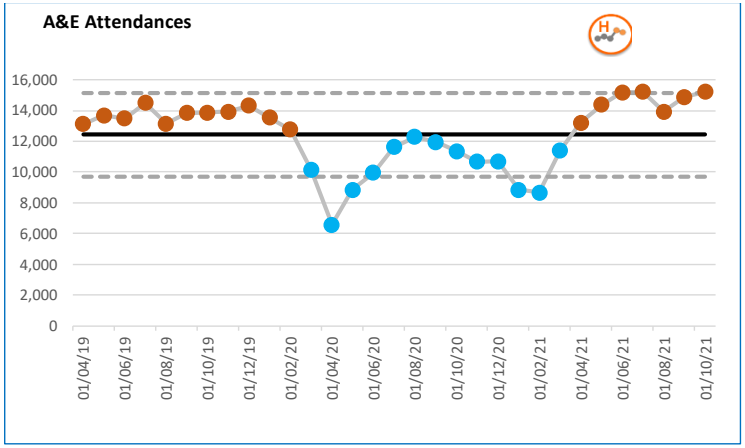
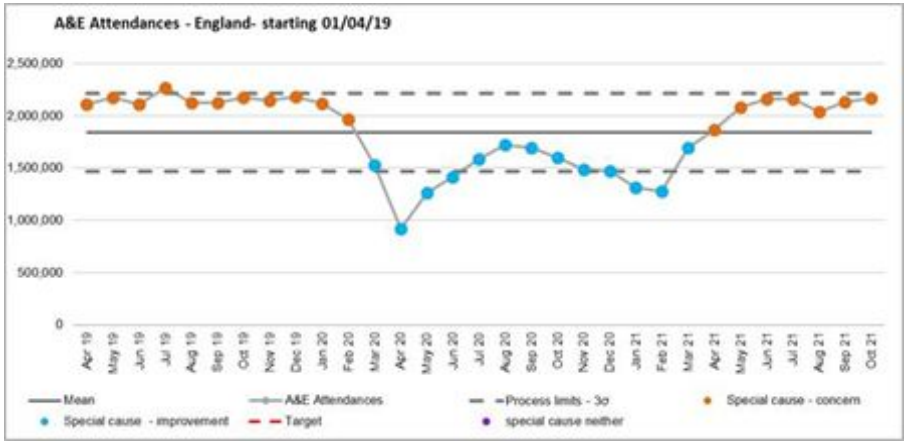
KPI	Latest month	Measure	Target	Perfomance	Assurance	Local or National Metric	Committee	Owner
Activity Metrics								
GP Referrals Made	Oct 21	7026	none			Local	F&P	COO
A&E Attendances	Oct 21	15203	none	H		Local	F&P	COO
1st Outpatient Appointments - All	Oct 21	10936	none			Local	F&P	CIO
1st Outpatient Appointments - Face to Face	Oct 21	8473	none			Local	F&P	CIO
Follow Up Outpatient Appointments - All	Oct 21	15691	none			Local	F&P	CIO
Follow Up Outpatient Appointments - Face to Face	Oct 21	10414	none	L		Local	F&P	CIO
Specific Acute Elective Ordinary Admissions	Oct 21	400	none			Local	F&P	COO
Specific Acute Daycases	Oct 21	2779	none			Local	F&P	COO
Specific Acute Non-Elective Admissions - 0 LOS	Oct 21	1571	none	H		Local	F&P	COO
Specific Acute Non-Elective Admissions - +1 LOS	Oct 21	2704	none	H		Local	F&P	COO
Completed Admitted RTT Pathways (Clock Stops)	Oct 21	1120	none			Local	F&P	COO
Completed Non-Admitted RTT Pathways (Clock Stops)	Oct 21	6371	none			Local	F&P	COO
New RTT Pathways (Clock Starts)	Oct 21	8985	none			Local	F&P	COO
PTL Volume	Oct 21	28837	none	H		Local	F&P	COO

West Hertfordshire Hospitals NHS Trust

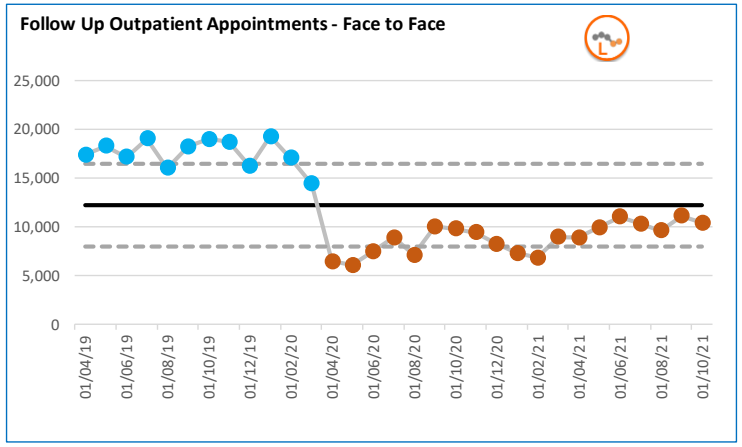
Special Cause Variation – Performance – A&E Attendances

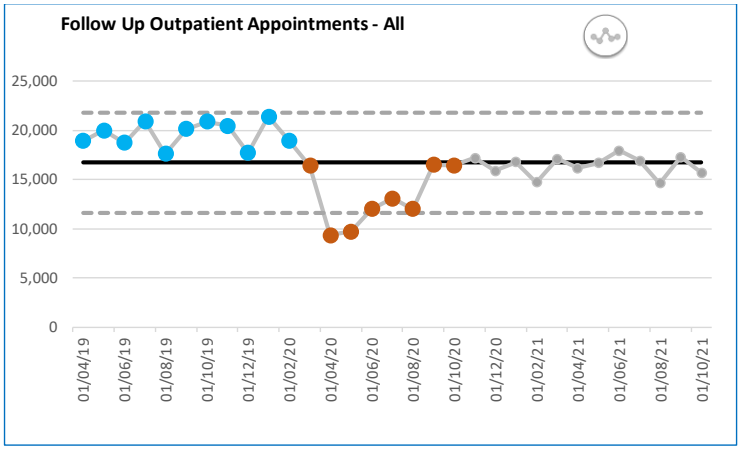




Background	What the Data tells us	Issues	Actions	Mitigations
A&E Attendances	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered to a breach of the upper control limit	Significant increase in demand vs previous month: Type 1 attendances up 9% CED attendances up 17.8%		The increase observed in A&E attendances at West Herts triggering an exception is equally observed when looking at all A&E attendances in England

Special Cause Variation – Performance – Follow Up Outpatient Appointments – Face to Face

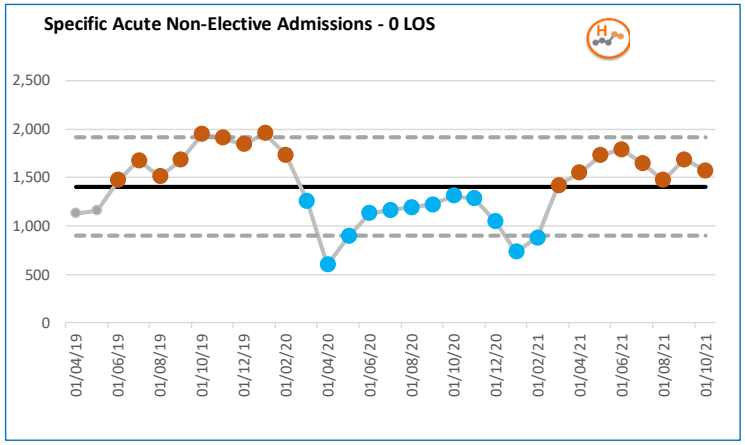


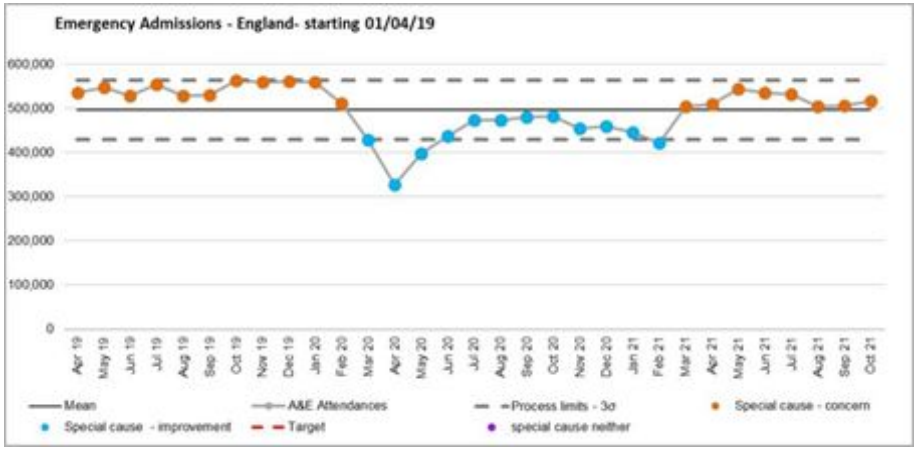


Background	What the Data tells us	Issues	Actions	Mitigations
Follow Up Outpatient Appointments – Face to Face	Exception triggered due to 7+ data points below the mean (a shift)	Face to face follow up outpatient appointments has triggered as an exception due to the move to more virtual appointments brought about by the Covid pandemic		When looking at all follow up appointments overall, the volume is around the average for the whole period

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Specific Acute Non-Elective Admissions

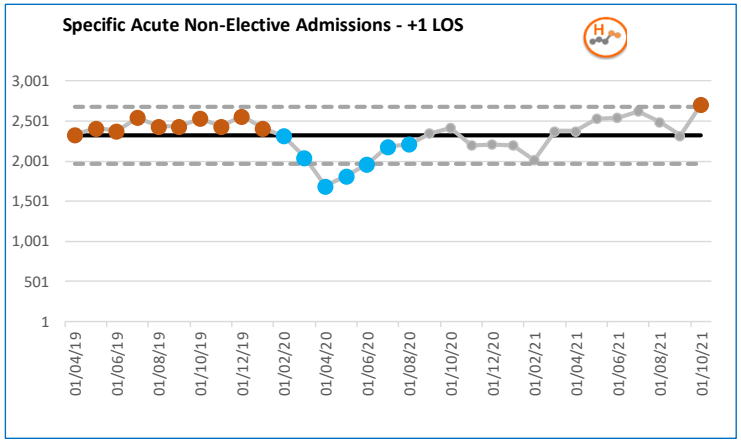


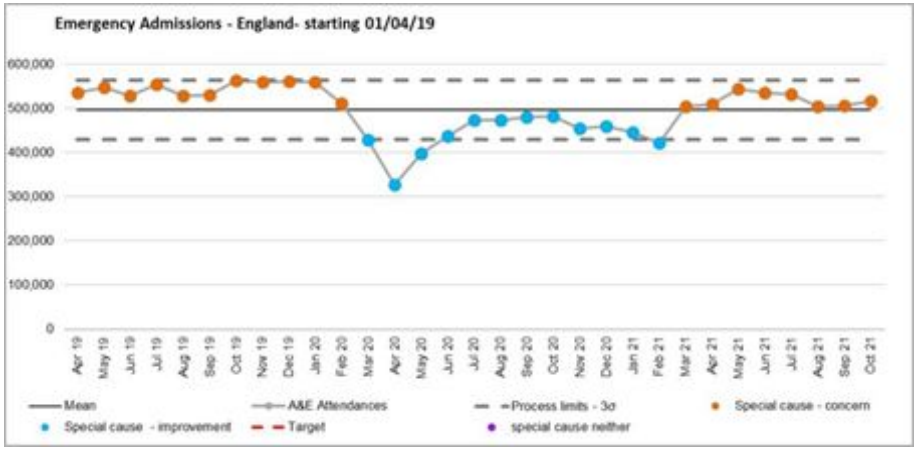


Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Non-Elective Admissions 0 LOS Specific Acute Non-Elective Admissions +1 LOS	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	A&E pressures leading to significant increase in non-elective admissions		Emergency admissions for England as a whole are also triggering an exception due to a shift (run of 7+ data points above the mean)

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Specific Acute Non-Elective Admissions

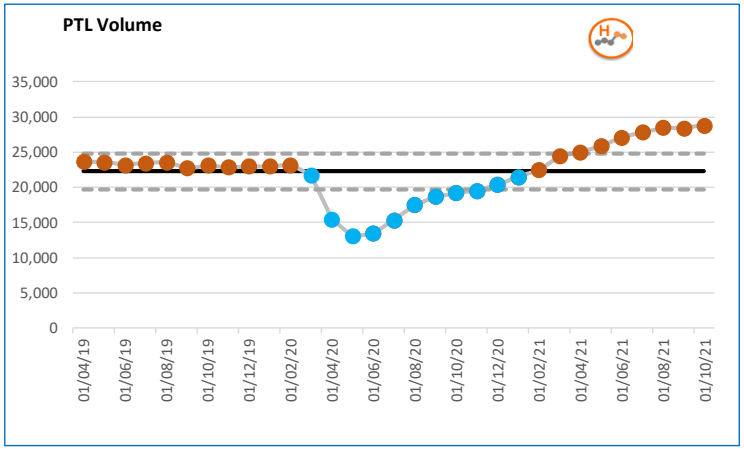




Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Non-Elective Admissions 0 LOS Specific Acute Non-Elective Admissions +1 LOS	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	A&E pressures leading to significant increase in non-elective admissions		Emergency admissions for England as a whole are also triggering an exception due to a shift (run of 7+ data points above the mean)

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – RTT PTL Volume



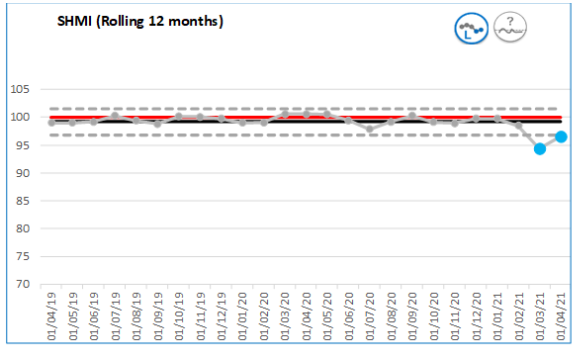
Trust	Aug-21	Sep-21	Variance
Mid And South Essex NHS Foundation Trust	113,602	116,035	2.1%
Norfolk And Norwich University Hospitals NHS Found	72,658	73,638	1.3%
Bedfordshire Hospitals NHS Foundation Trust	61,397	63,653	3.7%
East Suffolk And North Essex NHS Foundation Trust	60,636	62,903	3.7%
North West Anglia NHS Foundation Trust	57,841	59,548	3.0%
East And North Hertfordshire NHS Trust	54,456	54,747	0.5%
Cambridge University Hospitals NHS Foundation Tru	48,063	49,281	2.5%
West Hertfordshire Hospitals NHS Trust	**28,377**	**28,419**	**0.1%**
Milton Keynes University Hospital NHS Foundation T	26,893	29,303	9.0%
The Princess Alexandra Hospital NHS Trust	23,706	24,827	4.7%
West Suffolk NHS Foundation Trust	23,522	24,086	2.4%
The Queen Elizabeth Hospital, King's Lynn, NHS Fou	17,521	17,689	1.0%
James Paget University Hospitals NHS Foundation Tr	15,063	15,488	2.8%
Region Total	**603,735**	**619,617**	**2.6%**

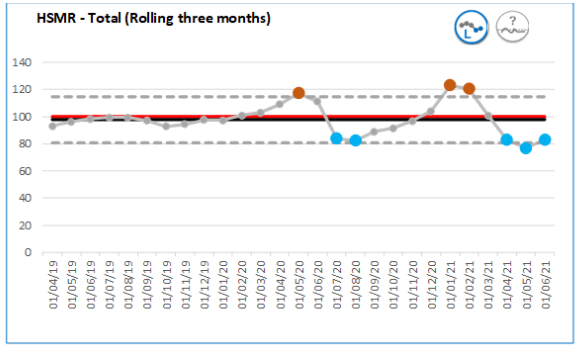
Background	What the Data tells us	Issues	Actions	Mitigations
RTT PTL Volume	Exception triggered due to breach of the upper control limit	Response to COVID diverted resources from elective care resulting in increase in backlogs and waiting times Prioritising the most clinically urgent patients results in longer waits for more routine patients Insufficient resources (capacity & workforce) to reduce backlog over a short timescale	External validation of the RTT PTL currently underway to support EPR implementation, but will also deliver a more accurate PTL which can influence performance.	Following the significant reduction in referrals during the Covid peaks rates have now increased

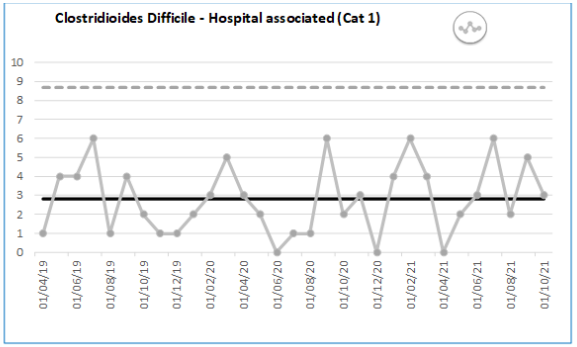
41

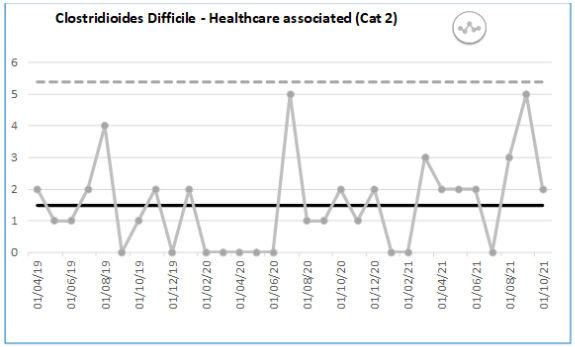
West Hertfordshire Hospitals NHS Trust

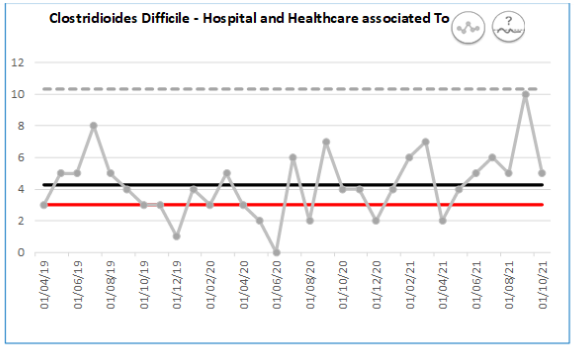
Appendix 1 – Safe Care and Improving Outcomes Metrics

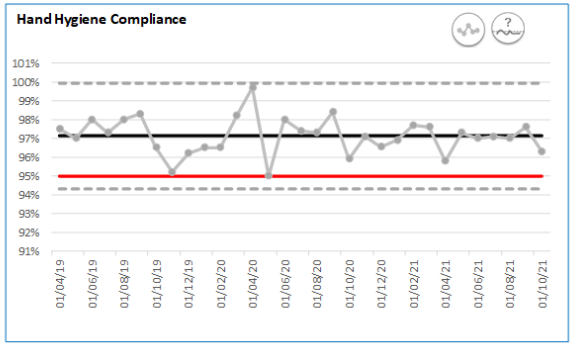






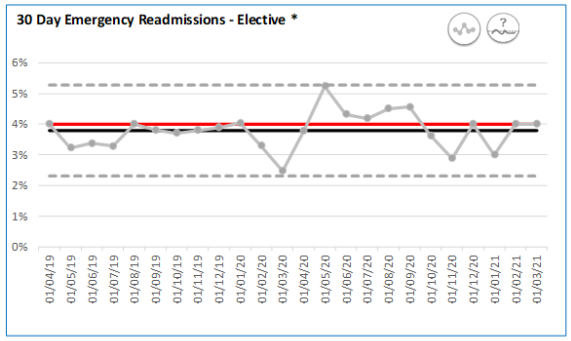


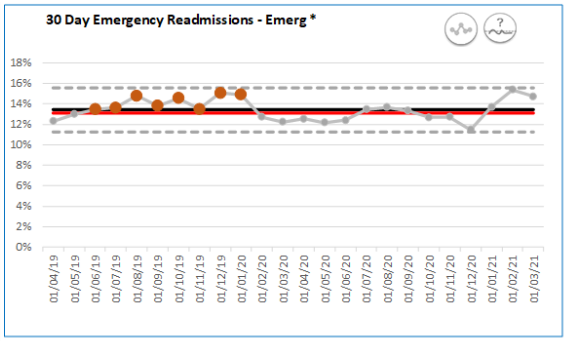


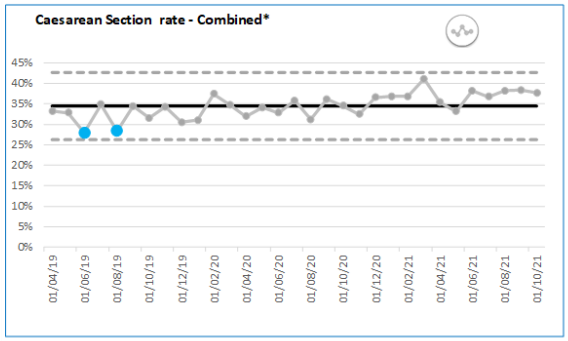


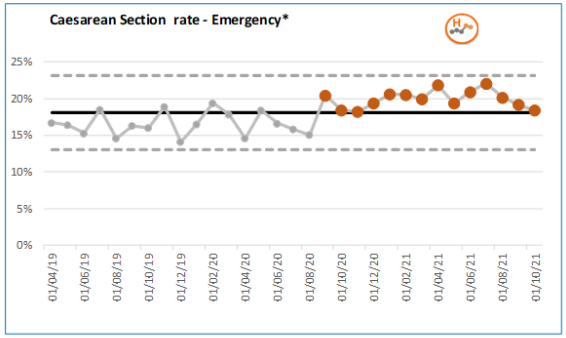
West Hertfordshire Hospitals NHS Trust

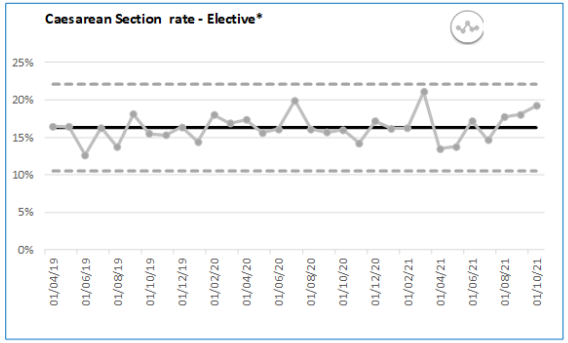
Appendix 1 – Safe Care and Improving Outcomes Metrics

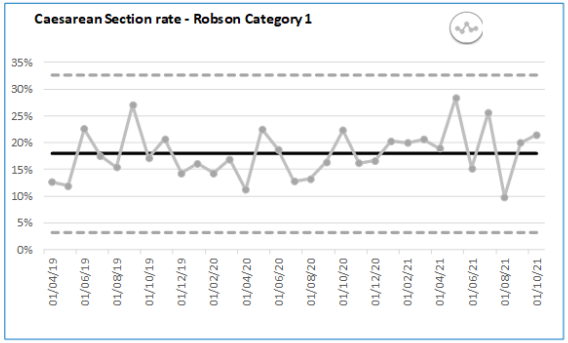






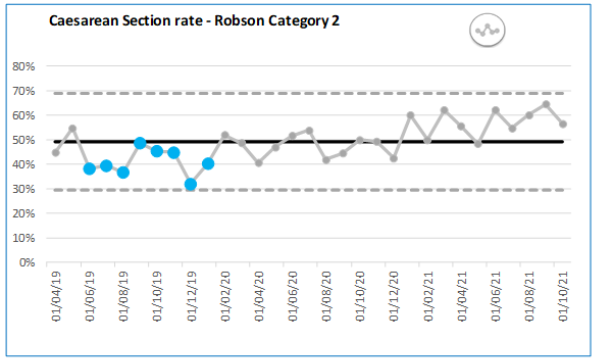


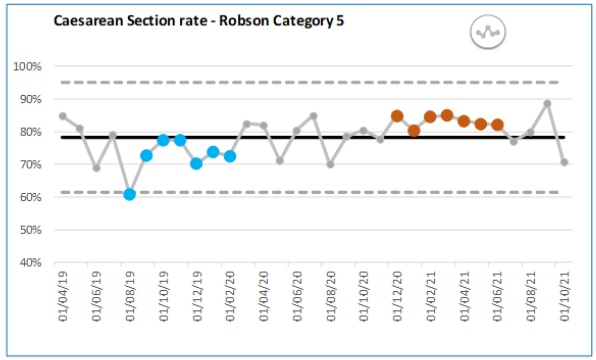


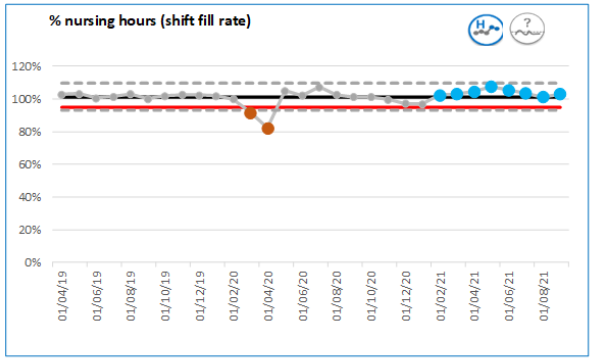


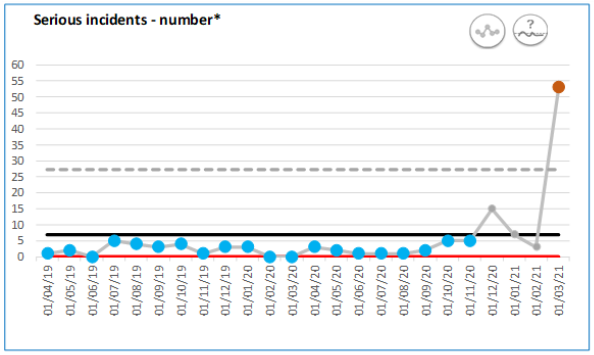
West Hertfordshire Hospitals NHS Trust

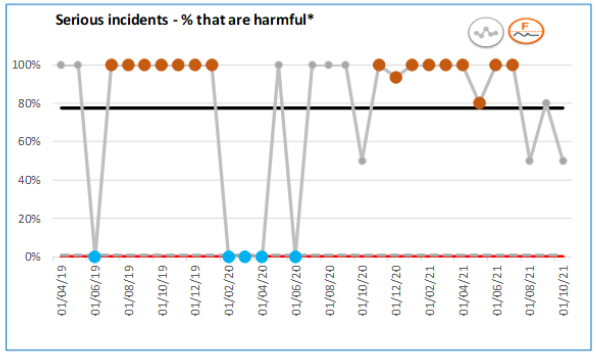
Appendix 1 – Safe Care and Improving Outcomes Metrics

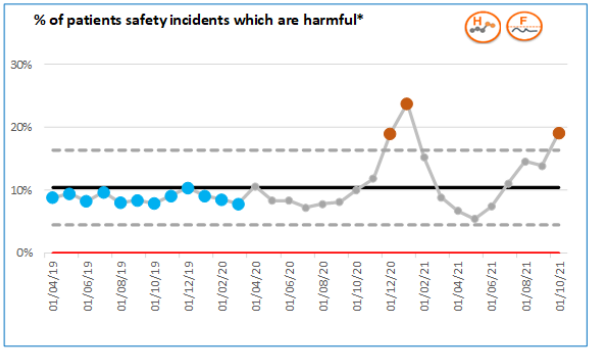












West Hertfordshire Hospitals NHS Trust

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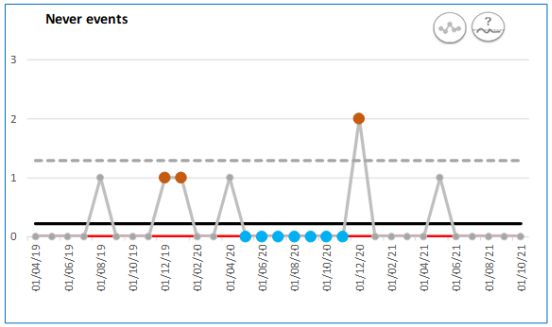
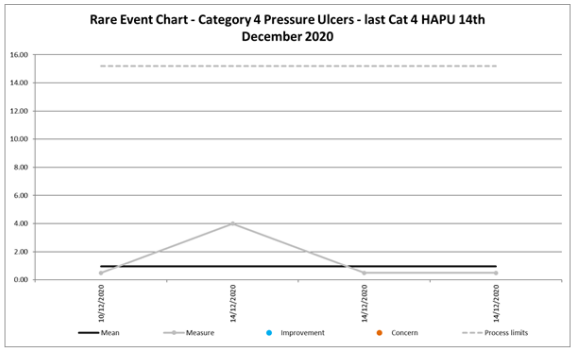
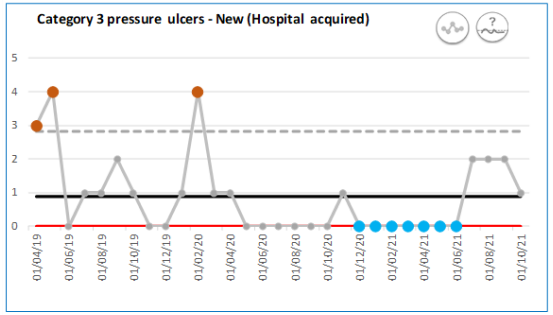
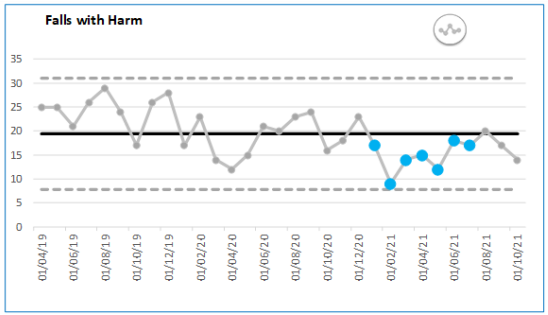
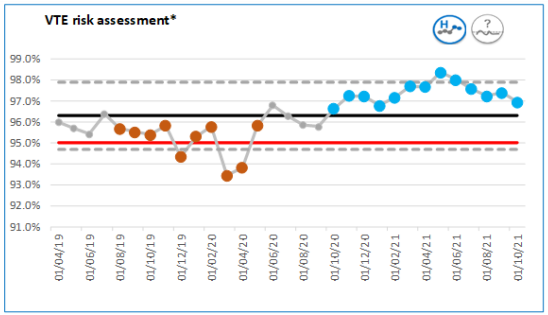
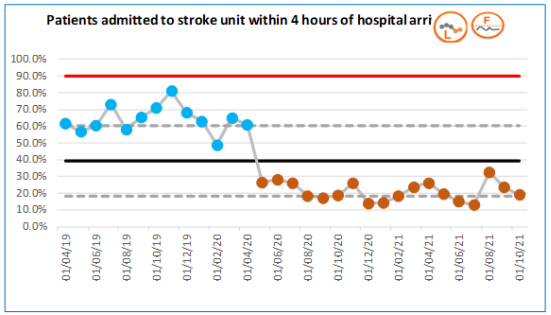






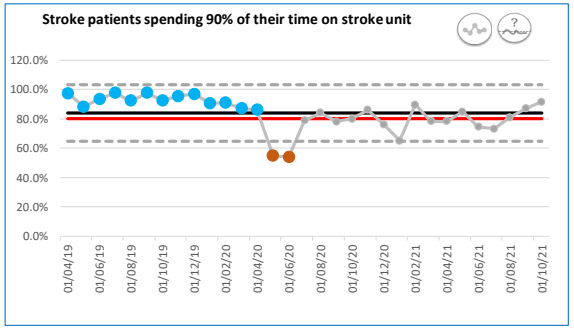


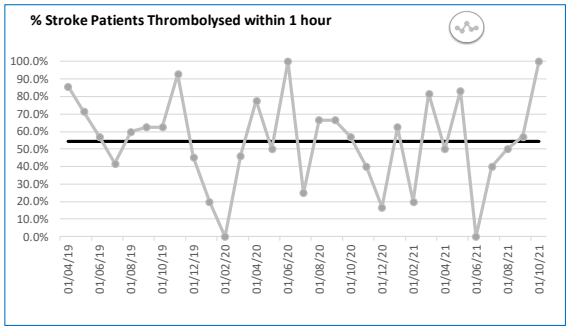




West Hertfordshire Hospitals NHS Trust

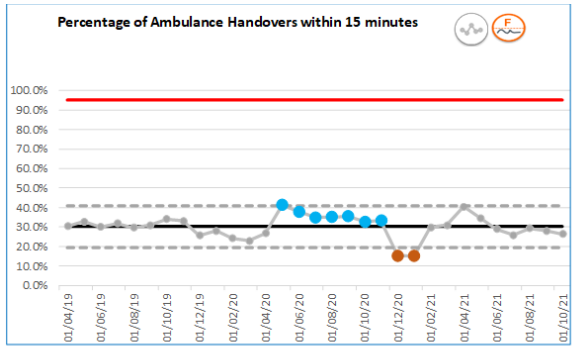
Appendix 1 – Safe Care and Improving Outcomes Metrics

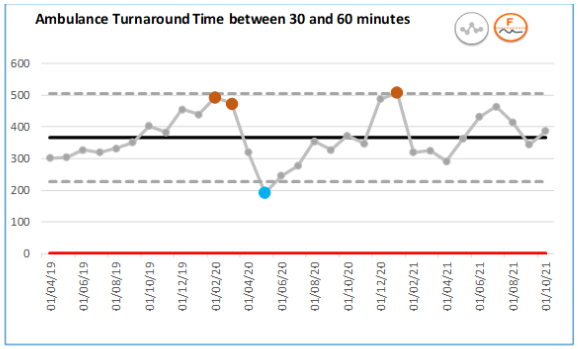


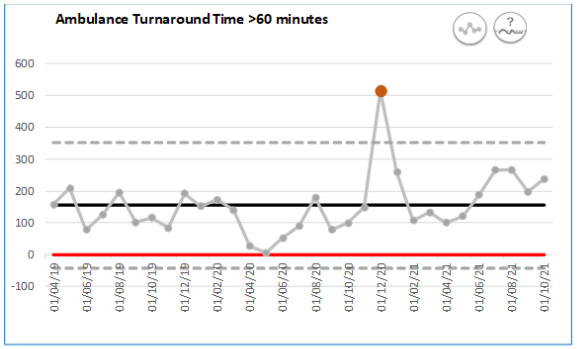


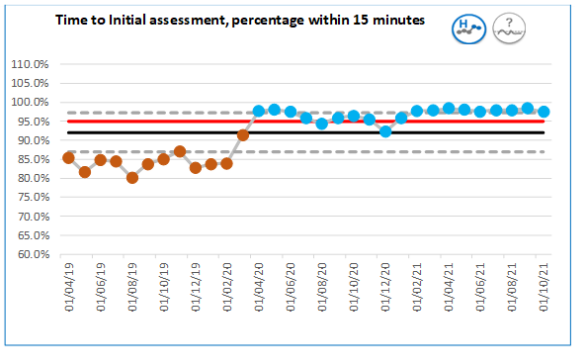
West Hertfordshire Hospitals NHS Trust

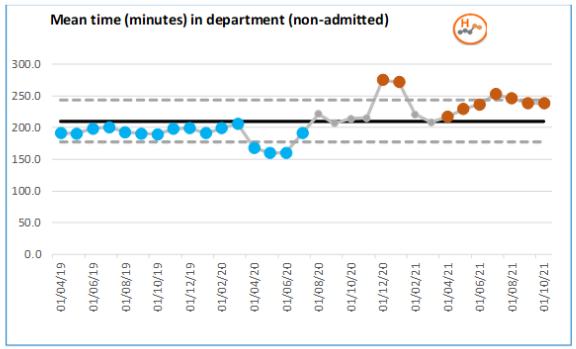
Appendix 2 – A&E Metrics

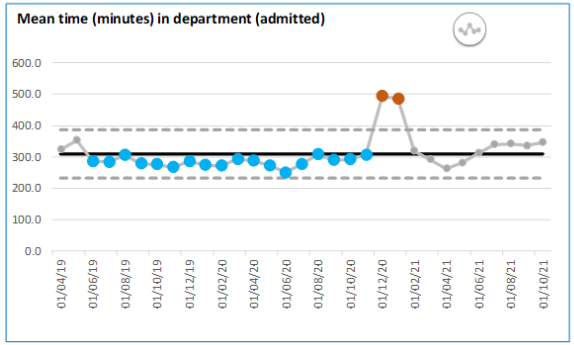






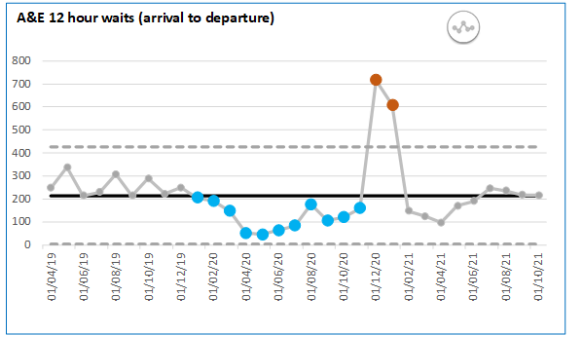


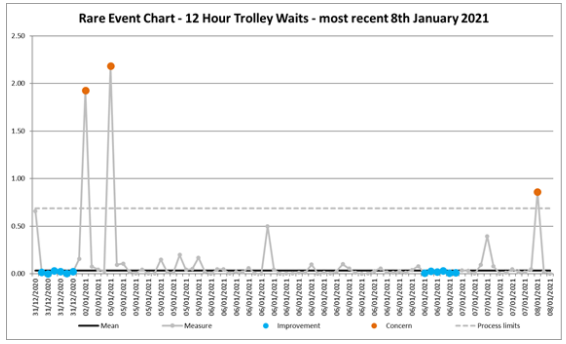


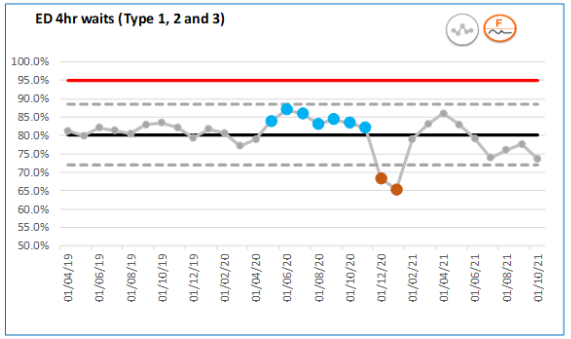


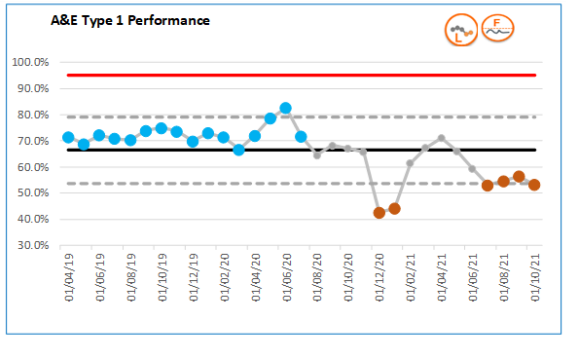
West Hertfordshire Hospitals NHS Trust

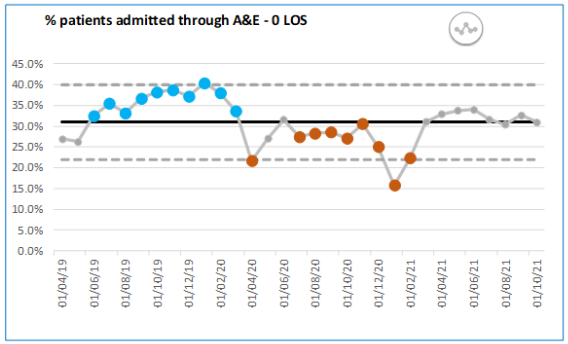
Appendix 2 – A&E Metrics





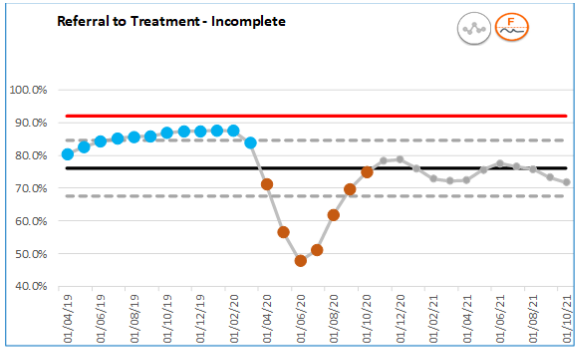


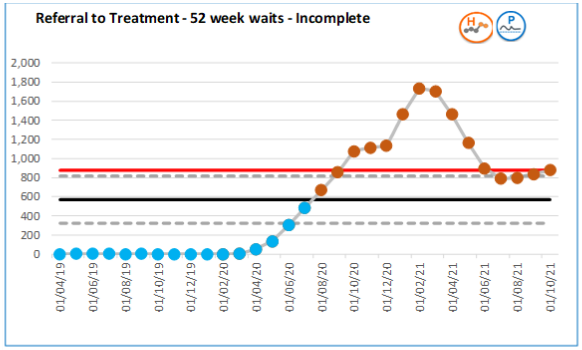


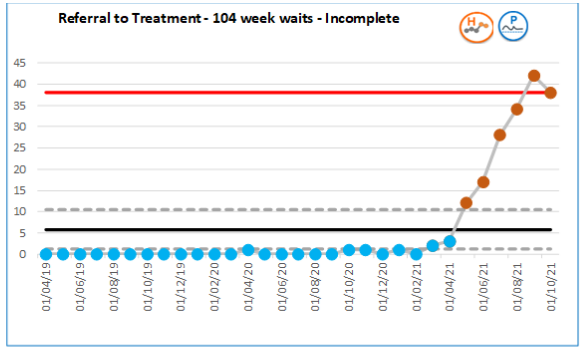


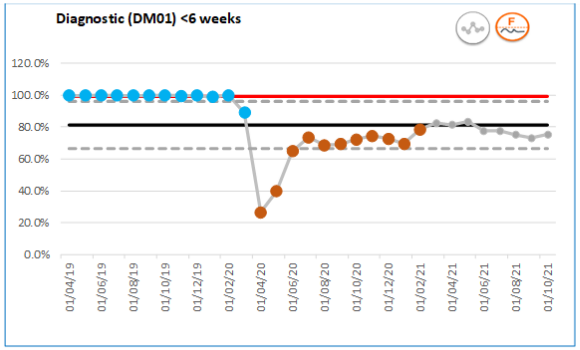
West Hertfordshire Hospitals NHS Trust

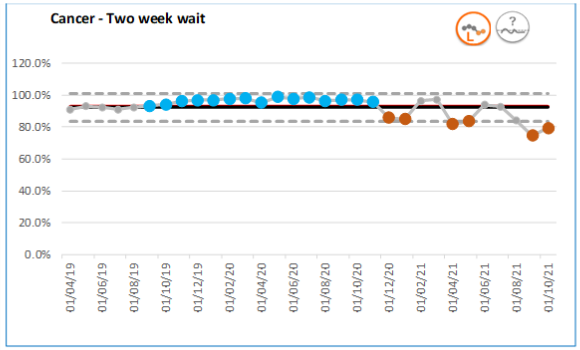
Appendix 3 – RTT, Cancer and Diagnostics Metrics

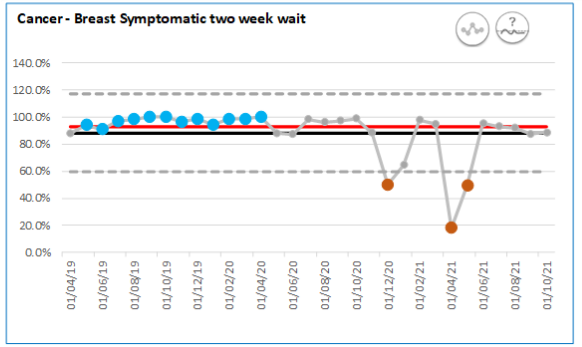






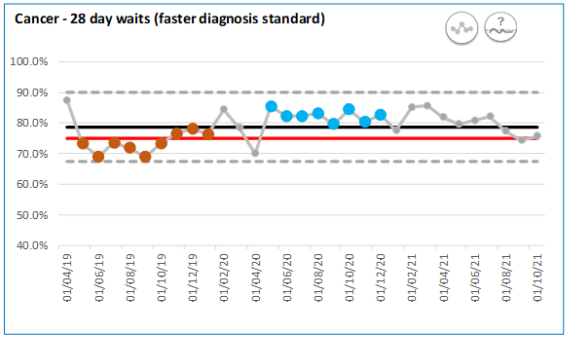


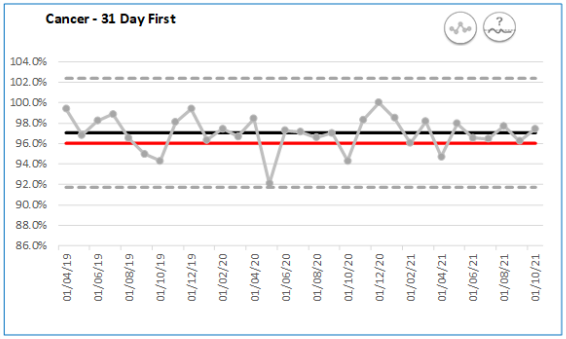


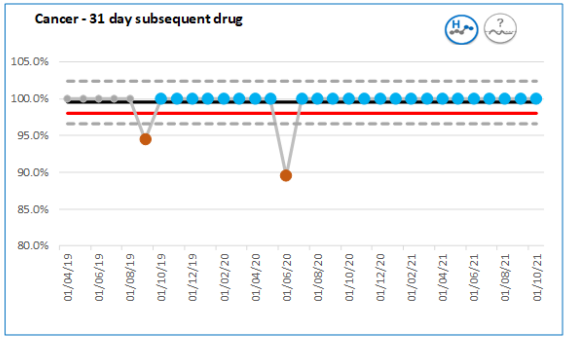


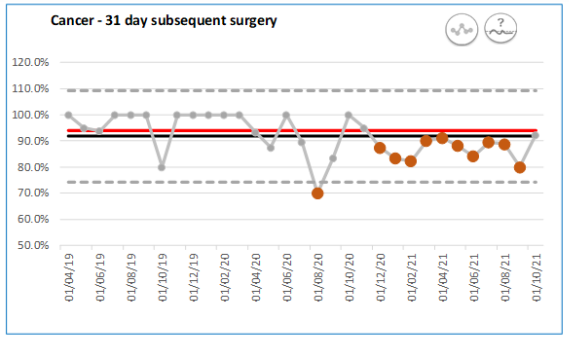
Appendix 3 – RTT, Cancer and Diagnostics Metrics

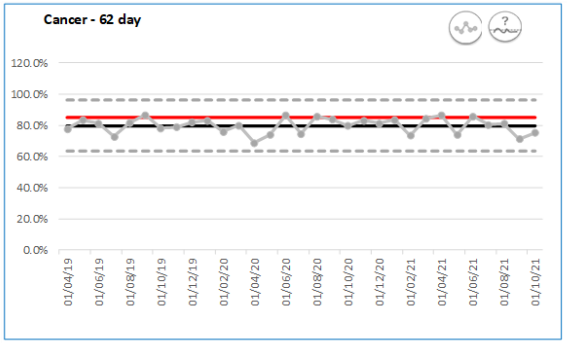
West Hertfordshire Hospitals NHS Trust

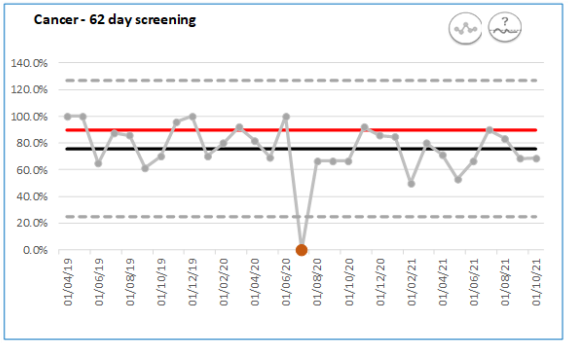












West Hertfordshire Hospitals NHS Trust

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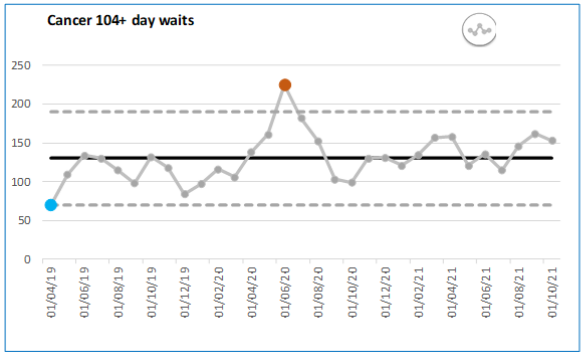
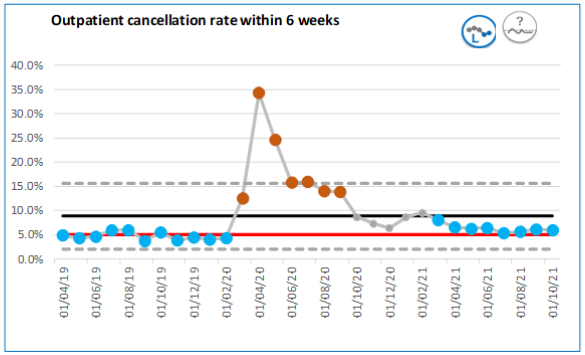
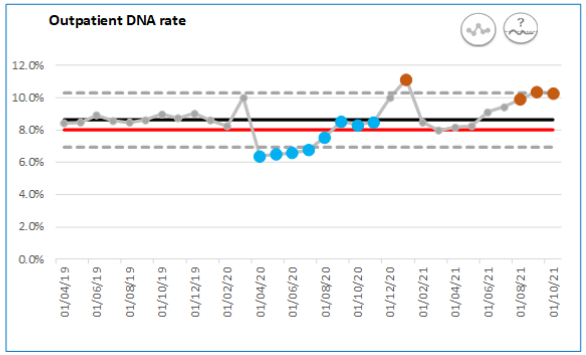
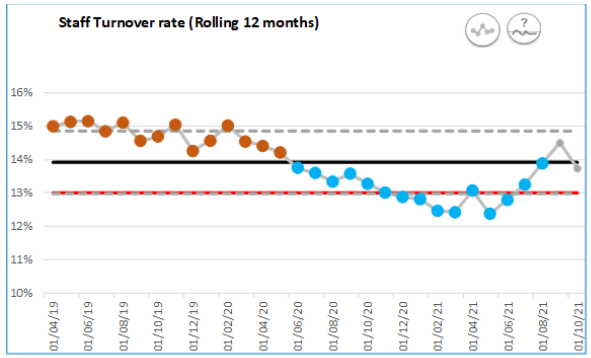


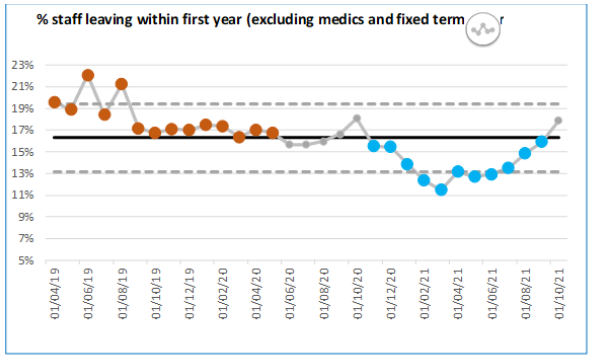


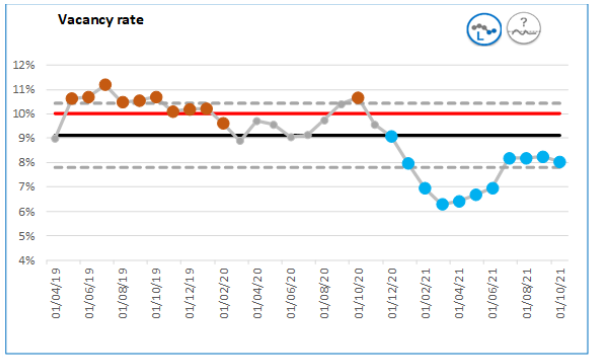


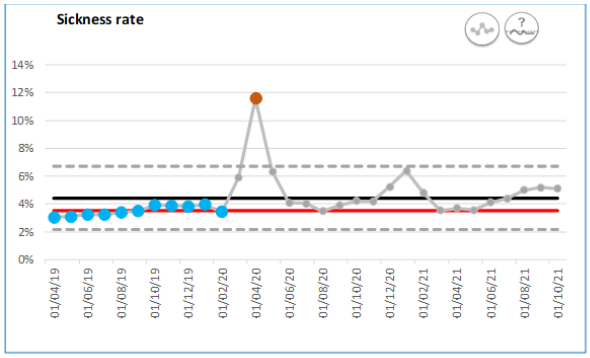
West Hertfordshire Hospitals NHS Trust

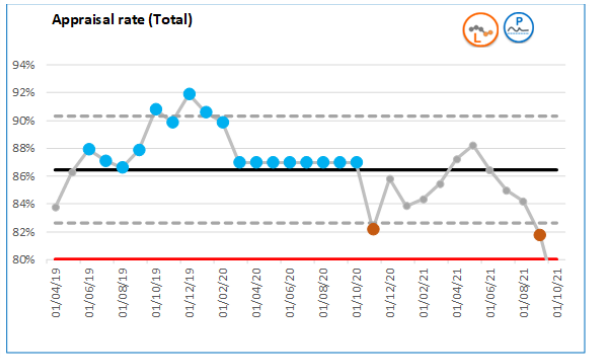
Appendix 4 – Workforce Metrics

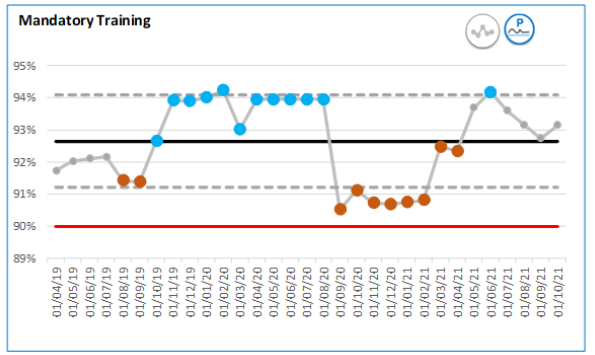












West Hertfordshire Hospitals NHS Trust

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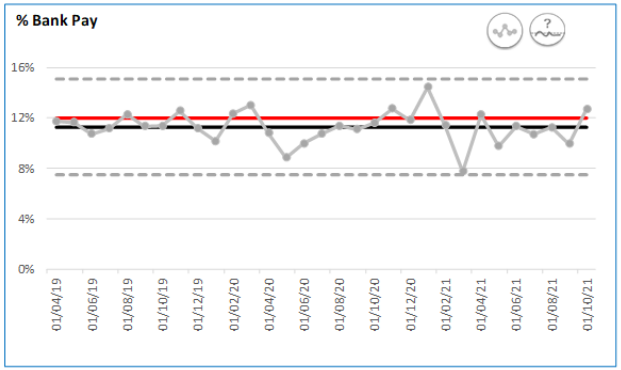
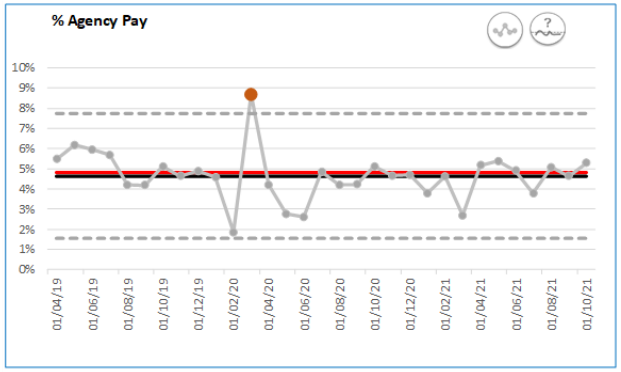
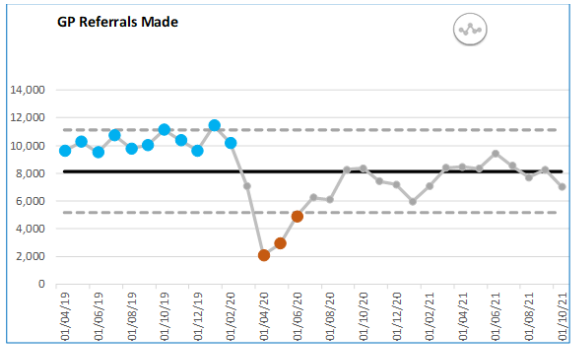
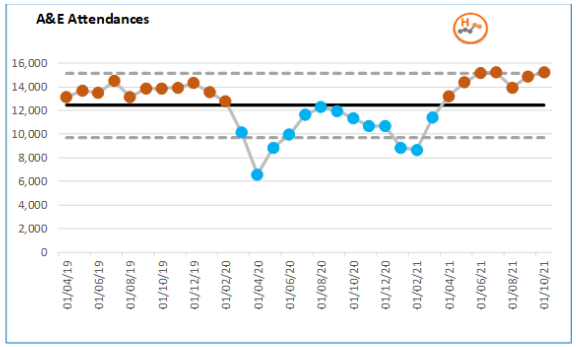


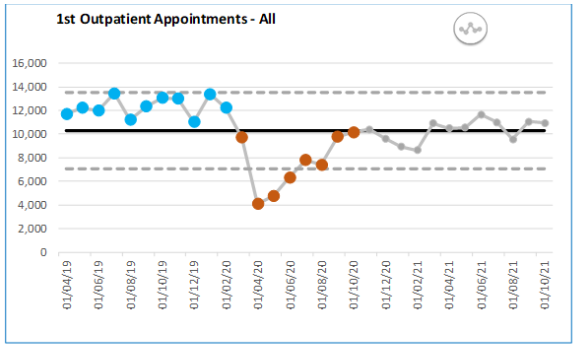


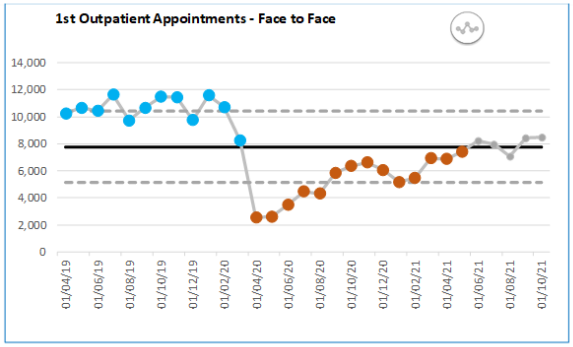
West Hertfordshire Hospitals NHS Trust

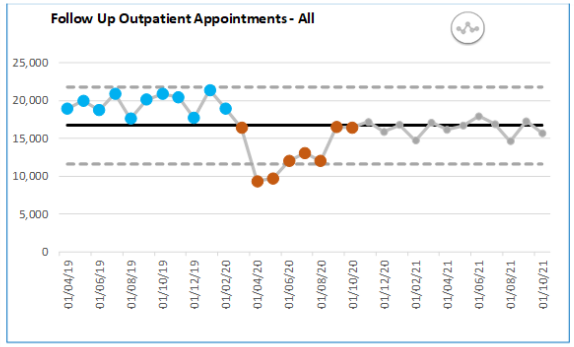
Appendix 5 – Activity Metrics

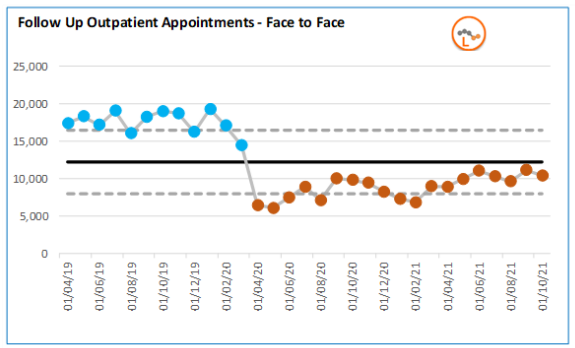












West Hertfordshire Hospitals NHS Trust

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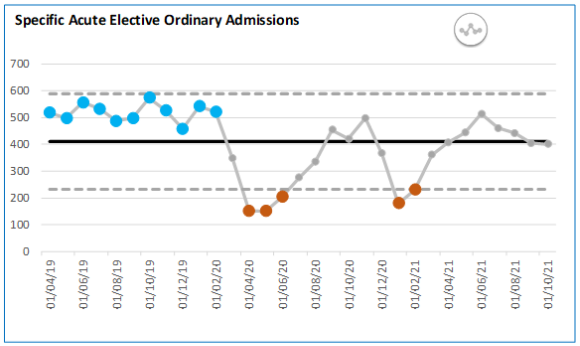

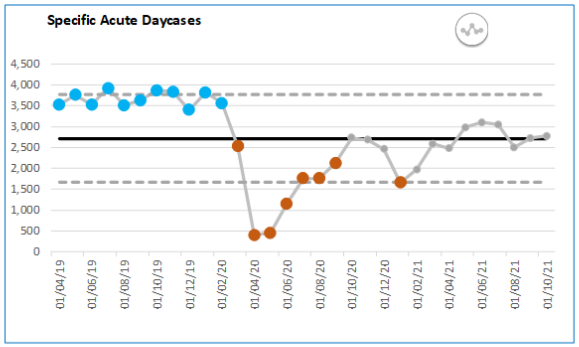

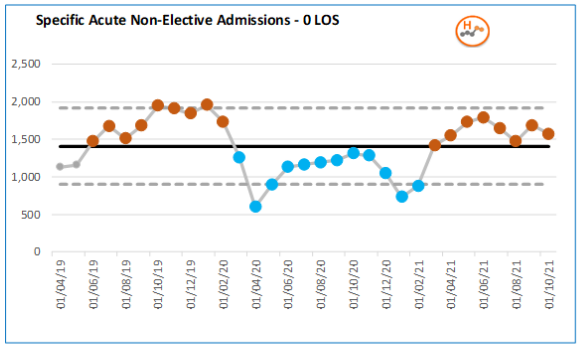

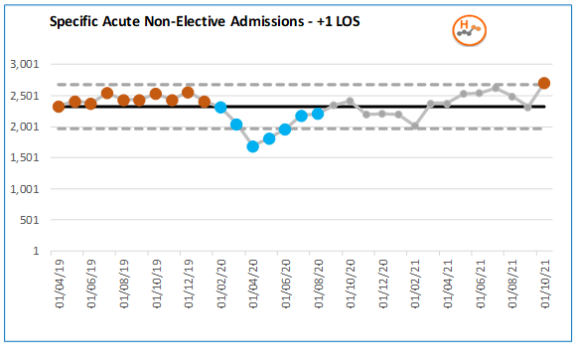

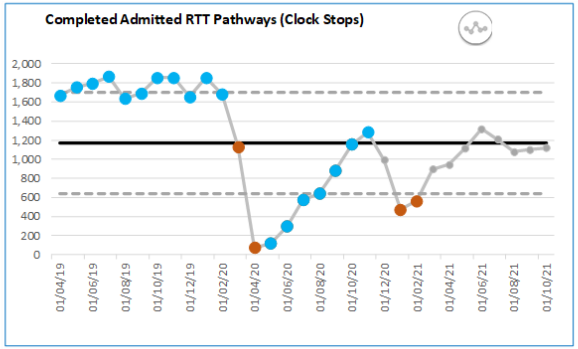

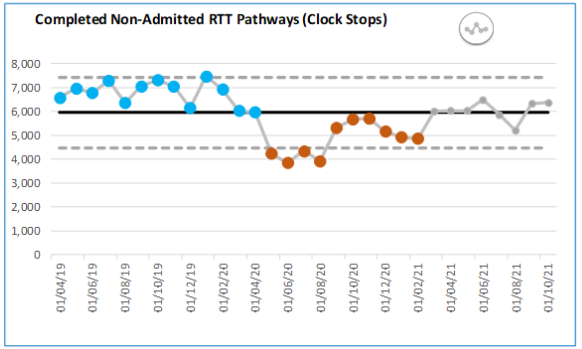

West Hertfordshire Hospitals NHS Trust

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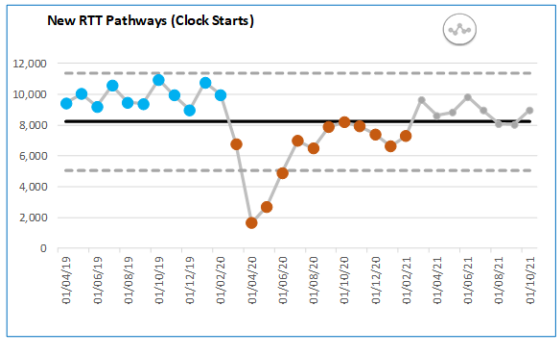

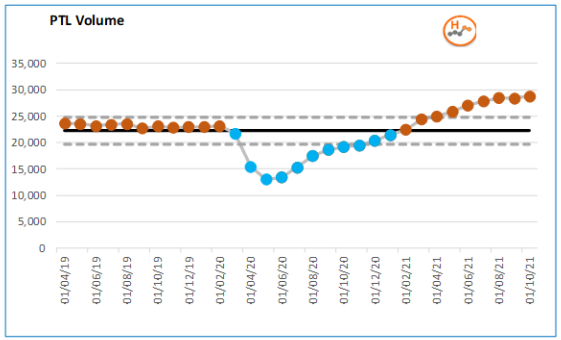

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Thank you

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OUR VALUES
Commitment
Care Quality

Trust Board Meeting
2nd December 2021

Title of the paper	West Hertfordshire Operational Resilience and Winter Plan 2021/22
Agenda Item	
Presenter	Sally Tucker, Chief Operating Officer
Author(s)	Tracey Pooley / Joan Plant, Herts Valley CCG
Purpose	For approval: For discussion: For information: X
Executive Summary	This plan sets out winter planning arrangements to manage the impact of winter pressures across health and social care for West Hertfordshire. Throughout this document the term "winter" refers to the period 1st October 2021 – 31st March 2022. In addition to winter planning arrangements this plan attempts to cover the ongoing response to Covid.
Trust strategic aims	Aim 1 Best care – Objectives 1-4: X 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	System Resilience Group (SRG) - 31st August 2021 ICS Urgent & Emergency Care Board (ICS UEC Board) – 12th October 2021
Action required	For Information

Vaccination as a condition of deployment (VCOD) for all healthcare workers

Tracey Carter

Background to Vaccination as a Condition of Deployment

- The Department of Health and Social Care (DHSC) formally announced on 9 November 2021 that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care.
- The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.
- This government policy takes into account specific exemptions, including those who are medically exempt; under 18 years of age; do not have contact with patients; or are a participant in a clinical trial investigating COVID-19 vaccination.

Where we are

Baseline 04.01.21 (%)

ESR listed staff receiving first dose 4,807

ESR listed staff receiving second dose 4,697

Unknown = 132

Decline = 239

Of which 48 = long term sick, 51 = maternity leave

92.4% of ESR listed staff received 1st dose when LTS & Maternity excluded*

Baseline 01.09.21 (%) Accurate as of 29/11 AM.

ESR listed staff receiving boosters 2742 (64% of eligible staff**)

* Of those unvaccinated not all will be undertaking CQC regulated activity

**Currently 75% of ESR staff are eligible for booster vaccine

Recommended approach (1)

Recommendation	Our response
Making it as simple and convenient as possible to receive the vaccine and to make the most of walk-ins, pop-ups, and other delivery models, such as hospital hubs, vaccinations centres and local vaccination services	We continue to run pop-up clinics in Watford and St Albans and will do so in January and early February. Staff can walk-in at HHGH any day. Wide communications coverage of other places to get vaccination.
Engagement with targeted communities where uptake is the lowest, including extensive work with BAME and faith networks to encourage healthcare workers to receive the vaccine.	Data consistently analysed for areas of low uptake. Strong involvement of the CONNECT group and faith leaders. Significant use of champions and communications.

Recommended approach (2)

Recommendation	Our response
Senior leaders and clinicians to proactively encourage vaccination uptake for all individuals through concerted communication campaigns and proactive engagement with individual colleagues	Have been working with senior leadership teams in Divisions to reach unvaccinated/unknowns. Strong communications campaign with senior leaders around specific topics e.g. fertility
One-to-one follow up with unvaccinated individuals to offer structured support and access to expert clinical advice.	Have offered one-to-one support throughout but will now ask **pro-vaccination** senior leaders to have formal one-to-ones with declining staff. Can refer to *Here for You*, signpost to range of NHSE/I resources and local resources.

Next steps

- Follow up new starters to confirm status, validate records (overseas), follow up long term sick and maternity leave staff to give rebased figures 01.01.22.
- Identify any exemptions (other than maternity leave this is likely to be minimal).
- Continue to actively follow up ‘unknown’ status (currently at c130 staff) – needs to be zero.
- Continue to circulate declined data to Divisional senior teams – increase to every 2 weeks.
- Record conversations with ‘declines’ through ER.

Next steps cont.

- Pop-up clinics in December, January and February.
- Continue targeted and frequent communications.
- Involvement of ER/HR.
- Review of recruitment materials to make prospective employees and new starters aware of new measures;
- To review and update contracts of employment to be in line with new mandated position;
- To review and update mandated position with our temporary staffing stakeholders to ensure these staff are aware and vaccinated.

Any questions?

Thank you

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Trust Board Meeting
2 December 2021

Title of the paper	Mortality and Learning from Deaths Quarter 2 2021/22
Agenda Item	20
Presenter	Dr Mike Van der Watt, Chief Medical Officer
Author(s)	Dr Anna Wood
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	This report reviews mortality and learning from deaths for the quarter 2 period, 2021/22. The latest Dr Foster intelligence report, (October 2021) spans the data period July 2020 to June 2021. Dr Foster has recently experienced difficulties with data extraction, so Trust reports have periodically been delayed. The September report was unavailable. Learning from deaths data spans 1 July 2021 – 30 September 2021. HSMR is reported as 93.5, which is lower than expected. If covid deaths are excluded, this drops further to 85.4. Women's and children's services however are above expected at 237.9. SHMI is reported as 96.53, which is within the expected range and SMR (all diagnosis) at 95.1. There are 2 outlying diagnosis groups; • Urinary tract infections • Other perinatal conditions
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

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☒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>QSG</td><td>16 November 2021</td></tr><tr><td>Quality Committee</td><td>25 November 2021</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for assurance on Trust mortality and learning from deaths scrutiny.</td></tr>
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West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item: 20

Quality Committee

Mortality and Learning from Deaths Quarter 2 2021/22

Presented by: Dr Anna Wood
Author: Deborah Wadsworth

1. Purpose

1.1 This paper aims to provide a review of trust mortality and related workstreams across quarter 2 2021/22 (2021) and to provide an update on current position (October 2021).

1.2 The last Mortality Review Group meeting was held on 18 May 2021. The group will meet next on 16 November.

2. Background

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

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

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

3. Mortality metrics

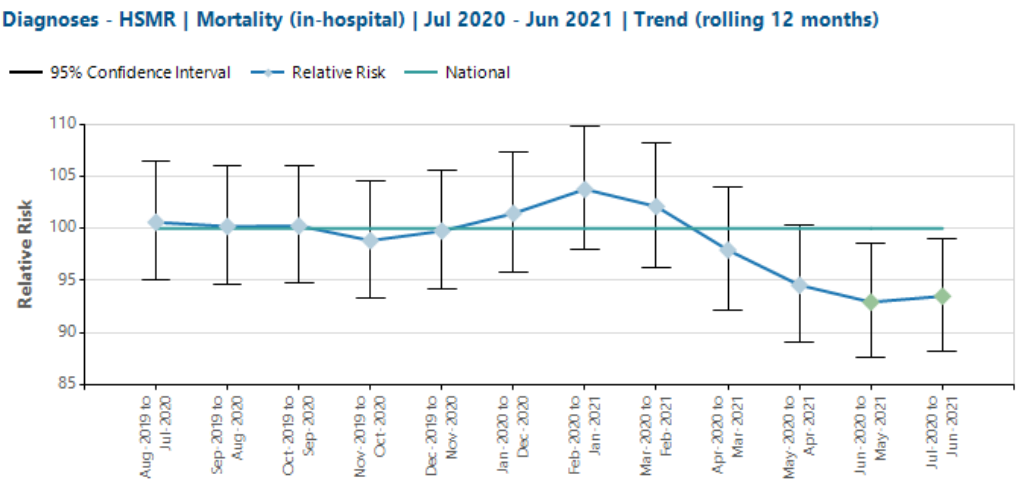
(From October 2021 Dr Foster update which encompasses data from July 2020 – June 2021)

- **HSMR** is 93.5 in the lower than expected range. If covid codes are removed HSMR falls to 84.5
- **SHMI** is within the expected range.
- **SMR** is and is in the lower than expected range

3.1 Overall quantitative performance (the metrics)

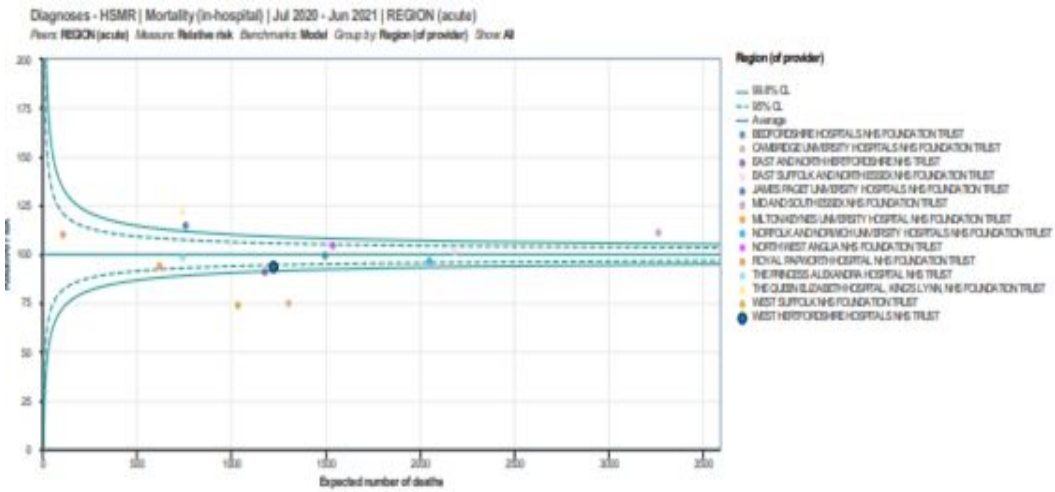
3.1.1 HSMR rolling 12 months (last point is 2021)

a) Chart 1 Monthly trend rolling 12 months

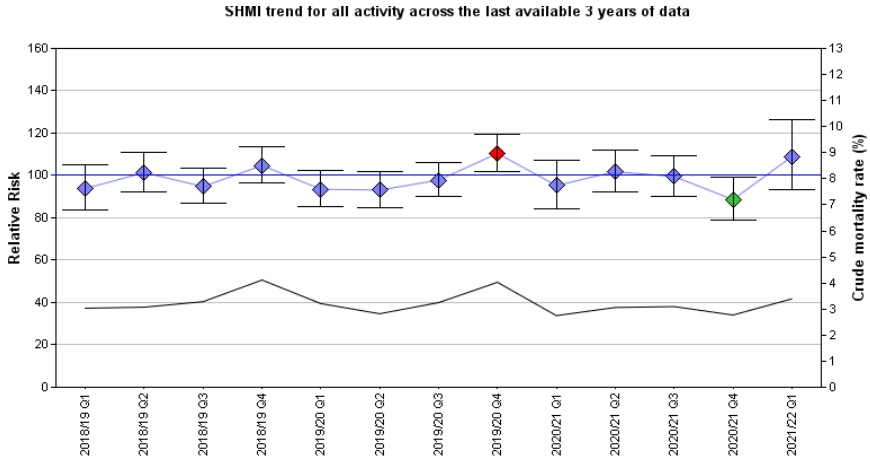


b) Chart 2 Peer comparison

The Trust is 1 of 4 Trusts within the East of England peer group of 12 with an HSMR in 'lower than expected' range.



3.1.2 **Chart 3 SHMI Last available 3 years (last data point 2021)**



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

3.2 Outlying SMR and HSMR diagnoses

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

3.2.2 The Dr Foster report highlighted There are 2 outlying groups:

- Perinatal conditions (19 observed deaths, of which 18 had an ICD-10 code of P95 'foetal death of unspecified cause)
- Urinary tract infections (55 observed deaths, of which 14 had a diagnosis on discharge of COVID-19)

3.3 Perinatal Mortality

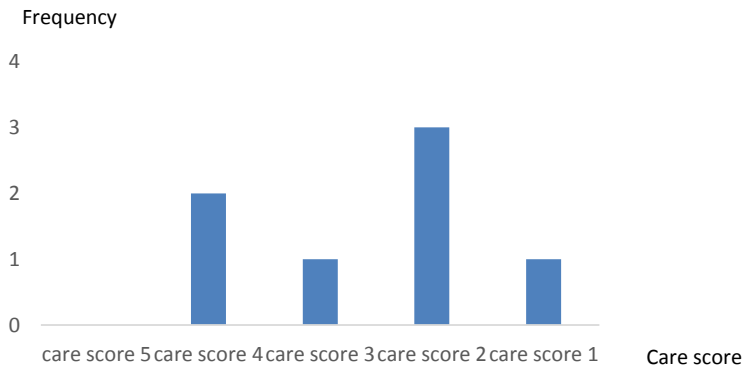
The WACS team have provided a full written analysis and have provided assurance that the 8 neonatal deaths reported by Dr Foster were all attributed to extreme prematurity. There is further analysis of 2 neonatal deaths due to congenital abnormalities which were unavoidable. The analysis of 5 in utero deaths beyond 37 weeks gestation (between August 2020-July 2021 inclusive) has been carried out and are under HSIB investigation but with exception of one where actions have been taken to reinforce the use of interpreters (case of reduced fetal movements) , the rest were unavoidable.

A further 8 in utero deaths between 28 weeks and 36+ weeks were analysed and in 50%, no cause could be determined and in the rest, multifactorial causes were determined but not avoidable.

4 Structured judgement review (SJR)

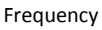
4.1 Between 1 July 2021 and 30 September 2021, 11 referrals for structured judgement review were made. 7 completed reviews were received back from consultant reviewers, with overall care scores ranging from 1 to 4. Of the 7, 2 scored a 4 (good care) 1scored a 3 (adequate care), 3 scored a 2 (suboptimal care), and 1 scored 1 (poor care).

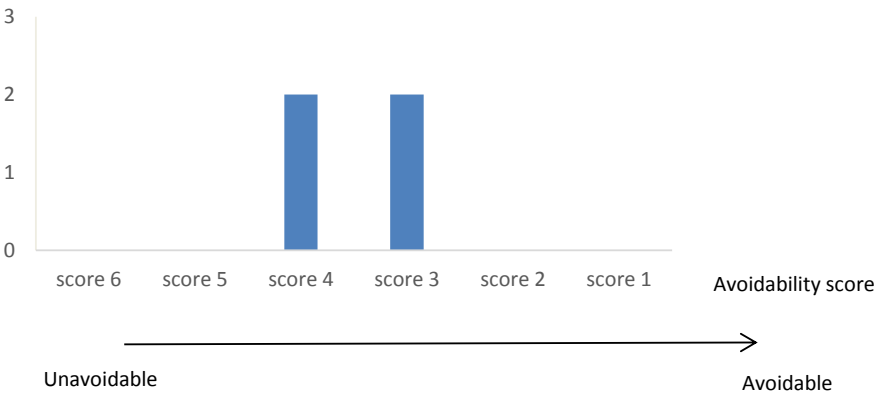
4.2 **Chart 4 SJR care scores for quarter 2 2021/22**



4.3 **Chart 5 potential avoidability of death for quarter 2 2021/22**

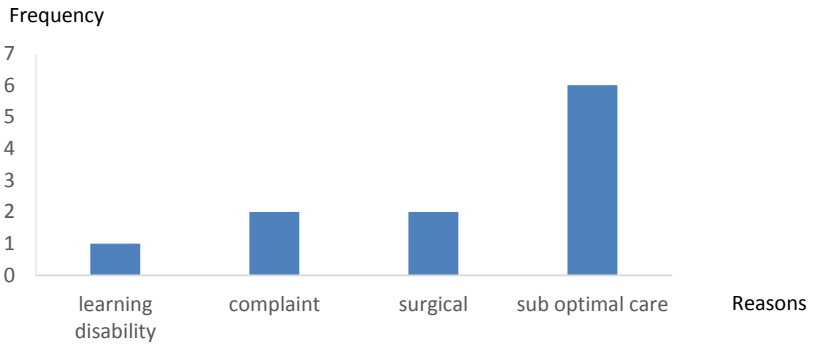
4 cases were referred to the tier 2 avoidability panel and reviewed





In conclusion there were 2 cases considered potentially avoidable (scoring 3 or less).

4.4 Chart 6 reasons stated for SJR referral (1 July 2021 and 30 September 2021)



4.5 SJR themes and learning

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

4.5.2 No new themes for SJR have been identified this quarter.

5 Medical Examiner service

5.1 Between 1 July 2021 and 30 September 2021, there were 363 in-hospital deaths and the Medical Examiners reviewed 279 of these (77%).

5.2 There is a national mandate for acute trusts to roll out the Medical Examiner Service to the community, this is a large project which will be carried out in an incremental way.

5.3 A business case produced to progress this work was approved by the Trust Management Committee on 22 September and interviews for additional Medical Examiners and Medical Examiner's Officers will take place in November.

6 Next steps

6.1 Next steps planned include:

- Recruitment of 10 additional Medical Examiners, totalling 1WTE and 4 additional Medical Examiner's Officers, totalling 3.4 WTE for the Community Medical Examiner Service

7 Risks

7.1 None identified.

8 Recommendation

8.1 The Group is asked to note the report for information and assurance.

Name of Director
Dr Anna Wood

Date October 2021

Trust Board
2nd December 2021

Title of the paper	Complaints and PALS Annual Report
Agenda Item	21
Presenter	Tracey Carter, Chief Nurse & DIPC
Author(s)	Brian Haig, Complaints Manager. Jackie Dick, Senior Nurse for Resolution and PALS
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	The annual Complaints and Patient Advice and Liaison Service (PALS) report was presented to the Quality Committee for discussion and assurance. The items discussed included what success would like for the year ahead and the percentage of improvement anticipated, it was acknowledged that due to the impact of the COVID-19 pandemic we may not see an improvement as it is likely that there may be an increase in complaints and litigation however the transition to datix icloud will support more granularity in the themes of complaints. A discussion followed on how we proactively respond to communication, which is a common theme, there has been educational support for our overseas nurses particularly in breaking bad news on the telephone. The chair thanked the complaints team for the sustained improvement during the pandemic. 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. This report provides a summary of patient complaints, and compliments received in 2020/2021. 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. This also includes a summary of the patient concerns received by PALS and performance regarding the Trusts performance in resolving these. **Complaints key points to note:** • In 2020/21 363 complaints were received as compared to 352 complaints during the same period in 2019/20 giving an average of 30 complaints per month. • Acknowledgments were made within the national target of 3 working days 100% of the time. • The Trust responded to 85% of all complaints within the time agreed

	with the complainant an improvement from 81% in 2019/20 and 71% in 2018/2019. • Improvements in response to complex cases. **PALS Key points to note:** • PALS information and details added to the WHHT Patient Experience website. • Development and building on the foundation of the Family Liaison line to roll out to all divisions during the pandemic. • Development of the online portal for interpreting requests throughout the Trust.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care — ***Objectives 1-4*** ✓ **Aim 2** Great team — ***Objectives 5-8*** **Aim 3** Best value — ***Objective 9*** **Aim 4** Great place — ***Objective 10-12***
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	Committee/Group — Date Quality & Safety Group — 16.11.2021 Quality Committee — 25.11.2021
Action required	The Board is asked to receive this report for information and assurance that the Trust is compliant with NHS England Complaints Policy.

Agenda Item: 21

Trust Board – 2 December 2021

Title of paper: Annual Complaints and Patient Advice & Liaison Service Report

Presented by: Tracey Carter, Chief Nurse & DIPC

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 Formal complaints, feedback, compliments and contacts are some of the useful tools West Hertfordshire Hospitals NHS Trust utilises to capture concerns 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 2020 to 31 March 2021.

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 while concerns have been dealt with by the PALS team.

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 clearer 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. New proposed National Complaint Standards

4.1 In 2021 the Parliamentary Standards and Health Ombudsman outlined new National Complaints Standards, which are currently in draft format and are being trialled at several NHS Trusts.

4.2 These are due to be implemented across the NHS during 2022 and outline a standardised process for all Trusts to follow, including one policy, underpinned by significant guidance.

4.3 These new standards will impact upon the complaint handling process for the Trust and are focused on early resolution as a core point of any complaint or concern handling process, with the expectation that all staff will be confident, trained and supported in being able to resolve complaints or concerns quickly and effectively.

4.4 Preparation for the implementation of the new processes will need to be undertaken during 2021/22 and is part of the 2021/22 workplan for complaints.

5. Impact of the Pandemic

5.1 2020/21 saw the Trust face unprecedented challenges in dealing with the COVID-19 Pandemic, with significant numbers of seriously ill patients and excess deaths. These pressures on front line staff have meant that on occasion, clinical and nursing staff were not always able to devote time to provide responses to complaints in the same manner or time frame as pre-pandemic.

5.2 As such, the Trust ensured that effective communication with complainants in setting out the challenges the Trust was facing and how this was likely to impact on time frames for responses was implemented from the onset. This included regular updates to the website for complaints and PALS, as well as through email and phone communication with complainants. This allowed for complainant's expectations to be managed and the Trust was therefore able to continue to accept complaints, register these and investigate these.

5.3 During April and May 2020 complaints fell to lower levels than previous year, however reached similar levels as in previous years from June onwards.

5.4 It was anticipated that the Trust would possibly see an increase in complaints as lockdowns eased and Patients, families and carers, who had perhaps held back on making complaints, while the NHS was no longer under the pressures they had seen during the height of the first and second waves. At present this has not shown a significant increase, however this may change as 2021/22 progresses.

5.5 Trust performance in April and May 2020 dropped below the 80% performance target, however this improved in June 2020 and was maintained for the remainder of the year, with the exception of December 2020, which saw the target not being achieved.

6. Overview performance 2020/21

6.1 In 2020/21, 363 complaints were received at West Hertfordshire NHS Trust compared to 352 in 2019/2020. In total 374 complaints were responded to. The additional responses were as a result of outstanding complaints from 2019/2020.

6.2 The Trust responded to 85% of all complaints within the timeframe agreed with the complainant; compared with 81% in the pre-ceding year. Of the complaints received in 2020/21, 179 (49%) of complaints were upheld or partially upheld, comparable to the number and percentage in 2019/20.

6.3 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.

6.4 The volume of complaints referred and considered for formal investigation to the Parliamentary and Health Service Ombudsman (PHSO) has remained at a low level and as the end of March 2021 there were only 2 matters, which PHSO were considering. This has however been impacted by the Pandemic, as PHSO paused any new referrals for a period of seven months. As a result, PHSO now has a significant backlog of cases, which they are now considering, this is likely to include some complaints relating to WHHT that are being considered but have as yet not reached the Trust.

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

6.6 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.

6.7 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 2020/21.

6.8 This last year has seen significant challenges for the Trust overall, including the complaints team as a result of the Pandemic. In April 2020, the complaints team had an establishment of 1 Complaints Manager, 1 Complaints Administrator, 2 Complaints Advisors and 2 Complaints Investigators, however due to reduced staffing levels there were 2 vacancies of 1 Investigator and 1 Advisor, which were in the process of being filled through a recruitment process.

Additionally, 2 staff were required to shield, in line with government advice, leaving 1 Advisor and the Complaints Manager, to manage complaints. The Complaints Manager had responsibilities for managing the Visitor Helpline during the period of March to July 2020. However, in May and June 2020 two new members of staff joined the team, bringing it up to establishment.

6.9 Despite the impact of the Pandemic, the Trust did not pause or stop the complaints process and continued to seek to respond to complaints throughout. Although performance for April and May 2020 was below the 80% target, subsequent responses have been consistently in excess of this, with only December 2020 being an exception to this.

7. Risks

7.1 There are no specific risks identified at this time.

8. Overview of compliance with Complaints Policy

8.1 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.

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

9. Analysis of Complaints Received in 2020/21
(Extracted from Datix Database)

9.1 The chart below records complaints per 10,000 bed days. This is reported monthly via the Integrated Performance report (IPR) and bi monthly to the Quality Committee. The Complaints Team continue to work with the divisions and to support their work. The number of complaints the Trust received has remained similar to the levels seen in 2019/20, however it is not known what impact the Pandemic had on the number of complaints.

9.2 **Fig 1**: Number of complaints – rate per 10,000 bed days April 2019 to March 2021.

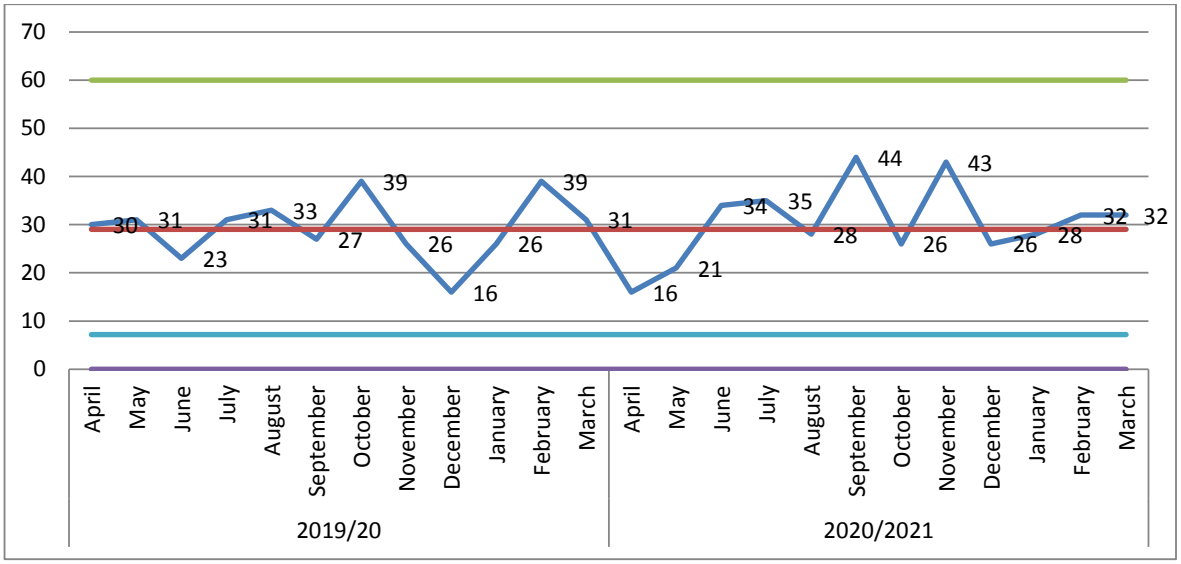


Fig 1

In 2019/20 complaints received averaged just under 30 a month. In 2020/21 this rose to just slightly over 30 a month. September and November 2020 saw significant numbers of complaints, above levels seen previously, however no reason could be readily ascertained for these increased numbers.

9.3 The Trust received a total of 363 complaints in 2020/21 (up from 352 the previous year) an increase of 9 complaints from 2019/20.

9.4 The last year has seen significant challenges arising due to the impact of the pandemic and necessitated some changes in the way the Trust managed complaints.

- Complaints are initially triaged by the Complaints team 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.

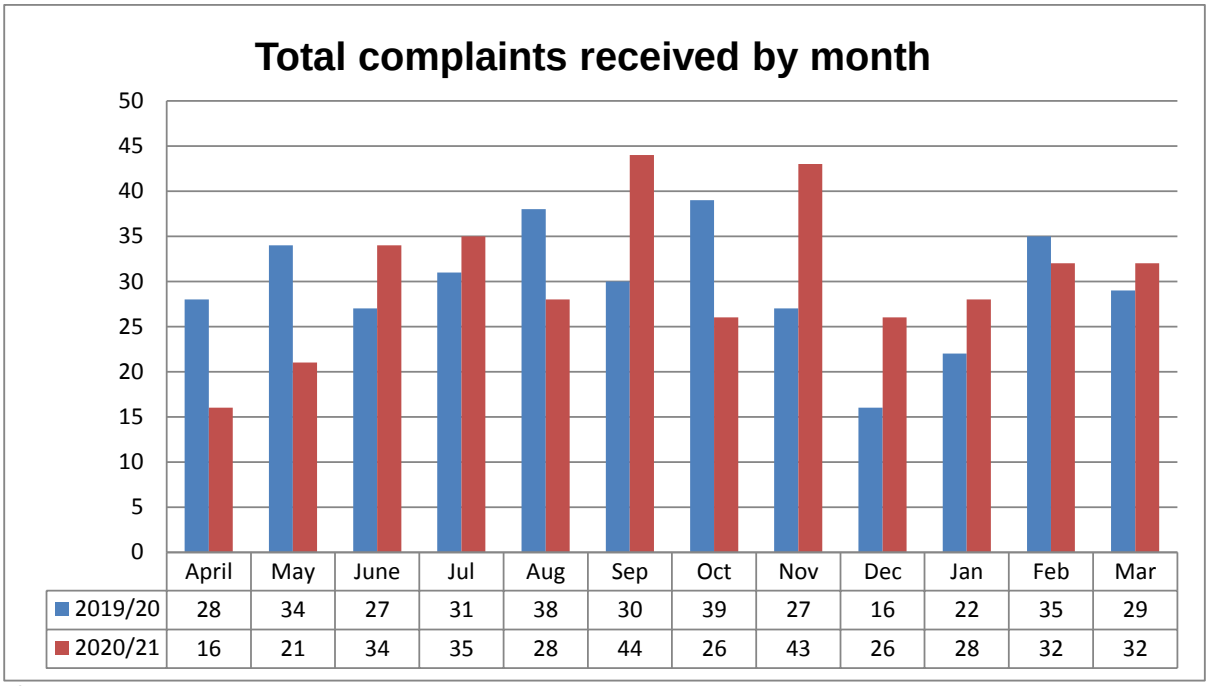
- Divisions have continued to evolve processes for the capture of learning/actions from complaints, so that these can be used to avoid reoccurrences and improve care and service provided.

- Surgery have now implemented a process whereby every complaint has a review at the conclusion to identify what went well, what didn't and what changes needed to be made to services or care. This is being trialled as an ongoing process through the Quality governance process.

- Ward staff continue to be proactive in resolving concerns before they escalate to become formal complaints, although this does 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.

10. Number of new complaints opened per month

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



	April	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	28	34	27	31	38	30	39	27	16	22	35	29
2020/21	16	21	34	35	28	44	26	43	26	28	32	32

Fig 2

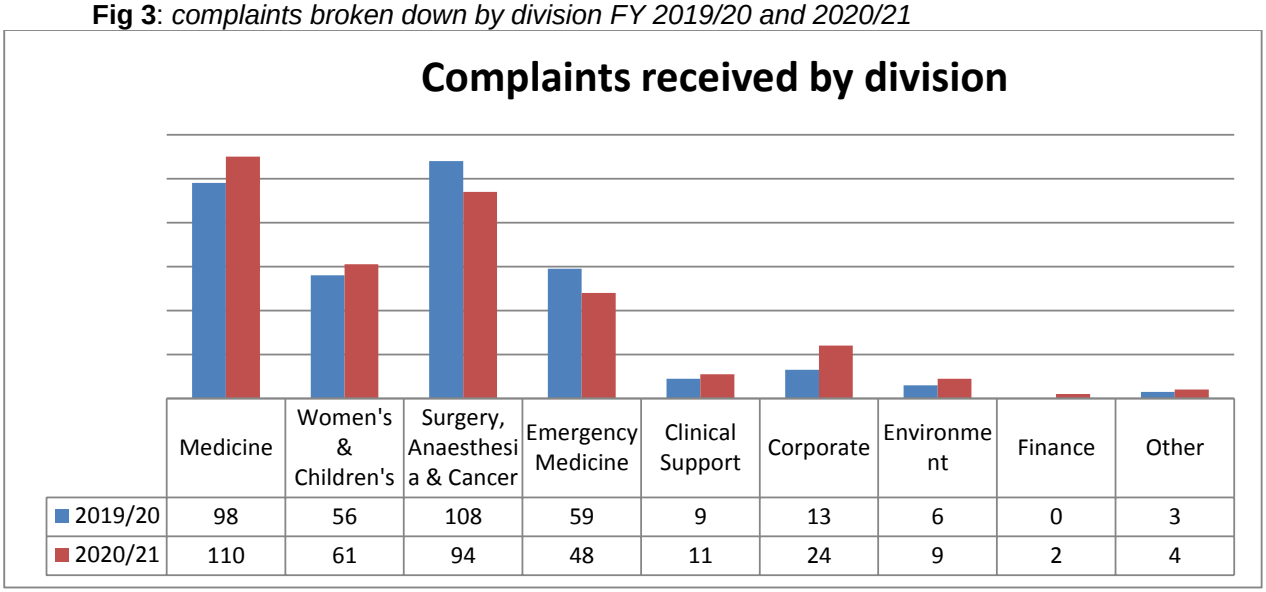
10.2 Overall complaint numbers remain steady with 1 per day on average.

11. Complaints acknowledged within 3 working days

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

12. Complaints received by Division by year

Fig 3: *complaints broken down by division FY 2019/20 and 2020/21*



	Medicine	Women's & Children's	Surgery, Anaesthesia & Cancer	Emergency Medicine	Clinical Support	Corporate	Environment	Finance	Other
2019/20	98	56	108	59	9	13	6	0	3
2020/21	110	61	94	48	11	24	9	2	4

Fig 3

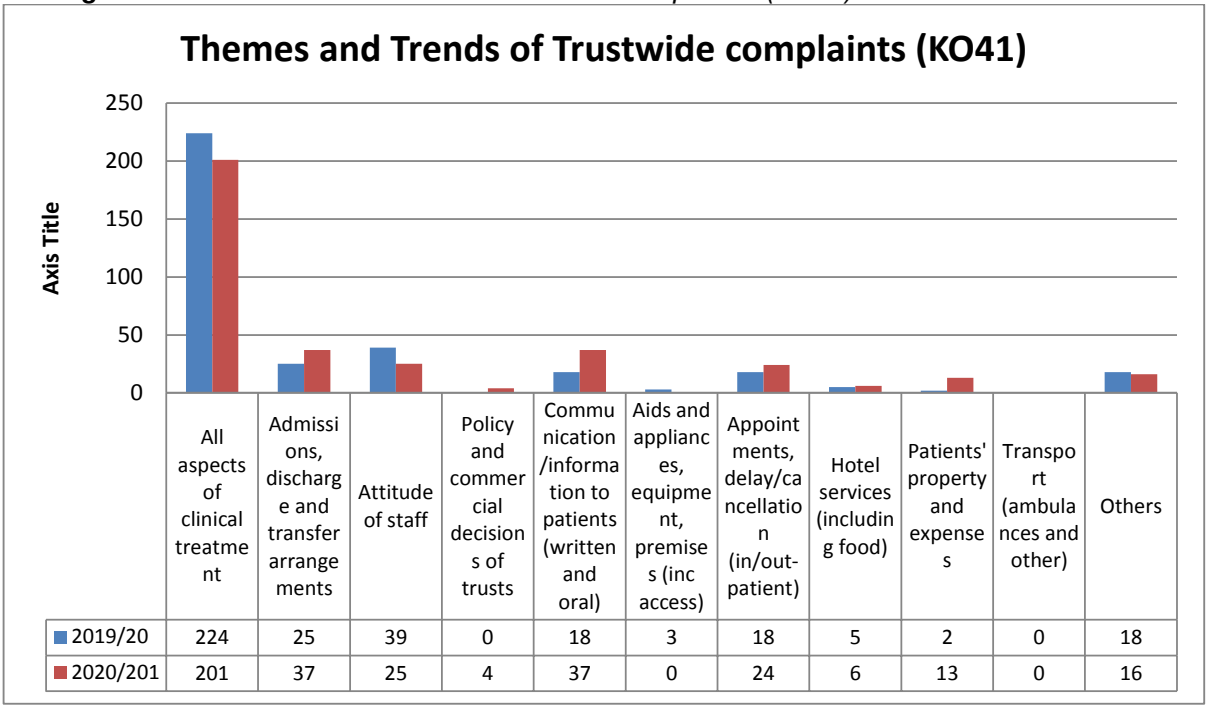
Medicine saw an increase in complaints by an average of 1 per month compared to the previous year (13) following a reduction in the previous year. Surgery, Anaesthetics and Cancer (SAC) in 2019/2020 had the most complaints (108) and saw a significant reduction in 2020/21 (94), however as surgical procedures were postponed as a result of the pandemic, it is not possible to identify if this was due to improved services and care or as less patients were seen.

The division of Women's and Children's Services (WACS) saw a slight increase in the past year, while Emergency Medicine also saw a decrease. Corporate complaints showed an increase primarily due to complaints relating to Medical Certificate Certifying Death (MCCD) delays and loss of property, as a result of the pressures on services due to the Pandemic.

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

13.1 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.

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

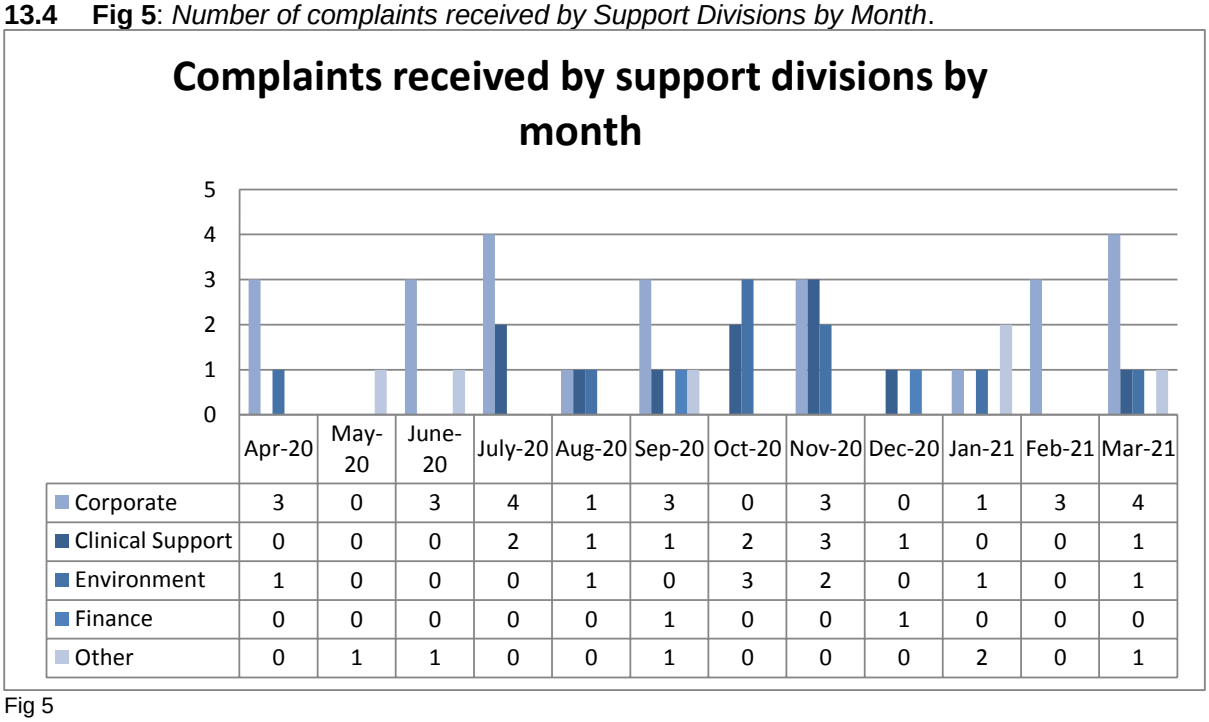


	All aspects of clinical treatment	Admissions, discharge and transfer arrangements	Attitude of staff	Policy and commercial decisions of trusts	Communication/information to patients (written and oral)	Aids and appliances, equipment, premises (inc access)	Appointments, delay/cancellation (in/out-patient)	Hotel services (including food)	Patients' property and expenses	Transport (ambulances and other)	Others
2019/20	224	25	39	0	18	3	18	5	2	0	18
2020/201	201	37	25	4	37	0	24	6	13	0	16

Fig 4

13.3 **Complaints received by Support Divisions by month**

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



	Apr-20	May-20	June-20	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Corporate	3	0	3	4	1	3	0	3	0	1	3	4
Clinical Support	0	0	0	2	1	1	2	3	1	0	0	1
Environment	1	0	0	0	1	0	3	2	0	1	0	1
Finance	0	0	0	0	0	1	0	0	1	0	0	0
Other	0	1	1	0	0	1	0	0	0	2	0	1

Fig 5

13.5 **Themes of complaints received by the Environment Division**

Complaints received were very few and primarily around difficulties around car parking, with disabled parking facilities being a specific concern, especially as measures implemented by

the Trust as a result of the Pandemic meant that disabled parking places were regrettably lost.

Particular issues raised: Disabled parking.

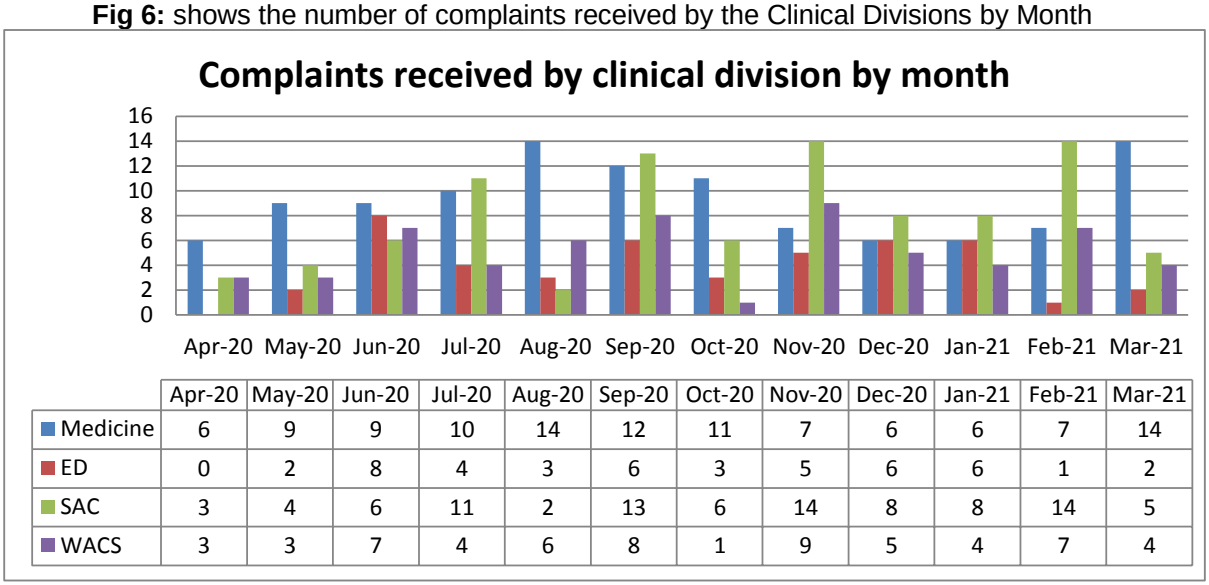
13.6 Themes of complaints received by Clinical Support Services
There were no themes identified due to the limited complaints received.

13.7 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.

14. Complaints received by Clinical Divisions by Month

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



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Medicine	6	9	9	10	14	12	11	7	6	6	7	14
ED	0	2	8	4	3	6	3	5	6	6	1	2
SAC	3	4	6	11	2	13	6	14	8	8	14	5
WACS	3	3	7	4	6	8	1	9	5	4	7	4

Fig 6

14.1 Themes of complaints received by the Division of Surgery Anaesthetics and Cancer
Trauma and Orthopaedics received the highest number of complaints, 33 (35%) followed by General Surgery, 27 (29%). 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 three years, although this has reduced in the last year from 40 to 33. Complaints continue to be 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.

14.2 Themes of complaints received by the Division of Medicine.
Care of the Elderly received the highest number of complaints, 34 (33%) followed by General Medicine 31 (23%). Complaints continued to relate to poor care and treatment, missed diagnosis, communication and attitude of staff, missed appointments, and concerns regarding nursing care.

All learning is captured by the division through their governance processes to aid improvements in service.

14.3 Themes of complaints received by the Emergency Department.

Issues raised included, delay in providing appropriate pain relief, diagnosis, lack of communication, attitude of staff, patient inappropriately sent home and delays in being reviewed. Waiting time delays did not feature as a complaint theme, despite there being delays due to number of staff attending A&E.

14.4 Themes of complaints received by the Division of Women's and Children's

Midwifery received the highest number of complaints 19 (31%) followed by Paediatrics 17 (29%) and Gynaecology 10 (16%). The complaints related to missed diagnosis, lack of post-operative care, lack of empathy, experiences in the delivery suite and staff attitude.

15. Complaint Outcomes

15.1 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 main 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.

15.2 **Fig 7:** *number of complaint outcomes.*

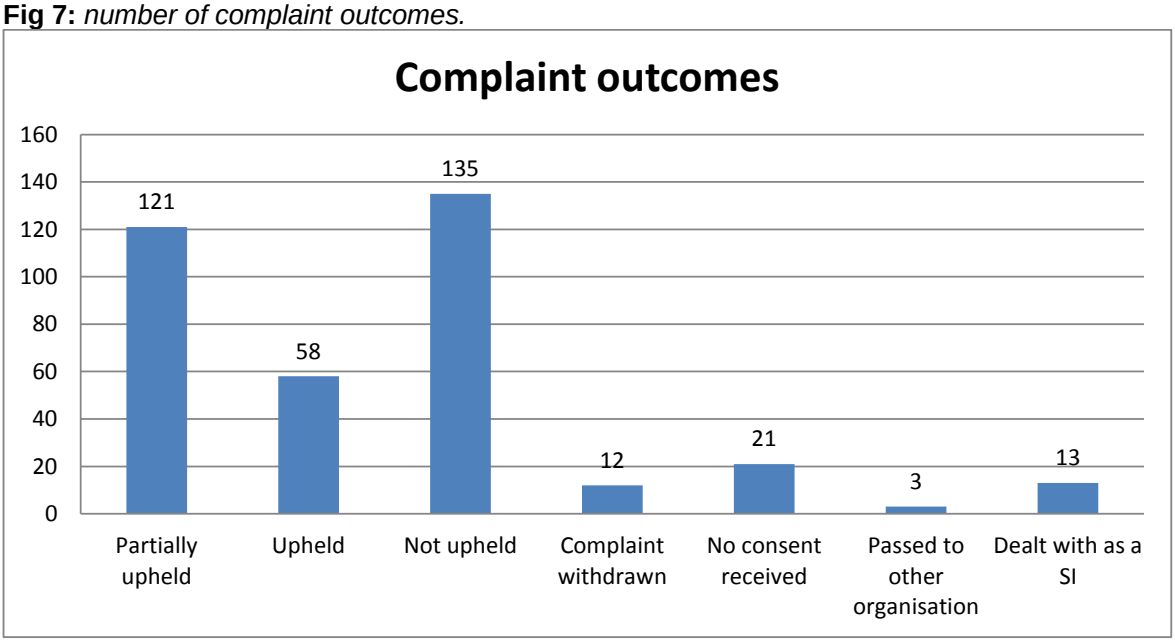


Fig 7

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.

As part of the continuing review of processes and procedures the Complaints team have engaged with Divisions to ensure learning is captured as part of all complaints. This is ongoing as part of the 2021/22 work plan.

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

Surgery, Anaesthetics and Cancer – 37
Medicine – 60
Emergency Department – 22
Women's and Children's – 31
Environment – 5
CSS – 7
Other – 3

Corporate – 14

16. Reopened/Reactivated complaints

16.1 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 32 (9%) of the 363 complaints received in 2020/21 were returned for further investigation/response, a very small increase against 27 (8% of all complaints received) in 2019/20.

16.2 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 previous periods 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.

16.3 Although the Trust seeks to resolve complaints, it is accepted that in some circumstances it is not possible to do so, despite our best attempts to do so.

16.4 During the twelve-month period from April 2020 to March 2021, 32 complaints were reopened in total - this figure includes complaints which may have been received in 2019/20 and cases where the complaint has been reactivated more than once.

16.5 **Fig 8:** *number of reopened complaints*

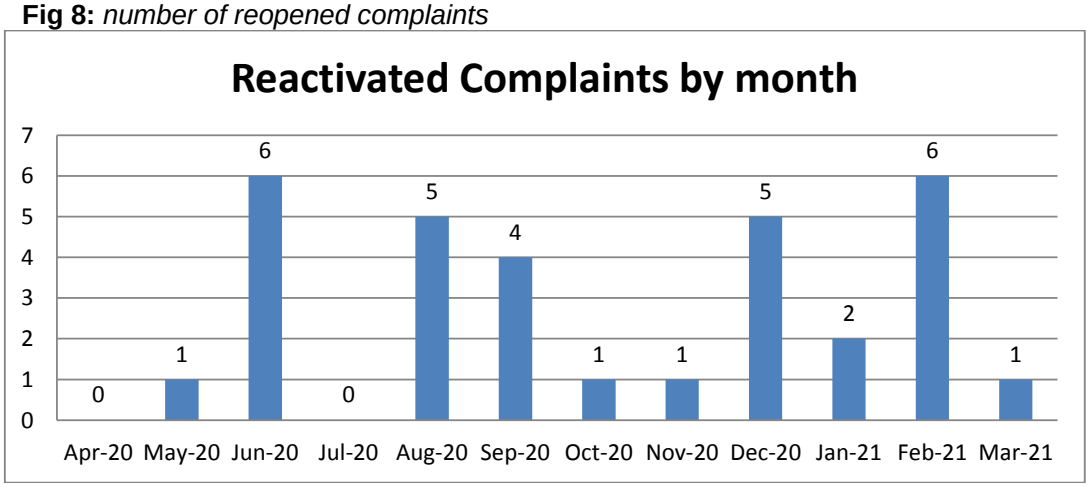


Fig 8

17. Local Resolution Meetings

17.1 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.

17.2 During 2020/21 the Trust dealt with 8 complaints by way of local resolution meetings (LRM). This was a significant reduction in the number of meetings, which was due to a variety of

factors, most predominantly the visiting restrictions in place within the Trust, which meant that face to face resolution meetings could not be facilitated. Although the Trust implemented the use of video meetings as these became available and made offers of LRM's this did not result in an increase of requests for meetings by complainants.

17.3 Of the 8 LRM's which took place, 5 were resolved by the end of the meeting. 2 were not considered resolved.

18. Complaints Performance

18.1 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.

18.2 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, after a significant dip to 58% and 37% in April and May 2020, although by the end of the period 2020/21 it averaged 85% for the 12-month period.

Fig 10: *Complaint response compliance April 2019 through to March 2021*

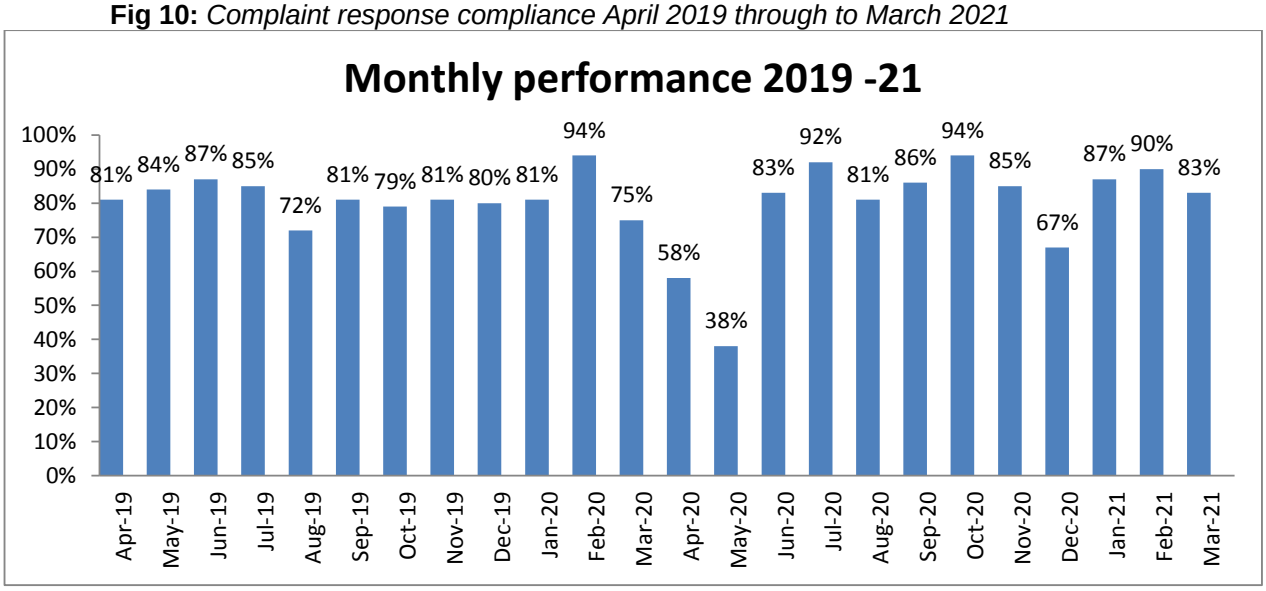


Fig 10

18.3 Divisional complaints performance is monitored weekly and the current position regarding live complaints and monthly performance is circulated at the beginning of each week, highlighting key performance data for each Division, including open, received and overdue complaints, broken down by Division/Department. 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.

18.4 Corporate Complaint Investigators/Advisors, who are each assigned responsibility over specific divisions, continue to 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. Despite the volume of complaints, the Trust receives, the team have been able to manage complaint responses to ensure that backlogs of complaints do not build up.

18.5 The Complaints team triage all complaints and allocate a 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, with the agreement of the complainant. 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.

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

19.1 There were a total of 35 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.

19.2 24 complaints involved the MP. The complaints covered areas such as clinical treatment, delay and cancellation of operations, parking issues and lack of care provided to the patient.

19.3 8 of the complaints were copied to the Care Quality Commission (CQC) and in 2 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.

19.4 We received 2 complaints in which the media had been contacted. Neither had any media contact with the Trust as a result of the complainant contacting the press.

20. Complaints that are Serious Incidents/RCA

20.1 There were 13 complaints investigated as part of the Serious Incident (SI) 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.

21. Parliamentary and Health Service Ombudsman (PHSO)

21.1 During the period of 2020/21 no complaints were formally opened for investigation by the Parliamentary and Health Service Ombudsman (PHSO). This was due to the fact that PHSO paused all new complaints for a 6-month period as of April 2020. Subsequently they have as of August 2021 a national backlog of over 2500 complaints and they are working through these.

21.2 It is anticipated that the Trust will see more PHSO investigations or request for information in 2021/22, as the backlog reduces.

22. Improvements to Managing Complaints and Organisational Learning

22.1 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.

22.2 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.

22.3 Due to the Pandemic complaint learning events could not be held, however the complaints manager attends the monthly Governance meetings for Surgery and Medicine, where learning has been shared.

22.4 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.

22.5 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.

22.6 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 continues to be scope for improvement .

All Complaints relating to end-of-life care and treatment are 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.

St Albans Hospital – patient raised concern regarding that they perceived as a lack of a COVID secure environment	Identified issues: Congested area in Phlebotomy waiting area meaning that patients were gathering. Excessive number of patients arrived prior to opening time of Blood Test Clinic The current process was not effective on a first come first served basis. Mask wearing and behaviour of patients is not always consistent, masks/visors are offered to patients attending without face coverings. Access to hospital main entrance was uncontrolled, with numerous patients able to walk into the waiting area, which is a thoroughfare to all other areas of the hospital. Action taken: Review current COVID Risk Assessment undertaken to ensure risks were effectively identified and managed. Review of opening hours for clinic to see if patients could be accommodated throughout the day rather than for specific periods. Implementation of appointment-based phlebotomy system across the Trust, with agreed first

	implementation at SACH. Security presence at known peak times to support social distancing, queue management and mask wearing.
Concerns from patient about the overlooked diagnosis of Gestational Diabetes (GTT).	Identified issues: Staff incorrectly analysed the GTT result as normal Unable to confirm that all staff are aware of the email address for the Diabetes team Staff failing to refer directly to the printed ICE lab results instead of handwritten assessments Ongoing poor glucose control Action taken: Updated GDM reference range posters displayed in ANC Posters display email address of the Diabetes team Reminder sent to all staff regarding best practice of referring directly to ICE results. Letter sent to GP on recommendations for follow up care. Patient made aware of follow up plan
Concerns from patient about the treatment and service from staff she experienced when she attended for a scan	Issues identified: Staff had a discussion in presence of patient where they discussed findings, without recognising possible impact on her. Additionally, failed to refer to the patient by her name at any time, making the experience impersonal. Method of examination caused patient distress. No chaperone offered or considered Information sent out prior to appointment did not prepare the patient for what to expect, causing her anxiety. Action taken: Clerical staff meeting - discussion about appropriate conversations and about referring to patients by their name Observation of Sonographers practice and interactions with lead Sonographers to work with Sonographer for one session and repeat following feedback Reminder that reports should state chaperone offered/declined and consent obtained Reassessment of information sent to patients about TV scans and preparing leaflet and ensure that this is sent out.
Concerns from patient's daughter regarding her father's attendance to A&E. Patient who has vascular dementia was discharged and found wandering around hospital. Staff were unaware patient had vascular dementia as appeared cognitive within A&E.	Issues identified: Clear instruction from patient's family was not recorded in notes that although the patient appeared cognitive, he had vascular dementia and should not be discharged without a family member present. The information provided to nursing staff was not recorded in medical notes. Patient advised doctor that his daughter was waiting in the car park and the doctor discharged the patient. No blue clasp on patient's wristband. Action taken: Nursing and medical team have been reminded regarding communication and recording vital information provided by relatives or carers. All staff now reminded to liaise with the safeguarding team to support ED in further dementia training and further training delivered.

	Recognising the impact of COVID-19 on vulnerable patients and how distressing it can be for them to be on their own, the decision has been taken to allow relatives to accompany patients in exceptional circumstances. It is hoped that this is not only reassuring and comforting for the patient and relative but will also enable the doctor to be assured they have gained an accurate and full history.
Concerns from patient about her care and treatment from the Trust relating to delay in receiving medication for cancer treatment.	Identified issues: Drug history and allergy check was not completed in a timely way Inaccurate stock level recorded on EMIS Nursing staff unaware of stock issues with medications resulting in unavailability on the day unit Unavailability of soluble prednisolone on the day unit Action taken: Drug history and allergy check to be completed by a pharmacist has been brought forward in the chemotherapy prescription validation process Process review to improve accuracy of stock level records completed. Review undertaken of to follow process to ensure effective communication within pharmacy and to clinical areas with regards to ordering and delivery status of medication that is out of stock Addition of soluble prednisolone to the medication stock list SOP amended and stock checks on daily basis completed.

23. Complaints Key Achievements of 2019 – 2020

23.1 Development of an informal guide to 'Writing Complaint Responses'

In order to improve the quality and content of our written complaint responses, an informal guide to writing has been created and is now available across the Trust in order to enhance complaint responses. This has however been superseded in part by the new Complaints Standards, due to be implemented in 2022 and will need to be reviewed and adapted.

23.2 Response time improvements

40 working days for complex complaints. The Complaints team continued to work with the divisions to consolidate the response time improvements and to achieve the Trusts 85% target, reaching 85% for the 12-month period. Out of 299 complex cases the average time taken to respond to the complainant was 33 days and of these cases 81% were responded to within the 40-day timeframe, a significant improvement on the 54-day average previously.

23.3 Enhanced capture of learning

The complaints team has undertaken discussions with all divisions regarding the capture of learning from complaints and both Medicine and Surgery Divisions have

implemented as standing agenda items, the sharing of learning from complaints. Further work is being undertaken in respect of this and will be ongoing throughout 2021/2

23.4 Review of Current Complaints Policy

The current complaints policy has been reviewed and updated.

23.5 Reduction in overdue complaints

The Trust has reduced overdue complaints, primarily those that are overdue by 3 months or more, to an average of one or two overdue at any one time.

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

24.1 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 problems. PALS are an integral part of the service we provide to our patients, relatives and carers, acting as a vital channel for feedback.

24.2 April 2020 saw the pandemic take hold at the Trust, which had an impact on the PALS team. Staff establishment in PALS is usually 1 manager and 4 advisors. Due to the pandemic, 2 advisers were isolated, 1 advisor was transferred to our Patient Affairs department to help with the large volume of deaths being recorded. This depleted our department, and we had an advisor who was new in post in March 2020 and a volunteer was helping in the department. Whereas some of the formal complaints team were working from home, the PALS team were in the Trust throughout the pandemic and maintained an excellent service.

24.3 Prior to the pandemic the complaints received by the Trust were triaged daily by the Senior Nurse for Resolution and a complaint advisor. This ensured any complaints or concerns were reviewed by the relevant teams or divisions for resolution which was very successful. This was discontinued during the pandemic due and all concerns were reviewed 'online'.

24.4 Due to the Trust not allowing visitors, the Senior Nurse for Resolution was tasked with setting up and organising the Family Liaison Line. This involved clinical staff contacting the covid positive patient's relatives to discuss the ongoing care and treatment of patients. The calls were made two times per day with a possible third as required. The Senior Nurse for Resolution found this an extremely challenging time, however also very valuable for the Trust patients and their families. A strong cohesive team was built.

24.5 Due to the success and building of the strong foundation of the Family Liaison Line, the Trust took the decision to maintain the line for more clinical areas. Staff throughout the hospital were redeployed to the line, to maintain their safety (due to shielding) during the pandemic and to ensure the staff had an active role in the Trust for communication with patients and families.

24.6 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

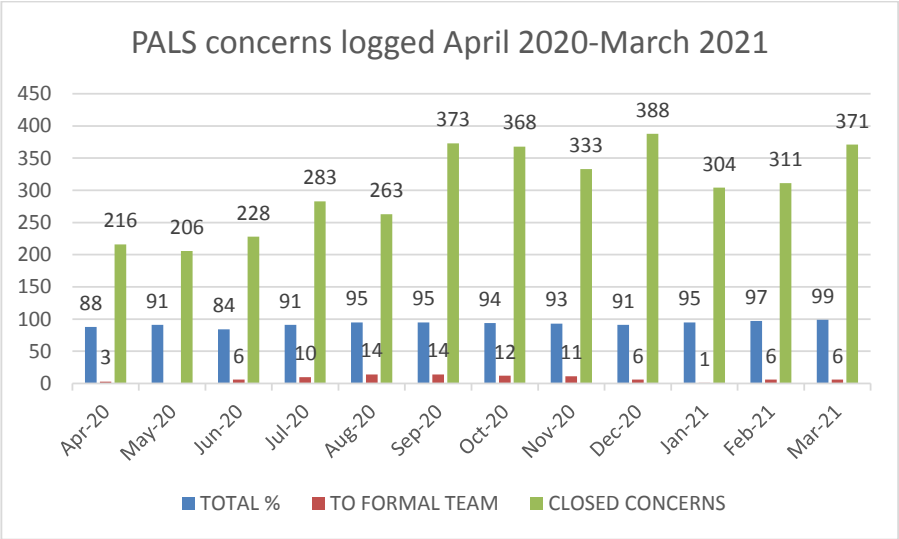
to complainants following a local resolution meeting (LRM), outlining any action's, however this has been reviewed and is now a standard procedure.

24.7 Following development of the weekly tracker, this has been reviewed and updated and continues to be imbedded 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.

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

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

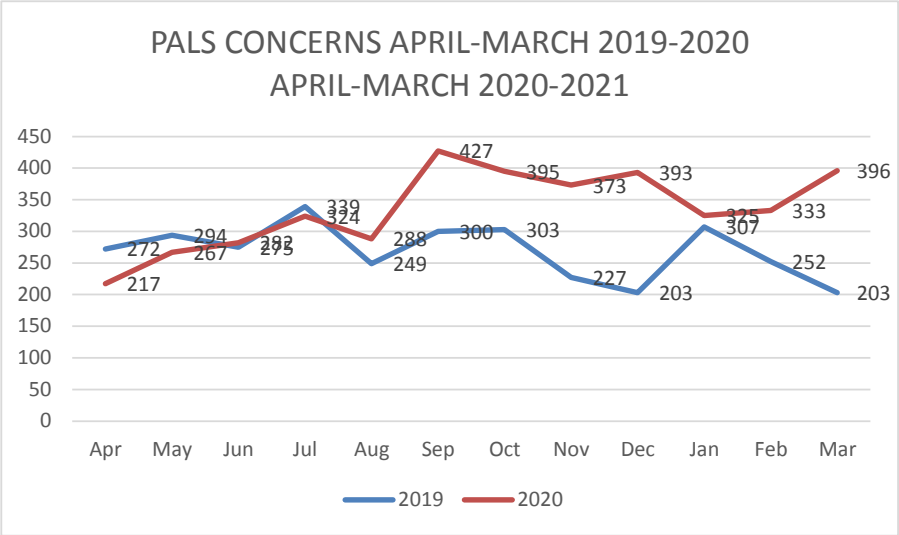
24.10 The graph below demonstrates the % of concerns closed within the 5 working day time frame.



25. PALS activity Trust wide

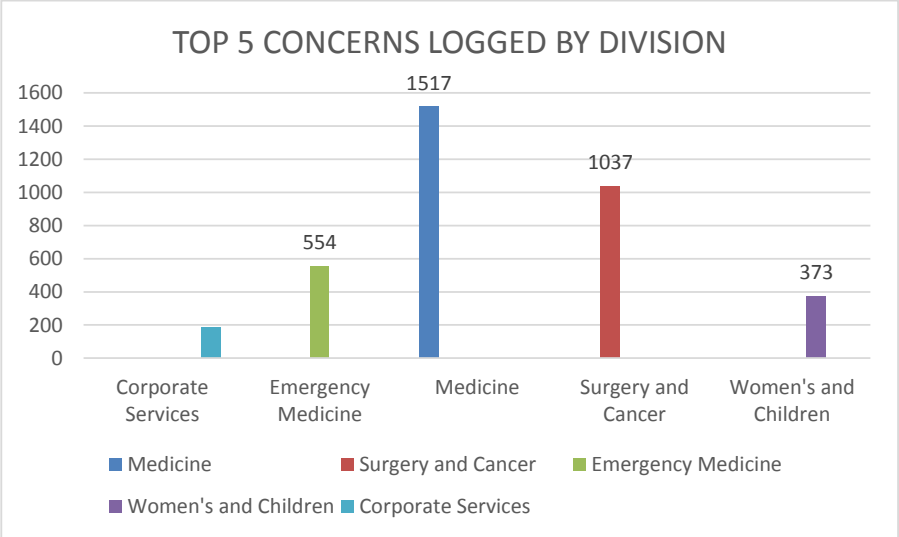
25.1 For the period year ending 31 March 2021 the number of contacts/concerns received was 3913; an increase of 681 when compared with 2019/20.

25.2 The following graphs detail the PALS activity for 2020/2021 compared to 2019/2020 followed by a breakdown of the concerns by division and subject and the conversion of PALS concerns to formal complaints.



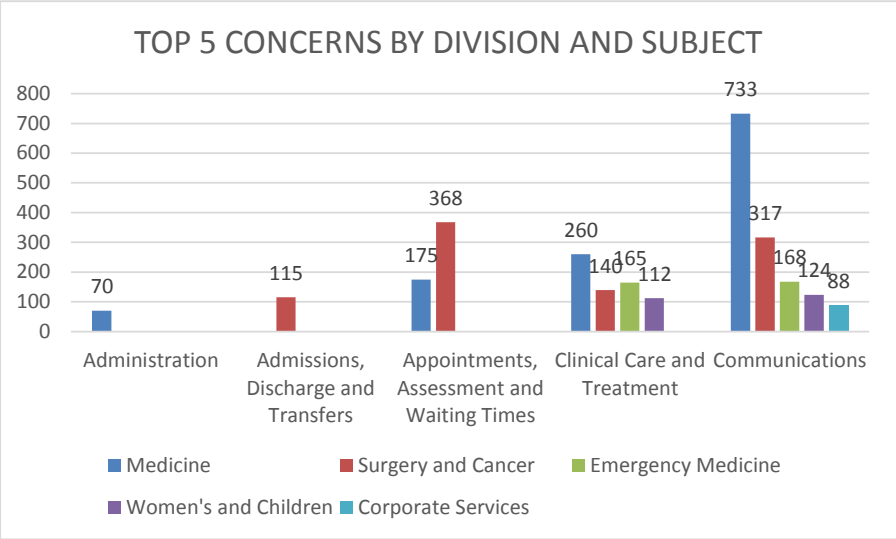
25.3 PALS top 5 concerns recorded by Division

The below graph demonstrates the concerns recorded by each Division, which shows the Medicine division received the most concerns followed by Surgery which is a switch compared to 2019/2020 where the main division for concerns was Surgery.



25.4 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.



26. Themes by Division update

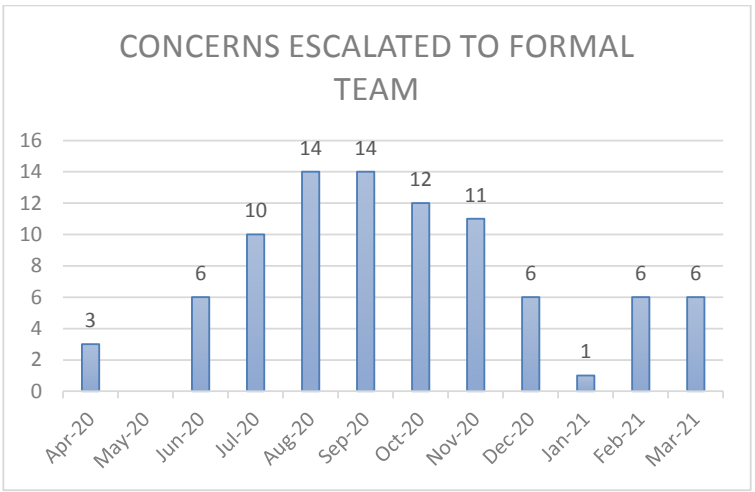
Medicine complaints were related to communication, which is poor communication or lack of communication. Due to the pandemic this was more evident despite the instigation of the Family Liaison Line as only covid positive patient's families were contacted and clinical staff were busy carrying out clinical duties on other ward areas.

Surgery the main concerns were regarding delay or lack of appointments. Appointment systems were reviewed and 'online' appointments were arranged.

Emergency medicine concerns were related to clinical care and treatment, followed by poor communication.

Women's and Children's concerns were regarding communication followed by poor clinical care and treatment**.**

27. Pals concerns to formal complaints department



27.1 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.

28. Learning from PALS concerns

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

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

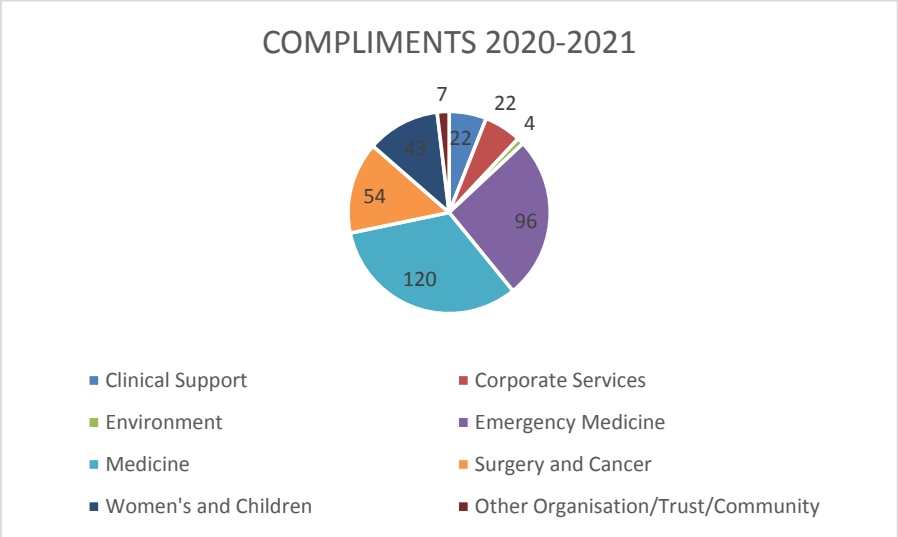
28.3 The PALS Standard Operating Procedure is a Key Performance Indicator (KPI) and reported on monthly as part of the Patient Experience & Carer Strategy dashboard.

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

29. Compliments received

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

29.2 There were 368 compliments logged for 2020-2021.



29.3 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.

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

30. Interpreting & Translation

30.1 The PALS Team are responsible for arranging all requests for interpreters, using the Hertfordshire Interpreting & Translation Service (HITS). The contract with HITS was reviewed and awarded for the year 2020-2021 with an option to extend for 1 further year.

30.2 A total of 4113 requests for interpreters was received in 2020-2021. The volume of requests has increased year on year since the data was recorded in 2016.

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

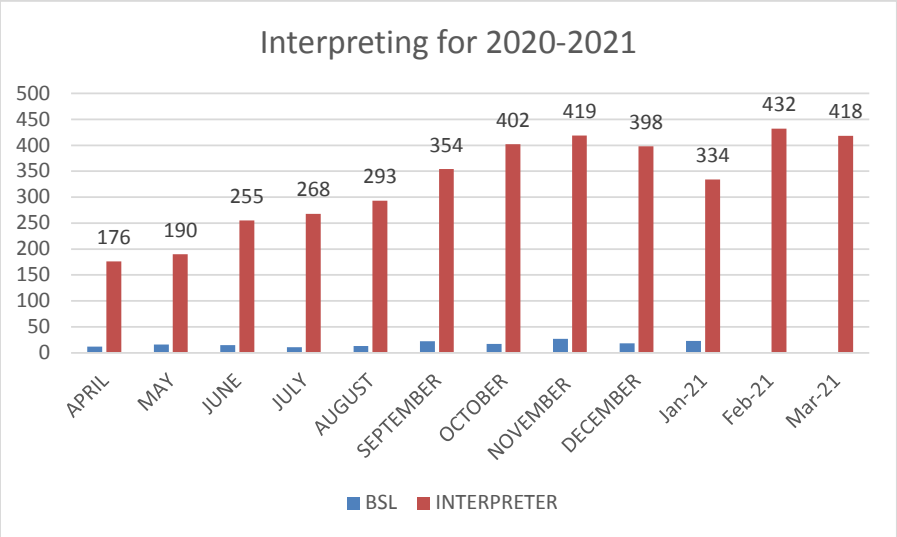
30.4 PALS are looking to improve the process for requesting interpreters as this is a high priority for the Trust in attempting to reduce spending in this area. The team are working with Herts Interpreting service. (HITs).

30.5 The PALS team met with HITs to review the process for requesting interpreters. They have developed an online system which is compatible with the Trust and free to use. This involves staff in ward areas completing a form 'online' and this automatically generates the request to HITs with a copy to PALS. This has been a successful rollout to the Maternity department and has decreased the volume of phone calls to and from the PALS department when forms are not completed correctly. This has made a reduction in paperwork and stopped copies of referrals already made by email (save on new envelopes being used). The online portal is being rolled out to other divisions.

30.6 Staff can review their requests, names of interpreters and cancel the request, therefore making a cost saving for the Trust.

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

30.8 The below graph demonstrates the monthly number of requests for the interpreting service over the year 2020-2021. The grand total of requests for the Trust for the year is **4113,** which is a reduction on the previous year of 350.



31. PALS Key Achievements for 2020-2021

- Review and improvement of the weekly Tracker for Divisions
- Maintaining above 95% resolution of concerns within the Standard Operating Procedure (SOP) of 5 working days
- 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 and building on the foundation of the Family Liaison line to roll out to all divisions during the pandemic.
- Development of the online portal for interpreting requests throughout the Trust
- Update of the interpreting policy

Executive Director: Tracey Carter – Chief Nurse & DIPC
November 21

Trust Board
2 December 2021

Title of the paper	Annual Legal Services Department Report 2020/21
Agenda Item	22
Presenter	Tracey Carter, Chief Nurse & DIPC
Author(s)	Shafia Ghaus, Head of Legal & Clinical Effectiveness
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	The Litigation and claims annual report was presented to the Quality Committee for discussion and assurance, the main items of discussion were how we learn from Prevention of Future Deaths reports (PFD'S) raised at other organisations, the process is evolving across the ICS to ensure system wide learning and this will be shared in the bi-annual report to the board and Quality Committee next April. The chair thanked the legal team for a thought-provoking report which raised some challenging questions. This report presents an overview and analysis of Claims, Inquests and Access to Health Records requests from 1st April 2020 to 31st March 2021; and where appropriate, uses comparative data from previous years. There were **55** Letters Before Action (LBA) received in 2020/21 in comparison to **77** in 2019/20, with Surgery Anaesthetics and Cancer (SAC) and Women and Children Services (WACS) Divisions receiving the most. In 2020/21 the Trust received **64** new clinical claims, an increase of **13** when compared with the previous year. SAC and WACS received the majority of these. **54** claims were closed (clinical & non-clinical); payments to Claimants were made in 29 cases (54%). The Trusts total contribution in 2019/20 to all NHS Resolution (NHSR) Indemnity schemes was **£23,360,746** an increase of **£5,980,357** from the previous year. The Early Notification Scheme (ENS) came into being on 1 April 2017 when it was a mandated requirement that all Trust's report using NHS Resolution (NHSR) referring criteria within 30 days. This was also in line with the criteria used by the Each Baby Counts programme of the Royal College of Obstetricians and Gynaecologists. During 2020/2021, there was only **1** ENS case which was reported by HSIB under this new process.

	There has been a slight decrease in the number of inquest files opened for 2020/21 – **54** compared with 68 the previous year. In 2020/21 the Trust did not receive any Prevention of Future Death (PFD) report during this reporting period. PFD's are reported to the Trust Board and Quality Committee and the response from the CEO shared.

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

Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	

Committee/Group	Date
QSG	16.11.21
Quality Committee	25.11.21

Action required	The Trust Board is asked to receive this report for information and assurance that the Trust is compliant with legal processes.

Agenda Item:

Trust Board – 2 December 2021

Title of paper: Annual Legal Services Department Report 2020/21

Presented by: Tracey Carter, Chief Nurse & DIPC

1. Introduction

Healthcare organisations should have in place methods for monitoring and reviewing patient mortality and outcomes to determine if the level of care provided is appropriate and benchmark themselves against other organisations. Inquests and claims form part of that process.

Claims set out the claimants' perspective of the care they should have received; this is often backed up by independent expert opinion. The receipt of a claim triggers a detailed examination of the care given which may involve obtaining the Trusts own independent expert evidence. The outcome could be that the claim is upheld, identifying areas where learning must take place or confirm that the care was appropriate thus reinforcing sound clinical practice.

The coroner acts as an independent investigator who determines how the patient came about their death, in order for him to issue a death certificate. This is done by critically appraising the care given, inviting staff to provide feedback and holding and inquest hearings to ask further questions. The coronial process is centred around the relatives of the deceased and provides a further opportunity for families to ask questions whilst allowing the coroner to complete his coronial duties.

2. Purpose

This report presents an overview of claims, inquests, and access request activity from 1st April 2020 to 31st March 2021. The data presented aims to compare activity against the previous year and present changes the organisation have adopted to improve patient safety.

The principal aim is data that can be used to develop the learning to reduce both harm and litigation.

The Legal Services Department ("the Department") is responsible for the management of:

- Clinical negligence claims;
- Employers and public liability claims;
- HM Coroner's inquests;
- Court of Protection applications;

- Access to health records requests;
- Oversight of payment of lost property claims

The department also provides a wide range of advisory services, including healthcare advisory work and straightforward contractual matters.
External solicitors are instructed on behalf of the Trust to provide specialist advice as required on healthcare and contractual issues that require further support; always ensuring that legal costs are proportionate to the issue.

NHSR provides the Trust with an annual scorecard detailing all claims received by the Trust with an incident date in the 10-year period 01/04/2010 to 31/03/2021. Within the scorecard NHSR have recorded 433 clinical claims with a total value of £268,743,740 and 120 non-clinical claims, with a value of £1,166,127. Both scorecards include both open and settled claims. Some of the open claims will be defended and closed without a payment of damages; there will also be some claims where the current estimated value is significantly higher or lower than what eventuates, as such the scorecard is intended to be used as a tool for learning rather than as an indication of future cost to the Trust.

The Trust's insurers, NHSR, are responsible for paying settled claims. Each NHS Trust makes an annual contribution to the scheme which is calculated according to each Trust's claims history.

Graph 1 presents the total number of clinical claims reported by the Trust to NHSR from July 2018 to date, benchmarked against the average number reported by similar trusts.

Graph 1 Number of Clinical Claims Benchmarked against other Trust groups

From this data we can see that the Trust reports less claims each quarter than similar Trusts, following a similar pattern with its peaks and troughs for the reporting period 2020/21.

The Trust's annual contribution to NHSR comprises of a Clinical Negligence Scheme Trust (CNST), Liabilities to Third Parties Scheme (LTPS) premium and a Property Expenses Scheme (PES). The Trust's contribution is calculated as a weighted average against three elements:

- A risk-based contribution based on size and activity levels of the Trust.

- A contribution based on paid claims over the five years to 31 March of the previous year: and
- A contribution based on known outstanding claims as at 31 March of the previous year.

The contribution is then adjusted to allow for any risk management discounts that apply. In addition, the contribution is adjusted if the Trusts claims payments have been significantly higher than the contribution over the 5 years to 31 March of the previous year.

In 2020/21 the Trusts total contribution (to all schemes) was £23,360,746 compared to £17,380,389 the previous year which was a significant increase of 34.4% (£5,980,357) from 2019/20.

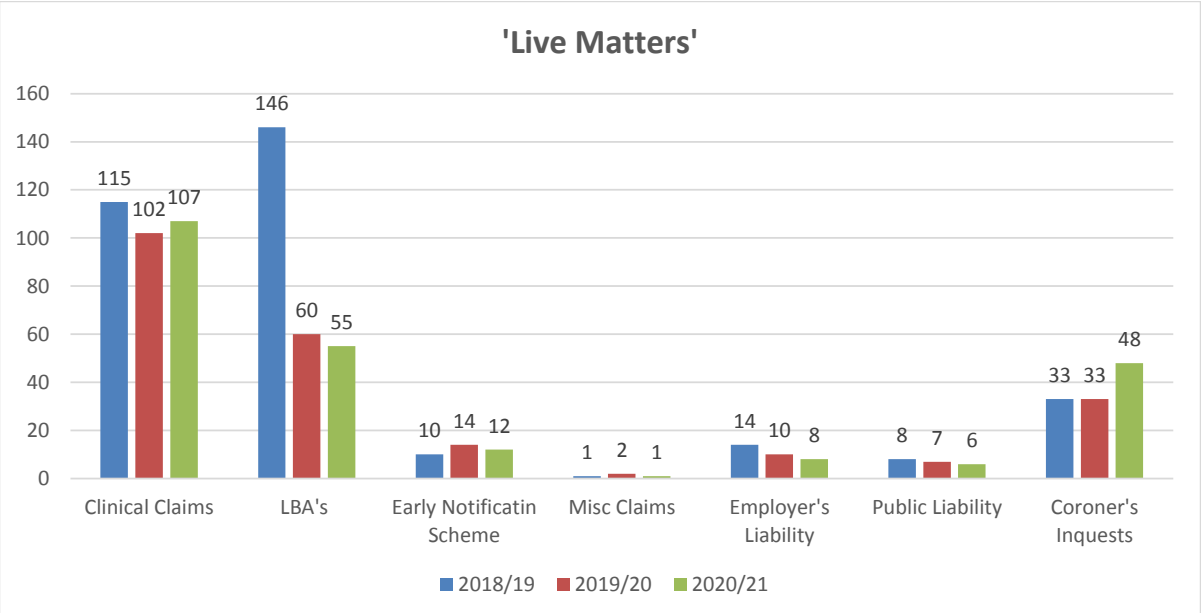
	2017/18	**2018/19**	**2019/20**	**2020/21**
CNST	£17,450,213	£16,869,146	£17,237,511	£23,186,072
LTPS	£161,562	£151,185	£125,427	£151,087
PES	£11,375	£31,190	£17,451	£23,587
Total	£17,623,150	17,051,521	£17,380,389	£23,360,746

The changes were due to updated Risk Weights -0.48% the % impact on the final 2020/21 contribution was due to the change in the risk weight parameters. The risk weight parameters estimate the level of risk associated with the exposure from each speciality.

Changes due to updated Maternity were 2.15%. This % impact on the final 2020/21 contribution due to the change in percentage of the total contributions attributed to maternity expenditure.

Graph 2 presents the number of “live” matters being dealt with at the end of Quarter 4 2020/21.

Graph 2 Number of Live Matters at year end



From the graph above, there is a slight increase in open claims from last year due to the coroner having to leave some inquests open during the peak of COVID-19 restrictions. This was due to difficulties relating to social distancing measures and availability of healthcare professional delivering frontline care to patients during the pandemic, who were required to attend the coroners court in person. This has resulted in a backlog of inquest relating to last year and an increase in the number of inquests which will continue to increase significantly, whilst the backlog is being processed.

The drop in open LBA's is due to a change in the way they are processed by the team; in essence, they are now closed as soon as the request for disclosure has been processed. A majority of LBA's do not go on to becoming claims and closing the 'access to record' aspect allows the team to identify the teams allocated caseload.

3. Changes in the Law/NHSR schemes

The passage of the Civil Liability Act 2018 reformed the way the personal injury discount rate (PIDR) is set. The PIDR governs the calculation of claims for future losses, such as medical care and lost earnings, and mainly affects claims where the injury sustained is permanent.

It was announced in July 2019 that the PIDR would be altered with effect from 5 August 2019 from minus 0.75% to minus 0.25%. Overall, the effect of this change is to reduce damages for future loss by a small amount, but compensation payments will still be much higher than they were before 20 March 2017, when the PIDR was plus 2.5%, a position that had remained unchanged since 2001.

In April 2020 NHSR launched a new scheme Clinical Negligence Scheme for Coronavirus (CNSC), to meet clinical negligence liabilities arising from NHS services provided in response to the coronavirus pandemic where no other indemnity or insurance arrangements are in place already to cover such liabilities.

The Trust has received four claims which are directly/indirectly related to COVID. Three of these claims are also being processed as inquests and an application for funding was made, leading to the early identifications of issues, and subsequently leading to an indication of early admissions.

4. Analysis of Claims

4.1 Clinical Negligence claims

Claims are categorised by the legal department as:

a) Letters before Action (LBA)

Notification is received by the Trust that a claim is under investigation with no formal allegations. In most cases this is a letter from solicitors where they are instructed by the claimant, requesting copies of their medical records and formal notification of investigation.

In most cases an LBA is investigated internally and not reported to the NHSR. Should internal investigation highlight a significant litigation risk, or a claim where damages are likely to exceed £500,000 the matter becomes reportable to the NHSR.

Table 1 represents the total number of LBA's received by each division. This demonstrates a decrease in the overall total number of letters before action in 2020/21, a reduction of 22 LBA, when compared with 2019/20. The highest increase was seen in WAC division.

Table 1: LBA's received by Division

Division	Letters Before Action	
	2019/20	**2020/21**
Clinical Support	0	0
Emergency Medicine	4	2
Medicine	12	9
Surgery, Anaesthesia & Cancer	29	22
Women & Children Services	26	17
Insufficient info to allocate to a division	5	5
Total	**77**	**55**

WACS and SAC have the highest numbers of LBA's which coincides with these Divisions also having the highest number of claims and which is aligned with the national trend.

b) Early Notification Scheme (ENS)

The Early Notification Scheme (ENS) came into being on 1 April 2017 when it was a mandated requirement that all Trust's report using the NHS Resolution (NHSR) referring criteria within 30 days. This was also aligned with the criteria used by the Each Baby Counts programme of the Royal College of Obstetricians and Gynaecologists.

Reflecting the impact of the COVID-19 pandemic on NHS Trusts, reporting to NHS Resolution was paused from 1 April 2020. Trusts continued to report all cases that met the criteria to the Healthcare Safety Investigation Branch (HSIB) for learning investigations to take place, who in turn reported potential eligible ENS cases to NHS Resolution for further consideration from a legal perspective.

NHSR are required to carry out a preliminary investigation of legal liability and where appropriate, with the Trusts agreement, make early admissions and will then take steps to quantify and settle the claim, thereby reduces the cost of litigation.

For cases within the scheme, NHSR also aims to provide support to healthcare staff involved in any reported case, offer advice and signpost to practical help in delivering duty of candour and mediation, where relationships between the organisation and the family have broken down.

During 2020/2021, there was only one ENS case which was reported by HSIB under this new process.

c) Claim

When a Letter of Claim is received, the Trust it is required to report this to NHSR within 24 hours. The Pre-Action Protocol requires that the Letter of Claim contains: the main allegations of negligence, details of the patient's injuries, present condition and prognosis and financial loss. The Trust must respond to a Letter of Claim within 4 months.

T**able 2** presents a comparison of claims received by division and specialty in 2019/20 and 2020/21. The Trust received **55** new clinical claims this reporting period, compared with 2019/20 when **51** clinical claims were received.

Table 2 Claims received by Division and Speciality

Division	**No. of Claims by speciality**			
	2019/20		20120/21	
Clinical Support	Radiology	(1)	Radiology	(2)
			Admissions	(1)
	Total =	**1**		
			Total =	**3**
Medicine	Care of Elderly	(2)	Care of Elderly	(2)
	Rheumatology	(1)	Rheumatology	(1)
			Cardiology	(1)
			Gastroenterology	(2)
			Respiratory	(1)
	Total =	**3**	**Total =**	**7**
Surgery, Anaesthesia & Cancer	General Surgery	(5)	General Surgery	(4)
	Trauma & Ortho	(10)	Trauma & Ortho	(7)
	ICU	(1)	Vascular	(1)
	Ophthalmology	(1)	Ophthalmology	(3)
	ENT	(2)	ENT	(2)
	Urology	(1)	Urology	(2)
			Oral Surgery	(1)
	Total =	**20**	**Total =**	**20**
Emergency Medicine	A&E	(6)	A&E	(6)
	AAU	(3)		
	Total =	**9**	**Total =**	**6**

Women & Children	Obstetrics Midwifery Gynaecology Paediatrics **Total =**	(7) (3) (5*) (3) **18**	Obstetrics Midwifery Gynaecology Paediatrics **Total =**	(7) (4) (7) (1) **19**
Total	**51**		**55**	

It is not possible to benchmark the Trusts claims profile against other similar trusts as this information is not publicly available. However, the NHSR's annual report[1] provides an overview of the numbers and types of claims they receive from all Trusts.

The data identifies that the specialities receiving the most claims nationally are the same as WHHT i.e., the top two specialities for claims received by NHSR are Emergency Medicine; Orthopaedics by volume; and Obstetrics remain the largest proportion in terms of estimated value, accounting for 59% (previously averaging at 50% hence an increase of 9% in 2020/21). The 59% accounts for 11% of the total number of new obstetrics claims.

This is due to the recognition of an additional 192 (254 in total) Early Notification claims, this is due to accelerated investigations, to establish liability and early settlement to reduce costs. The impact of the Early Notification Scheme and our accelerated activity in liability investigations on these claims has a direct impact on

[1] https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-2021-WEB-1.pdf

the value of clinical negligence claims reported. **EN claims now make up 2% of claims received by volume, and 27% by value, compared to less than 1% and 10% respectively for 2019/20**. Not all of these claims will go on to have damages payments made against them but will have an associate 'cost reserve' set aside.

Despite Orthopaedics receiving the most claims, according to the GIRFT data pack, which looks at 5 years of data, the Trust is not an outlier and sits in the middle of the table, in 73rd place out of 137 Trusts.

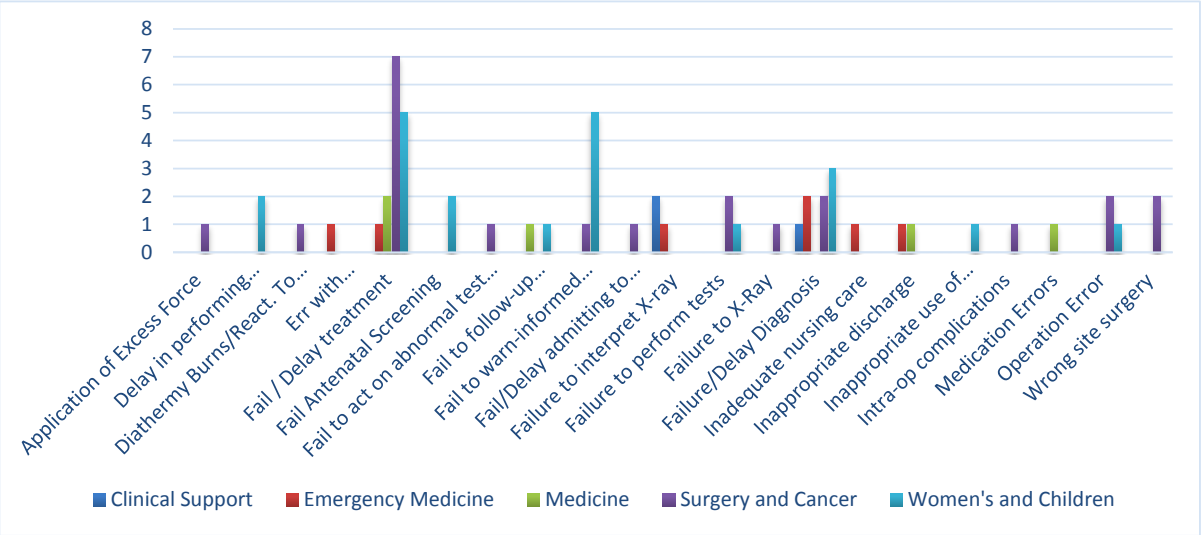
*NHSR continues to see an increase in cases relating to gynaecology, of which a large percentage are associated with vaginal mesh[2] related incidents being reported. The Trust did not receive any new claims in 2020/21 and received two claims in 2019/20, and one in 2018/19.

Summary of Clinical Negligence Claims 2020/21

4.2 Themes

Graph 3 presents the main allegation themes for claims received in 2020/21.

Graph 3 Allegation Type against NHSR Pre-defined Codes.



It is important to note that there can be more than one issue identified in a case and at present. Failure and delay in treatment accounts for the highest reported claims. Failure to warn/consent as the second highest.

No apparent themes were apparent in the failure and delay in treatment claims relating to surgery and cancer and WACS.

Allegations relating to consent have been rising nationally since 2015, following the Supreme Court case of Montgomery. In two of the five WACS consent cases the allegation is that there was a failure to discuss or concede to the mother's request for a caesarean section, which was the main allegation in Montgomery. In another two of the five WACS claims they

are mesh related cases; all these cases (nationally and internally) are based on lack of informed consent.

When investigating consent claims, the clinicians generally advise that they did warn the patients of the particular risk, or they did discuss alternative options with the claimant, but this is not always documented, making these claims difficult to defend. This is fed back to the relevant divisions during and at the end of the investigation. Cases identified with the GIRFT pack will also be reviewed and discussed at governance meetings by the respective divisions.

In order to provide clinicians with training on consent, Kennedys have been asked to assist and a webinar is scheduled to take place in November 2021. The invitations have been circulated to clinicians via the medical director and Kennedys have advised that currently WHHT has had the highest sign-up for attendance to this webinar.

4.4 Serious Incidents and Complaints leading to claims

Of the 42 clinical claims closed in 2020/21, 57% had previously had some form of internal investigation prior to receipt of the claim - **eight** (19%) had been investigated as a serious incident (SI); **three** (7%) as a divisional RCA and **16** (38%) as a complaint. These figures include three cases which were investigated as complaints and also as SI/Divisional investigation.

Some claims are received where the claimant's solicitor has not undertaken an investigation but chooses instead to 'serve' the Trusts RCA report or letter of response to a complaint and ask for an admission of liability based on the outcome of the Trusts own investigation. Where it is likely liability will be established, NHSR are informed and as appropriate, early admissions made. This approach can present a significant saving in respect of legal costs.

4.5 Learning from claims

An important part of the claims process is the action taken in relation to learning. This helps to mitigate risk and reduce future harm to patients. Historically, recommendations of actions were provided independently from panel solicitors or NHSR on cases which presented a high risk. This no longer happens, and Trusts are now expected to monitor their own recommendations and evidence that the actions identified have been completed.

On receipt of a claim the legal team check whether the incident has previously been investigated by the division involved. As shown above, in many cases the incident has previously been investigated and action/learning has been taken around the time of the incident. The claims process provides a further opportunity to consider whether additional action needs to be taken when the incident is reviewed during the claims process.

Of the 18 claims that had not been investigated at, or shortly after the incident, we successfully defended eight and a further three were settled on a risk basis, without any admissions being made. In the claims where we are, defending the allegations, it is often difficult to identify any learning as although the claimant/patient has had an experience or outcome that they are not satisfied with our clinicians, supported by independent experts, are of the opinion that the care provided was satisfactory.

The remaining seven claims which were identified as not having been investigated, did not identify any themes.

All these claims relate to allegation that did not become apparent until after the 'incident date'.

For each claim, the legal team ensure that the relevant speciality is actively involved during the claims process. All documents, including the expert reports and letter of response are sent and approved by the Divisional/Clinical director. Any learning taken from the claims is shared by the legal team with the divisional director and should be shared locally at the divisional governance meetings.

4.6 Clinical Negligence Claims of Significance

A clinical claim which related to the alleged negligent delay in the diagnosis and treatment of cauda equina syndrome ('CES') in 2012, leading to progression to complete CES with urinary retention; This claim had multiple defendants which included the Trust, East of England Ambulance Service and named General Practitioner (who was represented by the MPS).

The claim was heard in March 2019 and successfully defended by the Trust but appealed on a number of grounds. The appeal was heard in November 2020 and the judge upheld the judgement made at the trial in March 2019 and dismissed the appeal. No damages were awarded to the Claimant in this case.

During the period of April 2020 and March 2021 there were no claims of real significance. No claims have settled at 'high' value of over £500,000.

4.7 Employer and Public Liability Claims

NHSR's LTPS is a contributory scheme which provides financial assistance to Trust's in meeting damages and solicitor's costs in respect of employer's liability (EL) and public liability (PL) claims.
Unlike CNST the Trust is responsible for meeting the first £10,000 for employer's liability claims and £3,000 for public liability claims (including the legal costs of defending successful claims).

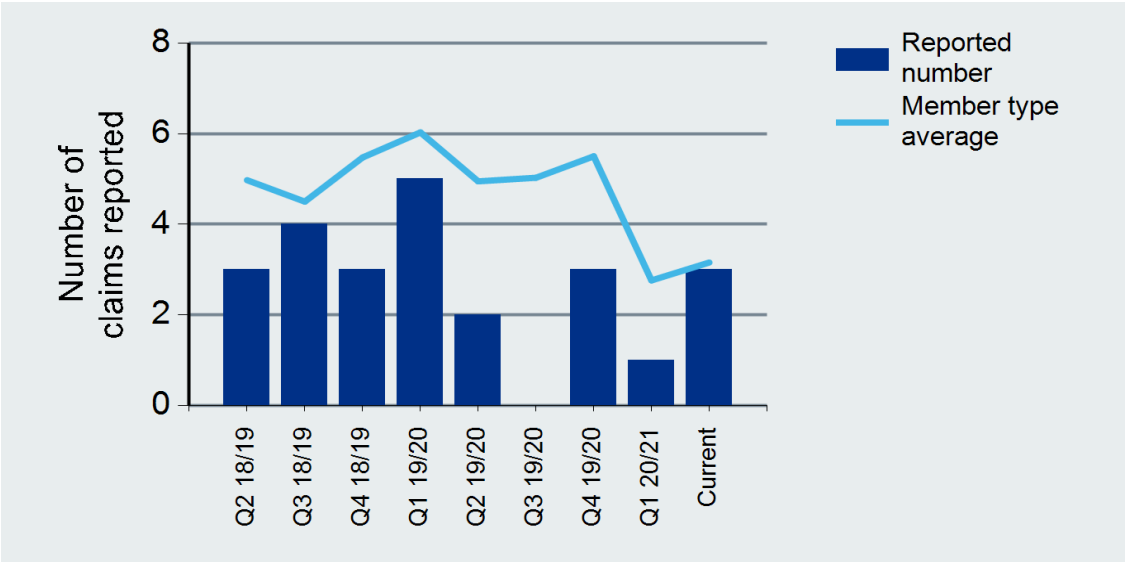
Claims are usually received via the NHSR portal for investigation and a response is required within 30 days.

The advantage of using the portal is a significant saving in legal costs for claims that the Trust cannot defend. If claims are not responded to within the prescribed timescale, they exit the 'portal', and the costs are dealt with at the conclusion of the claim which will result in the claim incurring further costs.

At the end of Quarter 4, 2020/21 the Trust had **eight** open Employer Liability and **six** Public Liability open claims.

Graph 4 represents the volume of EL/PL claims reported to NHSR by quarter, benchmarked against other similar Trusts. Throughout 2020/21 the Trust had reported fewer cases compared to other Trusts.

Graph 4 EP/ PL Claims Reported Claims 2018 to date.



In 2020/21 the Trust received a total of 14 EL/PL claims which was **four** (33%) more than the same as the previous year. NHSR has reported a decrease nationally for this period.

The following provides a summary of all Employers Liability and Public Liability Claims closed in 2019/20

- Public Liability - a total of **four** cases have been closed. Liability was accepted in all four cases: with damages £35,579 and legal costs £56,503 (totalling £98,082). **Three** of the cases related to the hospital's infrastructure falling on the claimants.

- Employers Liability - a total of **six** cases have been closed. In **three** cases, liability was accepted. A total of £13,190 has been paid in damages and an additional £12,695 in legal costs paid. No themes or trends have been identified from the staff claims.

Public liability claims are reported as incidents on Datix and monitored for action by the legal team; this includes liaising with estates to ensure the environment is fit for purpose.

Staff claims are also reported directly onto Datix. Claims are investigated in conjunction with the relevant departmental manager and the Trusts health and safety team, with estates involvement where appropriate.

5. Inquests

5.1 Overview of Inquests opened/closed in 2020/21

The Coroner investigates all deaths reported as violent and unnatural or the cause of death is unknown or the person died in prison, police custody or another type of state detention.

This reporting year, **54** new inquest files were opened, a decrease of **14** on the previous year.

Of those cases closed (48) in 2020/21, clinicians from the Trust gave live evidence at **19** (40%) hearings, compared to 24% the previous year.

A member of the Trusts legal team attends all hearings where Trust staff are called to give live evidence, to support the individual and to feedback the outcome and any learning. This is given directly to the relevant division, the Chief Nurse and Medical Director. Where appropriate, they will speak with the family and refer them to PALS or the complaints department, if they feel all of their concerns have not been resolved during the inquest process.

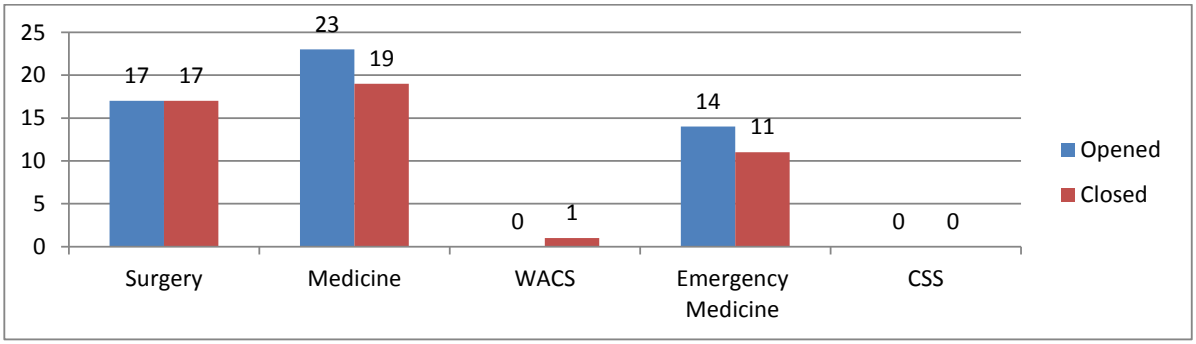
Should a claim be made, or immediately before the inquest hearing, the legal team will consider whether external legal representation would be beneficial. If, following an internal investigation, or having obtained expert opinion as part of the preparation for the inquest, it is apparent that there may be admissions of liability required, this will be done with NHSR agreement before the hearing. Although it is not the role of the Coroner to determine civil or criminal liability, if admissions have been made, it demonstrates that the Trust is discharging its duty to be being open and honest with the deceased's family. In most cases, this makes an inquest hearing a less stressful experience for the witnesses and the family.

In 2020/21 the Trust instructed external solicitors on **two** occasion.

At the end of Q4 2020/21 the Trust had **48** open inquests, this will include inquest that have been left open due to the COVID-19 restrictions.

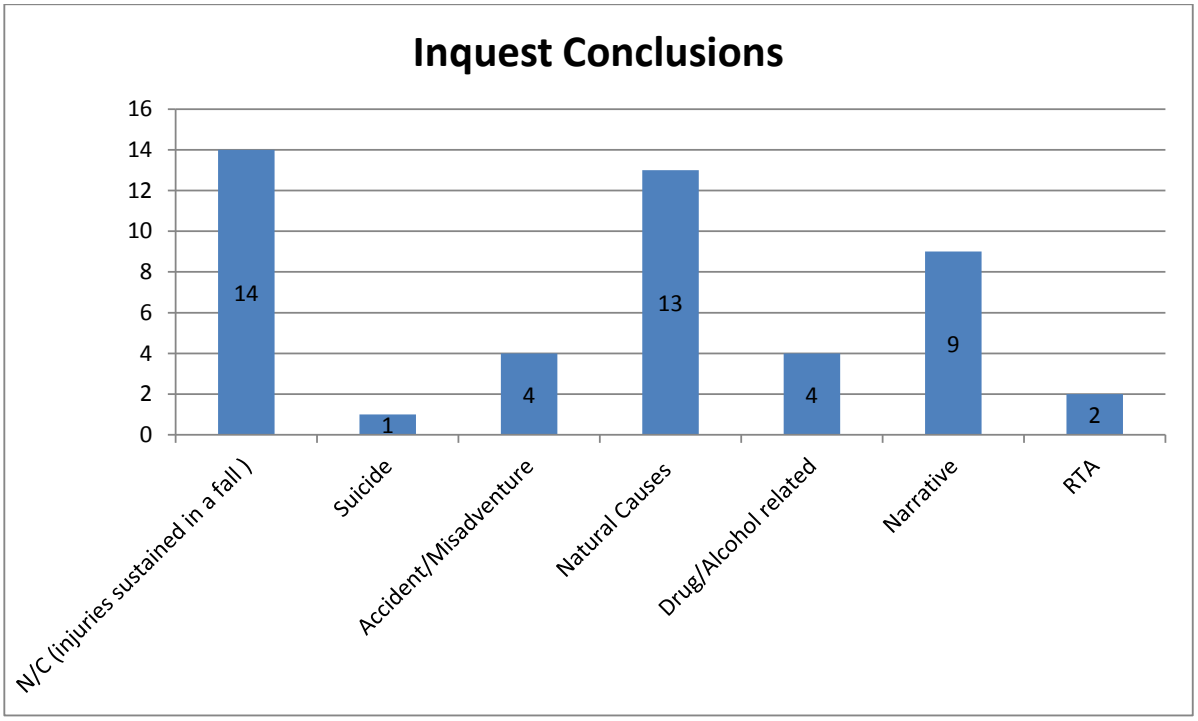
Graph 5 presents the number of inquest files opened and closed by division for 2020/21.

Graph 5 the number of inquests opened and closed by Division



Graph 6 shows the Coroners conclusion for all inquests closed in 2020/21. The Trust is requested to provide statements to support the Coroners inquiry. For the inquest where witnesses are not called to give oral evidence, we are not always informed of the outcome and the team will obtain the information from the coroner's website.

Graph 6 Inquest outcomes 2020/21



5.2 Inquests linked to Serious Incidents and Complaints

The number of SI investigations subject to an inquest from the total opened and closed in 2020/21 was **eight**. A further **four** were investigated as a complaint prior to inquest.

5.3 Prevention of Future Deaths reports (PFD'S)

At the conclusion of each inquest, the Coroner is required to report circumstances where they believe further deaths could occur if action is not taken to prevent them. If a regulation 28 report/Prevention of Deaths, (PFD) is received by the Trust, they are required to give the coroner a written response within 56 days, setting out the action taken or an explanation provided as to why no action is required. Copies of PFD's are usually sent to the Care Quality Commission (CQC) and are published on the judiciary website to raise awareness of lessons learnt.

In 2020/21 the Trust did not receive any Prevention of Future Death (PFD) report during this reporting period. PFD's are reported to the Trust Board and Quality Committee and the response from the CEO shared.

6. Access to Health Records

Most requests the Trust receives for access to records are dealt with by the Access to Health Records team. The A&E department respond to requests that are solely for A&E records, unless they are patient requests, which they forward to the access team. Radiology manages any request that relates solely to imaging.

Requests are made by patients; patient's representatives; solicitors investigating PI claims (not against the Trust); organisations investigating decisions in relation to NHS Continuing Care.

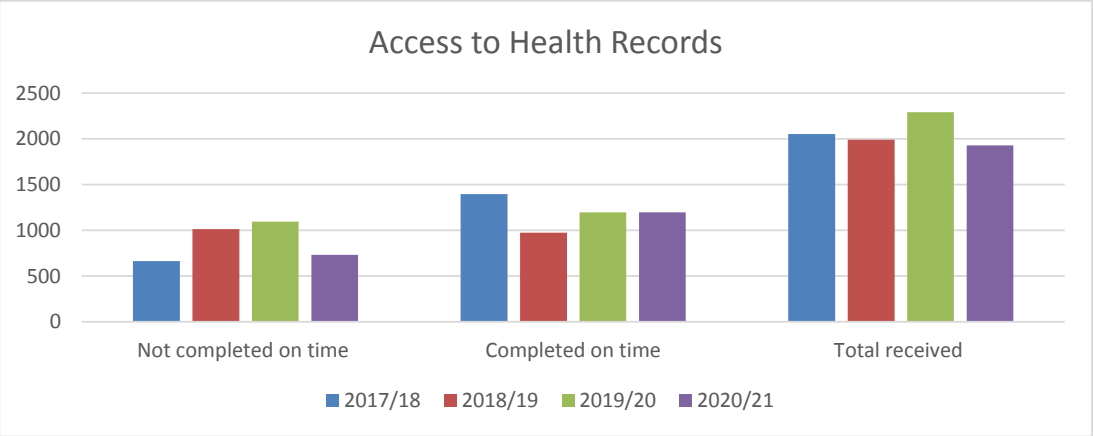
Prior to 2018, the team had 40 days to respond to requests and send out the records, however since the introduction of GDPR in 2018, the timescale to send out the records has reduced to 30 days. The reduction in timescale has led to increased pressure on the access to records team to send records within the revised timeframe. No additional resources have been made available to meet the reduced timescales. Whilst the team aims to be compliant with any relevant legislation, it is often not possible to meet this deadline due to the volume of requests received and due to a range of operational issues. (For example, the patient is an inpatient or has an outpatient appointment pending and the records are not easily accessible). The implementation of EPR will also impact on the time frames on the request for the provisions of records.

During the period of 1/4/19-31/3/20 there were a total of 2,148 requests for medical records received; 425 were requests received from patients by comparison, during the period 1/4/2020-31/3/2021, 1970 requests were received and 413 of these were requests received from patients. The number of requests received have reduced by around 8% and this is likely due to COVID. The number of requests received from patients has reduced by around 3% which is nominal and demonstrates that pressure remains on the team to send the records within the deadline.

In 2020/21 the team supplied requested records for 61% of the time, representing a slight improvement on 2020/21 when 52% of requests were supplied within the stipulated timeframe.

Graph 7 presents the total number of requests received from 2017 to 2021.

Graph 7 Overview of Received Requests against Response time



7. Plans for 2021/22

- Continuation of work with the medical and surgical specialities in respect of the litigation aspects of their GIRFT reports, to triangulate claims with learning from complaints, SI's, and inquests to ensure that where an internal investigation was not undertaken at the time of the incident no opportunity for learning is missed.

- Continue to raise the profile of 'good documentation' Trust wide to emphasise how important record keeping is to defend future claims.

- Continue to raise the profile for the recording of 'consent' Trust wide to emphasise how important the documentation and information provided to patients on risk, benefits, alternative and the risk and benefits if they choose to do nothing, which is required to defend a claim where there is an allegation that the patients were not properly consented.

- To provide training on consent and inquests, in collaboration with Kennedys. The consent training has been planned to take place in November 2021 and inquest training for junior doctors in January 2022.

- To work with SI, complaints and PALS to produce a quarterly CLIPs report.

8. Recommendation

The Trust Board is asked to receive this report for information and assurance that the Trust is compliant with legal processes.

Tracey Carter, Chief Nurse & DIPC
November 2021

Glossary

Bolam Test A test used to determine the standard of care owed by professionals to whom they serve.

Breach of Duty When someone owes a duty to that person and their actions fall below a standard expected. They are deemed to have breached their duty.

Capsticks Solicitors LLP. Previous NHSR Panel Solicitors who continue to represent the Trust in older clinical claims and other HR/business matters

Causation The relationship of cause and effect where and act or omission is alleged to have caused something.

Civil Procedure Rules and guidelines used by the Courts for managing claims.

Claimant Person or organisation bringing a claim against a Defendant.

Claims Same as **Proceedings** (below).

Commencing Proceedings The process of lodging a claim with the court.

Costs Solicitors costs payable on the winning or losing of a claim.

Damages Money paid to a person as compensation for loss or injury.

Defendant Person or organisation defending a claim from a Claimant.

Experts Independent specialists in their field appointed by the Court, Claimant and/or Defendant to provide an independent view on their area of expertise.

Inquest Judicial enquiry to ascertain the facts relating to an incident.

Issue Proceedings Same as **Commencing Proceedings** (above).

Kennedys Current NHSR panel solicitors, since June 2017, who represent the Trust on all new clinical matters

Letter Before Action (LBA) A letter sent by the Claimant to the Defendant briefly outlining its claim against the Defendant.

Letter of Claim (LOC) A formal letter setting out the allegations against the Trust; the contents of this letter are governed by the **Pre Action Protocol**

Legal Timescales When bringing a claim there are deadlines and timescales for dealing with certain aspects of the claim.

Liability only Trial Hearing dealing with evidence pertaining to breach of duty only.

Litigation Risk Weighing up the advantages/disadvantages of continuing to defend a claim when it may be financially more prudent to settle, even if liability is not admitted.

NHSR NHS Resolution - A Special Health Authority set up to deal with legal claims against the NHS.

NHS Reporting Guidelines set up by NHSR setting a series of triggers for reporting claims to the NHSLA.

Part 36 Offer An offer of settlement made under Part 36 of the Civil Procedure Rules. This type of offer can have financial implications going forward in a litigation.

Pre Action Protocol A series of procedural requirements that are a pre-requisite to commencing proceedings.

Proceedings The legal process where a person or organisation asserts their rights through a formal court of law.

Public Liability Organisations have a duty to members of the public. These are claims brought when that duty has been breached.

Quantum only Trial Hearing dealing with evidence pertaining to loss and injury only.

Root Cause Analysis A method used to establish the root cause of faults or problems.

RTA Road Traffic Accident

Staff Claims or Employers Liability Claims. These are claims brought by members of staff against an organisation for breaching their duties as employers.

Statute Barred the Limitation Act sets out how long a person has to bring a claim. To do so outside of these periods a Claimant is deemed to be statute barred.

Trust Board Meeting
02 December 2021

Title of the paper	Finance Report M7 FY21
Agenda Item	23
Presenter	Don Richards, Chief Financial Officer
Author(s)	Don Richards, Chief Financial Officer
Purpose	*For approval*: *For discussion*: √ *For information*: √
Executive Summary	The purpose of this report is to provide the Trust Board with short and longer-term financial health assurance. The report covers: - The revenue income and expenditure performance to the end of October 2021, with a forecast through to the end of the financial year. - Indicators of Divisional financial performance. - An update on the longer-term income and expenditure plan. - The value of the Trust's assets and liabilities, how and why the values have changed this year. - Sources of funds for capital investment, the spending so far and the forecast for the whole year. This is combined with an assessment of the risks to breaching spending limits. - In the appendices, indicators of financial transaction trends over the past 18 months to support understanding of any statistically significant or otherwise important financial variations. The key points to note are: • The Trust continues to operate under a financial regime where most of our income is fixed and includes a block sum to deal with additional costs linked to managing the effects of the pandemic. • The Trust accrued £229.5m of revenue income after 6 months under this regime and has accrued total revenue expenditure of £230.0m, resulting in a £0.5m deficit of income over expenditure. • There are many offsetting budget variances within the performance to date, mainly characterised by lower elective activity than budgeted for. An adverse revenue impact of this lower activity is however protected by the fixed funding regime, together with elective recovery fund (ERF) income. ERF additional income is granted to reward a steady recovery of elective activity.

	• Two notable issues, however, are that (a) costs attributed to managing the pandemic effects are £0.6m higher than funded (£14m vs £13m funded) and (b) the Trust spent an extra £1.0m so far this year on managing water hygiene. We have now sourced some revenue funding within the health system to cover the extra water hygiene management costs. • Agency staff costs continue to run at levels higher than targeted Costs totalled £8.4m after 7 months. However, within this sum £2.8m has been attributed to managing the effects of COVID. • Despite the difficulties posed by the pandemic the Trust has so far found new efficiencies worth £4.1m. • The appendix to the report includes three scenarios for the year-end revenue outturn with a likely outturn of balancing income with expenditure. The funding for the second half of the year (H2) is estimated within this report, while funding envelopes are finalised. The most material and volatile factors are: o The costs and potential funding of water hygiene management. o Expenditure linked to managing the staff and local testing costs of the pandemic. o Delivery of new savings. o The valuation of the impact of capital expenditure on the Trust's asset base and the consequential capital charges. • The budget for the financial year remains unchanged as the Trust's funding envelope is sufficient to match the budget set at the beginning of the year. • This month's report also provides an update on the assessment of the Trust's underlying (or recurrent) deficit in comparison to the long term I&E plan agreed with regulators. As part of the H2 planning discussion, NHSEI require Trust's to assess their underlying revenue position. The current basis for assessment is to o Assume that 'top up' funding (central funding equivalent to historical recovery funding) is treated as recurrent income o Assume that COVID funding is non recurrent o Reflect any COVID costs that are likely to remain stranded as recurrent. • As a result, the Trust has reported an underlying deficit of £18.1m which compares favourably to the previously targeted underlying 22/23 deficit of £53.2m. • The Trust's balance sheet, after six months of the year, shows the book value of our assets to be £262.6m (net of liabilities) compared to £236.2m at the start of the year. The increased value is driven by an additional £26.9m of PDC. This PDC injection has supported the Trust's capital programme.

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- The Trust's cash balance stands at £47.9m. This is up from £22.2m at the start of the year but down from £54.0m reported last month.
- The capital expenditure forecast is to spend £59m by the end of the year with some underspends necessary against previously planned projects to avoid breaching the Trust's Capital Resource Limit.
- Financial management **<u>actions</u>** will focus on:
  - Maintaining the revenue forecast toward at worst a break-even position.
  - In the event of a break-even position not being achieved, ensuring that cash, I&E and capital expenditure forecasts are affordable within the Integrated Health System (including resolving potential capital funding gaps).
  - Financially supporting emergency care and pandemic capacity requirements over winter and the objectives set out in the national H2 planning guidance.

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<tr><td>Trust strategic aims</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>
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<tr><td>Links to well-led key lines of enquiry</td><td>☐Is there the leadership capacity and capability to deliver high quality, sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☐Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td>
<table>
<tr><th>Committee/Group</th><th>Date</th></tr>
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<tr><td>Action required</td><td>The Board is asked to note the contents of this report and approve the actions summarised in the cover sheet above.</td></tr>
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NHS
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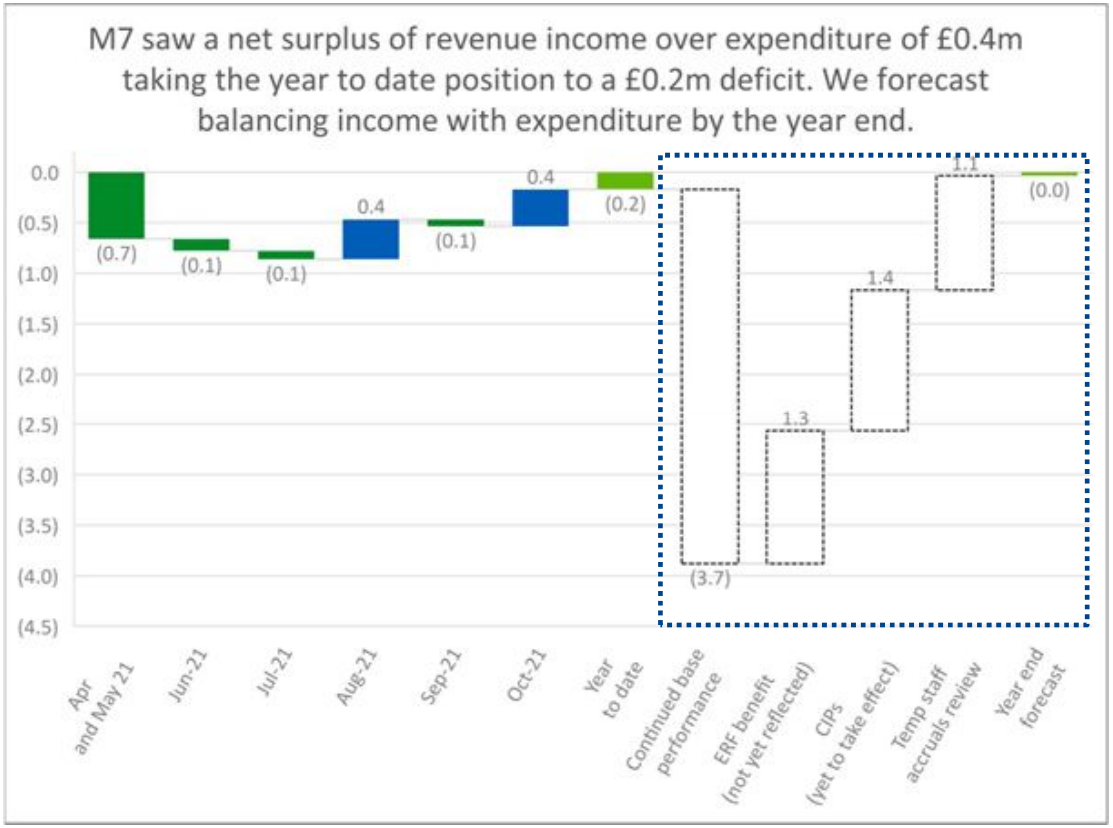
Month 7 Finance Report

October 2021 – main slides

West Hertfordshire Hospitals NHS Trust

The Trust remains on track to meet revenue targets



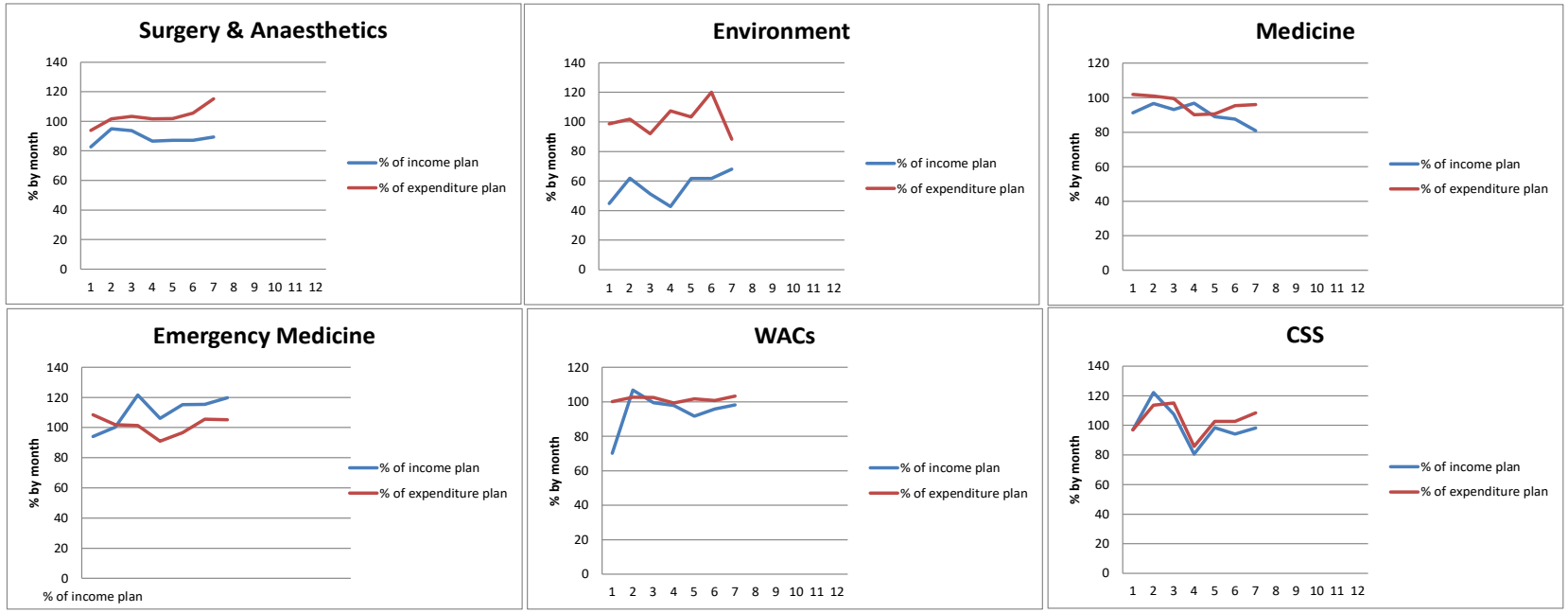
The Trust expects to balance income with expenditure by the year-end. However current underlying spending trends will need to be mitigated by new efficiencies in H2.

Revenue income is protected by the current block income regime despite relatively low elective activity levels. The regime is designed to preserve capacity for winter and elective recovery.

See appendices for more detail.

The Division of Surgery and Anaesthetics presents the most concern with costs increasing, but the value of caseload remaining flat, despite strong recovery efforts from management.

West Hertfordshire Hospitals NHS Trust

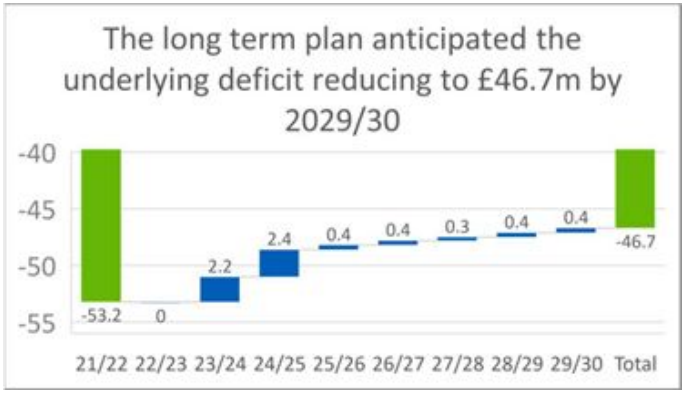


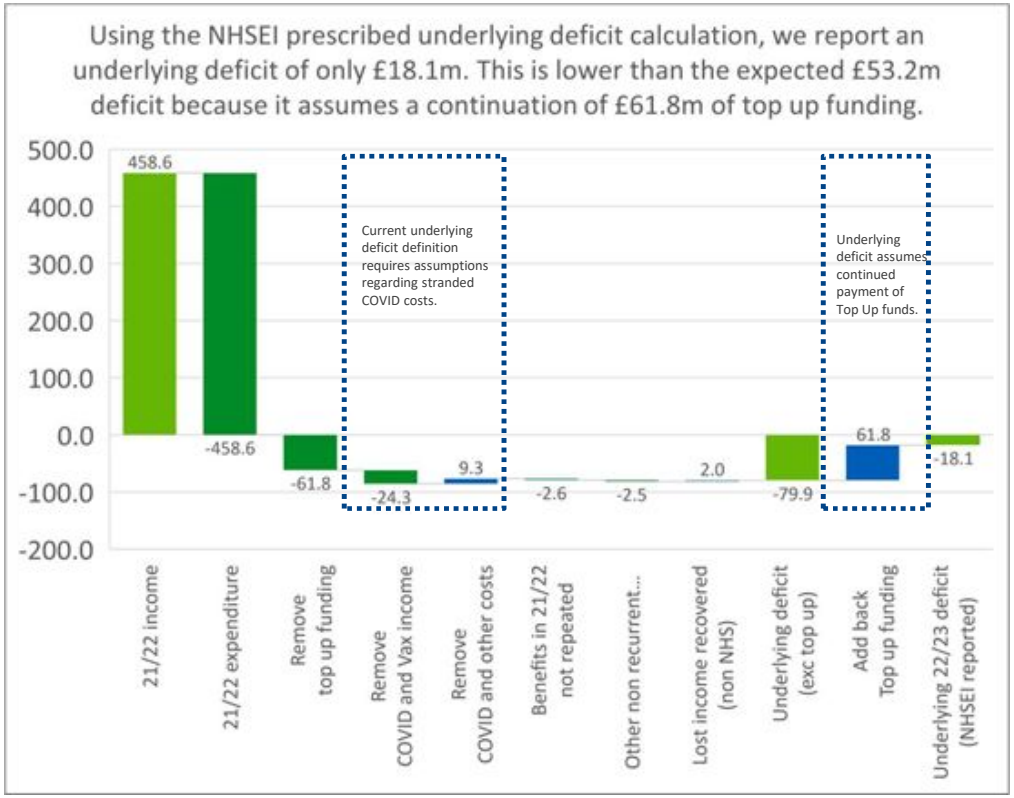
Background	What does the data tell us?	Key issues	Actions & Mitigations
Due to the focus on post pandemic recovery this slide indicates how each Division improves its output while controlling its costs by plotting each month's income as a % of plan (blue line) and expenditure as a % of plan (red line).	The ideal scenario is for (a) the blue line to always be above the red line and for the blue line to trend upwards while the red line remains flat or trend downwards.	The Surgery Division shows a trend completely contrary to what is expected and required. Income as a % of plan is not recovering but expenditure is steadily rising.	• A surgical capacity and productivity workshop in November. • General focus on efficiency and recovery for all Divisions. • Recovery actions presented at the finance performance review.

The long term financial plan is to keep WHHT on track with a financial trajectory that supports our investment agreements. The current definition of the underlying deficit recommended by NHSEI presents a more sustainable financial future.

West Hertfordshire Hospitals NHS Trust

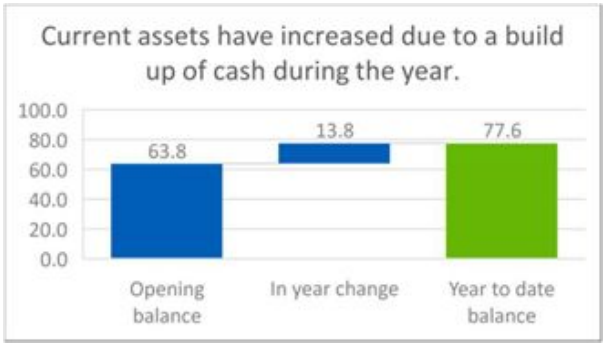
The Trust agreed to reduce the underlying deficit of income over expenditure in line with the table below. The underlying deficit target for 22/23 was £53.2m. In planning guidance for H2 21/22 NHSEI are asking Trusts to assume top up funding is recurrent and to assess what COVID costs remain stranded. This drastically changes the underlying deficit to £18.1m. (see to the right). However it should be noted that on a like for like comparison any recurrently stranded COVID costs would increase the underlying deficit.

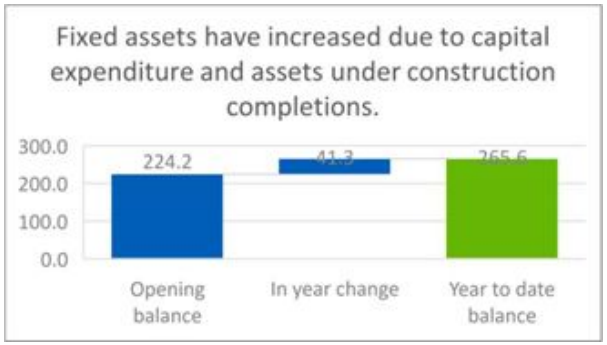


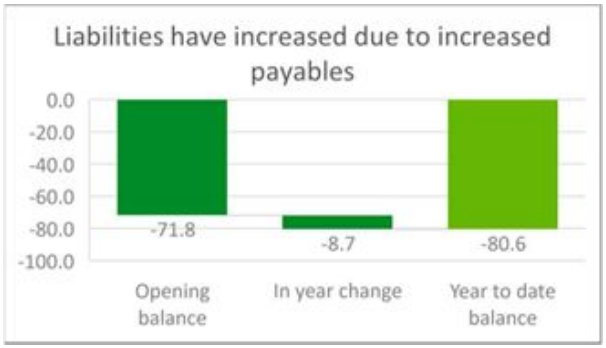


The balance sheet remains healthy. High cash balances are expected to fall later in the year.

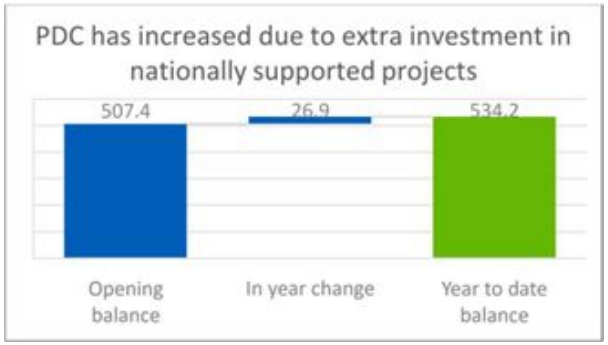
West Hertfordshire Hospitals NHS Trust

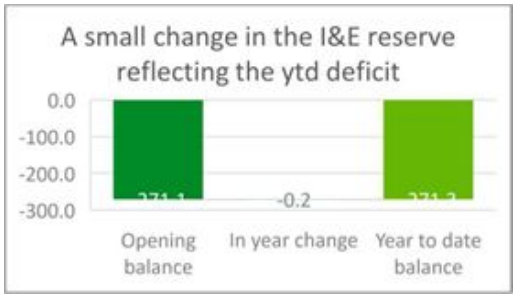






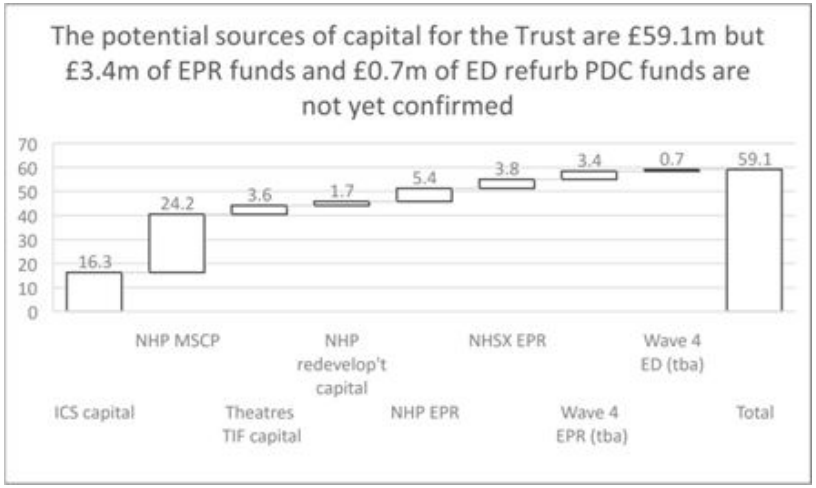
Regulators may pay attention to the build up of cash in conjunction with the build up in liabilities. (See appendix for more detail.

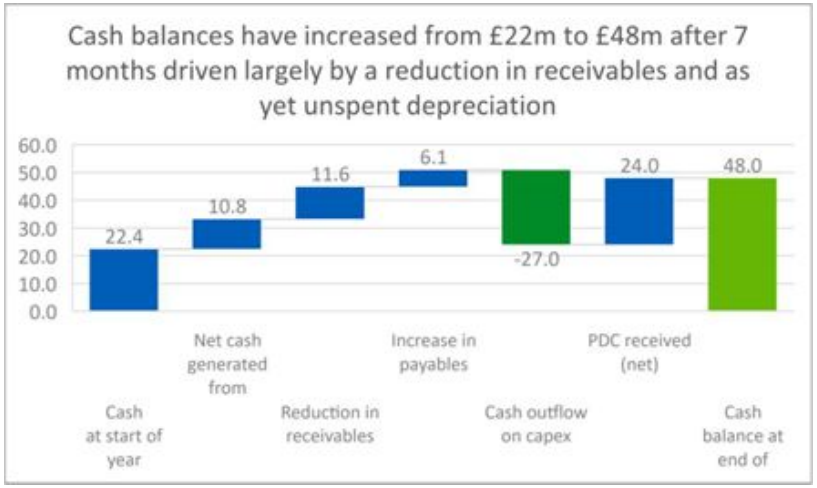


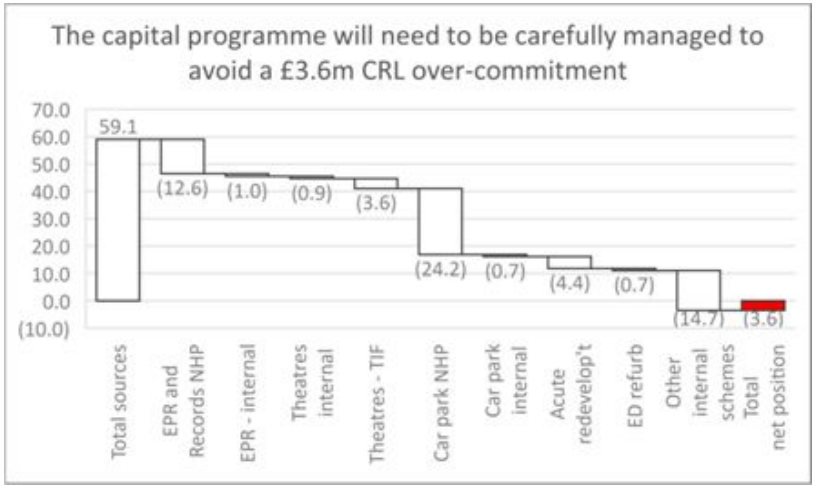


Cash balances healthy at £48m. Capital expenditure totals £29m after 7 months. However there are risks to breaching the capital spending limit.

West Hertfordshire Hospitals NHS Trust







NHS
West Hertfordshire Hospitals
NHS Trust

Month 7 Finance Report

October 2021 APPENDICES

Soheb Rafiq (Associate Director; Operational Finance)
Don Richards (Chief Financial Officer)

Contents

Content	Page
I&E in-month and year to date	3
I&E Forecast	4
Balance Sheet YTD	5
Cashflow Statement	6
Capital expenditure in month and year to date	7
Forecast year-end capital sources and applications	8
Divisional I&E trends	9

I&E in-month and year to date

West Hertfordshire Hospitals NHS Trust

Trust Definition	Expense Type	Annual Budget	In Month (£000s) Budget	Actual	Variance	Year to Date (£000s) Budget	Actual	Variance
Income	Divisional Income	114,191	10,028	11,006	978	66,307	68,640	2,334
	NHS Revenue	338,873	30,744	28,413	-2,331	199,606	200,287	681
Income Total		**453,064**	**40,772**	**39,419**	**-1,353**	**265,912**	**268,927**	**3,015**
Pay	Medical Pay	-84,042	-6,999	-7,867	-868	-49,026	-52,819	-3,793
	Non-Clinical Pay	-66,671	-7,791	-4,460	3,331	-39,050	-33,058	5,992
	Nursing Pay	-86,421	-7,402	-7,535	-133	-50,439	-51,199	-760
	Other Clinical Pay	-33,056	-2,490	-2,607	-117	-19,342	-19,027	315
	Scientific, Technical & Profes	-28,320	-2,334	-2,416	-81	-16,569	-17,094	-525
	Pay Unidentified CIPs	7,165	642	0	-642	2,007	0	-2,007
Pay Total		**-291,345**	**-26,375**	**-24,885**	**1,490**	**-172,418**	**-173,197**	**-778**
Non Pay	Clin Supp Serv	-29,914	-2,517	-2,880	-363	-17,289	-17,454	-165
	Drugs	-21,682	-1,775	-1,973	-198	-12,612	-13,434	-822
	OTHER (NON CLIN)	-96,408	-8,525	-7,687	838	-54,633	-54,506	127
	Recharges	222	-0	-0	0	222	222	-0
	Non Pay Unidentified CIPS	4,043	305	0	-305	782	0	-782
Non Pay Total		**-143,739**	**-12,511**	**-12,540**	**-28**	**-83,530**	**-85,172**	**-1,642**
Other Expenditure	Financing Charges	-17,979	-1,561	-1,629	-68	-10,176	-10,730	-554
Other Expenditure Total		**-17,979**	**-1,561**	**-1,629**	**-68**	**-10,176**	**-10,730**	**-554**
Month 7 Grand Total		**-0**	**325**	**365**	**40**	**-212**	**-172**	**40**

In month 6, an actual surplus of **£0.36m** was generated against a planned surplus of **£0.325m.** The YTD position now shows a deficit position of **£0.17m** against a planned deficit of **£0.2m**.

Income -Other operating income showed an overperformance of £0.9m. This was driven by an increase in income received from Health Education England (mostly offset with pay). The year-to-date overperformance includes the non-recurrent recognition of £0.5m historic R&D income and £1.8m worth of pass-through costs associated with junior doctors, drugs, and other recharges. Again, this is mostly offset by expenditure.

NHS Revenue - Revenues were lower than plan by £1.3m. £28.4m was recognised in month against a plan of £30.7m. The performance recognises Block payments that are being paid regardless of activity levels. Pump priming for UTC and income for pass through drugs continue into H2. The YTD Over Performance includes an additional £1.35m recognized in relation to the forecast achievement of the Elective Recovery Fund (ERF) and the pump priming UTC income received in addition to the block.

Pay - Actual pay costs in-month were £24.89m compared to the business-as-usual plan of £26.37m. Key points to note are £1.1m was spent in relation to covid-19. This was partially offset by income. In addition to this unidentified CIP amounts to £0.6m in month. Year to date, £173.2m has been spent against pay lines. This has caused a £0.78m overspend against the budget of £172.4m. This is driven by COVID-19 related spend (offset with income) and unidentified CIPs.

Non-Pay- Year to date, £85.2m has been spent against a budget of £83.53m. A total of £6.1m has been spent in relation to covid-19 (offset by income) and a further £1.3m spend has been recognised in relation to outsourcing to support the elective recovery fund.

Financing Charges – The timing of depreciation, offset by dividend charges is creating a £0.07m overspend in month against plan. The YTD position shows an overspend of £0.55m.

Background

The income and expenditure statement (I&E) is the highest profile indicator of the Trust's financial performance. The statement is important because the costs of day to day activities need to be sustained by sufficient income over the course of the year. NHS Trusts have a statutory duty to balance income with expenditure over a number of years.

What does the data tell us?

The data presented here includes the planned income from all sources for the whole year and year to date and compares this to the actual income for the year to date. Planned pay and non pay costs for the year to date. The variance represents the difference from plan. The surplus or deficit is the difference between actual income and actual expenditure.

Key issues

1. A YTD deficit of income over expenditure of £0.17m. This is driven by unidentified CIPs.
2. Unidentified CIPs across divisional positions.
3. Despite block payments, actual volumes of activity are below plan.

Actions & Mitigations

1. The ICS has now funded the water hygiene management cost pressure.
2. Cross Cutting efficiency workstreams have now been set up to help develop further cost improvement initiatives.
3. Continued organisational focus on Elective Recovery.

I&E Forecast

West Hertfordshire Hospitals NHS Trust

			£000s			
			Worst case	Likely case	Best case	Notes
H2 Forecast	a	Block mandated income (NHS Revenue)	202,417	202,417	202,417	The Trust anticipates a fixed funding envelope of £202.4m for the second half of the year. This includes income to cover the nationally agreed pay settlement.
	b	H2 Specialist Commissioning income	11,207	11,207	11,207	The block contract amount attributed to specialised commissioning equates to £11.2m.
	c	H2 Divisional Income	15,866	16,166	16,366	Outside of the Block Funding, Divisions are forecasting to generate £16.2m worth of additional income. The worst and best case adjusts for varying levels of private patient income.
	d	H2 Divisional Expenditure	(233,499)	(233,499)	(233,499)	Divisions forecast spending £233.4m in H2 before applying the effects of the matters below.
		Sub Total (Base Forecast)	**(4,009)**	**(3,709)**	**(3,509)**	H2 expenditure is forecast to be between £4.0m and £3.5m in excess of income before applying the effects below
	e	Unfunded Legionella Spend	0	0	0	Now that the Legionella cost pressure has been funded by the ICS, the month 7 forecast factors this in.
	f	H1 Elective Recovery Fund (ERF Income)	1,031	1,315	1,315	Draft elective recovery fund (ERF) calculations suggests that the Trust has earned £1.3m. The worst case scenario assumes that 20% of this will be clawed back to reflect poor performance in the last two months of H1
	g	Out of Envelope Income (Vaccination programme)	400	400	400	The trust expects further reimbursement in relation to its vaccination programme of £0.4m from HCT.
	h	Covid Revenue spend improvements	(1,200)	0	1,901	The likely scenario assumes COVID spend will continue at existing levels. The Worst case extrapolates the overspend seen in M7. The best case assumes we will reduce spend in line with the H2 funding envelope. The best case brings spend back to the funding envelope.
	i	Delivery of Trust wide CIPs in development	750	1,398	1,900	Additional trust wide savings worth £1.4m are expected in H2. The best and worst case accounts for financial risks to the delivery timetable.
	j	Release of Temporary Staffing Shifts not worked	600	1,132	1,200	Provisions will be released in H2 mainly relating to shifts booked but not worked.
	k	Increase in Financing Charges (dividends & impairments)	(1,104)	0	0	The worst case assumes that recent capital expenditure will lead to an overspend on depreciation and dividends payable. The likely case includes the capital charge impact of estimates of anticipated estate valuations.
		H2 I&E forecast	(3,532)	536	3,207	The H2 forecast ranges from a £3.4m deficit in the worst case to a £3.2m surplus in the best case. The likely case shows a breakeven position.
H1 Deficit		**H1 Reported Deficit**	(536)	(536)	(536)	
		Full Year Forecast	**(4,068)**	**0**	**2,671**	The full year forecast shows a likely case of breakeven.

Background	What does the data tell us?	Key issues	Actions & Mitigations
The I&E forecast provides scenarios for the year end I&E position. The report shows the material areas of income and expenditure variation that are likely to affect the year end outturn.	The data provides the Best, Likely and Worst case scenarios for the year end after modelling the most material and most volatile influences on outturn. After allowing for block income in the current temporary financial regime, points a to d show the base forecast (without recovery actions). Points e to k show the impact of recovery actions on the scenarios.	1. The Trust is forecasting a breakeven position in the likely case. 2. It should be noted that the forecast varies between a £4.1m forecast deficit to a £2.7m surplus in the worst and best case scenarios. 3. The likely case relies on the Trust not exceeding current levels of Covid-19 related spend. 4. The likely case relies of the delivery of a further £1.4m CIP.	1. Regional discussions to secure revenue to fund increased water hygiene costs have now been agreed. 2. Ongoing Chief Officer review of COVID-19 related initiatives. 3. Expected financial/productivity benefits from efficiency programme workstreams

Balance sheet year to date

Statement of financial position	Opening Bal £'000	YTD £'000
Non-current assets		
Intangible assets	8,391	12,843
Property, plant and equipment: other	233,712	250,755
Receivables: due from non-NHS/DHSC group bodies	2,132	1,969
Total non-current assets	**244,235**	**265,567**
Current assets	0	
Inventories	5,659	5,367
Receivables: due from NHS and DHSC group bodies	0	12,227
Receivables: due from non-NHS/DHSC group bodies	2,132	12,075
Cash and cash equivalents: GBS/NLF	22,232	47,893
Cash and cash equivalents: commercial / in hand / other	172	48
Total current assets	**63,833**	**77,610**
Current liabilities	0	
Trade and other payables: capital	(8,884)	(11,057)
Trade and other payables: non-capital	(53,685)	(58,277)
Provisions	(609)	(589)
Other liabilities: deferred income including contract liabilities	(1,930)	(4,256)
Total current liabilities	**(65,108)**	**(74,179)**
Total assets less current liabilities	**242,960**	**268,998**
Non-current liabilities	0	
Provisions	(4,711)	(4,371)
Borrowings	(2,000)	(2,000)
Total non-current liabilities	(6,711)	(6,371)
Total net assets employed	**236,249**	**262,627**

Financed by	Opening Bal £'000	YTD £'000
Public dividend capital	507,373	534,232
Revaluation reserve	60,248	60,248
Income and expenditure reserve	(331,372)	(331,853)
Total taxpayers' and others' equity	**236,249**	**262,627**

Background	What does the data tell us?	Key issues	Actions & Mitigations
The balance sheet shows the value of assets owned and liabilities owed. It also provides information on how net assets have been financed.	At the start of the year the trust had a total of £236m worth of net assets employed. This figure represents all assets minus all liabilities and is largely driven by the value of property, plant and equipment which the Trust owns. The financing section shows this has been funded through Public Dividend Capital (national equity investment) partially offset by a large historical deficit.	1. High cash balance as at month 7. 2. Large accumulated historical deficits all now offset by Public Dividend Capital. (Equity) 3. Payables and receivables are materially higher than at the start of the year.	• Cashflow management to reduce both receivables and payables • Ensuring I&E balance each year to avoid the need for more long term financing.

Cash flow statement ytd and forecast year-end cash

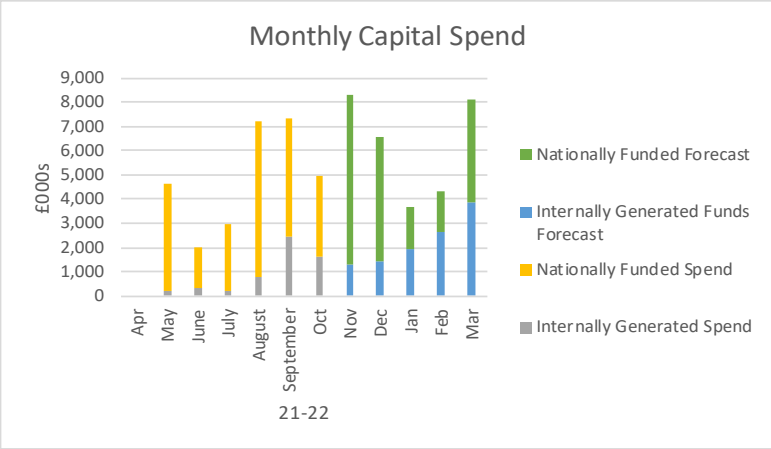
Statement of cash flows

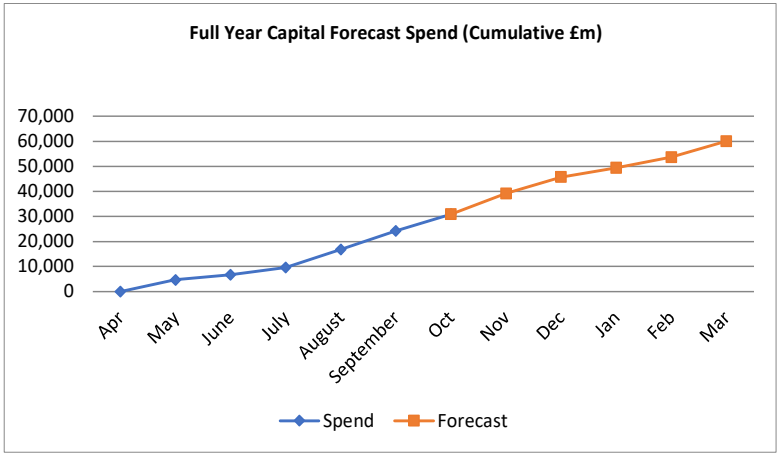
Cash flows from operating activities	YTD £000s
Operating surplus/(deficit)	2,971
Non-cash income and expense:	
Depreciation and amortisation	7,587
(Increase)/decrease in receivables	11,630
(Increase)/decrease in inventories	291
Increase/(decrease) in trade and other payables	6,417
Increase/(decrease) in provisions	(336)
Net cash generated from / (used in) operations	**28,560**
Cash flows from investing activities	
Purchase of intangible assets	(4,821)
Purchase of property, plant and equipment and investment property	(22,129)
Cash flows from (used in) other financing activities	
Net cash generated from/(used in) investing activities	**(26,950)**
Cash flows from financing activities	
Public dividend capital received	26,859
Interest paid	
PDC dividend (paid)/refunded	(2,932)
Net cash generated from/(used in) financing activities	**23,927**
Increase/(decrease) in cash and cash equivalents	**25,537**
Cash and cash equivalents at start of period	22,404
Opening balance adjustment	0
Restated cash and cash equivalents at start of period	22,404
Cash and cash equivalents at end of period	**47,941**

Background	What does the data tell us?	Key issues	Actions & Mitigations
The statement of cash flows shows how much cash the organisation is holding as at the end of the current month. It describes the sources of all cash inflows and outflows.	The trust is currently holding £47.9m worth of cash. The main sources of this are PDC financing for approved capital projects and cash brought forward from the last financial year.	1. High cash balance as at month 7. 2. The Trust expects to consume cash to end the year with c£9m.	Cashflow management and maintaining forecast against capital spend

Capital expenditure totals £29m after 7 months with £18m spent on the MSCP. Total spend expected to reach £60m by year end.

West Hertfordshire Hospitals NHS Trust





Project	M7 £m	YTD £m
MSCP	3.3	18
EPR	0.7	5.2
Acute redevelopment	0.3	3.1
ARP enabling costs	0.2	0.5
Cardiac Cath Lab	0	0.3
Other projects	0.5	2.01
Total	**4.9**	**29.1**

Background	What does the data tell us?	Key issues	Actions & Mitigations
Capital expenditures (CapEx) are funds used by an organisation to acquire, upgrade, and maintain physical assets such as property, plants, buildings, technology, or equipment. The trust expects to spend £60m this year on capital.	In month 7, capital expenditure totalled £4.9m of which £3.6m related to national schemes. YTD spend totalled £29.1m Nationally funded schemes include the Car Park, EPR and the Acute redevelopment.	1. Low spend against internal schemes 2. Funding risks associated with national funding streams	• Development of business cases to be presented and approved at CFPG

West Hertfordshire Hospitals NHS Trust

Forecast capital sources and applications

			ICS allocation				National allocation							
	Sources	£m	Depreciation	Internal cash	Other funds requiring CRL cover	Sub total	NHP	NHSX for EPR	NHSEI for EPR	NHSEI MSCP	Wave 4 ED	TIF	Sub total	2021/22 Total
1	ICS allocation	16.30	11.00	5.30		16.30							0.00	16.30
2	WBC MSCP (£3.7m cash but no CDEL)	0.00			0.00	0.00							0.00	0.00
3	Trust redevelopment funding	1.70				0.00	1.70						1.70	1.70
4	NHSX PDC for EPR	3.80				0.00		3.80					3.80	3.80
5	NHSEI PDC for EPR	5.40				0.00			5.40				5.40	5.40
6	NHSEI wave 4 capex for EPR	0.00				0.00							0.00	0.00
7	NHSEI PDC for MSCP	24.20				0.00				24.20			24.20	24.20
8	NHSEI wave 4 capex for ED	0.70				0.00					0.70		0.70	0.70
9	NHSE Targeted Investment Fund - Elective Recovery	3.55				0.00						3.55	3.55	3.55
15	NHSE Targeted Investment Fund - Digital (EPR) -tba	3.40				0.00						3.40	3.40	3.40
	Current estimate of sources	**59.05**	**11.00**	**5.30**	**0.00**	**16.30**	**1.70**	**3.80**	**5.40**	**24.20**	**0.70**	**6.95**	**42.75**	**59.05**
	FORECAST Applications													2021/22 Total
16	B/fs spending and contingency	(1.74)		(1.74)		(1.74)							0.00	(1.74)
17	EPR and health records	(13.60)		(1.00)		(1.00)		(3.80)	(5.40)			(3.40)	(12.60)	(13.60)
18	Trust redevelopment	(5.47)		(1.07)		(1.07)	(4.40)						(4.40)	(5.47)
19	Corporate office relocation	(1.90)		(1.90)		(1.90)							0.00	(1.90)
20	Theatre refurbishment	(4.40)		(0.85)		(0.85)						(3.55)	(3.55)	(4.40)
21	MSCP	(24.60)		(0.40)		(0.40)				(24.20)			(24.20)	(24.60)
22	ED improvement	(0.70)				0.00					(0.70)		(0.70)	(0.70)
23	Fire safety	(1.50)	(1.50)			(1.50)							0.00	(1.50)
24	Backlog maintenance	(2.06)	(2.06)			(2.06)							0.00	(2.06)
25	Clinical space - Urology centre @ SACH	(0.76)	(0.76)			(0.76)							0.00	(0.76)
26	Clinical space - Increasing wards capacity	(0.32)	(0.32)			(0.32)							0.00	(0.32)
27	Clinical space - PACS reporting room and offices	(0.06)	(0.06)			(0.06)							0.00	(0.06)
28	Equipment capacity - other	(0.81)	(0.81)			(0.81)							0.00	(0.81)
29	Equipment capacity - ward medicne cabinets	(0.40)	(0.40)			(0.40)							0.00	(0.40)
30	Equipment replacement - other	(1.26)	(1.26)			(1.26)							0.00	(1.26)
31	Equipment replacement - anaesthetic machines	(0.44)	(0.44)			(0.44)							0.00	(0.44)
32	Equipment replacement - histo tissue processor	(0.06)	(0.06)			(0.06)							0.00	(0.06)
32	IT development - digital dictation	(0.40)	(0.40)			(0.40)							0.00	(0.40)
33	IT obsolesence - Pathology	(0.35)	(0.35)			(0.35)							0.00	(0.35)
34	IT obsolesence - Windows 10	(0.63)	(0.63)			(0.63)							0.00	(0.63)
35	IT obsolesence - Digital Strategy	(0.43)	(0.43)			(0.43)							0.00	(0.43)
36	IT other	(0.62)	(0.62)			(0.62)							0.00	(0.62)
37	Other building capacity - NICU	0.00	0.00			0.00							0.00	0.00
38	Other building - Maternity	(0.04)	(0.04)			(0.04)							0.00	(0.04)
39	Other	(0.11)	(0.11)			(0.11)							0.00	(0.11)
44		0.00				0.00							0.00	0.00
		0.00				**0.00**							0.00	0.00
	Total applications	**(62.65)**	**(10.24)**	**(6.96)**	**0.00**	**(17.20)**	**(4.40)**	**(3.80)**	**(5.40)**	**(24.20)**	**(0.70)**	**(6.95)**	**(45.45)**	**(62.65)**
50	**Underspend / (Shortfall)**	**(3.60)**	**0.76**	**(1.66)**	**0.00**	**(0.90)**	**(2.70)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(2.70)**	**(3.60)**

Background

The Trust derives its funding for capital expenditure primarily from cash accumulated from revenue trading and charging for depreciation. The ICS agrees the amount of these funds that can be deployed by setting a health system capital programme. Additional funds can be secured by applying for additional equity investment in the Trust (PDC). This statement provides information on the sources of funds and how we expect to spend these sources.

What does the data tell us?

£16.3m of schemes are expected to be funded by internally generated cash and £43.75m funded through an injection of additional PDC. The largest areas of spend are: £24.2m on a new multi storey car park; £13.6m on a new Electronic Patient Records system (EPR); £4.4m on improving WGH theatres.

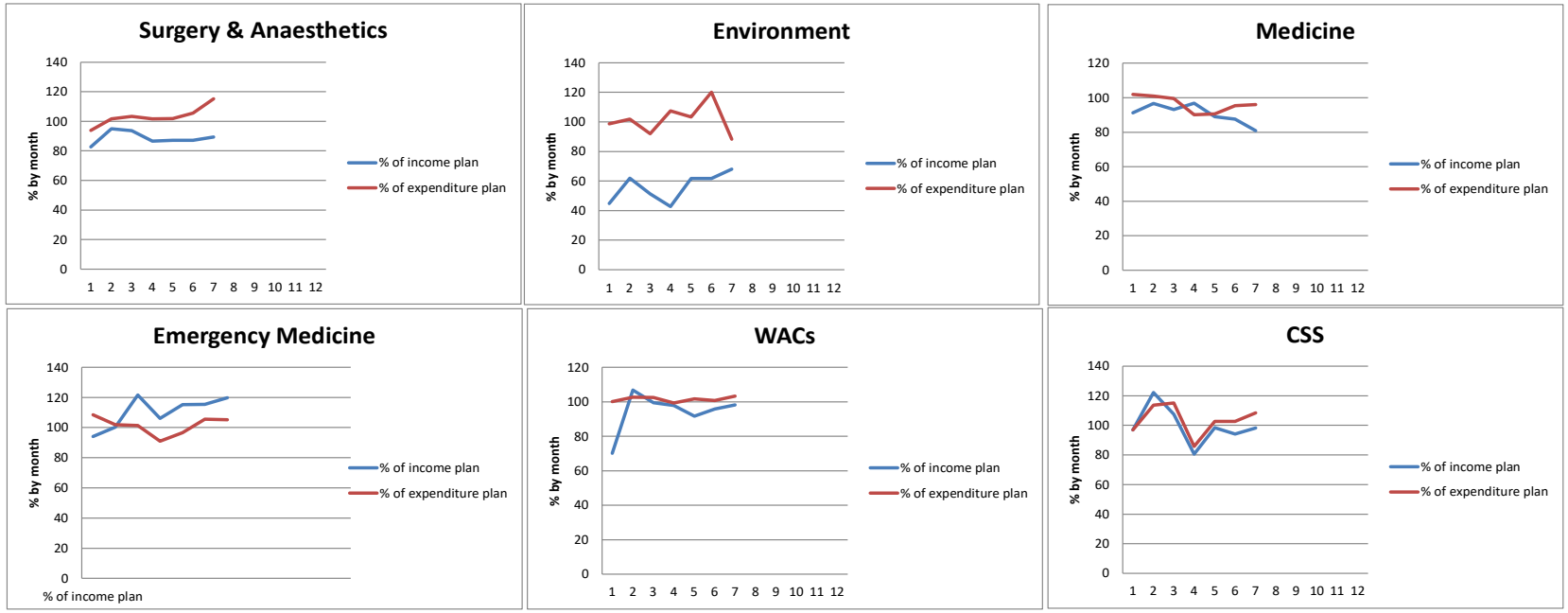
Key issues

At month 7, there is currently a £3.6m shortfall within the capital sources identified.

Actions & Mitigations

The Trust, ICS and Regional teams are working to identify alternative funding sources should TIF funding not be made available.

Divisional income and expenditure



Background	What does the data tell us?	Key issues	Actions & Mitigations
Due to the focus on post pandemic recovery this slide indicates how each Division improves its output while controlling its costs by plotting each month's income as a % of plan (blue line) and expenditure as a % of plan (red line).	The ideal scenario is for (a) the blue line to always be above the red line and for the blue line to trend upwards while the red line remains flat or trend downwards.	The Surgery Division shows a trend completely contrary to what is expected and required. Income as a % of plan is not recovering but expenditure is steadily rising.	• A surgical capacity and productivity workshop in November. • General focus on efficiency and recovery for all Divisions. • Recovery actions presented at the finance performance review.

Trust Board
02 December 2021

Title of the paper	**Strategic Priorities Update**
Agenda Item	**24**
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 2021-22.
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	November TMC
Action required	The Trust Board is asked to note the delivery status of the strategic priority projects.

Agenda Item: 24

Trust Board – 02 December 2021

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 2021-22 and provides an update on their development and delivery.

1.2 **Table 1: 2021-2022 Strategic Priorities**

WHHT 2021-22 Strategic Priorities	Best Care	Best Value	Great Team	Great Place
Clinical Strategy				
Clinical Strategy Delivery	✓	✓	✓	
Interventional Radiology	✓			
Embedding SMART as BAU	✓	✓		
Vascular Hub	✓			
Mount Vernon Cancer Centre Review	✓			
ICS / HCP Development	✓			
Integrated Care - Joint QIPP				
Outpatient Transformation	✓	✓	✓	
Paediatric Transformation Priorities	✓	✓	✓	
Developing an Urgent Care model for the St Albans and Harpenden Locality	✓	✓	✓	
Capital Programme				
Emergency Dept. Development	✓	✓	✓	✓
Completion of the Windows 10 Deployment	✓	✓	✓	✓
Watford Theatres Reconfiguration	✓	✓	✓	✓
Fire Safety Spend				✓
Off Site Back Office (Administrative Staff project)	✓	✓	✓	✓
Health Records FBC (phase 1) - COMPLETE (May 2021)	✓	✓	✓	✓
Health Records Programme Delivery (phase 2) COMPLETE (Oct 2021)	✓	✓	✓	✓
MRI Scanner (SACH) - COMPLETE (April 2021)	✓			✓
CT Scanner (WGH) - COMPLETE (July 2021)	✓			✓
Cardiac Cath Labs	✓			✓
Multi-Storey Car Park (MSCP)				✓
Outsourcing Pathology Services	✓			✓

2.0 Clinical Strategy

2.1 The final **Clinical Strategy** was approved by the Trust Board in September. Progress updates on planning for the delivery of the strategy (our 5 year change programme) will be provided to the Trust Board in December and February. A summary 'easy-read' version of the strategy has been developed for publication in December 2021. It was approved by Trust Management Committee in November and is being brought to the December Trust Board meeting for final approval prior to publication.

2.2 Interventional Radiology OBC – The tender for this project is expected to be back by 07 December 2021 (there has been a delay due to the structural drawing), ahead of finalising the business case for December TMC.

2.3 Virtual SMART (Senior Medics Assigning & Re-designing the Take) – No update this month. The next update will be provided in Q4.

2.4 Vascular Hub Project – The FBC for this project has been signed off by all parties involved and is currently out for regulatory approval. The surgical divisional team are now working with East & North Herts Trust to support planning of any changes involving WHHT. The full go live date is expected to be April 2023.

2.5 The **Integrated Care System (ICS)** has been running a series of task and finish groups to inform the future governance and operating model. The groups have completed their work and recommendations were considered by the ICS Partnership Board on 15 November, an update from this meeting will be reported next month.

2.6 Health and Care Partnership (HCP) Development - The South and West Herts Health and Care Partnership (HCP) was formally established in shadow from in October 2021. Partner Organisations have been asked to sign-off the Interim Strategy and to sign the Shadow Partnership Agreement. WHHT Board approval of the Interim Strategy and Shadow Partnership Agreement was secured in October. The focus of the next few months is producing a detailed operating model to support Shadow Operation and development of the governance and functions to support the next phase of the Partnership from April 2022.

2.7 The **Mount Vernon Cancer Centre (MVCC) Review** – work is continuing on the development of the pre-consultation business case. An application was submitted for the MVCC scheme to be included in the next phase of the New Hospital Programme (final 8 schemes for delivery by 2030). Clinical liaison meetings are continuing between WHHT, UCLH and Mount Vernon clinical teams to develop a joint clinical model and explore the opportunities arising from co-location on to the WGH site.

See *Appendix 1* for the latest Mount Vernon Cancer Centre Strategic Review Stakeholder Update.

3.0 Integrated Care Joint QIPP (part of Transformation Plan)

3.1 Outpatient Transformation - Priority areas for transformation have been jointly agreed between WHHT & Herts Valleys CCG (HVCCG).

Patient Initiated Follow Up (PIFU) a strand of personalised care and a key driver in the recovery plan is now live in a range of specialties and work is underway for the following services:

- **Diabetes** – PIFU launched on 01 November 2021.
- **Cardiology** – will roll out for arrythmia patients as the first pathway. The Standard Operating Procedure (SOP), Clinical criteria and patient information have all been developed. Other pathways to be added following a review in December 2021.
- **Ophthalmology** – SOP developed and launched 01 November 2021
- **Women's Health** launched April 2021 and was expanded to include PGP (pelvic girdle pain) from September 2021. Other physiotherapy areas to include are now being explored.
- Discussions are underway with **Gastroenterology** to formalise an existing "open access policy" to a formal PIFU pathway.

Integrated Respiratory Service Transformation:

- Interstitial Lung Disease (ILD) and Chronic Obstructive Pulmonary Disease (COPD) MDT pathway agreed and progress continues.
- COPD to be part of the initial Virtual Hospital (VH) roll out (see below)
- Transition of ILD clinics agreed, to be mobilised 01 November – delayed until 01 December 2021.
- Clinical sign off due end November 2021.
- Work to begin on Operational model for integrated Respiratory Transformation of service.

Virtual Hospital Implementation - After an initial planned start date in November, the revised planned go live date for Phase 1 of the SWHHCP (South West Herts Health and Care Partnership) Virtual Hospital is 06 December. A detailed statement of readiness has been prepared which will inform a go/no go decision before the service is launched. The final decision will be made by Executive colleagues at both WHHT and Central London Community Healthcare NHS Trust (CLCH) based on a recommendation by the Implementation Group.

Initially the focus will be supporting early discharge and reducing the length of stay for COPD and Heart Failure patients enabling them to go home for treatment and monitoring. Phase 2 will go live early in the New Year which will then include admitting appropriate patients from ED and EAU directly into the Virtual Hospital as an alternative to hospital admission.

A robust reporting and governance framework is in place which will inform and support not only the expansion and development of the Virtual Hospital but also future Integrated Service Developments and Transformation**.**

3.2 Paediatric Transformation Priorities (previously CYP) - The ICP level Paediatric Transformation Board is now well established with good clinical and operational engagement. The overall aim of the group is to review current paediatric & young person's service models and identify opportunities for transformation. Good progress is being made against transformation priorities previously reported.

Focused areas of work for the first stage include:

- **GP & Community hotline to a consultant paediatrician to seek advice and guidance** and potentially avoid a referral / unplanned attendance. The pilot ended on 28 May 2021 and the results were presented to the Paediatric Transformation Board on 30 June. The service is to continue in its present format going forwards using Consultant Connect as a pilot platform for 12 months.

- **MDT for Children with Complex Health Needs** – This has been put on hold for the time being as likely to be a duplication of other workstreams. The impact of existing workstreams will be assessed and whether this is needed in early 2022.
- Establish a **Single Point of Access** for all referrals to ensure right place right time access –Referral Assessment Service (RAS) for WHHT paediatrics and paediatric sub-specialties has been implemented. A revised referral form is being developed to support GPs in referring to the correct service. Working with HVCCG/Hertfordshire Community Trust (HCT) to assess the feasibility of HCT being able to refer directly to WHHT without the need for a GP to then refer onto WHHT and vice versa. Paediatrics has seen a significant benefit from implementing Advice and Guidance with 53% of all referrals in 2020/21 being managed through this route.
- Develop an I**ntegrated Nurse Led Model of Clinically Appropriate Admission Avoidance for children** with respiratory issues – The service has now launched.
- A new workstream has begun to produce **Education Resources for GPs** following themes identified through the hotline and advice and guidance requests.

3.3 Developing the Urgent Care Model for the St Albans and Harpenden Locality - It is yet to be confirmed whether there will be any interim unplanned care provision at St Albans City Hospital to support this year's winter pressures, however, the long term plan for the development of a primary care led urgent care hub is progressing well. The target mobilisation date is now June 2022. Informal discussions have taken place with potential bidders for the new service which have been positive, with a high level of interest. The current plan is to start the formal tendering process before the end of this calendar year.

4.0 Capital Programme

4.1 The **Emergency Department (ED) Development** – the Full Business Case (FBC) for the ED development has been approved by the Trust Board and submitted to regulators. The response from regulators is anticipated in January 2022, subject to which enabling work can start.

Whilst regulator approval is awaited, tendered costs will be received for all the work and the team will compile any outstanding actions from the FBC designs.

4.2 Windows 10 Deployment

Key Progress to date:

• 3199 W10 devices deployed to date.

• 117 additional devices will be replaced as soon as possible.

• 304 devices cannot be replaced until either the Theatre or Pathology existing systems are Windows 10 compatible. The existing Theatres application (Theatreman) will be replaced upon go live with EPR and this cohort can therefore be replaced after 29 November. The Pathology system is being upgraded to make it Windows 10 compatible and once completed we can then replace the Pathology devices for Windows 10 ones.

4.3 WGH Theatre Reconfiguration - The Theatre 5 Turnkey Project Manager attended site on 11 November and formally accepted the now emptied area where the new theatre will be installed.

During the past month the primary contractor Vinci has updated their programme to reflect delays to current phases. The Project Team continue to work closely with the contractor to explore all options

to mitigate these delays. In this regard the current phase has been split to enable earlier works occupation.

The Project Team continue to work collaboratively with the operational and clinical teams to arrange temporary access into live areas. Whilst this is not abnormal, it is now more acute given current and expected pressures on the Trust and the needs of the project to hit key dates.

The currently forecast dates for completion remain unchanged:

- Completion of the new Theatres 20 April 2022
- Completion of the Recovery area 21 April 2022
- Project Completion 05 May 2022

4.4 Fire Safety Works for 2021-22:

Fire Alarm Installation (SACH) - In October we have seen completion of fire alarm control panels to all areas with the exception of the Theatre complex, which is scheduled for the proposed closure for a week, commencing 27 December 2021.

The installation of the control field wiring for the new detectors is continuing within the Gloucester Building and due to complete by Christmas.

Asbestos licenced contractors will be attending site at the weekend of 13 /14 November to carry out some planned enabling works prior to the fire alarm installation.

The project is on plan to complete by the end of March 2022.

Emergency Lighting (SACH) – Following the successful install to Gloucester Wing, installation is now also nearing completion to Runcie Building and also Spice-of-Life/Former Kitchen Block.

The due diligence review of Fire Escape signage undertaken by the Trust's Authorised Engineer for Fire (AE) to coordinate the new and remove any unnecessary or potentially confusing signs has been completed and is being actioned.

Enabling works have also been booked with licenced Asbestos contractors for the removal of existing redundant fittings from these areas.

The project is on plan to complete in December 2021.

Emergency Lighting (HHH) - As planned, installation works to the Verulam Building, Plant Rooms, Main Building, Marnham and Jubilee Building are now complete. A further small plant room not in the original scope of works has been added to the programme and will be complete following delivery of the new fittings, week commencing 06 December 2021

As carried out in SACH, a due-diligence review of Fire Escape signage is again to be undertaken with the Trust's AE, with a site walk planned in the coming weeks to conclude the exercise.

The project will conclude in mid-December as planned.

4.5 **Off-Site Back Office Project** (Administrative Staff Project) **-** All legal paperwork has now been completed and the construction timetable has commenced.

The order for the fibre installation is being progressed (120 day lead time) with IT. The next stage is to commission new offices and ensure they are ready for staff to move into. The move to new offices and vacating existing accommodation at WGH is expected in May 2022.

4.6 **Cardiac Cath Lab** – Cath labs 1 & 2 are fully operational and are treating patients using the newly upgraded equipment. The staff seminar room outside the Cath lab will have new conferencing facilities installed, with works commencing in December.

The ventilation system upgrades sign-off has been delayed due to operational capacity issues (surge bed provision). The team is planning the final test for January, this does not impact on service provision or safety as there are Infection Prevention Control mitigations in place.

Planning for an Official opening event in January 2022 is underway.

4.7 **Multi-Storey Car Park** (MSCP) – The practical completion date is now forecast to be 09 February 2022, with Cardiff Road Staff Car Park to be handed back to Watford Borough Council 30 days after the practical completion of the MSCP. The MSCP is on plan to open in March 2022.

4.8 Key dates for the **Outsourced Pathology Service**:

- The BAFO (Best and Final Offer) will be released to the bidders in early December 2021 (this has been delayed from 15 November 2021).
- The Trust Board will be notified in March 2022 on the preferred bidder (previously January 2022).
- Full Business case – target date March 2022.
- Contract award and signature – target date April 2022.

5.0 Recommendation

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

Appendix 1

Mount Vernon Cancer Centre Strategic Review

Stakeholder Update – November 2021

This briefing provides the latest update on the Mount Vernon Cancer Centre Strategic Review, following a meeting of the Programme Board in November. Further information can be found at www.mvccreview.nhs.uk.

- **Capital Funding for the replacement of Mount Vernon Cancer Centre**

UCLH (University College London Hospitals NHS Foundation Trust) has submitted an Expression of Interest for funding for a new Mount Vernon Cancer Centre to the Department of Health and Social Care as part of the Government's New Hospital Programme. Longlisting is currently taking place of those schemes across the country which are seeking to become one of eight additional new hospital projects that will be added to the programme next Spring (2022).

Whilst UCLH do not currently manage the Mount Vernon Cancer Centre services, if funding can be agreed and the UCLH Board approves the transfer, it would be UCLH who would be responsible for building a new cancer centre at the preferred location, Watford General Hospital.

Replacing Mount Vernon Cancer Centre is one of the top priorities for NHS England in the East of England, who commissions the services, and fully supported by colleagues in London and the South East whose patients also use its services.

- **Options appraisal**

An options appraisal exercise has confirmed that replacement on the Watford site is the preferred option by a significant margin, with the options to do nothing, do minimum or disperse the service rating extremely poorly in comparison.

At the Mount Vernon Cancer Centre Review Programme Board this month, stakeholders reviewed the scores given to the options by 14 partner organisations, including a joint score from NHS England East of England and London, as well as the scores of a patient reference group made up of representation from across the Mount Vernon catchment.

The scores and rationale confirmed that a solution needs to be found to replace Mount Vernon Cancer Centre within the catchment, or risk making patient access even more challenging in an area where patients already have very long journey times for treatment and where cancer outcomes in some areas are significantly worse than the national average.

It was also noted that any option, including dispersing the services to other specialist cancer centres, involves substantial capital investment due to the size of the service and capacity of other cancer centres.

The patient reference group concluded that; "Adjacency with an acute hospital enhances staff recruitment, the range of treatments, quality of care and outcomes. It provides the right facilities and enables better staff recruitment and retention. It ticks all the boxes."

They said that the other options did not provide value for money, meet patient experience or access criteria or address concerns about patients who do not take up treatment because of access to care, patients' health and wellbeing, delivery of more complex treatments or staff recruitment and retention, amongst other concerns, branding alternatives "unacceptable."

Email: *engagement.east@nhs.net or write to: MVCC Review, Direct Commissioning, NHS England, Charter House, Parkway, Welwyn Garden City, AL8 6JL Briefing by: Jessamy Kinghorn, Head of Partnerships and Engagement, NHS England and NHS Improvement, issued 16/11/2021*

- **Networked Radiotherapy**

Following Programme Board meetings in February and May that gave the go-ahead to explore the option of a Networked Radiotherapy unit at either Lister Hospital in Stevenage or Luton and Dunstable Hospital, UCLH commissioned a feasibility study for the two options, and visits to the proposed sites have also taken place.

Networked radiotherapy would mean a satellite unit of the main cancer centre would be developed on a second site and run by the Mount Vernon Cancer Centre radiotherapy team. It would provide patients in the north of the catchment area with significantly shorter journey times for radiotherapy treatment.

The feasibility study used a template design and layout for comparison and has confirmed either site could host a Networked Radiotherapy unit. The ideal unit would have patient areas on the ground floor and staff areas on the first level, be well connected into the existing infrastructure of each hospital, and designed for net-zero carbon. In response to patient feedback it would have a sensory and holistic design with lots of natural light, with a calm, inward looking environment with a central courtyard and garden, and be consistent with the Cancer Centre developed at Watford.

At the Luton and Dunstable Hospital a site was identified with the potential for direct access to the main hospital building, adjacent to, and with visible entrance from the car park, main entrance and bus stop, independent access, ambulance drop-off and allowing for light into a courtyard garden. The space could be available as soon as 2024.

At Lister Hospital, the site has ground level access to the main hospital, with close proximity to the radiology scanning centre and tower block, with ambulance drop off in front of the proposed entrance and a short walk to the Lister Macmillan Cancer Centre. It also allows for light and views into a courtyard and has the opportunity for a dedicated, welcoming entrance. The space could be available as soon as 2022.

Analysis of the costs is ongoing but provisionally appears to be close to the assumption of £15m that has already been included in the business case.

Projected staffing requirements have assumed there would be a single radiotherapy team across the main centre and the Networked Radiotherapy Unit. The Networked Unit would run from 8am to 6.30pm, 5 days a week, with the equivalent of six weeks planning and maintenance built in, with each Linear Accelerator providing an average of 8,050 attendances each year – 16,100 for the unit.

The Programme Board also supported the team to explore the inclusion of a spare bunker (to allow for potential growth in demand) and options for CT (computerised tomography) provision at the Networked Radiotherapy unit and agreed that a no-Networked Radiotherapy option should be included when the proposals go to formal public consultation.

- **Patient and Public Engagement**

Involvement of patients, carers and local people is continuing as proposals are further developed, and a comprehensive summary of the feedback to date was received by the Programme Board. Opportunities for patient and public involvement are published on the www.mvccreview.nhs.uk website and promoted in many different ways, including a recent social media advertising campaign.

If you would like to find out more and cannot find the information you are looking for on the website, please contact engagement.east@nhs.net.

Trust Board
2 December 2021

Title of the paper	***Progress update – Five year change programme***
Agenda Item	Leave blank
Presenter	Clare Parker, Director of Strategy and Integration
Author(s)	Clare Parker, Director of Strategy and Integration
Purpose	*For approval*: *For discussion*: *For information*: ✓
Executive Summary	The purpose of this paper is to provide a progress update on the five year change programme. It details the progress made against the recommendations and next steps set out in the July board paper. The key areas of progress relate to the establishment of a business planning process and the completion of a summary version of the clinical strategy to enable wider communications and engagement, particularly with staff. Several of the projects set out in the clinical strategy are also progressing well.
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	Trust Management Committee 24/11
Action required	The Board is asked to: • receive this report for information • agree the proposed name for the 5 year change programme – '*Great Care, Delivered Differently*'

Agenda Item: xx

Trust Board meeting – 2 December 2021

Title of paper: *Progress update – five year change programme*

Presented by: Clare Parker

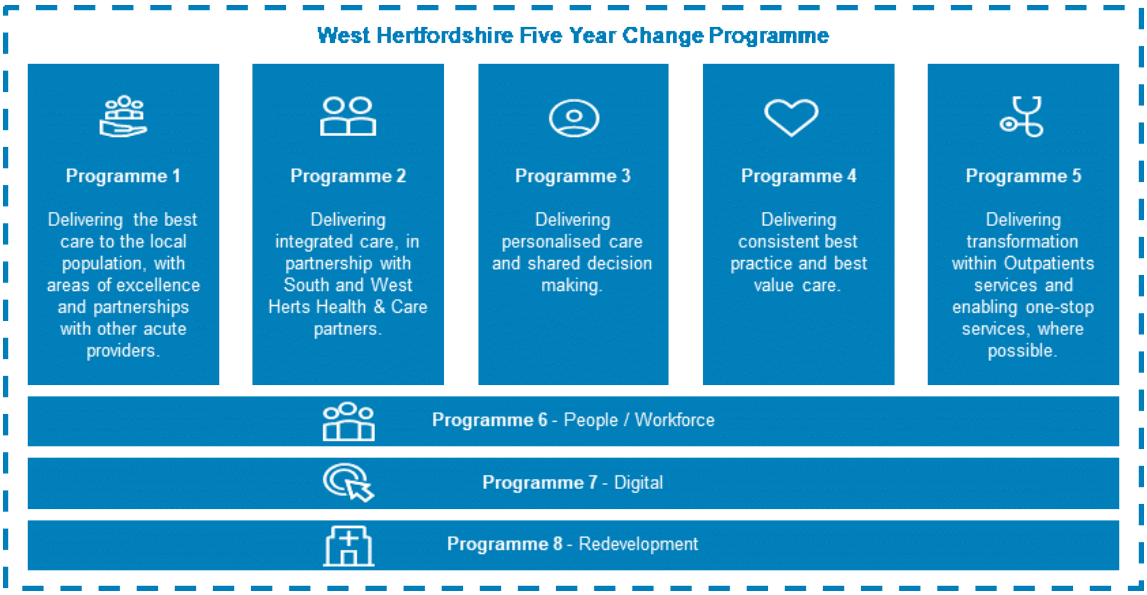
1 Purpose

1.1 The purpose of this paper is to provide a progress update on the five year change programme.

2 Background

2.1 The trust has a substantial strategic agenda to deliver. In addition to the redevelopment of our hospitals we also have ambitious clinical, digital and workforce strategies. A paper to the Board in July set out how we plan to deliver our ambitions through a five year change programme that will enable us to deliver care differently with digital as a key enabler. This will allow us to achieve maximum benefit from our new hospital once it is built.

2.2 The change programme is summarised in the diagram below.



2.3 The July paper made a number of recommendations to ensure that the programme is successful. These were:

Clear SRO accountability	A Senior Responsible Owner (SRO) should be allocated to each programme who will be accountable for overseeing progress, unblocking issues and manage connections with other programmes.
Regular governance	An overarching Programme Board should manage related project activities, resources, risks and interdependencies. There will be consistent governance processes and rhythm across all programmes. Updates from each programme feeding into the Trust Management Committee (TMC) then Trust Board.
Clinical and operational involvement	There should be appropriate operational and clinical involvement and ownership from every division to provide input, insight and ideas to shape the direction of the change programme.
Capacity to deliver	Appropriate levels of PMO / programme support resource should be assigned to each programme, based on change timescales and complexity, with a holistic view of how resources are utilised.
Consistent documentation	Programme management documentation should be designed so it is consistent across the Five Year change programme to provide TMC and Trust Board with the appropriate oversight and assurances.
Measurable impact	Each programme should define their success metrics with a focus on outcomes, quality and value. These will be connected to the ambition of the overall Change Programme with clear measurable indicators, which will be signed off by TMC and Trust Board.
Two-way feedback	Governance should enable two-way communications between Trust Board, TMC, Programme Boards and individual divisions to keep all colleagues informed, engaged and able to contribute to the future of the Trust.

3 Analysis/Discussion

3.1 Work to implement the change programme has been progressing with a target date of April 2022. A key element of this task is the introduction of a business planning process to determine strategic and transformational priorities alongside the normal finance, activity and workforce planning. This will result in the following outputs:

- A Trust business plan that sets out the strategic and operational priorities for 2022/23, with nominated operational and clinical leads for each element of the business plan to ensure accountability
- Divisional business plans that translate the trust plan to divisional level.

3.2 The business planning process has commenced across all divisions using standard documentation. The process is both top down and bottom up – the top down element relates to the trust wide priorities identified in the clinical strategy, while the bottom up combines the specialty level priorities from the clinical strategy and other locally identified issues. There will be consolidation and shortlisting at divisional level before review by the executive team to determine the priorities to be worked up in more detail, ahead of final board sign off in April.

3.3 Another key element has been to facilitate communications and engagement by producing a summary version of the clinical strategy and agreeing a name for the change programme to create a brand. The proposed name is '*Great Care, Delivered Differently'.* The summary version of the clinical strategy is on the agenda for information.

3.4 Progress against the recommendations is set out in table 1.

Table 1: recommendations from 5 year change programme (July 2021) and progress to date

Recommendation	Work to date	Planned work
Clear SRO accountability	An SRO and a clinical responsible officer (CRO) have been identified for each programme	Clarification of responsibilities and time commitments
Regular governance	The overarching programme board will be the Great Place Programme Board which will report to the Trust Board via the Great Place Programme Committee.	Supporting governance for each programme. All programme governance will feed into the GPPB.

Recommendation	Work to date	Planned work
Clinical and operational involvement	A CRO has been identified for each programme to provide clear clinical leadership.	The individual projects are being mapped to lead directorates and will be prioritised through the planning process at which point operational leads will be assigned
Capacity to deliver	Discussions with executive and divisional leads to identify the capacity and capability required, both PMO reporting and project management to deliver. Initiation of the business planning process to enable plans to be matched to appropriate resources	Completion of the business planning process Bid for funding for additional capacity via the budget setting process
Consistent documentation	Documentation to support the business planning process has been agreed	Development of all further documentation
Measurable impact	Commenced work to determine programme success metrics	Review of the breakthrough ambitions of the Trust strategy and development of a strategic dashboard to track key metrics. Agreement of outcomes for each prioritised project for 2022/23
Two way feedback	Development of summary version of the clinical strategy for internal and external communications Divisional input into business planning process	Finalising governance and communication arrangements

3.5 The paper also set out some next steps – progress is shown in table 2.

Table 2: next steps from 5 year change programme (July 2021) and progress to date

Next steps	Progress
Governance of overall Five Year Change programme: • Design and agree branding for overall programme. • Design and agree governance structure, methodologies and documentation to ensure consistency and alignment across the Change programme. • Defining governance roles within the programme. • Reviewing existing governance forums and committees.	Proposed name: '*Great Care, Delivered Differently'* Use GPPB as executive with strategic reporting to board Key roles will be SRO and CRO for each programme Ongoing
Finalising the programmes (and associated projects and timeframes) within the Five Year Change programme: • Clinical strategy (programmes 1-5) - the clinical strategy document is being finalised and sent to Board for sign off. • Integrated care (programme 2) - the HCP strategy is currently being designed in partnership with our system partners. We will need to ensure clear alignment and be assured on how system delivery will meet our needs. • People / workforce strategy (programme 6) - the people strategy document is currently being reviewed and updated - including projects and timeframes being finalised. • Digital strategy (programme 7) – the funding routes for the digital strategy are being finalised as part of the OBC work.	Approved at the September board. Summary version on agenda for approval Interim HCP strategy agreed and signed off by board November. 22/23 planning processes underway at both trust and HCP to ensure alignment. Further work to be done at the HCP on system delivery and accountability. See paras 3.7-3.12 Ongoing

Next steps	Progress
Governance of each programme within the Five Year Change programme:	
Identify SROs for each programme with a consistent set of responsibilities and collective kick-off for programme.	Identified SRO and CRO for each programme
• Identify and engage representatives from each division who will contribute to each programme, recognising appropriate demand on staff time.	In progress as part of planning process
• Completing detailed project planning for each project within their programme (PIDs and other documentation).	Next step in the business planning process, expected February 2022
• Identifying programme and project management resource required to support each programme/project.	In progress as part of business planning
• Establish guidance on success metrics for the overall change programme, with each programme then defining their relevant outcomes and success metrics (with indicators) and for each project where required.	Ongoing

3.6 As we establish the formal programme structure, resources and governance, we have continued to progress the delivery of projects within the eight programmes. While this has been affected by the ongoing capacity demands of Covid, good progress has been made in many areas. This includes:

- Implementation of NHS 111 First, with direct booking from 111 into the UTCs (working with HV CCG and HUC)
- Engagement on and agreement of the urgent care model for St Albans to replace the MIU (working with HV CCG)
- Agreeing the business case for the virtual hospital expansion, with an expected soft launch for COPD and Heart Failure on 22 November (working with HCP partners)
- Scoping a potential pilot model for delivering integrated proactive care to people with multiple long term conditions (working with HCP partners)
- Commissioning a detailed review of surgical demand and capacity to support Covid recovery
- Developing our plans for community diagnostics hubs at SACH and HHGH (working with HCP and ICS partners)
- Rolling out patient initiated follow up across six specialties to date
- Delivering the EPR programme, with go live planned for the weekend of 26 November
- Ongoing work to support the redevelopment business case and options appraisal.

3.7 The current People Strategy for the Trust was developed in 2019 and ratified by the Trust Board in February 2020. The impact of the pandemic alongside an escalation of activity regarding the Acute Redevelopment has provided an opportunity to reflect and review the existing strategy document and align to some of the changes from a workforce and health care context.

3.8 In addition, the national People Strategy has also evolved in the last few months with the publication and launch of the NHS People Promise. This is based on 7 promises and priorities that reflect some of the changes in the workforce context following the pandemic while focusing on some of the wider strategic challenges.

3.9 The national People Promise was shared at the previous PERC where the committee were also advised that work would commence to align the national strategy alongside a review of our own People Strategy. It was also agreed that the initial development and outline of the People Strategy would be presented at PERC in October 2021.

3.10 The next step is to share the draft document with staff at all levels of the organisation with an opportunity to listen and receive feedback. The intention is to engage and create an inclusive approach to developing this draft into a final document. Therefore there will be an emphasis on extended inclusion and ensuring our diverse workforce have an opportunity to be engaged in the development of how the Trust demonstrates and prioritises the workforce over the next 5 years.

3.11 The engagement will provide an opportunity for informal and safe space discussions alongside more formal opportunities with focus groups and established meetings.

3.12 It is expected that this engagement will commence immediately and allow for a final draft document to be presented to PERC in February 2022 with a formal launch at Board in March 2022.

4 Risks

4.1 The key risks to the successful delivery of the change programme are:

i. Capacity to deliver given the competing demands on executive and divisional leadership teams

ii. Development of the necessary skill set to support successful project delivery

iii. Willingness of staff to engage with and deliver the necessary change

iv. Securing the financial resources to provide the necessary capacity and capability.

4.2 The business planning process is being used to mitigate risks i., ii, and iv. Risk iii. arises from both the pressure and fatigue facing staff at present and the natural resistance to change. Effective communication and engagement regarding the benefits to patients and staff and strong clinical champions will be essential overcoming this risk.

5 Recommendation

5.1 The Board is asked to receive this report for information and to agree the proposed name for the 5 year change programme – '*Great Care, Delivered Differently'*.

Name of Director: Clare Parker

Date: 15 November 2021

Trust Board
2 December 2021

Title of the paper	Summary version of the Clinical Strategy 2021 – 2026
Agenda Item	26
Presenter	Clare Parker, Director of Strategy and Integration
Author(s)	Various
Purpose	*For approval*: *For discussion*: *For information*: ✓
Executive Summary	The Board approved the Clinical Strategy in September 2021. The main strategy document is a long and comprehensive document and does not easily lend itself to wider communication and engagement. A summary version of the strategy has therefore been produced that uses best practice examples from the divisions to demonstrate what we are seeking to consistently achieve across the trust. The document also references the five year change programme to show how we aim to implement the strategy. We plan to print a few hundred copies of the summary strategy as an A4 document for use internally with staff and externally with key stakeholders. The summary will also be available to the public on the website.
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	Trust Management Committee 24 November
Action required	The Board is asked to note the final document before publication.

NHS
West Hertfordshire Hospitals
NHS Trust

Our clinical strategy

2021 to 2026

Bringing our clinical strategy to life

teamwestHerts

Thank you for taking the time to read this document.

Bringing our clinical strategy to life is designed to give you more insight in our clinical strategy 2021-2026.

The strategy sets out how we will deliver our vision ***the very best care for every patient, every day*** and reflects the NHS Long Term Plan. It will give us the tools we need to make improvements across our services, on our hospital sites, within our teams and in the partnerships we have and will build.

The way we will deliver our clinical ambitions is set out in this graphic (right).

We will deliver high quality services with areas of excellence through a model that ensures care is integrated, personalised and consistent.

In the following pages, you will find more information about how we will deliver our clinical ambitions and about the amazing work already happening, which aligns to the strategy, and is creating a much better experience for our patients.

Contents

3 Introducing the clinical strategy

4-5 High quality services

6-7 Delivering integrated care

8-9 Delivering personalised care

10-11 Delivering consistent care

12-13 Transforming outpatient services

14-15 Great Care, Delivered Differently

Introducing the clinical strategy

Chief medical officer, Dr Michael van der Watt and chief nurse, Tracey Carter, give their take on the clinical strategy, how it will change our working practices and positively impact patients.

What is the point of the clinical strategy?

Tracey: It celebrates the progress we've made over the last few years and sets out how we will build on this and deliver great care to our patients into the next decade. It will equip us with the frameworks and support to deliver patient-centred care as well as modernise our services.

Mike: A lot has changed over the last few years, even before COVID-19. This strategy describes our ambition of providing integrated, personalised and consistent care for our patients. It talks about being at the forefront of an innovative clinical landscape, which is important to us and reflects our recent success in many areas.

How will it change our working practices?

Mike: The strategy supports us in becoming a more joined-up trust, not just within our own departments but with our local partners, including voluntary sector providers. We will be better coordinated and therefore more responsive, so we can deliver more personalised, patient-centered care.

Tracey: We are living in an age of rapid digital innovation and the strategy will ensure that digital underpins our clinical services. Improvements in our digital capability are a key part of our hospital redevelopment and will enable us to see patients online where appropriate and improve our booking processes and the way we record and manage information.

How will it impact our patients?

Mike: Coming to hospital can be a daunting experience and we have a duty to our patients to provide them with the best care we can. Patients can expect a more streamlined experience with fewer appointments at fewer sites and be encouraged to be more involved in the decisions about their care.

Tracey: They will also experience a more personalised service that understands and focuses on what they want from their care, with consistent points of contact to help them feel more comfortable and informed as their treatment progresses.

Does the strategy reflect the NHS Long Term Plan?

Tracey: Yes! The NHS Long Term Plan describes how the NHS will be more coordinated in its care, more proactive in the services it provides and more differentiated in the support it offers to individuals. Our strategy is based around the core principles of better integrating our care both internally and with partners; making our care more specific to reflect the needs of our patients and ensuring that our care is as consistently high quality as possible. The NHS Long Term Plan also talks about shifting our focus to population health to enable us to reduce health inequalities, which we know have widened during the pandemic. We will do this by working in partnership across health and local government through the South and West Herts Health and Care Partnership.

What are the next steps?

Tracey: We have created a five-year plan that brings together all the ways we can improve our services so when our new buildings open we are delivering 21st century care to match our surroundings. This is a golden opportunity to improve our services and work with our partners to meet the increasing demand and to help keep people well and in their own home.

Mike: While we need new buildings to realise some of our clinical ambitions, we can get on with delivering most of them now and in some cases, we already are. We will work with and support our staff through the changes to ensure that everyone has the skills they need for the future. We need to be adaptable and flexible in how we work, so things may change along the way to accommodate an ever-changing NHS landscape.

High quality services with areas of excellence

Our Ambitions

Ambition 1

We will continue to provide the very best care by delivering outstanding local hospital care, with some highly specialist services and areas of excellence, serving a wider population.

Ambition 2

We will continue in our aim to deliver care close to home where possible, and in the 'lowest intensity' setting that is clinically appropriate e.g. as some of the lower intensity settings will still be in hospital (ambulatory care not ward, day case not inpatient surgery).

This means improving our emergency and planned care, developing and building on areas of excellence and constantly challenging the way we deliver care with the expectation that patients only travel to our hospitals if they need to access the facilities there. There are examples of best practice already taking place across the trust that show how we can achieve this.

Case study: Modern management of cancer patients

Cancer Multidisciplinary Teams (MDTs) are the gold standard for supporting the modern management of cancer patients in the NHS but the way they are set up and operated can be extended to other conditions.

Our cancer MDTs bring together all the relevant clinicians and support teams required to formulate robust individual patient care plans.

They ensure patients have the best clinical decisions made to support them in their subsequent care.

Using video calls, clinicians work together across multiple sites. The decisions made within these meetings are recorded live, which allows real time updates to the patient's record.

Anonymised data from the MDTs can be used for regional and national cancer reporting systems, which can help to improve cancer services everywhere.

Case study: Children's cancer care closer to home

Receiving care and treatment in the most appropriate setting is key to ensuring patients have the best experience possible. Our strategy allows us to innovate and use new technologies to continuously improve our care and move it to the lowest intensity clinical setting available. Children with cancer are having shorter hospital visits and are able to spend more time at home with their families, due to the timely, informed and joined up care from our Paediatric Oncology Shared Care Unit (POSCU) at WGH.

The team provides prompt referral and support at the time of diagnosis, ongoing chemotherapy treatments, blood product transfusions and hospital admissions when children become unwell.

The POSCU team works with Great Ormond Street Hospital (GOSH) and University College London Hospital (UCLH) to provide the best care for children who need specialist input.

Other aspects of care are delivered at home by the children's community nurse teams including weekly blood tests and some chemotherapy. We also collaborate on the planning for palliative and end of life care.

An ethos of 'one team' has been established with regular communication across the team and within the fortnightly multidisciplinary team meetings, as well as within the virtual meetings with colleagues at GOSH and UCLH.

The children and young people in our care have shorter visits to our hospital and fewer visits to London. The average length of stay at WGH for chemotherapy is less than an hour including a consultant review. Patients on our wards are reviewed daily by our specialist team, who are always available for advice.

As a result, our patients have more time at home with their family and fewer school days are missed meaning parental working patterns and family finances are less negatively impacted.

NHS England expects POSCUs to provide safe care closer to home and in delivering our service for the children and young people of west Hertfordshire, we are providing the very best care for every patient, every day.

"We appreciate being able to travel locally for treatment, knowing that we are only a car journey away so that our daughter doesn't have to spend long periods of time out of school. When she has had to stay at Watford, she has always felt relaxed and comfortable because the team are so familiar to her."

Mother of Olivia,
Acute lymphoblastic leukaemia patient

Olivia Keith, 7, ringing the 'end of treatment bell', surrounded by her family.

Paediatric oncology team: left to right - Dr Jeremy Roskin, Dr Vasanta Nanduri, Helen Farmer and Susan Williams, Paediatric Oncology Clinical Nurse Specialists.

Case study: Transforming frailty services

Delivering emergency care for our community is one of our core purposes and saves lives. We have traditionally done this through our emergency department and inpatient wards, but with advances in medicine we can now offer care in other settings that avoid admission to hospital.

The Frailty Service is transforming our care for older people through high quality same day assessments. These are carried out by a range of staff including doctors, nurses and therapists.

In line with recommendations from NHS England's drive for Same Day Emergency Care and under our new model of care, patients are assessed as a matter of urgency before being seen by a consultant geriatrician, all within the Emergency Department. Medical problems are addressed to reduce the risk of falls and to mitigate against the impact of confusion.

Older people are encouraged to remain in their own homes with support through same day packages of care. If care packages can't be arranged for the same day, the team works together to ensure support is in place as soon as possible.

In the last year, we have reduced length of time waiting in the Emergency Department from 4.7 hours to 3.1 hours. We see more patients each day and arrange for more patients to leave hospital within 24 hours.

Colleagues in Emergency Medicine are receiving extra training, so they feel more confident identifying and managing frailty, which reduces unnecessary admissions to hospital for older patients.

Case study: Cutting-edge technology in respiratory medicine

Embracing new technology and underpinning patient treatment with high quality peer-reviewed research is elevating our services. For example, we are one of a small number of trusts in the country to use a cutting-edge respiratory diagnostic service so patients have shorter procedures, a smaller number of biopsies and fewer complications.

Our multidisciplinary respiratory team uses an Endobronchial Ultrasound (EBUS) supported by Rapid Onsite Evaluation (ROSE) to check patients for lung cancer, other cancers suspected of spreading to the lymph nodes, lymphoma and non-cancerous conditions such as sarcoidosis or tuberculosis.

EBUS is a minimally invasive but highly effective procedure that provides real-time imaging of the airways surface, blood vessels, lungs, and lymph nodes, allowing the physician to easily view small and difficult-to-reach areas.

ROSE is a technique whereby a sample of cells is taken from the patient via a needle passed down the EBUS scope. A small proportion of the sample is examined under the microscope in the endoscopy suite to see if there is malignant tissue.

Using the procedure saves patients from having repeat investigations, meaning less time spent in hospital and same-day discharge.

Delivering integrated care

Our Ambitions

Ambition 3

We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population.

Ambition 4

We will be active leaders in our health and care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy.

People are now experiencing more long term and complex health conditions which means it is vital for us to work with our partners in primary, community and social care settings to ensure we address the patients' whole needs instead of each issue individually. We need to make sure that pathways between different care providers are seamless, improving patient experience and getting the best possible outcomes for our population.

Many of our staff are already working in integrated ways with other NHS, social care and voluntary sector organisations. We have established the South and West Hertfordshire Health and Care Partnership to strengthen this further.

Case study: Hertfordshire Integrated Diabetes Service

Our strategy will enable us to move away from the current reactive system of care to a more proactive model that enables people to stay well by making changes to their lifestyle and taking an increased role in managing their own health.

The Hertfordshire Integrated Diabetes Service (HIDS) has demonstrated how giving patients access to appropriate specialist services relevant to their needs in a timely way, nearer to home and in the most clinically and cost effective way, improves patient experience.

Patients have access to a wide range of diabetes specialists including nurses, dietitians, podiatrists and consultants as well as structured education and mental health services. They have a single point of contact, allowing them to be triaged efficiently and signposted to the most appropriate healthcare provider.

As a result, the number of acute admissions for patients presenting with a primary diagnosis of diabetes has been reduced by half and their length of stay has reduced by 0.7 days (6.4 ave in 2017/18 to 5.7 ave in 2020/21).

The service promotes self-management, which is key to the success of living with a long term condition as set out in the NHS Long Term Plan. People are given support to manage the anxiety and depression that often comes with the diagnosis of long term conditions, improving their wellbeing as well as their physical health. Regular meetings take place with all healthcare providers, commissioners as well as patient representatives, to ensure communication is open and honest.

HIDS is the first locally commissioned integrated service in Hertfordshire and brings together every partner organisation involved in improving the quality of care of adult patients with diabetes whilst keeping them out of hospital.

We need to build on our existing integrated care models to develop fully integrated models across a wider range of specialties, based on where the benefit to patients is the greatest.

"Thank you. The service has been of huge value and without their support my condition would be unmanageable."

Patient feedback – Sept 2021

Case study: Our virtual hospital

In response to the pandemic, the trust established the UK's first virtual COVID-19 hospital, which has shown patient benefit from integrating urgent and emergency care pathways.

The new model involved a multidisciplinary team approach including respiratory consultants, respiratory physiologists, nurses, healthcare assistants and other clinical colleagues, as well as the local adult community provider Central London Community Healthcare NHS Trust (CLCH).

Patients in the virtual hospital were closely monitored and had easy access to the team looking after them. At first, this involved a combination of calls from consultants and readings from oximeters, which monitor the oxygen levels in blood. An app was then introduced to closely track changes in patients' symptoms, sending alerts when measurements moved out of a set range. Once the data is uploaded a green tick appears on the app, followed by another tick to indicate that all is well.

The data upload provides assurance for patients that their health is being closely monitored. Patients whose data is a cause for concern can quickly be seen in person, referred for additional tests or transferred to hospital if needed.

The service enabled patients to recover in the comfort of their own homes and hospital beds were freed up for seriously unwell patients who needed to be admitted.

The team was crowned Respiratory Team of The Year by the British Medical Journal for the service and the trust is now working with healthcare partners to roll out a virtual hospital model of care for heart failure and other respiratory conditions from December 2021, as a first step to a comprehensive virtual hospital model for all people with appropriate conditions.

More than **4,000** patients were able to stay at home and still be treated

Up to **3,000** bed days were saved

About **2,400** admissions were prevented

1,600 early discharges were achieved

Case study: Shared care

Patient care is sometimes fragmented, with insufficient sharing of information between organisations but the clinical strategy will support us in working more efficiently and openly with community partners.

This is already happening in our close working with Herts Valleys Clinical Commissioning Group to allow patients using complex medicines to have their care shared between hospital specialists and GPs.

This has enabled patients to receive their care closer to home.

Shared care guidelines have been created so the trust, GPs and patients have a shared understanding of the treatment being used, the benefits and possible adverse effects, and what monitoring is required.

Once care is shared, the GP is responsible for prescribing for and monitoring the patient. Our specialists continue to see the patient periodically to review progress and advise on any changes needed.

The guidelines include options based on clinical evidence and help to manage any changes.

Shared care ensures safety is fundamental in the pathway and complements the patients' best interests, agreement and preferences.

Delivering personalised care

Our Ambitions

Ambition 5

We will personalise the care we deliver through shared decision making, taking account of the goals of the our patients and providing appropriate information and support to enable people to manage their own care more effectively and take informed decisions about the care they receive.

Patients deserve care that meets their needs. A professional football player may have the same knee injury as an accountant, but their recovery goals will be completely different. We need to agree with each patient the right treatment decision for them and then deliver the best possible care.

Case study: Personalised medication

Polypharmacy is the regular use of at least five medications and a prevalent issue amongst the elderly population. It can cause adverse drug reactions, hospital admissions and healthcare costs.

There is a national focus on optimising the use of medicines especially for older people.

To ensure our patients are receiving the appropriate medication at the right time, our pharmacy team is using the STOPIT screening tool to conduct medication reviews for patients admitted with polypharmacy.

The reviews have allowed us to stop inappropriate medicines, prevent further medicines being prescribed to combat current adverse drug events and carry out thorough reviews.

Medication reviews are already part of routine clinical work across the trust and STOPIT has formalised this process for patients who may otherwise not have had the opportunity for review with their GPs or community pharmacies.

Case study: Postnatal incontinence

Empowering patients to make decisions about their care and follow up care is a key part of our clinical strategy and can have positive impacts on patient outcomes and how we run our services.

A video on the trust website is helping women who have given birth prevent pelvic floor dysfunction. Urinary incontinence and prolapse are common in postnatal women and can negatively impact on quality of life. Incontinence can stop women completing day to day activities and even prevent them from leaving the house as well as being a source of embarrassment.

After watching the video, women were assigned a physiotherapist and had the opportunity to make a follow up appointment within three months if there was no improvement, deterioration in their condition or new symptoms developed.

Another video giving advice was also made available in August 2020 and has been viewed nearly 300 times. Feedback from new mothers has been very positive and other trusts have requested details of the service, so they can follow our example.

The NHS Long Term Plan pledges improved access to postnatal physiotherapy for women who need additional support to recover from childbirth. Guidance published in 2020 by the Royal College of Obstetricians & Gynaecologists recommends offering women physiotherapy to reduce the risk of urinary incontinence.

This video was launched during the pandemic to ensure women still had access to support during lockdown.

"If it were not for this service, I may not have sought help and tried to manage [it] myself, no doubt with repercussions for me and the NHS later in life."

Patient feedback – Sept 2021

Case study: Mental Health support

Our personalised care should go beyond the physical and incorporate mental health aspects as well.

The Lavender Team is demonstrating how including personalised mental health support within our services benefits our patients.

Perinatal mental illness affects up to 20% of new and expectant mums and can include severe anxiety or depression.

Working with other agencies and community midwives, our team is offering mental health support as well as support with safeguarding and child protection matters.

The team is available across our hospital sites, as well as in children's centres to ensure the service is more accessible to mums. Home visits can also be arranged.

The team has improved the environment in which antenatal appointments take place so women can discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and recreational drug use.

Helen Birch was supported by the Lavender team in 2016 after her partner died by suicide when she was eight weeks pregnant. She said: "The care was tailored to me. They pared back about 25 appointments into one and gave me my own room. I can't praise the care enough."

"Without the support of that medical team I don't know where I would be, but I wouldn't be here."

Helen Birch

Case study: Advanced care planning

Despite end of life care in the UK being ranked among the best in the world, many patients still die in a place that is not of their choosing.

In line with recommendations from NICE, our palliative and end of life care teams are working with specialties across the trust and with partners in the community to shift the focus of considering patients' preferences for care at the end of life to much earlier in the course of their illnesses.

The teams attend more multidisciplinary team meetings in more specialities to drive earlier recognition of a patient who is deteriorating and empower our clinicians to consider symptom control and advance care planning alongside active management of the underlying illness. The meetings also facilitate timely referrals to palliative care both in the trust and in the community to support patients and families alongside their specialist teams.

Through integrated advance care planning, our patients are able to express what is important to them as their condition progresses and where they and their family feel most comfortable. This is improving quality of life for our patients and means their preferences are considered earlier in the process.

The team also plans to launch the Supportive & Palliative Care Indictors Tool (SPICT) which will support us further in identifying people earlier, so they can benefit from advanced care planning.

Delivering consistent care

Our Ambitions

Ambition 6

We will standardise the way we deliver care to achieve consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation.

Ambition 7

We will provide more one stop and multidisciplinary clinics that enable rapid diagnosis and treatment, reducing the number of times that people have to travel to our hospitals.

Ambition 8

We will encourage innovation and research and will harness new technologies to enable us to continually improve the services that we offer.

The national *Getting it Right First Time* programme demonstrates that if you standardise the delivery of care you can improve patient outcomes. We have taken this approach to help us simplify patient pathways, reduce the number of times people attend hospital and speed up the time from referral to diagnosis and treatment. We have excellent examples of where we are doing this already.

Case study: Induction of labour

Bringing clinicians together to design and systematically implement best practice care pathways alongside using the latest evidence to improve them will result in consistent care.

We are doing this through our clinical practice groups (CPG) programme, which aims to standardise our most common pathways to improve patient outcomes.

Under the CPG programme, our maternity unit has introduced a new way of offering induction of labour on an outpatient basis, after it showed it was a safer option and reduced the length of labour.

A recent study (the Dilapan Rods Pilot Study, November 2020), showed the benefit of a non-pharmaceutical and low intervention induction for women with low-risk pregnancies.

Women are now offered Dilapan and are then able to go home, before returning to hospital 12 to 15 hours later to continue their induction.

Being at home during the early stages of labour allows women to be more comfortable and relaxed in familiar surroundings, which promotes the production of hormones related to labour.

Additionally, it helps us coordinate workflow across the service and reduces inpatient bed stay pressures, improving patient experience and easing workloads of staff within the unit.

On average
104 women
a month have a planned induction

Case study: Continuity of care in pregnancy

Continuity of care (CoC) in maternity allows pregnant women to form relationships with our staff before, during and after birth. Those who experience CoC are more likely to have better birth outcomes and feel satisfied with their experiences of maternity care. Those who are more vulnerable also benefit, especially where they experience social and psychological complexities.

After the successful launch of the first CoC team, Orchid, in January 2021, the trust will roll out the second team in January 2022, with the initial focus on caring for those from ethnic groups and areas of deprivation known to be at higher risk of complications in pregnancy and infancy.

CoC has been shown to positively impact the working environment making it more flexible with better communication between midwifery and wider multidisciplinary teams. Our workforce challenges will impact how quickly and fully we can implement the roll out.

Ensuring our patients receive their treatment from the same person, where clinically appropriate, will enable them to feel safer and better cared for.

CoC helps us achieve our ambition to reduce rates of stillbirth, neonatal death, maternal death and brain injury by 50% by 2025.

Case study: Prostate cancer

Currently, our waiting times are longer than the national standard for some patients and some of the ways we communicate with patients are old fashioned. Our strategy sets the course for a proactive understanding of needs, demand and capacity so we can better respond to changes in demand.

A new 'straight to test' pathway for patients with prostate cancer has removed an unnecessary consultation appointment and mainly takes place over the phone, which is more convenient to patients and prevents the stress of coming to hospital.

As a result, patients receive MRI appointments faster and it allows biopsies to be done more quickly, should the patient need it.

Prostate cancer is the most common cancer among men with more than 47,500 new cases every year. During diagnosis and treatment, patients may need to attend multiple appointments, which can be overwhelming.

Moving to this faster way of managing referrals is cutting the wait for important diagnostic procedures.

Our planned redevelopment will compliment this even further by improving our diagnostic processes and consolidating services to St Albans City Hospital to ensure the necessary procedures and scans take place in a timely way, making the experience for our patients and their families less stressful.

Straight to test pathway has reduced the time from referral to MRI by
10 days

Average number of days from referral to diagnosis has reduced by
31 days

Transforming outpatient services

We need to apply our ambitions for more integrated, personalised and consistent care across all of the services we deliver. Outpatient care is an area where we are planning transformative change, taking advantage of new digital opportunities and the benefit of an evidence-based approach.

Case study: Dermatology

Providing GPs with specialist advice and guidance is helping them make informed decisions about their patients and allows the patients to access the support they require more quickly, reducing anxiety.

This is being demonstrated by our dermatology advice and guidance service where GPs refer patients to our service with images of the skin condition causing concern. Our consultant dermatologists triage the referrals daily (Monday to Friday), within two working days for urgent referrals, and four working days for routine referrals, into one of the following options:

- Advice back to the GP (via our electronic referral system)
- Appointment for a nurse-led clinic and treatment
- Appointment for consultant-led clinic and investigation
- Direct booking to a surgical list (after telephone consultation explaining diagnosis and treatment)

The result of GPs and hospital specialists working together more closely at the point of referral sets the patient on the right treatment journey and avoids unnecessary appointments.

In 2020, nearly a third of all dermatology referrals were managed with advice and guidance saving more than 3,000 appointments.

By providing direct feedback on referrals patients experience improved waiting times and access to care, while the trust has increased clinical capacity for patients who really need to see a specialist.

Case study: Our new patient portal

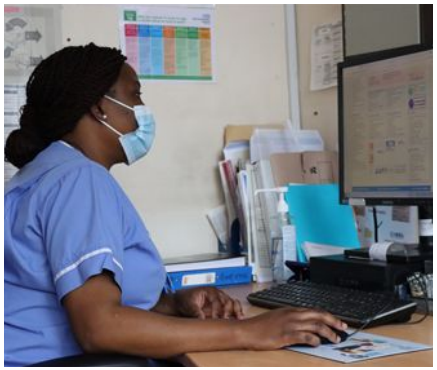
Underpinning our services with quality digital support will empower the population of west Hertfordshire to have more control over their healthcare and enable our staff to provide high quality, personalised and efficient care.

In 2022, we will launch a new patient portal, which allows patients direct access to their medical records on their smart device or laptop. It will also allow them to receive lab results and letters, book and reschedule appointments and give us their feedback.

The patient portal will be available on all smart devices via a mobile webApp and on desktop browsers. Through this flexible digital service, our outpatient services will become more efficient and effective.

This service is already being used at neighbouring trusts and is having a positive impact on patient experience. We expect the number of missed or failed appointments to drop significantly.

Nearly **400,000** patients across the NHS are using the portal



Case study: One stop clinics

Many of our patients make multiple trips to our hospital sites for tests on one or more days, and to see a consultant in outpatients on a different day. However, more one stop clinics like the ones described below are going to be implemented across the trust that enable test and diagnosis on the same day.

Paediatric allergy clinics

The spectrum of allergic conditions in children is increasing and over the past few years we have seen more children referred to us with allergic problems and more complex allergies.

Coming into hospital can be a daunting time for any patient, especially a child. To ensure the experience is a smooth and efficient as possible, children are seen in a one stop allergy clinic where they are reviewed by a senior clinician and, if appropriate, have their allergy testing done on the same day.

At the same time, our allergy nurses provide all the information and training the child and their family needs to manage allergic reactions, use of autoinjectors, inhaler techniques and intranasal steroid administration. Dietician services are also on hand to provide appropriate support.

As a result, our one stop service is providing a prompt diagnosis, appropriate investigations and information to the patients and their families in the fewest possible visits.

Fracture clinics

Patients who have experienced a fracture and are referred for a follow up now have the benefit of having all their interventions in one visit through a new one stop clinic.

They see the orthopaedic doctor, have their plaster changed or removed and have repeat radiology and wound checks. They also receive exercise, advice and education at the earliest opportunity instead of waiting 10 working days for their initial physiotherapy assessment.

The appointment usually takes under an hour.

The clinic has enabled us to improve communication between the multidisciplinary team and through being given early advice, patients are less likely to contact the fracture service with questions. The clinic also prevents unnecessary referrals as patients who can self-manage their condition are easily identified.

Great Care, Delivered Differently

So far, we have described how our clinical strategy will enable us to deliver better care for our patients, but this is only part of our story. With the planned redevelopment of our three hospital sites the future is full of possibility and exciting change for the trust, our staff and our patients.

Our redesign of health and hospital services in west Hertfordshire will create welcoming, safe and medically advanced environments which are easy for patients to navigate and provide services that fit logically together.

But to provide 21st century care in a 21st century hospital, we need a programme of work that encompasses all the necessary changes over the next five years in the lead up to moving into our new hospital buildings.

***Great Care, Delivered Differently* is a comprehensive programme bringing together our clinical strategy, digital strategy, people strategy, and redevelopment strategy to detail the steps we need to make to ensure the changes remain in line with our clinical and digital ambitions and enable them to take place efficiently.**

There are eight programmes:

What does this mean for our patients?

Great Care, Delivered Differently will allow patients to:

- see the right clinician, in the right place, at the right time for them
- choose how they access healthcare and initiate their own follow ups
- get the same outcomes whatever time or day
- stay well at home, and receive more care in home or community settings via virtual monitoring
- avoid unnecessary hospital visits or inpatient stays
- receive valuable information that is easily understood
- access all their records digitally and see all their information is in the same place
- understand more about their condition so they can actively participate in their own care
- understand the outcomes of their care and have greater control over their care
- experience reduced waiting times and late cancellation of operations
- have an open dialogue with our clinical teams
- benefit from a better environment when they do need to visit our sites

Great Care, Delivered Differently

Programme 1
Delivering the best care to the local population, with areas of excellence and partnerships with other acute providers

Programme 2
Delivering integrated care, in partnership with South and West Herts Health & Care partners

Programme 3
Delivering personalised care and shared decision making

Programme 4
Delivering consisitent best practice and best value care

Programme 5
Delivering transformation within Outpatients services and enabling one-stop services, where possible

Programme 6 - People / Workforce

Programme 7 - Digital

Programme 8 - Redvelopment

How are we going to get there?

We recognise and understand the challenges many of our teams are facing at the moment and the thought of these changes could be overwhelming.

The programme will be shaped from clinical input, so patients and our staff are at its heart and we will be investing in extra resources to help deliver the programme. Feedback and two-way communication are really important for it to be successful, so we will be regularly keeping colleagues informed and will encourage staff to get in touch with their comments.

We have made some excellent progress over the past few years, especially in how we continued to provide quality care for our patients through the global coronavirus pandemic. It's not been easy, but the spirit of the #TeamWestHerts way has shone through and enabled us to meet the challenges we face head on.

Looking to the future, our clinical strategy will enable us to continue this momentum and deliver the very best care to our patients into the next decade. It will equip us with the tools we need to modernise our services as we move into our new hospital.

Thank you for all of your hard work and dedication – we are only able to provide the services we do, because of your commitment. We will continue to keep you updated on the strategy's progress.

If you'd like to get in touch about this document or have it translated in to a different language, please contact the trust's communications team on 01923 436280 or email: **westherts.redevelopment@nhs.net**

Find us online @WestHertsNHS

www.westhertshospitals.nhs.uk

Trust Board Meeting
2 December 2021

TITLE OF THE PAPER	Corporate Risk Register Report
AGENDA ITEM	27
PRESENTER	Mike Van der Watt - Chief Medical Officer
AUTHOR(S)	Mustafa Kahn – Risk Lead
PURPOSE	*Please Tick The Appropriate Box* *For Approval*: *For Discussion*: ✓ *For Information*: ✓
EXECUTIVE SUMMARY	The purpose of this report is to provide an update on the status of the Corporate Risk Register (CRR) to the Trust Board. This report captures the decisions made by the Risk Review Group (RRG) on 11 November 2021. **Where applicable, d*ecisions made by the RRG are highlighted in amber under the risk.*** The final data for this report was extracted from Datix on 16 November 2021, with some updates made following the RRG meeting; a total of **27** open risks were registered on the Corporate Risk Register (CRR) at that time. In addition, the RRG reviewed all escalated, de-escalated, closed, increased, reduced, and merged risks where applicable. All risks that were not reviewed at the last meeting of the RRG will be reviewed over the next 12 months in line with the risk review cycle. In response to the Quality Committee's and Trust Board's recommendations, all risks across all divisions are being updated for the current fiscal year, with time signatures in the report's updates section. In addition, the report contains 7 open risks on the CRR arising from the Covid-19 pandemic. The RRG now reviews all Covid-19 related risks on Datix (on the CRR and Divisional risk registers) every quarter.
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	Risk Review Group – 11 November 2021
ACTION REQUIRED	The Trust Board is asked to discuss and review the corporate risk register and endorse the changes.

Agenda Item: 27

Trust Board – December 2021

Title of Paper: 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 Trust Board is the Board's subcommittee, 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. Any outstanding risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to this Committee to agree on future action.

3. Corporate Risk Register

3.1 This report captures the decisions made by the RRG on 11 November 2021. Data for this report was extracted on 16 November 2021, with some updates made following the RRG. ***Decisions made by the RRG are highlighted in amber under the risk.*** A total of **27** open risks were registered on the CRR at that time.

3.2 A full summary of all corporate risks presented to the Risk Review Group on 11 November 2021 is provided in Appendix 1.

3.3 The table below presents risks on the CRR by Division against each month since September 2020.

CLINICAL INFORMATICS	RISK ID		SEPT 2020		OCT 2020		NOV 2020		DEC 2020		JAN 2021		FEB 2021		MAR 2021		APRIL 2021		MAY 2021		JUNE 2021		JULY 2021		AUG 2021		SEPT 2021		OCT 2021		NOV 2021	
	*3899		20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	*4197		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	*4283		15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	*4335																16		16	↑	16	→	16	→	16	→	16	→	16	→	16	→
CLINICAL SUPPORT SERVICES	4444																								16		16	→	16	→	16	→
	*3828		20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	*3120		20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	*4207		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	*4280		20	↑	20	→	20	→	20	→	20	→	20	→	20	→	15	↓	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	*4279				**20**		20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	*4238																				15		15	→	15	→	15	→	15	→	15	→
EMERGENCY MEDICINE	*4019*																						16		16	→	16	→	16	→	16	→
	4068																						16		16	→	16	→	16	→	16	→
	4394																		15	→	15	→	15	→	15	→	15	→	15	→	15	→
ENVIRONMENT	*2883																20		20	→	20	→	20	→	20	→	20	→	20	→	20	→
	*4332				**15**		15	→	15	→	15	→	15	→	15	→	20	↑	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	*2795		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	*4380																16		15	↓	15	→	15	→	15	→	16	↑	16	→	16	→
	4438																								15		15	→	15	→	15	→
	4439																								15		15	→	15	→	15	→
	4451																										20	→	15	→	15	→
	4359										16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
MEDICINE																																
SURGERY & CANCER	*4419																						16		16	→	16	→	16	→	16	→
WOMEN & CHILDREN	*4425																						15		15	→	15	→	15	→	15	→
	4339								16		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	4161		**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→	**16**	→
	4427																						16	↓	15	→	15	→	15	→	15	→

4. Risk Activity

The following provides an overview of risk activity as discussed at the RRG on 11 November 2021:

4.1 New risks (0)

No new risks were presented to the Risk Review Group (RRG) for approval to be added to the CRR.

4.2 Changed Risks (0)

4.3i De-escalated Risks (0)

No de-escalated risks were presented to the RRG meeting for acceptance onto the CRR.

4.3ii Escalated Risks (0)

No escalated risks were presented to the RRG meeting for acceptance onto the CRR.

4.4 Closed Risks 0)

No risks were presented to the RRG meeting for closure.

4.5 Increased risk score (0)

No risks were presented for an increase in the current risk rating at the RRG meeting.

4.6 Reduced risk score (0)

No risks were presented for an increase in the current risk rating at the RRG meeting.

4.7 Merged Risks (0)

During this reporting period, there were no merged risks to consider.

5. Risks Arising From The Covid-19 Pandemic

5.1 There are currently 7 open risks on the CRR 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.

ID	DIVISION	CURRENT RISK RATING	RISK TITLE	EXEC LEAD
4425	Women and Children	15	Closure of co-located Low risk birthing centre and the Impact on women's choice and experience	Tracey Carter - Chief Nurse and Director of IPC
4359	Environment	16	Increase in Mitie Cleaning requirements - during COVID	Hennessey, Patrick - Director of Environment
4339	Women and Children	16	Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels	Tracey Carter - Chief Nurse and Director of IPC
4280	Corporate Services	15	Workforce Wellbeing	Andrew McMenemy - Chief People Officer
4279	Corporate Services	20	Increased Staff unavailability through sickness absence or Covid isolation/symptoms etc	Andrew McMenemy - Chief People Officer
3828	Corporate Services	20	Patients may come to harm and have a poor experience due to long waits for elective care	Sally Tucker - Chief Operating Officer
4444	Clinical Support	16	The six-week diagnostic wait for MRI, as measured by the DM01 key performance indicator, has not recovered since the Covid19 pandemic first began (last performing at 100% in March 2020) and has deteriorated significantly as the waiting list backlog has grown in recent months. WHHT does not have enough MRI capacity to meet demand, with referrals increasing in number and complexity. Current routine waiting time for an MRI is 13 weeks.	Dr Michael van der Watt - Medical Director

5.2 Emerging Risks

There were no emerging risks proposed to the RRG for consideration.

6. Risks

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

7. BAF Report

7.1 The BAF Report prepared by the Trust Secretary has been created in a separate document which will be presented separately.

8. Recommendation

8.1 The Trust Board is asked to discuss and review the corporate risk register and endorse the changes.

Executive Lead: Mike van der Watt
Chief Medical Officer
Date: November 2021

APPENDIX 1 – Corporate Risk Register (by Division)

COVID-19 RELATED	ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	UPDATE	RATING (CURRENT)	EXECUTIVE LEAD
CLINICAL SUPPORT SERVICES (1)							
Yes	4444	15/09/2021	Increased waiting times for routine MRI	16	03/11/2021 - Continuing to outsource to OSD and BMI to maintain/reduce waiting times. Enablement works near completion for mobile scanner however, delay in scanner arrival by 3 weeks. Waiting on date from supplier.	16	Van der Watt, Michael - Medical Director
NOVEMBER RRG MEETING UPDATE There are delays identified in the scanner arriving at HHGH. Discussion to take place with Executives to review Covid-19 classified risks and are they now due to recovery or normal business. **26 November 2021 Update – The scanner is now operational at HHGH.** **Current Score 4 x 4 = 16**							

CLINICAL INFORMATICS (4)							
No	3899	12/06/2017	ICT Trust Bleep System	20	03/11/2021 - Emergency planning (EP) have received data back from the divisions but there are still a lot of gaps. EP have also found on the intranet another list of bleeps, which didn't match up to the other list provided by switchboard. Next steps are to consolidate these two list into one list and then try and bleep each one we aren't sure on (approx. 70% of the list). EP has limited time available to work on the above due to other Trust pressures. Without a validated list of bleep holders that EP agree with we cannot move this project forward. Consequently, deployment of new bleeps is not expected before January.	20	Paul Bannister - Chief Information Officer
NOVEMBER RRG MEETING UPDATE No further changes. **Current Score 4 x 5 = 20**							

No	4197	16/08/2019	Missing Patches - ICT Server Estate	16	14/06/2021 - Onsite (Windows 2012 and above operating systems) Majority of the servers are now on the regular monthly maintenance schedule. 88% of windows servers have been patched to date. Remaining servers require an agreed maintenance/outage windows with the relevant business areas to add these to the ATOS schedule. Onsite legacy (pre-Windows 2012 operating systems) 63% of the windows legacy servers have been patched. 30 of these are WinPATH servers - previous attempts to patch this have failed given the fragile nature of these servers and caused significant disruption to pathology services. 5 servers are part of the Apogee managed print infrastructure and a maintenance/outage windows to do these servers is under discussion with the business Consolidated hypervisor platforms to ensure all hosts are on up-to-date platforms - Legacy hypervisors decommissioned or upgraded.	16	Paul Bannister - Chief Information Officer
NOVEMBER RRG MEETING UPDATE All onsite servers, except for the Winpath production environment are now regularly patched (monthly). The risk being reviewed and updated for December Trust Board. **Current Score 4 x 4 = 16**							

No	4283	20/05/2020	Vulnerabilities causing a cyber security incident	15	20/09/2021 - No change to risk	15	Paul Bannister - Chief Information Officer
NOVEMBER RRG MEETING UPDATE No further changes to this risk. **Current Score 3 x 5 = 15**							

No	4335	04/11/2020	Winpath LIMS Hardware & Software	12	17/09/21 - The project has commenced. Atos have built the infrastructure. Clinisys are now configuring the software. However the next phase of work is delayed due to Clinisys resource. This has been escalated within Clinisys. Risk remains unchanged.	16	Paul Bannister - Chief Information Officer
NOVEMBER RRG MEETING UPDATE The project is continuing as per the project plan however, no further changes to this risk score. **Current Score 4 x 4 = 16**							

CORPORATE SERVICES (6)							
No	4207	12/09/2019	Inadequate post in-patient discharge appointment booking processes	20	04/11/2021 - The business case is nearing completion and it is anticipated that the new process will take place for 12 months to be reviewed in line with the EPR roll out. The risk remains the same until the change is implemented.	16	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Business case has been approved and a report is being presented at TMC. **Current Score 4 x 4 = 16**							

Yes	4279	28/04/2020	Increased Staff unavailability through sickness absence or Covid isolation/symptoms etc	16	04/11/2021 - Risk level remains the same	20	Andrew McMenemy – Chief People Officer
NOVEMBER RRG MEETING UPDATE For review in December 21 due to Covid-19 or a general unavailability. **Current Score 4 x 5 = 20**							
No	4238	03/12/2019	Lack of in reach mental health services and tier 4 specialist provision for under 18yrs patients including eating disorders	20	04/11/2021 - Named Nurse for mental health and complex social needs now in post and providing support, clinical oversight and case management to all under 18s admitted with mental health issues. MARSiPAN process embedded for under 18s admitted with acute eating disorders. 3 days of clinical holding training completed for clinical staff. Ongoing provider meetings with partners across ICS - model for MHLT for CYP being developed.	15	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Liaison model has been funded with HPFT as the lead provider working with partners to implement. **Current Score 3 x 5 = 15**							

No	3120	09/07/2014	Lack of Storage facility for Patient Medical Notes leading to missing, poor condition and delayed location	20	16/06/21 - Outsourcing of medical records to commence 26 July 2021 - To be completed late September 2021. This will mitigate the risk due to record only being held within the Trust for future appointments 10 days pending. Risk will then be closed at that stage	20	Paul Bannister - Chief Information Officer
NOVEMBER RRG MEETING UPDATE Review taking place prior to December Board. **Current Score 4 x 5 = 20**							

Yes	3828	09/11/2016	Patients may come to harm and have a poor experience due to long waits for elective care	15	08/11/2021 - Director of Performance advised there is no change to the risk.	20	Sally Tucker - Chief Operating Officer
NOVEMBER RRG MEETING UPDATE No change to this risk. **Current Score 4 x 5 = 20**							

Yes	4280	28/04/2020	Workforce Well-Being	16	04/11/2021 - Risk level remains the same. Actions noted at end of August continue to be implemented.	15	Andrew McMenemy – Chief People Officer
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the update provided. **Current Score 5 x 3 = 15**							

EMERGENCY MEDICINE (4)							
No	4019	30/04/2018	Ambulance handover delays affecting patient pathway and escalation	20	01/11/2021 - Ambulance conveyances to WGH continue to be high, in September the average ambulance handover time improved from 31 minutes in August to 29 minutes in September. Conveyances are 23.3% higher than in 2019/20. The number of over 60-minute offload delays significantly improved from 267 in August to 197 in September. EEAST faced significant challenges throughout September across the region seeing unprecedented high number of calls resulting in declaration of a critical incident. As a consequence of the off-load delays incurred across the region. on 26th October all Trusts in the ICS received a letter from NHSE/I addressing their concerns regarding ambulance handover delays.	16	Sally Tucker - Chief Operating Officer
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 4 x 4 = 16**							

No	4068	23/08/2018	Challenges in maintaining patient flow at times of peak operational and capacity pressures	20	01/11/21 - Attendances continue to remain high along with high ambulance conveyances. Our Covid19 footprint has increased to provide additional Covid19 positive beds. These measures impact on flow due to the reduction in the general acute bed base together with the requirement to use part of EAU as an inpatient area.	16	Sally Tucker - Chief Operating Officer
NOVEMBER RRG MEETING UPDATE Risk reviewed at Risk Review Group on 11 November 2021 with no further updates or actions. **Current Score 4 x 4 = 16**							

No	4451	29/09/2021	Challenges in maintaining patient flow at times of peak operational and capacity pressures	20	04/11/2021 - Mental Health pathway is in place and staff are using the pathway. Mental health training programme started for nursing staff	15	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Risk reviewed at Risk Review Group on 11 November 2021 with no further updates or actions. **Current Score 3 x 5 = 15**							

No	4394	14/05/2021	Mental Health patients in Emergency Department (ED)	15	04/11/2021 - Continue to audit the use of MH pathway in ED. Mental Health Training provided for nursing staff.	15	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Risk reviewed at Risk Review Group on 11 November 2021 with no further updates or actions. **Current Score 3 x 5 = 15**							

ENVIRONMENT (7)							
No	2883	13/10/2012	Control of Legionella and Management of water systems	16	17/11/2021 - No change to score, assurances or controls.	20	Patrick Hennessy-Director of Environment
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 5 x 5 = 20**							

No	4439	26/08/2021	Electrical infrastructure risks on the SACH site	15	17/11/2021 - No change to score, assurances or controls.	15	Patrick Hennessy- Director of Environment
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 3 x 5 = 15**							

No	4438	26/08/2021	Electrical infrastructure risks on the WGH site	15	17/11/2021 - No change to score, assurances or controls.	15	Patrick Hennessy- Director of Environment
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 3 x 5 = 15**							

Yes	4359	14/01/2021	Increase in Mitie Cleaning requirements - during COVID	16	04/11/2021 - Mitie are struggling to maintain cleaning standards overall across both the contracted cleaning and the temporary variations to contract that have been put in place. Mitie have been unable to recruit staff so existing staff are under pressure working long hours over extended periods. Mitie have used agencies for temporary staffing but this has also impacted on the efficacy of cleaning Facilities staff are regularly auditing Mitie cleaning allocations and there is a particular problem at weekends. It has been identified and documented that Mitie have insufficient staff to maintain standard cleaning and enhanced cleaning in public areas, especially over weekends and bank holidays. Along with Audits for standard and enhanced cleaning, Facilities are carrying out ATP testing and UV testing will be used going forward. As a result of the reductions in standards and the lack of assurance over cleaning standards, Principles Meetings have been instigated and an action plan has been put in place in an attempt to resolve the ongoing concerns raised.	16	Patrick Hennessy-Director of Environment
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 4 x 4 = 16**							

No	2795	15/12/2011	Management and control of - Asbestos Containing Materials (ACMs)	20	17/11/2021 - No change to score, assurances or controls.	16	Patrick Hennessy-Director of Environment
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 4 x 4 = 16**							

No	4332	12/10/2020	Water Safety Incident affecting PMoK, Cherry Tree House and Restaurant buildings	20	17/11/2021 - No change to score, assurances or controls.	20	Patrick Hennessy- Director of Environment
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 4 x 5 = 20**							

MEDICINE (0)

SURGERY & CANCER (1)							
No	4419	30/06/2021	Long term sickness & vacancies within theatres resulting in reduced capacity available for emergency & elective theatre lists	**16**	06/11/2021 – Recruitment drive and Adverts out. (ongoing). Working with theatres on promotion video Nov 21 - due to current capacity. Looking at development plans in all of theatre roles and lateral development as well as into more senior roles. Est. plan Jan 2022. Also initiating conversations into blended skill working to reduce resourcing issue. This is a 2-3 year plan. 2022 due to capacity. Theatre workforce plan with short medium and long term goals. (July 2022). Staggered start dates of 13 successful candidates to ensure sufficient training and support. Dates to be confirmed.	16	Andrew McMenemy – Chief People Officer
NOVEMBER RRG MEETING UPDATE No further updates received at the group further to the review of the risk. **Current Score 4 x 4 = 16**							

WOMEN'S AND CHILDREN (4)							
Yes	4425	19/07/2021	Closure of co located Low risk birthing centre and the Impact on women's choice and experience	15	04/11/2021 - From today ABC will be open for low risk women on an individual case basis due to low acuity and current staffing levels being manageable on DS. Staffing projections over the 3 weeks will be assessed to formally open the ABC from Monday. Staffing has improved due to preceptors now finishing their induction periods and are now in the staffing levels. The homebirth service remains ongoing throughout this period where staffing allows.	15	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Risk to be reviewed in December 21. **Current Score 3 x 5 = 15**							

Yes	4339	20/11/2020	Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels	20	06/11/2021 - Risk reviewed at the November 2021 Risk Review Group. TC stated we are reviewing this monthly. DB confirmed we have 17 new starters who will start to be included in the staffing numbers. We are still recruiting, there is another projected 20 midwives. TC stated we will review in January to see if we can reduce the risk rating.	16	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Risk reviewed at Risk Review Group on 11 November 2021 with no further updates or actions. **Current Score 4 x 4 = 16**							

No	4161	13/04/2019	Lack of appropriately trained staff to safely manage level 2 high dependence cases in OOB on D/S	20	07/10/2021 – 4 Midwives starting the HDU course this semester to address the shortfall in appropriately trained staff. Due to increased staffing pressures still not achieving 5.22 W.T.E to achieve 24hour cover. given maternity, career break and core this leaves a deficit.	16	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE Risk reviewed at Risk Review Group on 11 November 2021 with no further updates or actions. **Current Score 4 x 4 = 16**							
No	4427	1/04/2019	There are recurrent delays in the Induction of Labour (IOL) Pathway including planned admission from home for IOL and transfer from the antenatal ward to the delivery suite for further care and management.	16	07/10/2021 - Improvement to IOL pathway delayed due to long term sickness. More staff have now been trained to address this. Delays in transfer to delivery suite is reviewed daily as part of the bleep holder duties and brought to the senior midwives safety brief. Non-clinical and managerial staff are redeployed to offer support as required to meet the fluctuating needs of the service. EOE acknowledges staffing vacancies and sickness increasing number of shift vacant within maternity services. Staff heat map within the east of England as part of the escalation process and multi-speciality working with external agencies and organisations. Informing review of in utero transfer if delay in induction of labour cases.	15	Tracey Carter - Chief Nurse and Director of IPC
NOVEMBER RRG MEETING UPDATE The RRG agreed to bring this risk back in January 22 to take into consideration NICE guidance changes. **Current Score 3 x 5 = 15**							

Trust Board
2 December 2021

Title of the paper	Items considered in November Private Trust Board
Agenda Item	28
Presenter	Barbara Anthony, Trust Secretary
Author(s)	Barbara Anthony, Trust Secretary
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	To note in the public domain an outline of the matters covered in private, due to their confidential nature, since the last meeting in public on 2 November 2021.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care – *Objectives 1-4*: ✓ **Aim 2** Great team – *Objectives 5-8*: ✓ **Aim 3** Best value – *Objective 9*: ✓ **Aim 4** Great place – *Objective 10-12*:
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	Committee/Group: Date:
Action required	The Board is asked to note matters discussed at the last meeting in private (Part 2) session.

ITEMS FOR DISCUSSION	
	None
ITEMS FOR DECISION	
1	None
ITEMS FOR INFORMATION AND ASSURANCE	
2	Feedback on Board ward and departmental visits – the Board received feedback from visits by Board members to: o SACH Community Midwifery Team (Virtual) o Breast Clinic o Tudor o Paediatrics
3	SI Report – the Chief Medical Officer updated the Board about serious incidents that had occurred in the previous 2 months.
4	Riddor staff reporting – the Chief Nurse updated the Board on the report made to HSE.
5	CQC inspection (maternity) update – the Chief Nurse updated the Board about the recent inspection of maternity services.
6	HSE pathology update – the Divisional Director for Clinical Support Services updated the Board about the recent inspection of pathology services.
8	Strategy update – The Deputy CEO updated the Board on progress with the Trust's strategy and redevelopment plans.

Trust Board Meeting
2 December 2021

Title of the paper	**Audit Committee Annual Report 2020/21**
Agenda Item	29
Presenter	Edwin Josephs, Audit Committee Chair
Author(s)	Barbara Anthony, Trust Secretary
Purpose	*For approval* [ ] *For discussion* [ ] *For information* [√]
Executive Summary	In line with best practice in other sectors, the Audit Committee is required to prepare an Annual Report to the Board that sets out how the Committee has discharged its responsibilities and met its terms of reference. The Annual Report summaries the activities undertaken by the Audit Committee for the year 1 April 2020 to 31 March 2021. Points of note during the year: • Financial year 2020/21 was an extraordinary year due to the pandemic which caused disruption to the committee assurance programme, publication of the Quality Account and the end of year audit of the financial statements. • A limited programme of assurance reports was received from TMC and Great Place Programme Board during 2020/21. The Audit Committee was assured that the Committees were meeting their terms of reference. • The external Auditors issued an unqualified opinion on the financial statements and issued an audit certificate following completion of their work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. • The Head of Internal Audit provided moderate assurance that there was a sound system of internal control, designed to meet the Trust's objectives and that controls were being applied consistently. • The membership of the committee changed. Edwin Josephs became the Chair, Helen Davis are Natalie Edwards non-executive director members.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** **Best care** — ***Objectives 1-4*** — √ **Aim 2** **Great team** — ***Objectives 5-8*** — √ **Aim 3** **Best value** — ***Objective 9*** — √ **Aim 4** **Great place** — ***Objective 10-12*** — √
Links to well-led	☐Is there the leadership capacity and capability to deliver high quality,

<table>
<tr><td>key lines of enquiry</td><td>sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
X Is there a culture of high quality, sustainable care?
X Are there clear responsibilities, roles and systems of accountability to support good governance and management?
X Are there clear and effective processes for managing risks, issues and performance?
X Is appropriate and accurate information being effectively processed, challenged and acted on?
X Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
X Are there robust systems and processes for learning, continuous improvement and innovation?
X 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>N/A</td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to accept the annual report as assurance on the effectiveness of the committee’s work in 2020/21 and that it took appropriate steps to perform its duties delegated by the Board.</td></tr>
</table>

Agenda Item: 29

Trust Board meeting – 2 December 2021

Audit Committee Annual Report 2020-21

Presented by: Trust Secretary

1. Introduction

The Audit Committee is a senior independent non-executive Committee of the Board. This report summarises the activities undertaken by the Committee to satisfy its terms of reference for the year 1 April 2020 to 31 March 2021.

2. The role and operation of the Audit Committee

The NHS Code of Conduct and Accountability and the NHS Audit Committee Handbook requires that an Audit Committee is established to provide an independent and objective view to the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes and securing economic, efficiency and effectiveness (value for money).

The establishment and constitution of the Audit Committee is mandated by the Trust's standing orders, which were updated and endorsed by the Board in November 2020.

The Audit Committee is authorised to take decisions on behalf of the Board on matters relevant to the purpose of the Committee (but not reserved to the Board), to obtain outside legal or other independent professional advice, and to secure attendance of others with relevant experience and expertise if they consider this to be necessary.

2.1 Governance, establishment and duties

2.1.1 Membership of the Committee

Members of the Audit Committee are appointed by the Board to ensure that the non-executive directors have sufficient knowledge to identify key risk areas and to challenge both management and the Auditors on critical and sensitive matters. As well as the three non-executive Committee members, there is an open invitation to the remaining non-executives to attend Audit Committee meetings if they wish.

The regularly invited members of the Executive to attend meetings are: Chief Financial Officer, Deputy Chief Executive, Chief Nurse and Director of Infection Prevention and Control and Director of Clinical Governance. The Chief Executive attends when the Committee considers the process for assurance that supports the Annual Governance Statement and the annual Report and Accounts.
Internal Auditors, external Auditors and the local counter fraud specialist are required to attend each meeting.

The Trust Secretary provides support to the Chair and the wider Committee.

The members of the Committee disclosed their declarations of interest at each meeting. The following were the interests declared during the period of this Report.

Paul Cartwright, non-executive director and Chair of Audit Committee (1 April 2020 – 9 October 2021)

- Member of Council of King's College London
- Member of Charity Committee for West Hertfordshire Hospitals NHS Trust

John Brougham, non-executive director (1 April 2020 – 5 January 2021)

- Non-Executive Director and Chair of the Audit Committee of Technetix Ltd

Edwin Josephs, non-executive director and Chair of Audit Committee (November 2020 – to date)

- Member of the Vine House Health Centre Patient Participation Group

Helen Davis, associate non-executive director (from January 2021 – to date)

- Director and shareholder at Brierley Advisory LLP
- Associate Consultant at Archus (until June 2021)
- Partner - senior civil servant at DHSC

Natalie Edwards, non-executive director (from 5 January 2021- previously associate non-executive director).

- None

2.1.2 Meetings and attendance

All meetings were quorate and chaired by a non-executive director. Natalie Edwards was a nominated reserve non-executive director and therefore was only required to attend meetings when the quorum would be compromised. A breakdown of attendance of meetings is presented below:

	Audit Committee members		
Meeting date	Paul Cartwright (Chair of Committee)	John Brougham	Natalie Edwards (nominated reserve)
28 April 2020 (informal)	✓	✓	Not required
15 June 2020 *(extraordinary to approval of annual documents)*	✓	✓	Not required
24 July 2020	✓	✓	Not required
9 October 2020	✓	✓	Not required
Meeting date	Edwin Josephs (Chair of Committee)	John Brougham	Natalie Edwards (nominated reserve)
19 November 2020	✓	✓	✓
27 November 2020	✓	Apologies	✓
Meeting date	Edwin Josephs (Chair of Committee)	Helen Davis	Natalie Edwards (nominated reserve)
19 February 2021	✓	✓	Not required

2.1.3 Terms of reference

The Committee's terms of reference (appendix 1) were reviewed against the revised guidance for Audit Committees issued by the UK Corporate Governance Code and the Financial Reporting Council (FRC) in April 2018 and adopted by the Board on 19 February 2021.

2.1.4 Delivery of the work plan

The work of the Committee was delivered around a structured work plan (appendix 2), aligned with its terms of reference and endorsed by the Board on 3 June 2021. Each meeting agenda included the standing items listed below, with the exception of meetings on 28 April 2020 and 15 June 2020, which focused on the development and approval of the Annual Report and Accounts and 19 and 27 November 2020, which focused on the approval of the Quality Account.

- Chief Financial Officer's overview
- Internal Audit progress report
- Local counter fraud report
- External audit progress report
- Review of the following:
  - Tender waiver register
  - Losses and compensation register
  - Review of salary overpayments
  - Hospitality and gifts register
  - Central register of interests
  - Trust seal

The Committee relied on the internal audit programme of work to review the arrangements in place to manage risk, including the maintenance and monitoring of the board assurance framework (BAF), which was adapted due to the disruption caused by the pandemic. The Trust maintained the risk management strategy and procedure developed over the previous year which had been reviewed to reflect a revised governance structure. Work continued throughout the year to improve the Board Assurance Framework (BAF) and, following approval of a refreshed set of strategic objectives, the format of the BAF was reviewed to ensure that it fully met the needs of the Board.

On a limited rolling programme, the non-executive chair and executive lead for each Committee provided assurance to the Audit Committee that TMC and Great Place Programme Board were operating effectively and were appropriately controlling risk.

The Committee reviewed the 2019/20 quality account on behalf of the Trust Board prior to publication in December 2020.

During the year, the Committee continued to systematically monitor and have 'deep dives' into the controls in place around tenders, losses and compensation and salary overpayments. The Committee noted the progress in reducing instances of salary overpayments particularly that an electronic form was now in place to action salary changes. The Committee would continue to monitor salary overpayments on an on-going basis.

In addition to the areas covered above, during 2020/21, the Audit Committee also monitored the following areas:

- Committee effectiveness and terms of reference
- Conflicts, gifts and hospitality registers
- Clinical audit plan
- Standing financial instructions, standing orders and scheme of delegation
- Annual Accounts and Annual report, including Annual Governance Statement
- Directors' liability insurance
- Insurance policy compliance

2.1.5 Reporting from the Committee

The chair of the Committee provided an assurance report to the Board following each meeting and escalated areas of concern and underperformance.

3. COVID-19 Pandemic

Following the declaration of a level 4 national incident on 3 March 2020, interim governance arrangements were put in place to maintain reasonable and appropriate processes and effectively streamline activities to prioritise Executive and clinical focus on COVID-19. The Audit Committee requested a desktop review be carried out to ensure that all decisions made by the Trust during the pandemic had been appropriate an in line with the Trust's standing orders. As a result of the review the Committee took assurance that decisions taken during the COVID-19 pandemic for the period 5 March 2020 to 28 May 2020 were appropriate and in line with the Trust's Standing Orders.

4. Independent assurance

4.1. Internal Audit

BDO acted as the Trust's Internal Auditors in 2020/21 and a structured Audit Plan was approved by the Audit Committee on 15 June 2020. BDO provided progress reports on the delivery of the Plan at each meeting and an end of year report. During 2020/21, internal audit undertook 11 audits and issued six moderate and 3 substantial assurance opinions for design and 7 Moderate, 1 substantial and 1 limited assurance opinions for operational effectiveness. In addition, there were two advisory reports.

All internal audits were mapped to an assurance Committee and aligned to an executive lead to ensure full ownership. A full report was received at each meeting on progress towards implementing the recommendations, with particular attention paid to overdue actions which the Committee continues to monitor.

For the 12 months ended 31 March 2021, the Head of Internal Audit opinion provided moderate assurance that there was a sound system of internal control, designed to meet the Trust's objectives and that controls were being applied consistently.

4.2. External Audit

External audit services were provided by Grant Thornton UK LLP (GT) and it completed a full and thorough audit of the Trust's accounts for 2020/21. This was against the backdrop of restrictions caused by the Covid-19 pandemic and resulted in the audit having to be conducted remotely. The Trust received an unqualified opinion on the 20/21 accounts.

4.3. Local counter fraud service

Local counter fraud services were provided by RSM UK. Regular reports were received through the year from the local counter fraud services which provided assurance to the Committee and provided detail on investigations undertaken to counter fraudulent activities. The Committee received assurance that benchmarking had suggested that that the Trust's counter fraud measures were as effective as other Trusts.

5. Internal assurance

5.1. Freedom to Speak Up (whistleblowing)

The Freedom to Speak Up (FTSU) arrangements were reviewed by the Committee during the year but following the appointment of the FTSU Guardian, this responsibility was transferred to People, Education and Research Committee for 2021/22. The Audit Committee would assure itself on the effectiveness of FTSU through its conversation with PERC via the committee assurance process.

5.2. Audit performance

The Audit Committee undertook a self-assessment of its performance to measure its effectiveness on 24 July 2020. The outcome of the self-assessment revealed that the Committee had met its terms of reference in 2019/20.

6. Conclusion

As Chair, I can confirm that the Audit Committee has reviewed its business over 2020/21 and appropriate steps have been taken to perform its duties as delegated by the Board. There are no significant issues of concern for the Board in this Annual Report.

The Committee has contributed to improving internal control within the Trust and can provide the Board with assurance that, by meeting its terms of reference, the Committee has scrutinised the levels of controls in place to ensure the Trust remains compliant with its legislative and statutory duties.

In making this statement, the Committee acknowledges the support provided to it by management, in particular the Chief Financial Officer, the Deputy Chief Executive, the Director of Governance, the Trust Secretary, and by the internal and external auditors.

During 2021/22, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its effectiveness.

Edwin Josephs
Chair, Audit Committee

September 2021

Appendix 1. Terms of reference 2020/21.
Appendix 2. Work plan 2020/21.