TRUST BOARD MEETING IN PUBLIC
AGENDA

4 February 2021 at 09.30 – 12.00
Executive Meeting Room and via Zoom, Watford Hospital

Apologies should be conveyed to the Interim Trust Secretary, Barbara Anthony on
barbara.anthony@nhs.net
or call 01923 436 361

Time	Item ref	Title	Purpose	Accountable officer	Paper or verbal
Standing items					
09.30	1/87	**Opening and welcome**	Information	Chair	Verbal
	2/87	**Patient story**	Information	Chief Nurse	Verbal
09.50	3/87	**Apologies for absence**	Information	Chair	Verbal
	4/87	**Declarations of interest**	Information	Chair	Paper
	5/87	**Minutes of previous meeting on 3 December 2020**	Approval	Chair	Paper
	6/87	**Board decision log.**	Information	Chair	Paper
	7/87	**Board action log**	Approval	Chair	Paper
	8/87	**Chair's and Chief Executive's report**	Information	Chair / Chief Executive	Paper
Performance					
10.00	09/87	**Board Assurance Framework**	Approval	Chief Executive	Paper
10.10	10/87	**Activity Recovery Update & Access Standards Performance**	Information and assurance	Chief Operating Officer	Paper
	11/87	**Integrated performance report** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Finance Officer • Chief Information Officer	Information and assurance	Chief Operating Officer	Paper
Aim 1: Best Care					
10.25	12/87	**Covid-19 Briefing – update**	Information and assurance	Chief Nurse	Paper
	13/87	**Ockenden Review of Maternity Services**	Information and assurance Approval	Chief Nurse	Paper /presentation

Aim 3: Great Team					
Aim 4: Great Place					
10.45	14/87	**Strategic Priorities Update**	Information and assurance	Deputy Chief Executive	Paper
	15/87	**Clinical Strategy**	Approval	Deputy Chief Executive	Paper
	16/87	**Clinical Engagement plan**	Approval	Deputy Chief Executive	Paper
	17/87	**Hertfordshire and West Essex ICS update (referenced in item 14/87)**	Information	Deputy Chief Executive	Newsletter and Verbal
Risk and Governance					
11.25	18/87	**Corporate Risk Register report**	Approval	Chief Medical Officer	Paper
	19/87	**Board Engagement report**	Information and assurance	Chief Nurse	Paper
Committee Reports					
11.30	20/87	**Trust Management Committee**	Information and assurance	Chief Executive	Paper
	21/87	**People, Education and Research Committee**	Information and assurance	Chair of Committee/Chief People Officer	Verbal
	22/87	**Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
	23/87	**Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	24/87	**Great Place Committee**	Information and assurance	Chair of Committee Deputy Chief Executive	Paper
	25/87	**Charity Committee**	Information and Assurance	Chair of Committee / Deputy Chief Executive	Paper
Closing Items					
11.45	26/87	**Any other business previously notified to the chair**	N/A	Chair	Verbal
11.50	27/87	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal
	28/87	**Questions from our patients and members of the public**	N/A	Chair	Verbal
12.00	29/87	**Date of the next board meeting: 4 March 2021** Executive Meeting Room and via Zoom, Watford Hospital	Information	Chair	Verbal

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Acronyms and abbreviations

A

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

B

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

C

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

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

D

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

E

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

F

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

G

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

H

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

I

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

J

JSNA	Joint Strategic Needs Assessment

K

KLOE	Key Line of Enquiry
KPI	Key Performance Indicator

L

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

M

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

N

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

O

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

P

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

Q

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

R

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

S

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

T

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

U

UCC	Urgent Care Centre
UTI	Urinary Tract Infection

V

VFM	Value For Money
VSM	Very Senior Manager
VTE	Venous Thromboembolism

W

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

Y

YTD	Year to date
YCYF	Your care, your future

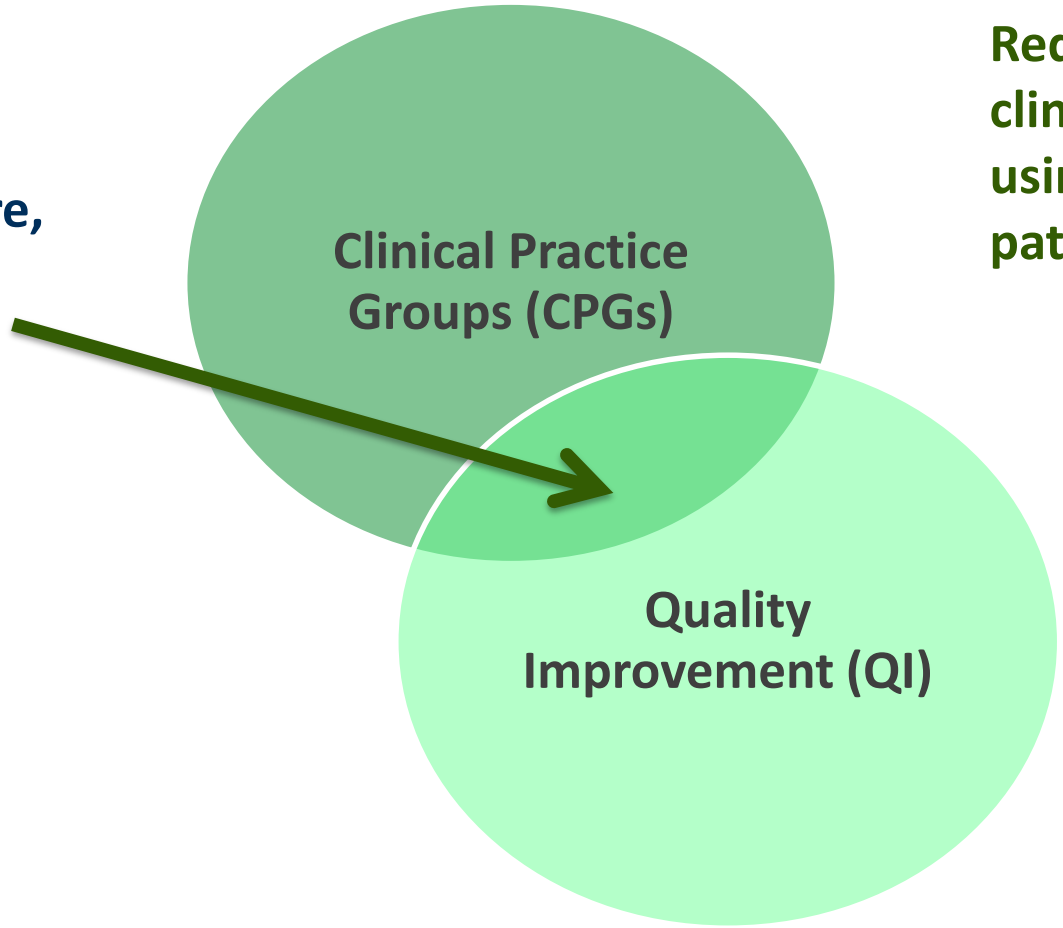
Impact of the CPG Programme on Patient Outcomes and Flow

February 2021

Tejal Vaghela – CPG Programme Manager
Freddie Banks – Associate Medical Director for Strategy/CPG Lead Clinician
Fran Gertler – Director of Integrated Care

Clinical Practice Groups (CPGs)

Optimise patient care, safety and outcome



Reduce unwarranted clinical variation using standardised pathways

Develop a continuous improvement culture

CPG Team Structure

Mike Van der Watt / Tracey Carter
(Medical Director/Chief Nurse)
To deliver the best quality care for our patients
Getting to Good

CPG Core Team

Helen Brown
Deputy Chief Executive
Fran Gertler
Director of Integrated Care
Freddie Banks
Associate Medical Director for Strategy/CPG Lead Clinician
Tejal Vaghela
CPG Programme Manager
Miriam Schechter
CPG Data Collection Officer
Liezel Wolmarans/Olivia Schiffer/Seena Shah
CPG Analyst
Mark Wykes
Finance
RFL Clinical Partnership
Kam Kalaria
Associate Director-Service improvement
(Provides bespoke CPG programme training and leadership)

Quality Improvement (QI) team

Michelle Boot
QI Lead Nurse and Team

Women's and children's Division

Wheezy child: Dr Lynn Sinitsky
Induction of labour: Miss Folasade Akhanoba
Early Pregnancy: Miss Folasade Akhanoba

Medicine Division

Anaemia: Dr Branov Czako
Frailty: Dr Gemunu Cooray

Emergency Medicine Division

Pneumonia - Dr Ajitha Jayaratnam
Chest Pain – Dr Shajeel Khan; Dr Niall Keenan; Dr Mohammed Arif

Surgery Division

Right Upper Quadrant Pain: Mr Daniel Sinitsky
Prostate: Mr Freddie Banks

Prostate

Aim

Reduce unwarranted variation in patient access to diagnostic by implementing nurse led triage of prostate cancer 2ww referral for “straight to test” process.

Pathway Changes

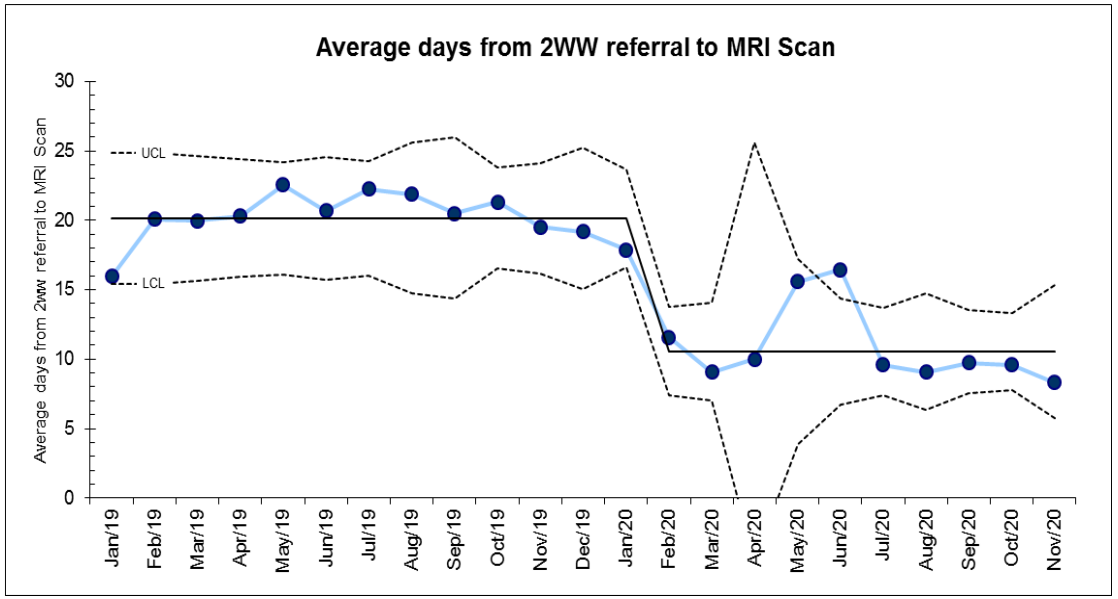
- Nurse triage referrals (MRI)
- Phasing out TRUS biopsy in theatres in preference of Template biopsy under local anaesthetic

Expected impact

→ Faster diagnoses

→ Patient wellbeing and satisfaction

→ Reduction in theatre time



“Straight to test pathway” implemented Jan 20

Average days from 2WW referral to MRI scan

↓10 days

Frailty

Aim

Early identification of people with frailty to enable appropriate decisions, improve outcomes

Pathway Changes

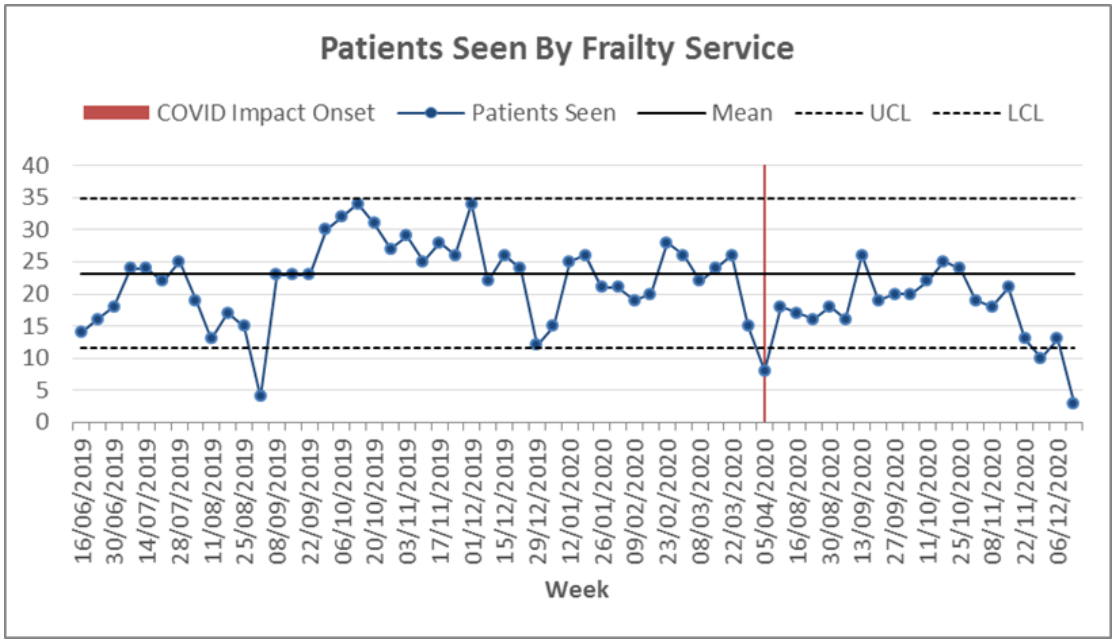
- Identifying patients who have frailty
- Frailty February to raise awareness of frailty

Expected impact

→ Reduces avoidable hospitalisation

→ Better outcomes for frail patients

→ Increased awareness of frailty



- **100%** CFS score recorded for admitted patients
- Average **24** patients seen weekly by Frailty service
  - **50%** of these patients are discharged when would have otherwise been admitted without the service
- **Frailty service was paused during the COVID19 pandemic**
  - from April to August 20, and From Dec 20 to present

Induction of Labour

Aim

Improve clinical outcomes and reduce hyperstimulaton by introducing a mechanical form of the IOL method

Pathway Changes

- Minimising time taken for data collection
- Data availability to show duration of each process for Induction of labour
- Dilapan rods-mechanical method of induction rather than Propess

Expected impact

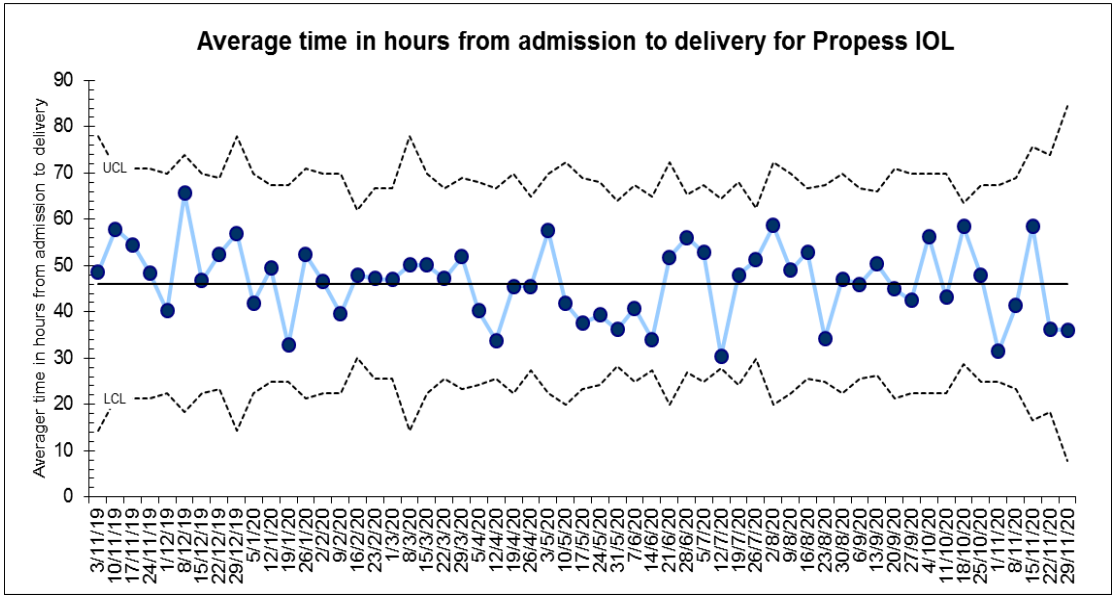
→ Reduces inpatient LOS by 1 day

→ Increase in patient satisfaction

→ Reduction in hyperstimulaton and SBCU admissions

→ More outpatient IOL using Dilapan rods

	Original data collection	New data collection
Number of manual fields	24	14
Approximate time on each patient	15 minutes	2.5 minutes
Average number of patients analysed per month	90	90



Manual data ↓**41%** and collection time ↓**83%**
Dilapan pilot showed average time from insertion to cervical ripening 16 hrs vs 24 hrs for Propess IOL ↓**33%**

Anaemia

Aim

To improve quality of life in patients presenting with iron deficiency anaemia by effective and efficient increase in Haemoglobin

Pathway Changes

Reflex ferritin on low Hb for pre op admission implemented on 28th October 2020

Developing IV iron infusion pathways

Expected impact

- → Reduce re-admissions
- → Reduce LOS post op
- → Optimise patients pre surgery/delivery
- → Reduction is blood transfusions

- Heart failure patients
- Haematology and gastro patients
- Pregnant women
- Pre-operative patients

31% of anaemic pre-operative patient had ferritin test

Post Automatic reflex testing for anaemic pre-operative patients in the lab for ferritin levels

↑100%

Cardiac Chest Pain

Aim

To streamline management of patients presenting with cardiac chest pain to reduce avoidable admissions

Pathway Changes

- Introduction of “One hour pathway”

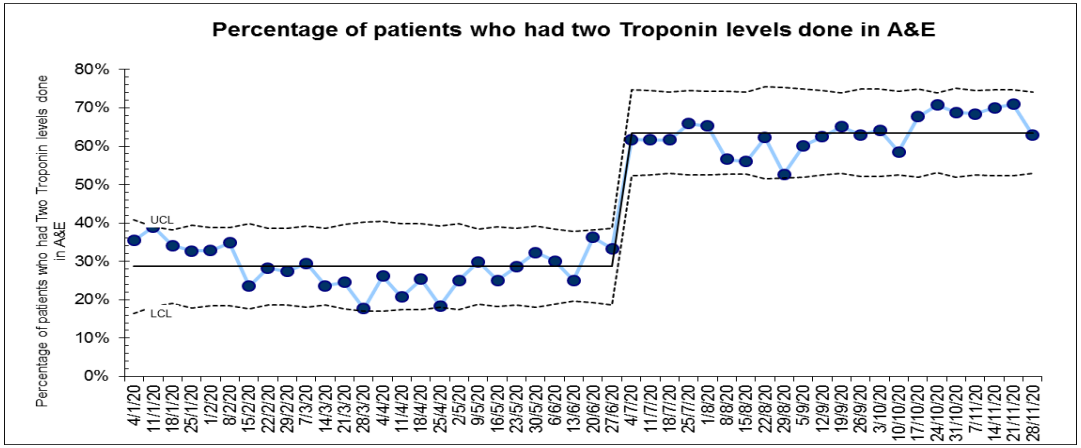
Expected impact

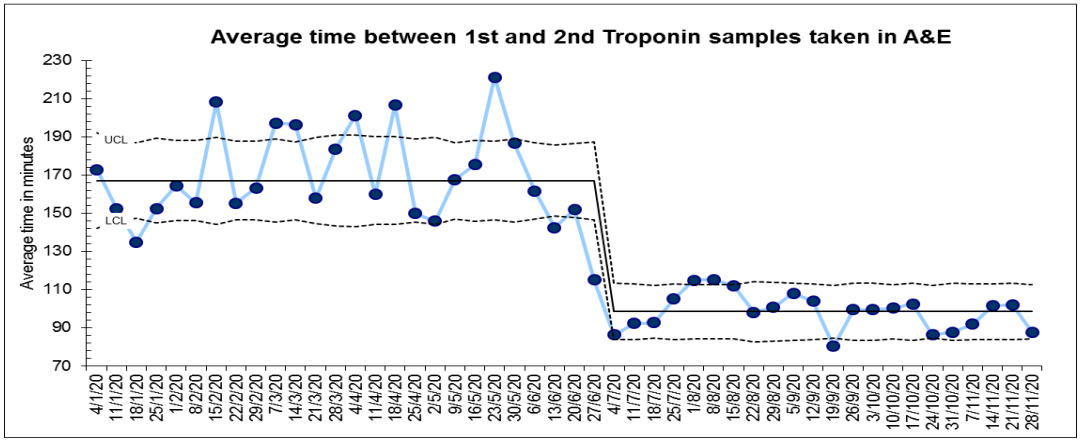
→ Reduces avoidable admissions

→ 4 hour AE targets

→ Faster diagnosis

→ Patient satisfaction





Number of patients with Two Troponin levels done in ED ↑35%

Time interval between 1st and 2nd Troponin sample ↓41%

Wheezy Child

Aim

95% of children 2-16 years managed according to wheeze pathway.

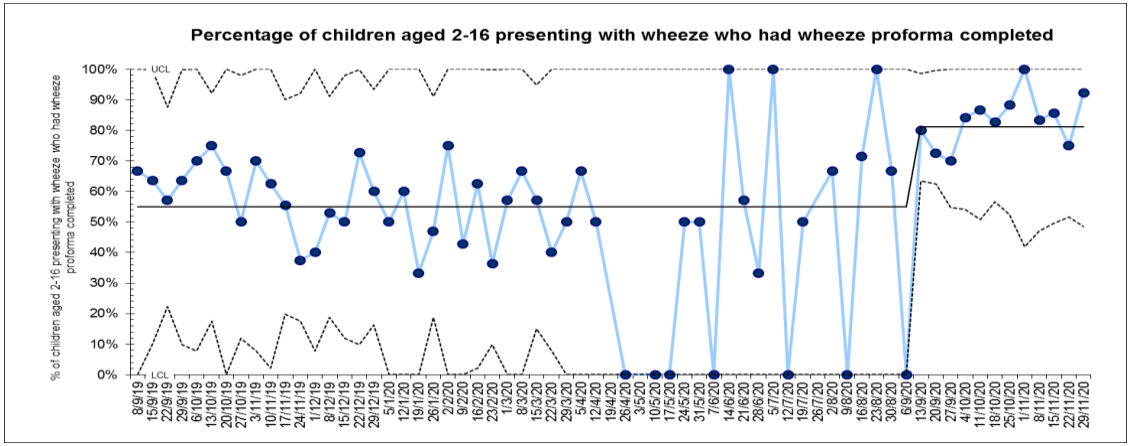
Pathway Changes

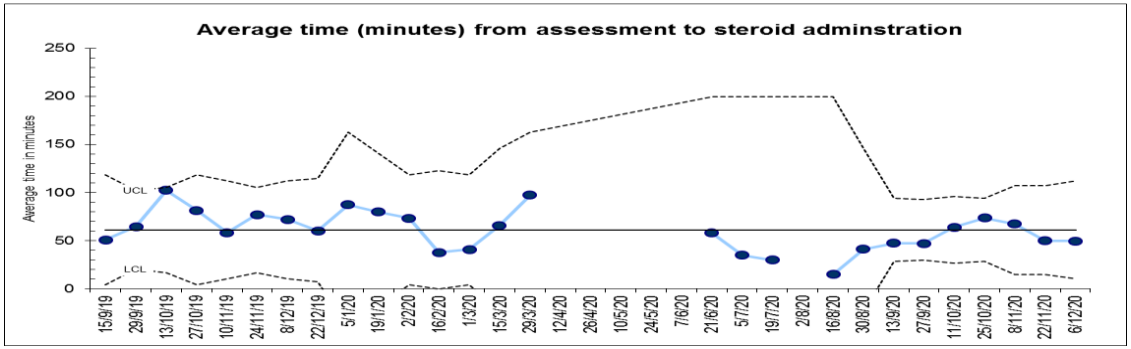
- Data collection process
- Wheezy Child Pathway update
- Steroid administration within 1 hour of assessment
- Patient co-design

Expected impact

→ Reduction in LOS

→ Reduction in readmission/re-attendances





Proforma usage ↑27

Time from assessment to steroid administration: 61mins

Early Pregnancy

Aim

High quality, timely and accurate diagnosis of pregnancy for women who present with vaginal bleeding to the EPU.

Pathway Changes

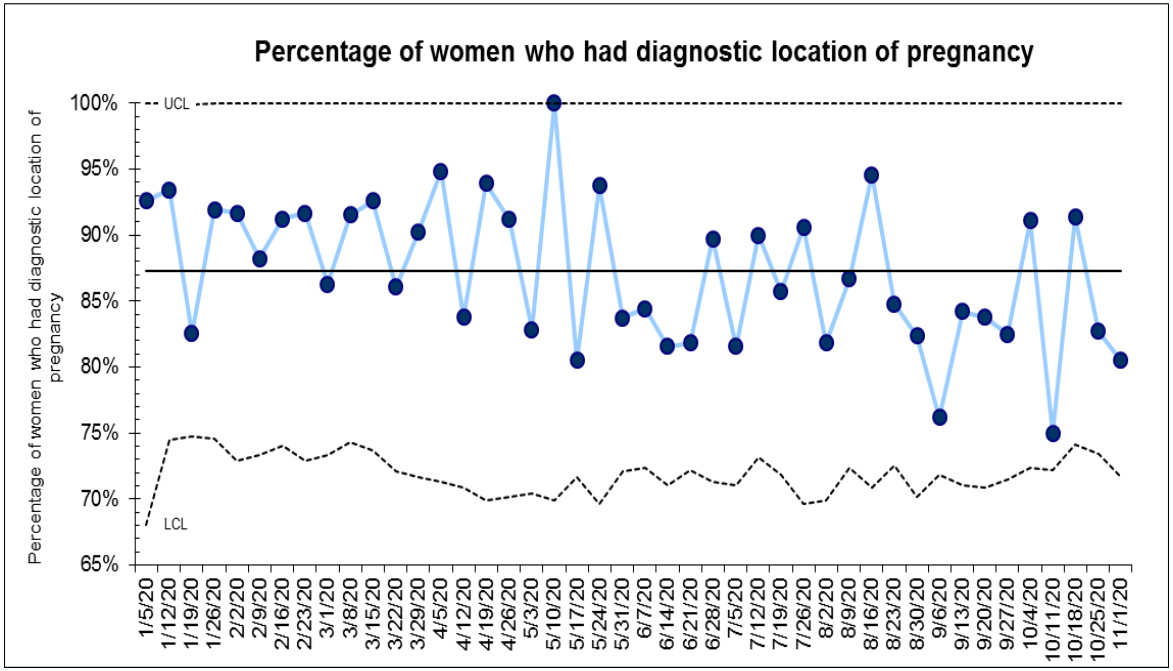
- EPU diary updated to improve data collection
- Patient co-design

Expected impact

→ Pregnancy of Unknown Location below 15%

→ Improved patient satisfaction, wellbeing and experience

→ Faster diagnosis



87% of women had diagnostic location of pregnancy

Pregnancy of unknown location rate to be ≤ 15%

11% rate of pregnancy of unknown location

Right Upper Quadrant Pain

Aim

Patients with acute biliary pain/cholecystitis or gallstone pancreatitis who are assessed as medically fit for surgery and who choose to have surgery on urgent basis would follow the “hot bladder pathway”.

Pathway Changes

- Implementation of online referral process to general surgeon

Expected impact

→ Faster time to surgery

→ Reduced re-admissions

→ Better patient experience

3% of patients presenting with hot gallbladder go on “hot gall bladder pathway”

Community Acquired Pneumonia

Aim (reviewed for COVID-19)

To streamline management of community acquired pneumonia with the aim to reduce inappropriate admissions and unnecessary antibiotic usage.

Pathway Changes

- Identifying and managing patients from a diagnostically coded patient cohort using evidence-based medicine practises

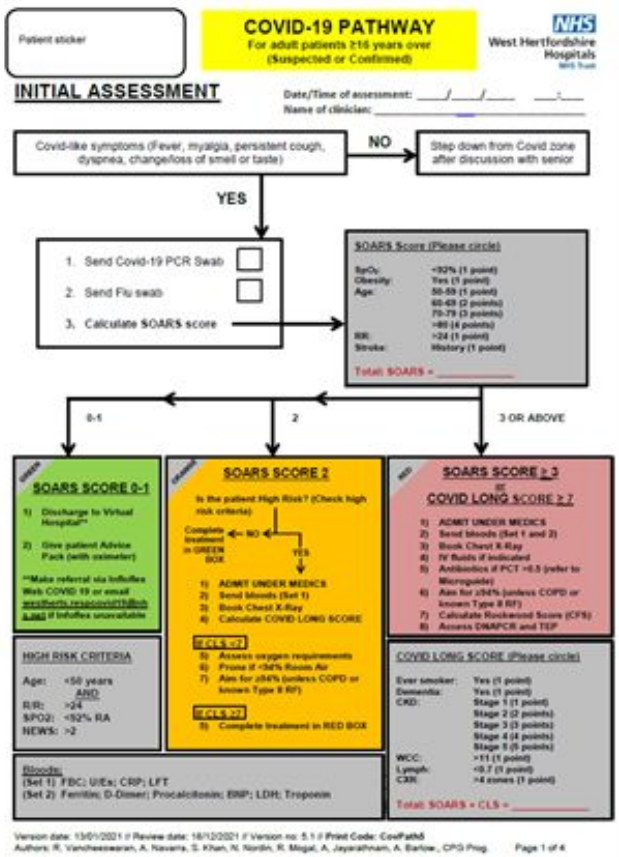
Expected impact

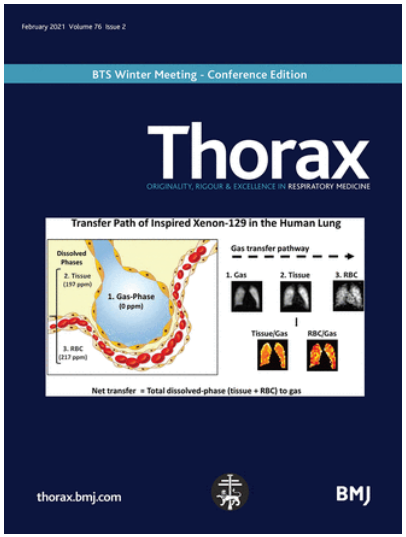
→ Reduction in unnecessary antibiotic use

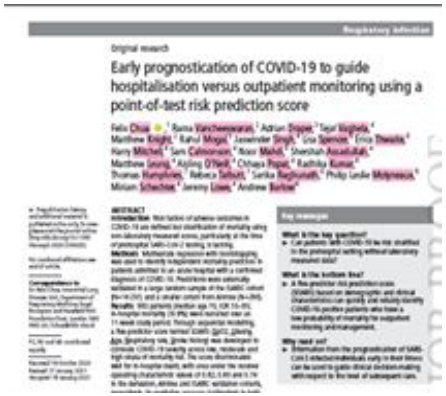
→ Reduction in inappropriate admissions

→ Better patient discharge

→ Improved teamwork







COVID-19 Pathway facilitates early, accurate identification and safe discharge to Virtual Hospital

Next Steps

- **Benefit realisation**
- **Patient co-design**
- **Business case for 40 pathways in 3 years**
- **Integration with the EPR system**
- **WHHT CPG workshop**
- **Exploring next step pathways with RFL**

team westHerts

NHS
West Hertfordshire Hospitals
NHS Trust

Thank you

www.westhertshospitals.nhs.uk
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OUR VALUES
Commitment
Care Quality

Declarations of board members and attendees interests
4 February 2021

Agenda item: 04/87

Name	Role	Description of interest
Phil Townsend	Chairman	• Son works for ATOS Sintel a separate legal entity wholly on work associated with the BBC
Christine Allen	Chief Executive	None
Paul Bannister	Chief Information Officer	None
Dr Andy Barlow	Divisional Director, Medicine	• Barlow Medical Services Ltd • Director, London & Hertfordshire Respiratory Diagnostics Ltd
Helen Brown	Deputy Chief Executive	None
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	None
Paul Cartwright	Non-Executive Director	• Member of Charity Committee, West Hertfordshire Hospitals NHS Trust • Member of Council of King's College London
Paul da Gama	Chief People Officer	None
Helen Davis	Associate Non-Executive Director	• Director and shareholder at Brierley Advisory LLP • Partner is senior civil servant at DHSC
Ginny Edwards	Non-Executive Director (Vice-Chair)	• Trustee Peace Hospice Care (ended 6 October 2020) • Director of Edwards Consulting Ltd • Charity Committee for West Hertfordshire Hospitals NHS Trust • Executive coaching for Cross sector leadership exchange (CSLE) • Executive support Public Health England • Husband is CEO of The Nuffield Trust

Last updated: January 2021

Name	Role	Description of interest
		• Husband is Director of Edwards Consulting Ltd • Husband is a non-remunerated member of the Strategy Committee of Guy's and St Thomas's Charitable Trust • Trustee Infection Prevention Society
Natalie Edwards	Associate Non-Executive Director	None
Louise Halfpenny	Director of Communications	None
Edwin Josephs	Non-Executive Director	• Member of the Vine House Health Centre Patient Participation Group
Jonathan Rennison	Non-Executive Director	• Trustee of NHS Charities Together (formerly the Association of NHS Charities) (ended October 2020) • Change Management and strategy support with Kings College London • Director of Yellow Chair Ltd • Edgecumbe Consulting - Associate • The Teapot Trust - Coaching • In Touch networks - coaching consultant • Charity Committee for West Hertfordshire Hospitals NHS Trust
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 – from 01 April 2020	• Director Northampton Hip and Knee
Dr Anna Wood	Director of Governance	None
Andrew McMenemy	Interim Chief People Officer	None

Last updated: January 2021

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

Chair	Title	Attendance
Phil Townsend	Chairman	Yes
Voting members		
Christine Allen	Chief Executive	Yes
John Brougham	Non-Executive Director	Yes (virtual)
Helen Brown	Deputy Chief Executive	Yes (virtual)
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	Yes (virtual)
Ginny Edwards	Non-Executive Director (Vice-Chair)	Yes
Jonathan Rennison	Non-Executive Director (Senior Independent Director)	Yes
Don Richards	Chief Financial Officer	No
Dr Mike Van der Watt	Chief Medical Officer	Yes
Non-voting members		
Paul Bannister	Chief Information Officer	Yes (virtual)
Dr Andy Barlow	Divisional Director, Medicine	Yes (virtual)
Paul Da Gama	Chief People Officer	Yes (virtual)
Helen Davis	Associate Non-Executive Director	Yes (virtual)
Natalie Edwards	Associate Non-Executive Director	Yes (virtual)
Sally Tucker	Chief Operating Officer	Yes (virtual)
Rodney Pindai	Director of Contracts and Commerce – Deputy CFO	Yes (virtual)
Dr Anna Wood	Director of Governance	Yes (virtual)
Dr Simon West	Divisional Director, Surgery, Anaesthetics and Cancer	No
In attendance		
Laura Abel	Assistant Trust Secretary	Yes (virtual)
Meg Carter	HealthWatch Herts	No
William Forson	Divisional Director Women's and Children's	Yes (virtual)
Thomas Galliford	Consultant physician	Yes (virtual)
David Thorpe	Deputy Chief Nurse	Yes (virtual)
Rod While	Trust Secretary (notes)	Yes

3 members of the public were in virtual attendance

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/86	**Opening and welcome**		
01.01	The Chairman welcomed the Board and members of the public to the meeting. He reminded presenters to assume that all papers had been read in advance of the meeting and advised members to ask questions of clarification or for additional assurance.		
02/86	**Patient story**		
02.01	The Deputy Chief Nurse presented the co-production programme: Coproduction: Developing our approach to engaging and involving local people and partners, noting the following; • Co-production is where service users, carers and communities work in an equal partnership, sharing responsibility in the development, design and delivery of services. • A Board is in place which has prioritised five projects. • For example, a project had been initiated to gain accessible feedback and complaints process for people with learning disabilities. The evidence was that feedback was not being received from patients with learning disabilities and their carers. He described how this was being addressed. • Future developments were to o Further develop trust and collaborative working within the Coproduction Board o Continue to listen to members and their networks on what matters to them o Develop further projects o Develop more coproduction facilitators to support projects o Facilitate an AGM for the Network		
02.02	The Chairman asked how the co-production programme would develop alongside the Integrated Care Partnership. The Deputy Chief Nurse stated that there were already good links across the local system and this would be further developed over the final quarter of 2020/21.		
02.03	Jonathan Rennison asked what resource was required to drive the programme forward and what would be the difference for patients and carers. The Deputy Chief Nurse stated that resources were based on goodwill currently and there is a patient support team in addition to Health Watch which is involved in the programme. A business case is being developed to gain further resources. He noted that the difference was that the community was coming into the organisation to discuss their needs and services would be focused around their needs.		
02.04	Ginny Edwards asked for further detail on shared decision making. The Deputy Chief Nurse noted that this was focused on shared professional decision making in which wards become empowered and had panels which reported into a leadership panel. Panels discussed and proposed what was important to them and the co-production programme supported this process.		
OPENING			
03/86	**Apologies for absence**		

Agenda item	Discussion	Lead	Dead-line
03.01	Apologies were received from Chief Financial Officer, the Divisional Director, Surgery, Anaesthetics and Cancer, and Health watch.		
04/86	**Declarations of interests,**		
04.01	No changes were reported to the declarations of interest from those circulated prior to the meeting.		
05/86	**Minutes of previous meeting**		
05.01	It was noted that there was an error in 09.01 final paragraph, as this should state "from an external consultancy"		
05.02	10.04 should state Chief People Officer, not Deputy Chief People Officer		
05.03	**Resolution**: The Board approved the minutes of the meeting of the Board in public on 5 November 2020 as a true and accurate record, subject to the amendments listed above.		
06/86	**Action log**		
06.01	It was noted the action was complete and should be closed.		
07/86	**Chair's and Chief Executive's report**		
07.01	The Chairman noted the following: • He welcomed Edwin Josephs to the Trust Board and noted a number of governance changes relating this. • He noted that John Brougham was leaving and thanked him for his enormous contribution. • MP updates have been continued and MPs had been extremely supportive		
07.02	The Chief Executive noted the following: • A letter had been received from NHSE informing the Trust that it had moved from segment 3 to segment 2, which was a move from mandated support to targeted support. • Freedom to speak up month took place during October and staff were very engaged in this. • "We value you" week had taken place, the prior week. • The launch of a compassionate leadership programme.		
08/86	**Board Assurance Framework (BAF)**		
08.01	The Chief Executive introduced the report noting that it was the latest version. The BAF described how the Trust was managing the risks relating to the achievement of those objectives. All BAF risks were routinely evaluated at the appropriate Board Committees. She noted that all changes made to the BAF since the previous Board meeting were highlighted in red. She requested that where dates had changed, commentary was included. **ACTION**: Chief Officers to ensure that commentary included in the BAF to explain any changes in dates.	Chief Officers	Feb 2020
08.02	**RESOLUTION**: The Board approved the Board Assurance Framework.		
PERFORMANCE			
09/86	**Activity Recovery Update & Access Standards Performance**		

Agenda item	Discussion	Lead	Dead-line
09.01	The Chief Operating Officer made the following points • A&E 4 hour performance was slightly lower than the previous month. • RTT performance had improved significantly to 74.8% • Diagnostics performance was progressing well at 72% • Dexa scanning was a challenge within diagnostics and the Trust was working with other Trusts to increase capacity. • UTC Hemel Hempstead performance had been consistent at 99%. • 52 week waits was an ongoing challenge with a further increase in this, some of which was driven by patient choice. • Ambulance handover delays were an ongoing issue with a high number of conveyances compared to surrounding Trusts. This was undergoing further investigation.		
09.02	Paul Cartwright asked what proportion of 52 week waiters was due to patient choice. The Chief Operating Officer stated that she would include this data in future reports but it was not available at the present time.		
09.03	Paul Cartwright asked what would be the impact of COVID on the ability of the organisation to continue to improve access performance. The Chief Operating Officer stated that the vaccination programme would be a challenge but it is expected that there would be no deviation from planned activity.		
10/86	**Integrated performance review**		
10.01	The Chief Operating Officer introduced the report and gave the following headlines: • COVID-19 positive patients, there were 84 confirmed, 4 in ITU, 8 in the suspect ward. • The Trust was currently under a great deal of pressure with 100 beds closed for COVID related reasons. • 310 staff were currently absent from the organization, 193 for COVID related reasons.		
10.02	The Chief Operating Officer provided her Chief's update: • ED attendance had continued to fluctuate and had increased to around 300 per day over the past few days. • Further pressures were experienced by the Trust in mid - November and as a result of this a business continuity incident was declared. • Cardiac cath lab replacement works had commenced and phase 2 of the Emergency Assessment Unit was progressing.		
10.03	The Chief Nurse gave the following updates: • Key actions for the Infection Prevention and Control Guidance had been reviewed. A number of actions had been taken already to prevent nosocomial infections. • Caring and responsive: the Trust has continued to work to expand maternity visiting. It had been agreed by the Trust Management Committee that there would be an expansion to the family liaison line to improve communication.		
10.04	The Chief Medical Officer gave the following updates: • The Trust had been reviewing the schedule of		

Agenda item	Discussion	Lead	Dead-line
	accommodation and most of the divisions had been covered. • There had been a good response to the “call to arms” regarding the vaccination programme from the medical community.		
10.05	The Deputy Chief People Officer gave the following updates: • The purpose of “We Value You” Week was to recognise the efforts of staff and to signpost additional health and wellbeing support. A number of videos were made featuring staff discussing their experiences during COVID. • Lateral flow test kits had been rolled out to staff. These allowed staff to test themselves twice a week. • Vaccinations would be rolled out from Watford Football club and bank nurses would be used to staff this. The service would be run for 6-8 weeks. • Flu vaccinations currently at 78%, though these would end on 4 December.		
10.06	The Deputy Chief Finance Officer gave the following updates: • October represented a new funding regime with a fixed envelope for cash flows across the ICS. • The Trust was currently forecasting a £5.6m deficit and this was driven by work needed to be done to achieve recovery. • However the Trust was being challenged to deliver a more ambitious forecast and this had been reduced to £4.2m. • For month 7 there was a slight overspend of £12k for the month and year to date was at breakeven. • Capital spending was at £6.8m against a total of £50m by the year end.		
10.07	The Chief Information Officer presented the following updates • There was a significant incident on 6 October due to an upgrade taking place at one of the data centres. The Trust network had coped well with this with minimal disruption. • The Trust had attended the Joint Investment Committee to present the EPR business case.		
10.08	The Chairman asked what the strategy was to reduce staff absenteeism. The Chief Nurse noted that all templates had been reviewed and different templates would be used at different times depending on the COVID challenge. There was a low vacancy rate but COVID had introduced other challenges.		
10.09	John Brougham noted that the Board in part 2 would be looking for assurance on the £4.2m forecast.		
10.10	Jonathan Rennison noted that the staff videos had been very well received outside of the NHS. He noted that there had been a visit from the region and from the CCG regarding nosocomial infections and asked what the nature of this was. The Chief Nurse stated that the visitors were happy with actions taken to prevent nosocomial infections and noted the changes that had been made to deliver this.		
10.11	Natalie Edwards asked whether staff were utilising the wellbeing facilities on offer. The Chief People Officer noted that there was greater awareness but it wasn’t clear whether utilisation had changed.		
10.12	Paul Cartwright asked how relationships were with care homes. The Chief Operating Officer noted that discharged COVID patients were		

Agenda item	Discussion	Lead	Dead-line
	being moved to community bases rather than care homes. There was a weekly out of hospital meeting to address and monitor this issue.		
11/86	**Paediatric Establishment Review**		
11.01	The Chief Nurse noted that the paper had been discussed at the People, Education and Research Committee. The whole of the paediatric establishment had been reviewed and seasonal variation introduced.		
12/86	**End of Life Care Annual Report**		
12.01	The Chief Nurse noted that the report had been reviewed by Quality Committee and continued to demonstrate the commitment to end of life care across the organisation. A new strategy had been developed for 2021-22 and this would come to Board for approval. A national audit had been conducted and the outcomes of this were used to shape the strategy.		
12/86	**Strategic Priorities update**		
12.01	John Brougham asked that the team consider whether any delegated approval might be needed for any programmes prior to the February Board meeting. The Deputy Chief Executive noted that The EAU business case would be retrospective and would be discussed at February Board.		
12.02	The Chairman noted there was a red status for defibrillators. The Deputy Chief Executive noted that it had been assumed that some defibrillators needed to be replaced but it had emerged that all needed to be replaced, though a business case had been approved to address this.		
12.03	Paul Cartwright asked for details on the review of the Urgent Treatment Centre service in Hemel Hempstead, due to take place in January 2021. The Deputy Chief Executive stated that the national urgent care strategy required a phasing out of minor injuries units and there had been an ongoing discussion with the CCG on this matter, though COVID had delayed this.		
13/86	**Digital Strategy**		
13.01	The Chief Information Officer stated the following: • The strategy had been reviewed at a number of forums, including most recently at the Great Place Committee. The strategy would take the Trust through to the opening of the new hospital. • The strategy was ambitious and had EPR at its core and represented a strong desire to build on recent improvements. • There was significant cost associated with the strategy but it was required to deliver the ambitions of the Trust		
13.02	Helen Davis noted that the Great Place Committee had fully endorsed the Digital Strategy.		
13.03	**RESOLUTION:** The Board approved the Digital Strategy		
14/86	**Freedom to Speak Up Activity and Case Report**		
14.01	The Chief People Officer stated that there had been 13 cases between March and October 2020. Five had been closed with positive feedback, the others were ongoing.		
14.02	Ginny Edwards asked how easy it was for the FTSU Guardian to speak to members of the Executive. The Chief Executive noted that		

Agenda item	Discussion	Lead	Dead-line
	there was a formal meeting with the FTSU Guardian on a monthly basis or more frequently if required		
15/86	**Flu Assurance Paper**		
15.01	The Chief People Officer stated that the paper reviewed activity that the Trust is expected to deliver and all activity had been delivered with one exception and this had been a “drop in” clinic facility which had not been possible due to COVID.		
16/86	**Corporate Risk Register**		
16.01	The Chief Medical Officer noted that the risk register had been fully discussed at the Quality Committee. There were currently 20 open risks and one new risk regarding legionella contamination of the hot water supply. There were two COVID related risks that had been escalated and five de-escalated risks.		
16.02	**RESOLUTION:** The Board approved the Corporate Risk Register		
17/86	**Assurance Report from the Trust Management Committee**		
17.01	The Chief Executive noted that the report covered the meetings that took place in September.		
18/86	**Assurance Report from the People, Education and Research Committee**		
18.01	No meeting held in the period		
19/86	**Assurance Report from the Finance and Performance Committee**		
19.01	The Board noted the report.		
20/86	**Assurance Report from the Quality Committee**		
20.01	Ginny Edwards stated that the committee had reviewed the learning from deaths report, report on perinatal mortality and had made a recommendation to Audi Committee on the Quality Account.		
21/86	**Assurance Report from the Audit Committee**		
21.01	Edwin Josephs noted that the Committee had had two brief meetings, the first had approved the tendering process for external audit, and the second meeting scrutinised and approved the Quality Account which would be published in December.		
22/86	**Assurance Report from the Great Place Committee**		
21.01	Helen Davis noted that the Committee had reviewed the risk relating to the pathology outsourcing programme and this had now been resolved.		
23/86	**Charity Annual Report**		
23.01	Jonathan Rennison reminded the Corporate Trustee that the item was being heard as the Corporate Trustee and not the Trust Board. And decisions would be taken in the interest of the charity rather than the Trust. The Annual Report was a statutory document which needed to be submitted to the Charity Commission by the end of January. The report had been reviewed by the Charitable Funds Committee and also the external auditors		
23.02	It was noted that the report would be published on the Trust website and on the Charity Commission website.		
23.03	**RESOLUTION:** The Corporate Trustee approved the Annual Report		
24/86	**Questions from Hertfordshire Healthwatch**		

Agenda item	Discussion	Lead	Dead-line
24.01	There was no attendance from Healthwatch.		
23/86	**Questions from the patients and members of the public**		
25.01	There were no questions from members of the public.		
24/86	**Date of the next Board meeting**		
24.01	4 February 2020		

BOARD AND CORPORATE TRUSTEE DECISION LOG			
Board meeting/decision date	**Decision reference (from minutes)**	**Item presented to Board for action**	**Comments/outcome**
3/5/2020	13.03/80	2019 annual gender gap report	The Board approved the 2019 annual gender gap report.
3/5/2020	14.03/80	2019 annual equality report	The Board approved the 2019 annual equality report for publication.
3/5/2020	15.02/80	2018/19 medical appraisal annual audit report	The Board approved the 2018/19 medical appraisal annual audit report for submission
3/5/2020	17.02/80	Proposal to extend the patient administration system contract	The Board approved the extension of the contract and the completion of a waiver
3/5/2020	18.03/80	Corporate risk register report	The Board approved the corporate risk register
4/2/2020	07.05/81	Board Assurance Framework	The Board approved the draft Board Assurance Framework
4/2/2020	16.03/81	Outline business case for electronic patient record programme	The Board approved option C of the outline business case and to explore further approaches to deploy the EPR and other potential funding solutions.
4/2/2020	17.03/81	Business case for managed print service	The Board approved the business case to negotiate a six month extension to the current managed print service contract and to proceed to tender for a new contract.
4/2/2020	19.02/81	2020/22 corporate objectives	The Board approved the 2020/22 strategic objectives subject to the measures being re-based following the COVID-19 pandemic.
4/2/2020	20.03/81	Corporate risk register report	The Board approved the corporate risk register
4/2/2020	23.02/81	Assurance report from Charity Committee	The Corporate Trustee approved 1) the establishment of an urgent appeal to raise funds to support staff and volunteers working on the frontline to manage the COVID-19 virus and 2) the use of dormant funds for the purpose detailed above
5/7/2020	08.02/82	Board Assurance Framework	The Board approved the draft Board Assurance Framework
5/7/2020	08.07/82	Corporate risk register report	The Board approved the corporate risk register
5/7/2020	13.03/82	2020/21 budget	The Board approved the financial plan for the year, noting the potential to refresh in August pending NHSE/I advice.
5/7/2020	14.03/82	Contract for enabling works to support the multi-story car park at Watford hospital	The Board approved the use of emergency powers to make the contract award decision
5/7/2020	16.02/82	Annual statement of actions taken in 2019/20 to prevent slavery and human trafficking	The Board approved the annual statement on actions taken in 2019/20 to prevent slavery and human trafficking
5/7/2020	17.03/82	Board and committee governance: 2020/21 terms of reference and work plans	The Board approved the terms of reference and work plans for the Trust Board and committees
5/7/2020	22.02/82	Annual report and accounts	The Board approved the delegation of the approval of the final annual report and accounts to the audit committee.
6/4/2020	06.04/83	The replacement of two catheter labs	The Board ratified the urgent decision made in respect of the replacement of two catheter labs.
6/4/2020	16.03/83	Capital expenditure programme	The Board approved the capital expenditure programme for 2020/21
6/4/2020	19.07/83	Board self assessment of effectiveness	The Board approved the assessment of effectiveness subject to a small number of ammendments
7/2/2020	12.04/81(part 1)	Theatres redvelopment	The Board delegated authority to the Finance and Performance Committee to approve the business case for theatres at its meeting in July*
7/2/2020	13.02/81 (part 1)	Corporate risk register report	The Board approved the corporate risk register*
7/2/2020	19.01/81 (part 1)	Charity funding requests	The Corporate Trustee ratified the funding requests of over £25k as listed in the assurance report*
7/2/2020	11.02/84 (part 2)	Procurement of a design team and other specialist services to support the OBC	The Board approved the proposal to delegate authority to the Great Place Programme Board to confirm the appointment of a design team*
7/2/2020	13.03/84 (part 2)	Integrated Care System (ICS) governance	The Board approved the Trust's proposed feedback on the ICS governance proposals as outline in the paper
7/2/2020	15.01/81 (part 2)	Electronic Patient Record business case	The Board approved that an extraordinary Board meeting be set up for the Board to review the business case
8/13/2020	04.09/85 (Extraordinary Board meeting)	Electronic Patient Record (EPR)	The Board approved the following: • The timetable set out for FBC and coming back to board for approval in October. • The spend through to December of £5.4m, subject to written confirmation of funding. • The risk related to procurement challenge, subject to confirmation that there was no risk to individual Board members. • The formal launch of the programme
9/3/2020	08.03/82	Board Assurance Framework	The Board approved the Board Assurance Framework
9/3/2020	15.02/82	Corporate Risk Register	The Board approved the Corporate Risk Register
9/3/2020	16.03/82	Great Place Committee Terms of Reference	The Board approved the Terms of Reverence for the Great Place Committee
9/3/2020	10.04/86 (Part 2)	Phase 3 Recovery Letter	The Board approved the recommendation to delegate to the Executive team final sign off of the forecast submission to the ICS
10/1/2020	06.04/83	Redevelopment options shortlist	Taking into consideration all of the information and analysis provided by the option appraisal report, emergency care high level risk assessment, the communications and stakeholder engagement report and the independent site feasibility report the WHHT Board: 1. Approved the proposed shortlist and preferred options for emergency and planned care 2. Noted the activities undertaken over the past four months to ensure that local people are informed of and engaged in planning for the redevelopment of WHHT hospital facilities. 3. Approved the recommended actions to address and mitigate the key concerns identified via the engagement activities summarised within the stakeholder engagement report.*
10/1/2020	08.03/84	Board Assurance Framework	The Board approved the Board Assurance Framework
10/1/2020	15.05/84	Office relocation of HR and finance staff	The Board approved the proposals for office relocation as set out in the business case
10/1/2020	16.02/84	Corporate Risk Register	The Board approved the Corporate Risk Register
10/1/2020	21.02/84	The current charity investment strategy	The Corporate Trustee supported the current investment strategy be continued
10/1/2020	21.02/84	Outsourced charity finance function	The Corporate Trustee supported the move to an outsourced finance function
10/1/2020	21.03/84	£10k contribution to an endoscopy simulator	The Corporate Trustee approved a £10k contribution to an endoscopy simulator
10/1/2020	21.03/84	Conribution to staff wellbeing facilities	The Corporate Trustee approved up to £150k for staff wellbeing facilities at Watford, St Albans and Hemel Hempstead
10/1/2020	09.06/87 (Part 2)	Full Business Case for Electronic Patient Record	The Board approved the Full Business Case for EPR
10/1/2020	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
11/5/2020	08.02/85	Board Assurance Framework	The Board approved the Board Assurance Framework
11/5/2020	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
11/5/2020	16.02/85	Corporate Risk Register	The Board approved the Corporate Risk Register
12/3/2020	08.02/86	Board Assurance Framework	The Board approved the Board Assurance Framework*
12/3/2020	13.03/86	Digital Strategy	The Board approved the Digital Strategy*
12/3/2020	16.02/86	Corporate Risk Register	The Board approved the Corporate Risk Register*
12/3/2020	23.03/86	Charity Annual Report	The Corporate Trustee approved the Annual Report*

* Subject to final Approval of minutes

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda item: 08/84

Action log Part 1 – 04 February 2020

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	08.01/86	Chief Officers to ensure that commentary included in the BAF to explain any changes in dates.	Chief Officers	February 2021	

Trust Board Meeting
04 February 2020

Title of the paper	**Chairman and Chief Executive report**
Agenda Item	**08/87**
Presenter	**Phil Townsend, Chairman and Christine Allen, Chief Executive**
Author(s)	**Barbara Anthony, Interim Trust Secretary**
Purpose	**For approval**: **For discussion**: **For information**: ✓
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	Aim 1 Best quality care *Objectives 1-5* ✓ Aim 2 Great place to work *Objectives 6-8* ✓ Aim 3 Improve our finances *Objective 9* ✓ Aim 4 Strategy for the future *Objective 10-12* ✓
Links to well-led key lines of enquiry	✓ Is there the leadership capacity and capability to deliver high quality, sustainable care? ✓Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ✓Is there a culture of high quality, sustainable care? ✓Are there clear responsibilities, roles and systems of accountability to support good governance and management? ✓Are there clear and effective processes for managing risks, issues and performance? ✓Is appropriate and accurate information being effectively processed, challenged and acted on? ✓Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ✓Are there robust systems and processes for learning, continuous improvement and innovation? ✓How well is the trust using its resources?
Previously considered by	Committee/Group: N/A; Date:
Action required	The Board is asked to receive the report for information.

Agenda Item: 08/87

Trust Board Meeting – 04 February 2021

Chairman and Chief Executive's report

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

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

COVID-19

2.1 The Board last met on 3 December 2020 when hospital COVID admissions were increasing. Staff have worked tirelessly to care for our patients in very difficult circumstances. We greatly appreciate just how challenging this has been and we would want to thank our staff for their dedication and hard work.

2.2 The Trust continues to work with its local health partners to manage the impact and implications of the second wave. In addition to asking our staff to observe social distancing rules over Christmas, Tracey Carter, Chief Nurse also worked with Herts Valley CCG to issue a public message urging our local community to observe social distancing measures.

2.3 The new Covid-19 testing hub was also opened on 7 January 2021 by Theresa Maunganidze, Lead Matron for COVID testing. 2 new Covid-19 secure rooms were opened in the children's emergency department at Watford. These rooms provide the children's emergency department with the facility to isolate their resus patients as well as a safer, more family centred environment for our most unwell children.

2.4 Staff welfare remains a priority for the Trust. Following MHRA approval of the Pfizer vaccine on 2 December 2020, our vaccination centre for staff was opened at Watford Football Club on Monday 4 January 2020 and we have now vaccinated significant numbers of our staff and those of our health partners. Once again, Watford Football Club have been extremely generous in allowing us to use their facilities for the vaccination centre and their Horizon Restaurant as a dining room overflow for staff to purchase a sandwich lunch and take a break. We continue to be extremely grateful for Watford Football Club's support.

2.5 The Christmas period was also a time for reflection and for remembering those who passed away during the pandemic. On 20 December 2020, our pastoral care team streamed a memorial service to remember friends and family members who had passed away in the last year and can be accessed the pastoral care team's You Tube channel.

ARCU

2.6 Chief Nurse, Tracey Carter opened our new acute respiratory care unit (ARCU). The new eight bed unit is a respiratory high dependency unit (HDU) that cares for patients with respiratory failure. Previously these patients were cared for on Aldenham, the respiratory ward. The Board would like to thank everyone involved for creating this must needed addition to our trust.

National hospital redevelopment and capital improvement programme

2.7 Natalie Forrest has been appointed to lead the government's hospital building programme. Ms Forrest most recently led the construction and operationalisation of NHS Nightingale London. She was also Chase Farm Hospital's Chief Executive in North London, where she successfully led on their hospital rebuild. We look forward to working with Natalie on the redevelopment of Watford General Hospital.

2.8 We have been allocated approximately £4m from the government's capital building fund launched in the summer to help eradicate the maintenance backlog in NHS hospitals. The funding allocation relates to 16 projects which will see staff, patients and visitors benefiting from the refurbishment programme.

National Clinical Excellence Awards

2.9 The National Clinical Excellence Awards (CEA) opened for applications on Monday 7 December 2020. The awards will recognise the extraordinary work staff have undertaken over the last four-to-five years, including efforts this year in response to the unprecedented COVID-19 pandemic in relation to patient care, research or COVID-19 related clinical trial work. Those who have delivered nationally in other clinical services, teaching or training during this period will also be recognised. Applications are particularly sought from women and clinicians from the BAME community.

2.10 To reduce the burden on staff and employers, the process has been simplified and the application window extended from the usual eight to fourteen weeks. Following the suspension of the 2020 awards due to the pandemic, a higher number of awards will be available this year.

Care Quality Commission

2.11 The CQC confirmed on 13 January 2021 that it will continue to pause its routine programme of hospital inspections due to the current pressure hospitals are facing in responding to Covid-19. It will continue to only undertake inspection activity in response to a serious risk of harm or where it supports the system's response to the pandemic.

3 COMMUNITY NEWS

3.1 Chris Badger has been appointed as Director of Adult Care Services at Hertfordshire County Council. We wish him well in his permanent role.

3.2 Dorothy Hossein, Chief Executive of East of England Ambulance Services, has announced that she will be stepping down from her role with immediate effect due to illness. We wish her a full recovery.

4 BOARD NEWS

Changes to the Board

4.1 Natalie Edwards has joined the Trust as a Non-Executive Director in January 2021 having previously been an Associate Non-Executive Director at the Trust since March 2019. Natalie brings significant human resources experience to the Board and will take up the newly created role, 'Guardian of Wellbeing', seeking assurance that the trust's wellbeing strategy continues to meet its goals. Natalie is passionate about equality, diversity and inclusion. She is looking forward to working closely with the trust's BAME Connect Network.

Electronic Patient Records

4.2 The Board signed a contract with Cerner on 23 December for the delivery of a new electronic patient record. This is essential for the future delivery of quality, co-ordinated, safe care. It will play an important role in transforming clinical models of care in preparation for the opening of the Trust's redeveloped hospital in 2025 as well as an opportunity to form a partnership with the Royal Free London NHS Foundation Trust and their EPR implementation of Cerner "Model Content" solution.

Board visit programme

4.3 As part of the monthly board visit programme, in December 2020 the Board visited the Family Liaison Service, AAU Level 3 and Estates at Watford and the Urgent Treatment Centre at Hemel Hempstead via MS Teams. There were no visits in January 2021 as Board was cancelled. Verbal feedback from the session will be given to the private session of the Board.

Chair's meetings

- Selected winners for recycled bikes in St Albans.
- Reviewed Cultural Intelligence proposals.
- Led the Christmas lights ceremony.
- Conducted MP updates with CEO.
- Attended subcommittees.
- Conducted a round of 121's with NEDs.
- Chaired Cerner (EPR) contract approval & signing.
- Agreed WHHT feedback on ICS form.
- Reviewed current governance processes.
- Several Chair sessions on system collaboration
- Helped PAH recruitment of new NED.
- Session with CEO NHSX
- Met with new Deputy MD.

5 RECOMMENDATION

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

Phil Townsend
Chairman

Christine Allen
Chief Executive

February 2021

Trust Board Meeting
04 February 2021

Title of the paper	Board assurance framework report
Agenda Item	**09/87**
Presenter	Christine Allen, Chief Executive
Author	Jean Hickman, Trust Secretary
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	This report is to provide the Board with assurance that risks to achieving the Trust's 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 BAF were reviewed on 07 January 2021 by the People, Education and Research Committee and on 28 January 2021 by the Quality Committee and the Finance and Performance Committee. All updates to the BAF since the last Board report are marked in red and no changes to the rating of any risks are recommended to the Board at this time.
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	• People, Education and Research Committee – 07 January 2021 • Finance and Performance Committee – 28 January 2021 • Quality Committee – 28 January 2021
Action required	The Board is asked to consider and approve the latest version of the BAF.

Agenda Item: 09/87

Trust Board meeting – 04 February 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's 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 in particular it picks up all the controls that the Trust has in place to manage, minimise and/or remove the identified risks and points towards concise and comprehensive evidence that the controls are working.

2.2 The BAF forms part of the Trust's overall board assurance and integrated risk management arrangements. It brings together three things:

- The Trust's four aims and twelve underpinning strategic objectives
- A headline summary of all the issues (risks) that might get in the way of achieving those objectives
- A headline summary of what the Trust is doing about those issues, along with a concise description of how the Board can be assured that what is being doing is working.

2.3 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 approved risk appetite statement and threshold matrix is 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 current BAF can be found in appendix 2. The description, controls, assurances and actions to address gaps in controls and assurances were reviewed and updated by executive leads in January 2021.

3.2 Elements of the BAF were reviewed on 07 January 2021 by the People, Education and Research Committee and on the 28 January 2021 by the Quality Committee and the Finance and Performance Committee. The updates are marked in red on the BAF and no changes to the risk ratings are recommended to the Board at the current time.

3.3 There are no areas of extreme risk (red) identified on the BAF and 10 risks assessed as high (amber) for which only limited assurance can be gained by the Board.

4. Next steps

4.1 The BAF will have an annual review and refresh as required over the next six to eight weeks and the BAF risks will be cross referenced against the 2021/21 committee work plans to ensure that all risks are being appropriately monitored.

4.2 Work has started to review the risk appetite statement and threshold matrix and assess whether this is being used appropriately to assess the level of risk that the Trust is prepared to accept in pursuit of its objectives. The outcome of this work will be presented to the Board in Spring 2021.

5. Risks

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

6. Recommendation

6.1 The Board is asked to consider the latest version of the BAF.

Christine Allen
Chief Executive

February 2021

Appendix 1. Risk appetite statement and threshold matrix
Appendix 2. Board Assurance Framework

Appendix 2

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 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 its estates, due to the age and condition.

Threshold matrix

Category	Risk Appetite	Risk Appetite Score
Quality safety	VERY LOW risk appetite for risks that may compromise safety	1 - 5
Quality effectiveness	LOW risk appetite for risks that may compromise the delivery of outcomes for service users	6 - 9
Statutory compliance	LOW risk appetite for risks that may affect statutory compliance	6 - 9
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
Finance/value for money	MODERATE risk appetite for financial/value for money which may support the financial sustainability of the organisation whilst ensuring the Trust complies with statutory requirements	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	MODERATE risk appetite for actions and decisions taken in relation to workforce	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

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure		Risks Identified	Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Key Controls	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)			Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc.	Low/Medium/High / Extreme	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific action)	Time scale /review date	Update
AIM 1: BEST CARE																	
AMBITION 1. **Mortality (SHMI & HSMR): 'as expected' or 'better than expected' for HSMR and for SHMI.** **Avoidable Harm (harm free care): continuous improvement and better than national average for new pressure ulcers, falls with harm, new venous thromboembolism, urinary tract infections (in patients with a catheter) and e-coli**	**Reduce the gap between weekend and week day mortality To prevent Covid-19 outbreaks in a hospital setting To develop blue and green pathway staffing templates**	**% deaths reviewed by a medical examiner, evidence of learning from deaths (bi-annual report to QC) Definition of an outbreak of COVID in hospital settings: 2 or more confirmed cases in the same ward/clinical area in the preceding 14 days. (To be used in conjunction with the categories of hospital-acquired infection). The categories help to distinguish between hospital and community-acquired infections. Cluster: 2 or more confirmed cases of COVID-19 among staff / inpatients within 14 days Harm free care in line with or above national average and staff fill rate above 90%**	1a	Excess mortality due to COVID-19 and non-COVID-19 patients	Chief Medical Officer	Quality Committee	4272	CQC	High	1. Morbidity and mortality meetings 1. Structured judgement review process fully embedded 1. Divisional Governance meetings 1. Consultant coders and medical examiners fully established 2. Quality, Mortality review group 2. Quality Committee reports 3. Dr Foster Mortality reports	The effect of Covid-19 on mortality from non-Coved conditions is not precisely known. Furthermore, the reluctance of patients to attend ED is significant	1) Divisional governance meeting, 2) Quality Committee 3/ Dr Foster	As Covid-19 is a new disease, the medium term effects are unknown	No additional actions are currently possible	CMO	Dec-20	
			1b	Failure to implement the IP&C Board Assurance Framework leading to the risk of nosocomial infection	Chief Nurse	Quality Committee	4287	CQC, HSE	High	Infection & Prevention control panel Recovery Governance Framework IMT Enhanced cleaning	Continually changing national guidance based on increasing evidence as we move through the pandemic	Gap analysis Quality Committee reporting CCG review/nosocomial reporting external review with PHE, CCG and regional IPC teams Board IPR Staff & Pt testing programme	As Covid-19 is a new disease, the medium to long term effects are unknown	Updating practice, education as evidence available Introduction of RCA process for all cases with a COVID positive result at 7 days and over with themeatic review	AF/GB	Feb-21	Actions completed and in place. IPC BAF reporting part of QC workplan and repository in place on PM3. RCA's completed for Covid cases over 7 days. Staff & Pt testng in place and business cases developed and approved. Further monitoirng in place and to reivew further actions with new IP&C guidance. 1) Ventilation review 2) Monitor IPC BAF and Covid risks 3) Assessments for Covid protection and soical distancing. IPR reporting on nosocomial infections further updated. External reivew visit by regional IPC and CCG IPCN
			1c	Changes in pathways due to COVID-19 could prevent the Trust from meeting safe staffing ratios and impacts on harm free care	Chief Nurse	Quality Committee	4287	CQC, NQB	High	Daily staffing review meetings E-roster and KPI's with use of 'Safer Care' Senior clinical rota to review staffing until 2100 Mon-Fri and 0800 - 2000 Sat - Sun on site Quality Improvement programme	Continually changing national guidance based on increasing evidence as we move through the pandemic	Divisional Quality Summits Quality Improvement Forum (QIF) Bi-annual establishment reviews Quality Committee reporting and IPR NHSE/I review and level 4 attainment	None	Quality impact assessments to be undertaken of templates Staff training to support development of skills Trialling a night sister role to support and develop junior staff Overseas recruitment to begin now access to the country has changed.	DT	01/11/2020 Feb-21	Quality Impact Assessment completed and also a review of COVID templates. Night sister role embeded and to continue this financial year Education and Training courses recommenced Focus on International recruitment with OSCE training recommenced Matron position introduced into the Harm Free Care team to support surveillance and improvement. **Review February 2021**
			1d	Failure to reduce the gap between weekend and weekday mortality	Chief Medical Officer	Quality Committee	4272	CQC	High	Adherence with 7 day working standards, SMART support to ED. Improved patient flow. Clinical Outreach service. Sepsis screening	The effect on COVID has been profound, and excess mortality has been seen throughout the UK. Reduction in outpatient capacity, access to primary care may further reduce our capacity to apply 7 day working standards, and a second wave of COVID would once again severely test our ability to provide timeous interventions	1) Divisional governance meeting, 2) Quality Committee 3/ Dr Foster	As Covid-19 is a new disease, the short and medium term effects are unknown, especially if we get another outbreak	None	CMO	Dec-20	
	25% reduction in e.coli by 2021	**Baseline 40 cases, aim to have no more than 30 cases in 20/21 90% staff trained in correct PPE usage**	1e	Failure to reduce e.coli in line with agreed trajectory	Chief Nurse	Quality Committee		NHSE/I	Medium	RCA process for all cases Catheter passport Review of all patients admitted with a catheter	Oversight and management of catheter insertion across the trust	E.coli working group with the CCG IP&C	Reporting of all catheter insertion and use of passports	QI hydration project Audit catheter usage and trial catheter restriction programme Review and update catheter care plan	GB	Jul-21	This work has been delayed and has been included in the IPC forward plan and will be reviewd in **July 21**
			1f	Failure to put in place appropriate training in line with PHE guidance and the use of PPE	Chief Nurse	Quality Committee			Medium	PPE training Communication campaign/posters for designated areas Donning and Doffing areas	Compliance with the wearing of PPE	IP&C panel Recovery governance reporting on PPE	Consistent compliance in the wearing of PPE	PPE audited as part of the 'code of practice' audits PPE campaign Risk assessing correct PPE usage PPE spot checks Safety message and check of PPE at handover Training films development	GB	01/10/2020 Feb-21	Actions completed and ongoing. PPE being reviewed according to new IP&C guidance and updated guidnace issued. To continue with current actions.
AMBITION 2. **Access to care (national waiting time standards): continuous improvement and top 25% of hospitals for emergency department 4 hour waits, 18 week referral to treatment and diagnostic waiting time and better than national average for cancer two week wait, 62 day urgent GP referral to first definitive treatment and the new faster diagnosis standard (maximum 28 days to communication of definitive cancer / not cancer diagnosis).**	**Implement primary care led urgent treatment model at Watford and procure UTCs and Hemel Hempstead and St Albans from 1 April 2021 Deliver agreed improvement trajectories for key standards.**	**% of patients seen in primary care led UTC model**	2a	Impact of COVID-19 on emergency care demand may prevent delivery of emergency care access standards	Chief Operating Officer	Quality Committee	4269	NHS Constitution National waiting times standards	High	**Demand management** Promotion of UTC as an alternative to the acute COVID site Think 111 First Advice & guidance offer to primary care (acute admission avoidance) Virtual SMART (admission avoidance) Segregation of COVID / Non COVID pathways Daily system (ICP) calls Daily ICS Gold command calls stood up during pandemic (January) **Performance Oversight** Daily oversight in place ED performance improvement programme & Access meetings Ambulance handover improvement plan	Inability to influence demand Capacity constraints due to social distancing requirements reduce flow IPC requirements impact on flow to diagnostics, cubicle utilisation and flow to correct designated bed base Workforce constraints (vacancy rate & absence related to COVID 19)	Daily performance insight 2 hourly ED status report ED escalation, improvement and transition plans Discharge working group Hospital Efficiency Group (HEG) ED team check ins with CEO Trust Management Committee Finance & Performance Committee Joint Urgent Care Programme Board (with HVCCG) System resilience group Local Delivery Board NHSI Progress Review Meetings	As COVID 19 is a new disease the short and medium term effects are unknown and the impact on demand for emergency services is therefore unpredictable	No additional actions are currently possible	COO	Mar-21	
		Performance against trajectories	2b	Impact of COVID-19 on capacity to meet planned care (diagnostics and RTT) and cancer demand in line with national standards	Chief Operating Officer	Quality Committee	3828 4269	NHS Constitution National waiting times standards	High	**Demand management** Collaborative working with commissioners on referral management and transformation of pathways **Recovery** Establishment of a phased service (including Diagnostics) restart plan, including new ways of working (virtual outpatient models) Planned additional capacity achieved through use of independent sector, CT in a box (from October 2020) , MRI in a box (expected April 2021) Activity tracker **Performance oversight** Elective Care Programme Board RTT & Cancer Access meeting Weekly NHSEI RTT & Cancer reporting	Inability to influence demand A second or subsequent wave of COVID-19 would result in the re-suspension of planned care to a currently unknown degree Capacity constraints due to social distancing requirements reduce flow IPC requirements impact on flow to diagnostics, cubicle utilisation and flow to correct designated bed base Workforce constraints (vacancy rate & absence related to COVID 19)	Enhanced governance framework in place, i.e. CDP, ODG Elective Care Programme Board RTT Performance improvement dashboard RTT Improvement Programme Cancer Improvement Programme Weekly RTT & Cancer Access meeting Divisional performance reviews Trust Management Committee Finance & Performance Committee NHSI Performance Review meeting HVCCG Contract & Quality Review Meeting	As COVID 19 is a new disease the short and medium term effects are unknown and the impact on demand for emergency services may necessitate the re-suspension of planned services	No additional actions are currently possible	COO	Mar-21	
			2c	Failure to deliver UTCs in line with planned delivery dates	Deputy Chief Executive	Quality Committee			Medium	1. Programme Director in post 2. Programme Plan for July start for WGH UTC in place	3. Programme plan for procurement of HHGH and SACH UTCs to be finalised	1. Urgent Care Programme Board - joint with HVCCG 2. updates to Board via Strategy Update		1. finalise programme plan for procurement of HHGH and SACH UTCs	HB	Jul-20	Completed.
AMBITION 3 Patient Experience: improve our scores on the Friends and Family Test and national patient survey result to better than national average.	**Improving communications with our patients and carers**	**25 Selected questions from 9 of the 12 sections from inpatient survey**	3a	COVID-19 outbreak negatively impacts on patient experience	Chief Nurse	Quality Committee	4269 4287	CQC	High	1. Patient Experience Group 2. Family Liaison line introduced as an extension of PALS 3. Visitors helpline 4. Use of technology to face time 5. Letter to a loved one introduced 6. Additional staff within patient affairs 7. Increase in establishment within Spiritual & pastoral care	The national and local visiting policy has the potential to have negative impact with no or reduced visiting Reduced visiting for end of life, LD, MH and dementia patients	1. Divisional Governance meeting 2. Patient Experience Group 3. Quality Committee 4. national inpatient surveys 5. Healthwatch report 6. Coproduction Board formed and project on visitation to gather feedback, codesign solutions, more informed community	FFT and national surveys within maternity and Inpatients suspended	1.Monitor PALS, Complaints and thank you correspondence. 2. Compassionate conversation call back service to be reinstated which will gain valuable patient feedback. 3.Continue Healthwatch interaction to monitor their feedback intelligence from their members. 4.Coproduction work wiht Healthwatch and reporting to PEG and QC	DT	01/10/2020 Mar-2021	Continue to review complaints and PALS to enable themes to be monitorted. Call back service continues to operate with no major themes emergeing but patient issues being resolved at source i.e. medication explanation, OT deliveries, patient discharge follow up. Coproduction Board project initiation documents being completed and reviewed. Future codesign support with CPG and redevelopment. Organisational information being sent to update coproduction board members and their networks. PEG reviewing all CQC Picker surveys to enable corporate focussed support. Review again in **March 21**
			3b	Failure to communicate effectively with our patients and carers and improve the experience of discharge.	Chief Nurse	Quality Committee	4207	CQC	Medium	1. Discharge working group 2. Discharge checklist 3. Divisional and ward level performance analysis at QIF 4. Compassionate conversation call back service 5. Electronic discharge letters 6. Communication bundle introduced	1. National PPE policy and the challenges that it brings with effective communication 2. Due to visiting restrictions reduced MDT communication with family	1. Discharge Working Group 2. Patient Experience Group 3. Quality Committee 4. Trust management Committee 5. Healthwatch reports		1. Reinforce the communication bundle to improve collaborative planning of care and goal setting using QI methodology. 2. The coproduction board will reach out to members to enable engagement and involvement and codesign work to support planning and evaluation	DT	Mar-21	Coproduction Board to form working party to support visitation. Review of ITU visiting to enable first visit to be managed. Friends and Family Liaison line business case to be completed this month after further discussion within CAG regarding medical support. Review again in **January 21** **Family liaison line business case completed, approved and being implemented. ITU visitation was implemented although has reduced wiht the new phase of the pandmenic. New codesign projects accepted and underway. Review again in March 21**
	Implementing new outpatient pathways to improve patient experience	**Dropped call rate / local patient survey**	3c	New outpatient model fails to improve patient experience	Chief Nurse / Chief Information Officer	Quality Committee		CQC	Medium	1. A milestone plan has been developed for the completion of the digital telephony programme. 2. Expert telephony resource has been secured. 3. Regular progress meetings are held between our ICT and outpatient administration teams to ensure alignment in activities.	1. A potential lack of alignment between the technical and administrative enablement and the operational and clinical development of new pathways	1. Outpatient Transformation Group. 2. Trust Management Committee 3. Patient surveys		1. Centralisation of outpatient administration support, standardising and simplifying process as we go. 2 Production of an outpatient specific clinical plan - this should emerge out of the restart plans and the clinical strategy for the new hospital 3. The coproduction board will reach out to members to enable engagement and involvement and codesign work to support planning and evaluation	PB TBC DT	Mar-2021 Feb-2021 Feb-2021	

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Standards	Rating of risk to delivering objective	Key Controls	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)			Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc.	Low/Medium/High/ Extreme	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective evidence?	Actions to address control and assurance gaps.	Exec lead (to deliver specific	Time scale /review date	Update
AIM 2: BEST VALUE																	
AMBITION 4 Deliver our annual control totals and reach breakeven by 2023. Achieve a 'cost per weighted activity unit' that places us in the top 50% of acute trusts for efficiency (using the NHS Improvement Model Hospital metrics).	**Ensure that revenue income balances with revenue for each of the next two years**	**Deliver financial plan for 2021 and ensure that all clinical Divisions are able to either demonstrate costs are within 2020/21 budget or an improvement in patient care productivity.**	4a	Costs of responding to COVID-19 and restarting COVID-19 activity exceed available budget	Chief Financial Officer	Finance and Performance Committee	N/A	N/A	High	Chief sign-off of all Covid-19 related costs. Regular updates on criteria and processes by which costs may be recorded and reimbursed.	Possibility that postings may be made to dedicated Covid-19 centre outside of this process.	Submission of revenue and capital returns re Covid-19 and subsequent payments. Internal scrutiny at Finance and operational levels.	Timing delays confirming outcome of a given submission.	Regular scrutiny of all transactions within the dedicated Covid-19 centre. Regular communication with NHSEI and others to ensure timeliness of response and rapid resolution of queries.	CFO	Mar-21	Reimbursement mechanism moving to fixed payments, reinforcing the need for existing controls in order to avoid an increased risk of cost under-recovery. The plan for months 7-12 of FY21 have been submitted and signed off by the ICS / STP in the last week. The Trust deficit indicated by that plan is £4.2m. The Trust has incurred covid costs of £2.2m and £2.5m for November and December respectively and this is above the fixed average allocation of £1.7m per month.
	Ensure that there is an improvement in costs per weighted activity unit in comparison to other acute trusts	**Improved controls to ensure that there is a direct link between agreed staff deployment patterns and staff expenditure.**	4b	Impact of COVID-19 on operational efficiency	Chief Financial Officer	Finance and Performance Committee	N/A	N/A	High	Where services remain operational, ringfence resources to maintain.	Advancement of Covid-19 outside of existing control measures, and subsequent drain on resources otherwise devoted to non-Covid activity.	Maintenance and improvement of operational efficiences per existing measurement mechanisms.	Current systems geared towards business-as-usual operation, and while appropriate workarounds have been enacted, sufficiently flexible systems are not yet in place to ensure this is seamless.	Post-Covid assessment of systems and operational requirements in response to a future pandemic or other prolonged major incident.	CFO	Apr-21	Planning cycles well underway in relation to the remainder of 2020/21 and for the following financial year, both of which include appropriate assessments of Covid recovery actions. Efficiency savings of 1% have been included in the 2020/21 forecast outturn. Year to date savings achieved are in line with target. The Trust plans to achieve 4% (£16m) of efficiencies in 2021/22 as per 10 year plan subject to business planning guidance being issued in early spring of 2021.

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure	Risks Identified		Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Key Controls	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
What the organisation aims to deliver (outcome required)			Risk no.	What could prevent us from meeting this objective?	Board level lead responsible for achieving the objective	The sub-committee responsible for monitoring the risk	Risks scored 15 and above	CQC, NHSLA, HSE, etc.	Low/Medium/ High/ Extreme	What controls have been put in place to mitigate the risk?	What are the key gaps in controls?	1. First line of assurance (divisional) 2. Second line of assurance (committee) 3. Third line of assurance (external)	Where we are not gaining effective	Actions to address control and assurance gaps.	Exec lead (to deliver specific	Time scale /review date	Update
AIM 3: GREAT TEAM																	
AMBITION 5 **We want to be one of the best hospitals in England for staff engagement and in top 20% of acute hospital Trusts in the country for NHS national staff survey results.**	**Ensure that all of our staff feel engaged and included (equality, diversity and inclusion)**	**Equality, diversity and inclusion domain of the staff survey - improvement to above national median**	5a	Impact of COVID-19 on staff morale and wellbeing (in the context of west Herts being a badly affected community)	Chief People Officer	People, Education and Research Committee	3422		Medium	1. H&WB programme with psychological support. 2. Compassionate leadership programme commenced in November 2020. 3. Continuing to provide reduced cost lunch and encouraging people to take breaks. 4. Development 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. 5. Introduction of the Inclusion Charter.	1. The development of key performance indictors to assess progress for engagement and inclusion. 2. Some of the measures for well-being are only funded for a temporary period and therefore do not provide sustainable support.	1, Divisional Performance Meetings. 2. PERC 3. Staff survey (including F&FT)	It is still unclear as to the precise impact of COVID19 upon our staff	1. Extending the programme of compassionate leadership for all staff regarding behaviours and compassion. 2. Finalise plans for 12 months support from staff based on new well-being strategy.	CPO	Mar-20	
		Trust wide vacancy rate less than 10%	5b	The differential impact of COVID-19 on BAME staff adversely affects the engagement of BAME workforce	Chief People Officer	People, Education and Research Committee	4292	HSE	Medium	The development of the inclusion charter has supported improved engagement with BAME colleagues. This will be developed further with significant focus on events and development that will support improvement levels of engagement and inclusion. This includes a review of current recruitment processes in order to provide effective levels of diversity on interview panels.	Implementation of the actions that support the Inclusion Charter including the revised recruitment procedures. The vaccination programme is also planned with provisions for those staff in vulnerable groups.	1, Divisional Performance Meetings. 2. PERC 3. Staff survey (including F&FT)	A number of the initiatives are still in development	1. Implementation of inclusion charter and supporting actions. 2. Continue to work with Connect. 3. Roll out of vaccination programme for staff.	CPO	Mar-20	
	Reduce vacancy rates in hard to recruit "hotspots"		5c	There is a risk that vacancy rates will increase as a result of COVID-19	Chief People Officer	People, Education and Research Committee	3912		Medium	1. We have an on-going recruitment campaign in place with emphasis on international recruitment of nurses. 2. Plans to develop an ICS 'grow your own' nursing programme with better utilisation of the apprenticeship levy for Nurse Associate and Nurse Degree programmes. 3. Turnover rates and vacancy rates continue to fall and improve.	1. Effective retention and engagement strategy to support continue levels of low turnover. 2. Implement the 'grow you own' strategy to support the successful international recruitment.	1. Divisional performance Reviews 2. TMC/PERC	N/A	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.	CPO	Mar-20	
		Reduced vacancy rate in hotspots vs. baseline	5d	Increased staff absence as a result of COVID-19	Chief People Officer	People, Education and Research Committee	4279		Medium	1. Have in place the Enhanced Absence Management Hub. 2. Clear reporting is in place. 3. Point of mental health support are in place to help support staff	Whilst there is good absence control across many of our staff groups more work is required in relation to managing the absence of medical staff, particularly our junior doctor population	1. Divisional performance Reviews 2. TMC/PERC	N/A	1. Business case being prepared to make our Enhance Absence Management Service a permanent service. 2. A number of H&WB initiatives are being put into place to help our staff with psychological support as well as the contribution from Charitable Funds for the redevelopment of staff rooms.	CPO	Mar-20	

BOARD ASSURANCE FRAMEWORK 2020/21

Strategic Objective 2020/21	Breakthrough Objective (priority areas of focus for 2020-22)	Breakthrough Measure		Risks Identified	Exec lead	Lead Committee	Link to Corporate Risk Register	Link to Stand-ards	Rating of risk to delivering objective	Key Controls	Control Gaps	Identified assurance	Assurance Gaps	Actions to Address gaps (controls and assurance)			
AMBITION 6 Ambition 6: Paperless hospital by 2025 New Hospital facilities - building work to commence 2023	IT infrastructure: increased time to care	Reduced log in times, reduced downtime	6a	Failure to deliver planned improvements to IT infrastructure and releasing time to care	Chief Information Officer	Great Place Committee	3896; 3894; 3899	CQC	Medium	1. Detailed programme plan and weekly reporting of progress. 2. Interim recruitment of infrastructure expertise. 3. Closer working relationships with Atos.	1. Hybrid model - gaps in knowledge and control of infrastructure. 2. Lack of complete network diagrams		Definitive evidence of improvements in stability and performance	1. Post completion of the network upgrade we will compile feedback from users plus monitor the number of network related incidents. 2. Establishment of the Great Place subcommittee	PB PB PB	Mar 21	The Local Area Network programme has been completed, a programme closure report has been produced. The HSCN upgrade has also been completed, meaning we are much more resilient from a network perspective. We are now driving forward performance improvements with the deployment of W10 and Office 365. We now have network diagrams and much more knowledge of how our network is structured. We continue to work with our outsourced supplier on the best future operating model and the next contractual arrangement. Our remaining area of significant infrastructure weakness is in Pathology, we are working on a business case to upgrade both the hardware and the software.
	Redevelopment OBC approved	Key milestones	6b	Failure to progress redevelopment OBC in line with the programme plan	Deputy Chief Executive	Great Place Committee			Medium	1. RFL & PA advisory support commissioned. 2. Detailed programme plan, workstreams established and PMO reporting in place.		1. Great Place Programme Board (TMC) 2. Monthly regulator calls 3. Partnership Board convened on ad hoc basis		1. Establish formal Board sub-committee 2. Programme Director in post 3. External assurance arrangements TBC (e.g. Gateway reviews)	HB HB HB	Mar-21	First Great Place Board sub-committee held 17/09/20 Programme Director commenced in post July 2020. A national assurance programme for HIP One schemes is being developed - initial meeting held with DHSC lead. Assurance approach to be further developed for sub-committee review and approval. Overall programme to OBC completion remains on track for autumn 2021. Some slippage to milestone of preferred option approval due to COVID pressures and delay to finalising the schedule of accommodation and capital costs. Reprogramming of milestones underway.
			6c	Insufficient engagement of clinical staff and stakeholders in planning for the new hospital results in a sub-optimal solution	Deputy Chief Executive	Great Place Committee	Reflected in programme risk register		Medium	1. Clinical Workstream established. 2. First draft clinical packs developed and clinical & technology brief in progress. 3. activity and capacity workstream updating demand assumptions.	1. Clinical engagement limited by COVID - increased dedicated clinical sessions required. 2. Team capacity - vacant posts. 3. Clinical Brief to be finalised - current focus on activity and capacity modelling and agreement of functional content.			1. Appoint clinical leads with dedicated time. 2. Appoint to vacancies in programme team. 3. Establish User Groups.	HB HB HB	Mar-21	In progress. Good clinical engagement via user groups. Offers made - 2 x new project managers to commence in November. 3rd candidate withdrew. New 'nurse lead' role to be developed. User groups now well established and meeting regularly. Second wave COVID is impacting in clinical engagement at the current time, however the programme team continue to engage within constraints posed by current pressures. Reprogramming as above will allow for further engagement before preferred option and design is finalised.
	EPR secure funding and FBC mobilised	Key milestones	6d	Failure to secure funding for EPR	Chief Information Officer	Great Place Committee	4116	CQC	High	1. Written and verbal communications established with CEO of NHSX cross checked with Regional Director of Digital transformation at NHSE 2 Cross referencing of NHSX and HIP 1 communications 3 SFI's and board governance that ensure EPR programme cannot commence until funding is secured	1. Inability to influence national leaders to decide on route and amount of technology funding. 2. Inability to have an effective conversation on internal commitment to technology funding.	1. IT Digital Strategy steering group. 2. Trust Management Committee. 3. External assurance from technology partners, Deloitte, Atos, Berkely partnership	Certainty of progress, the nature of this risk and its impact on our progress is not linear and will test our risk appetite	1. Appointment of external technology partners for both EPR provision and longer term technology delivery 2. Establishment of the Great Place subcommittee	PB PB PB	Mar 21	Funding for EPR has been secured and the ten yr contract with Cerner was signed on the 23rd December. So for this year the strategic objective has been achieved. However the funding required to implement the digital strategy that supports the Trsuts longer term ambitions has not been identified. An ongoing commitment to digital invesment is required.

Trust Board Meeting
4 February 2021

Title of the paper	Activity Recovery Update & Access Standards Performance (December 2020 data reporting period)
Agenda Item	10/87
Presenter	Sally Tucker Chief Operating Officer
Author(s)	Jane Shentall Director of Performance
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓

Executive Summary

Activity Recovery

Activity recovery in CT is above the 2019/20 baseline level. MRI and Endoscopy however remain challenged and are unlikely to achieve target for some months. Outpatient, elective inpatient and day case activity have been affected by the rising COVID and emergency demand, requiring the cancellation of some outpatient activity and the suspension of admissions to St Albans.

Performance

Performance data is provisional at the time of writing (29/1/2021) and a few of the cancer indicators may change until closure of the formal submission period.

December's COVID-19 demand has affected all care pathways with increased demand or suspension of some elements of service. However, rising staff absence required a review of the SACH surgical model with actions implemented to release staff to support the acute site. As a result inpatient admissions at SACH ceased just before Christmas, leaving only day case activity in place initially although this was subsequently paused as well. This will obviously have a significant effect upon performance and waiting time recovery the impact cannot be fully quantified at the current time.

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	68.4%	↓
Diagnostic waits	99%	72.5%	↓
RTT incomplete pathways < 18 weeks	92%	78.8%	↑
52 week waits	0	1131	↓
2 week wait referrals	93%	85.5%	↓
2 week wait breast symptomatic referrals	93%	50.0%	↓
28 day Faster Diagnosis standard	70%	81.4%	↑
31 day first definitive treatment	96%	100.0%	↑
31 day subsequent - surgery	94%	87.0%	↓
31 day subsequent - drug	98%	100.0%	↔
31 day subsequent - palliative	94%	100.0%	↔
62 day referral to first treatment	85%	80.5%	↓
62 day screening referral to first treatment	90%	86.7%	↓

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

	Performance against the A&E 4 hour waiting time standard has deteriorated significantly in comparison to the previous month (82.1%) at 68.4%. While a slight drop is always anticipated (historical data indicates a decline of approximately 2.5% in recent years), services have been under enormous pressure with growing COVID and non-COVID demand and the challenges associated with onward admission with significant constraints arising from bed closures (COVID contacts) and availability of COVID positive/suspected beds. The increasing pressure of managing urgent and emergency care pathways has also impacted on diagnostics waiting times where performance has fallen to 71.5% (previously 74.3%). RTT performance has improved slightly at 78.8% (from 78.4% last month). Although there has been an increase in 52 week breaches, the slow down in growth continues. In December there were 1131 waits, up 19 from the December position of 1112. A number of the cancer waiting standards were not achieved in December: • Two week wait 85.5% (target 93%) • Breast Symptomatic 50% (target 93%) • 31 day subsequent surgery 87% (target 94%) • 62 day referral to first treatment 80.5% (target 85%) • 62 day screening 86.7% (target 90%)
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care — *Objectives 1-4*: ✓ **Aim 2** Great team — *Objectives 5-8*: **Aim 3** Best value — *Objective 9*: **Aim 4** Great place — *Objective 10-12*:
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	Committee/Group — Date Trust Management Committee — 27 January 2021 Finance & Performance Committee — 28 January 2021
Action required	The Committee is asked to receive this report for information.

Trust Board Meeting
4 February 2021

Agenda Item: 10/87

Trust Board Meeting – 4 February 2021

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

Presented by: Sally Tucker, Chief Operating Officer

1. Purpose

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

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

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

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

ACTIVITY RECOVERY

2 Recovery to date (December 2020)

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

2.2 Overall referrals received in November amounted to 75% of the 2019 total, lower than the previous month. However, cancer referrals were at 100% of the previous year. New ways of working, including Advice & Guidance and Referral Assessment Services (RAS) mean that not all referrals progress to an outpatient consultation and this is likely to result in lower level of outpatient activity than in previous years, but is a positive change and approximately 10% of referrals went through an Advice & Guidance Service.

2.3 CT (109%) recovery continues to do well but MRI (85%) and Endoscopy recovery is more challenged.

2.4 Outpatient activity was slightly lower than the previous month although non-face to face outpatient targets have been achieved. This is due to the cancellation of some activity so that staff could be released for redeployment to the wards and virtual hospital in response to the increasing COVID and urgent care demand.

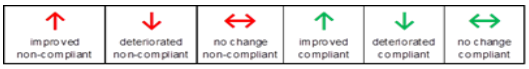
2.5 Elective activity (inpatient and day case) was suspended in mid December so that staff could be redeployed to WGH in response to the increasing levels of staff sickness absence.

ACCESS STANDARDS PERFORMANCE

3 Indicators not achieved in the reporting period

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

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	68.4%	↓
Diagnostic waits	99%	72.5%	↓
RTT incomplete pathways < 18 weeks	92%	78.8%	↑
52 week waits	0	1131	↓
2 week wait referrals	93%	85.5%	↓
2 week wait breast symptomatic referrals	93%	50.0%	↓
31 day subsequent - surgery	94%	87.0%	↓
62 day referral to first treatment	85%	80.5%	↓
62 day screening referral to first treatment	90%	86.7%	↓



3.2 December's COVID-19 demand saw increasing pressure on both urgent and planned care. Attendance rates particularly late afternoon and in to the evening, were extremely high with over 100 patients in the department on a number of occasions and high numbers of EEAST ambulances waiting to offload patients with significant delays of many hours and a return to corridor care. Flow through the department was challenging, with exceptionally high numbers of patients with decisions to admit with access to beds constrained by availability of the right bed, ie COVID positive, suspect/holding etc and ultimately this has resulted in 12 hour breaches.

3.3 Rising staff absence, particularly at WGH, required a review of the SACH surgical model with actions implemented to release staff to support the acute site. As a result, inpatient admissions at SACH ceased just before Christmas, leaving only day case activity in place (but also paused subsequently) and cancellation of some cancer and urgent admissions were necessary due to bed availability, staff absence or lack of theatre or ICU capacity.

3.4 All of the above have obviously had a significant effect upon performance and waiting time improvement and until the second wave peak has been reached, the impact cannot be fully quantified or recovery forecasts attempted at the current time.

4 A&E 95% target

4.1 Overall performance against the 95% 4 hour standard was much lower than the previous month at 68.4% (previously 82.1%).

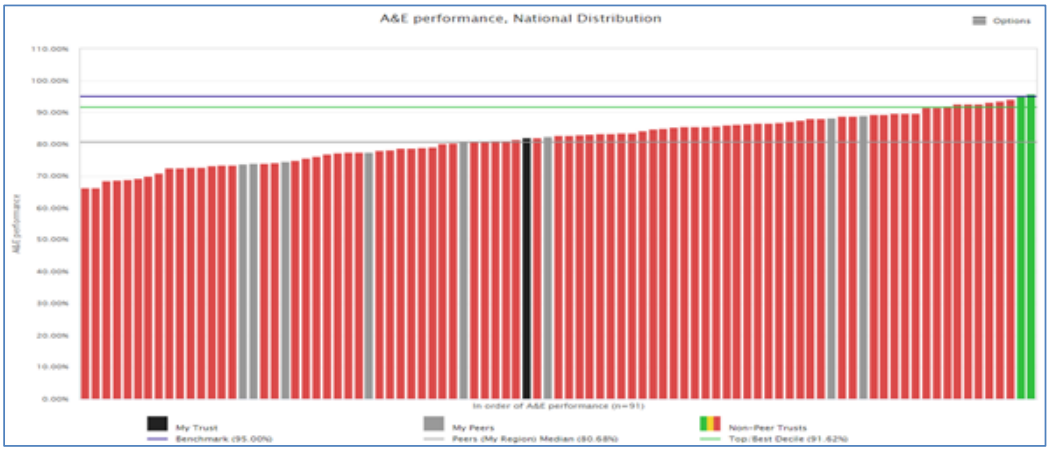
- Type 1 performance (WGH excluding UTC) was 43% (previously 66%).
- CED performance was lower than the previous month (92.6%) at 91.3%.
- Flow of Majors patients remains challenging with only 32.9% (previously 59.6%) compliance with the target but it should be noted that there was an 8% increase in majors pathways.
- Non-admitted performance was 58.8% (previously 78.6%) for the month with an 11% increase in pathways.
- The Urgent Treatment Centres at Hemel Hempstead and Watford both achieved 99% compliance.
- The Minor Injuries Unit at SACH remains closed.

4.2 Type 1 attendances (5843) increased by 5.6% in comparison with November (5529). Type 3 (Watford UTC) attendances (2421vs 2609) were just over 7% lower.

4.3 49% of type 1 attendances were patients arriving in an EEAST ambulance.

4.4 Model Hospital benchmarking (November 2020 performance) shows the Trust (the black bar) position is just below the second quartile, slightly below the national median of 82.7% but better than the regional median which was 80.7% (regional peer trusts in grey).

Model Hospital has not been updated to show December performance at the time of writing.



5 12 hour breaches

5.1 As noted in section 3.2 very significant bottlenecks have arisen in ED, throughout the entire pathway, particularly affecting ambulance offloads and onward admission. This was at its worst at the end of the month after Christmas, and on 30 and 31 December 21 patients waited longer than 12 hours from the time of decision to admit to departure from ED. Nine of these patients were COVID negative.

5.2 In the event of a 12 hour breach, trusts are required to declare an SI. However, there is a temporary change to guidance, which states that due to current pressures and the numbers of breaches, providers are not required to declare each breach when this is based purely on timescale and no harm has come to the patient. Instead, a record of breaches should be kept in case there is a national requirement to declare them retrospectively. If a breach resulted in significant harm, this should still be declared.

5.3 On that basis, an iReporter page was constructed which contains a record of all 12 hour breaches and an updated version was emailed to key staff in the trust each morning and latterly will now only be circulated in the event of a new breach. This report is also shared with commissioners to support their discussions with NHSEI.

5.4 The Emergency Medicine team are in the process of reviewing all 12 hour breaches to assess whether any harm occurred and to identify opportunities for learning and to agree any actions.

6 Ambulance Handover Delays

6.1 The number of patients arriving at A&E in an East of England ambulance was 4.4% higher than previous month, and accounted for 49% of all type 1 attendances at WGH. Just over 98% of EEAST conveyances were to ED, the highest in the region (ranging from 82.3 to 98.5%). The year to date growth in conveyances at the end of December was 6.8%. This remains the highest in the region.

6.2 Handover delays between 30-60 minutes rose by 40% to 488 (from 347). Delays over 60 minutes increased by an enormous 250% (514 from 148). When delays occur, patients are offloaded in clinical priority. There is regular communication between the trust and the ambulance service day and night and EEAST have provided invaluable support in the management of offload delays and patient cohorting.

6.3 The late afternoon, early evening peak of ambulance arrivals in clusters continues to be a factor in handover delays and the increase in conveyances month on month has continued. There has been further discussion on factors influencing this growth between system partners and commissioners and community providers are reviewing the utilisation of the rapid response servicer with a view to improving uptake, which has been low to date.

7 Changes to ED Access standards

7.1 Following the March 2019 interim report of the Clinically Led Review of NHS Access Standards[1], on 15 December 2020 a consultation[2] was launched, giving patients, the public and clinicians an opportunity to respond to the recommendations on urgent and emergency care standards. The consultation period ends on 12 February 2021.

7.2 There are 9 recommended new measures (p32 of the report) which cover the urgent and emergency care pathway to and within emergency departments, as follows:

- Response times for ambulances
- Reducing avoidable trips (conveyance rates) to Emergency Departments
- Proportion of contacts via NHS 111 that receive clinical input
- Percentage of ambulance handovers within 15 minutes
- Time to initial assessment – percentage within 15 minutes
- Average time in department – non-admitted patients
- Average time in department – admitted patients
- Clinically ready to proceed (time from agreement that patient is ready to leave ED to actual departure, ie admission)
- Percentage of patients spending more than 12 hours in A&E
- Critical time standards (time to treatment for the highest priority patients)

7.3 The thresholds for these measures have not been quantified at the current time, but where possible, internal shadow reporting will commence in January/February 2021 in order to provide an assessment of current performance in preparation for the implementation of the new standards.

7.4 Options for performance monitoring and reporting (p33 of the report) include an aggregation of the measures, scores derived from each measure which are weighted and aggregated or a bundle of separate measures. Reporting will continue to be on a monthly basis.

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[1] NHS. Interim Report of the Clinically-led Review of NHS Access Standards
https://www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf

[2] Transformation of urgent and emergency care: models of care and measurement
https://www.england.nhs.uk/wp-content/uploads/2020/12/Transformation-of-urgent-and-emergency-care_-models-of-care-and-measurement-report_Final.pdf

7.5 Further updates will be provided when the outcome of the consultation is announced.

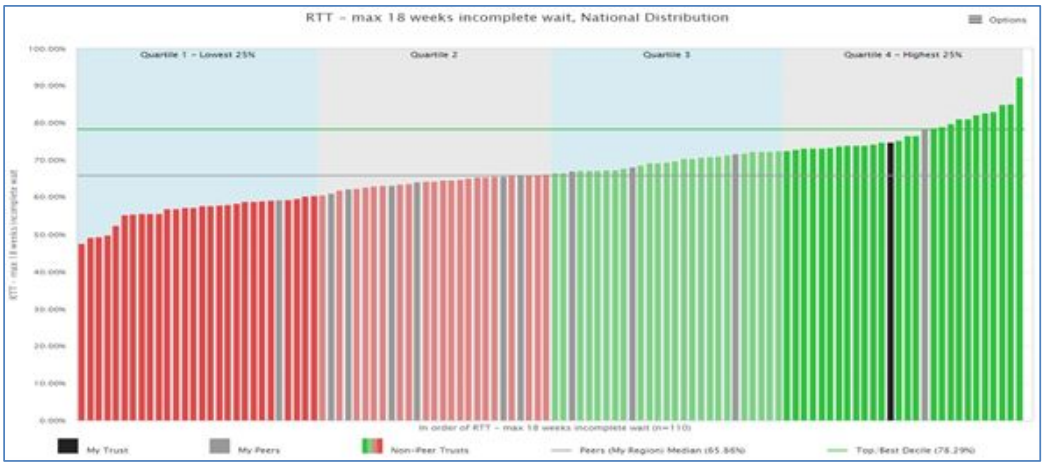
8 RTT Incomplete pathways

8.1 There has been further improvement in RTT open pathway performance, now at 78.8%. A specialty level breakdown is shown in appendix 3, along with an indicator showing the change from the previous month.

8.2 The PTL has grown (20409 vs 19533) but remains lower than in previous years. The backlog has risen slightly, from 4220 in November to 4331.

8.3 Model Hospital benchmarking (October 2020 performance at 74.8%) shows the Trust (the black bar) in the top quartile (16th from top). It should be noted that no organisation achieved the standard, the highest performance being 87.4%. The regional median 65.8% and national median 66.5% are better than previous months.

Model Hospital has not been updated to show December performance at the time of writing.



9 Long (52+) waits

9.1 The number of patients waiting more than 52 weeks has risen, but the rate of increase remains slower than seen in previous months. In December there were 1131 x 52 week waits in comparison to 1112 in November, an increase of 21.

9.2 In December 318 pathways over 52 weeks were closed, 104 non-admitted and 204 admitted.

Service	Dec-20
ENT	253
ORAL SURGERY	227
OPHTHALMOLOGY	183
TRAUMA & ORTHOPAEDICS	118
UROLOGY	91
GENERAL SURGERY	85
PAIN MANAGEMENT	67
VASCULAR SURGERY	32
COLORECTAL SURGERY	21
ORTHODONTICS	16
PAEDIATRIC UROLOGY	12
PAEDIATRIC OPHTHALMOLOGY	10
UPPER GI	8
NEUROLOGY	2
CARDIOLOGY	2
BREAST SURGERY	1
GYNAECOLOGY	1
DERMATOLOGY	1
GERIATRIC MEDICINE	1
Total	1131

Service	Nov-20
ORAL SURGERY	277
ENT	238
OPHTHALMOLOGY	177
UROLOGY	104
TRAUMA & ORTHOPAEDICS	95
GENERAL SURGERY	86
PAIN MANAGEMENT	54
VASCULAR SURGERY	23
ORTHODONTICS	13
COLORECTAL SURGERY	13
PAEDIATRIC UROLOGY	12
PAEDIATRIC OPHTHALMOLOGY	8
UPPER GI	5
DERMATOLOGY	4
NEUROLOGY	2
GASTROENTEROLOGY	1
Total	1112

Service	Oct-20
ORAL SURGERY	300
ENT	220
OPHTHALMOLOGY	177
UROLOGY	97
TRAUMA & ORTHOPAEDICS	94
GENERAL SURGERY	88
PAIN MANAGEMENT	36
VASCULAR SURGERY	24
ORTHODONTICS	12
PAEDIATRIC UROLOGY	9
COLORECTAL SURGERY	8
PAEDIATRIC OPHTHALMOLOGY	7
DERMATOLOGY	1
UPPER GI	1
GASTROENTEROLOGY	1
Total	1075

9.3 At the end of the month there were 76 patients waiting over 78 weeks. A growing number of patients (23%) are indicating their wish to defer surgery due to concerns regarding COVID with a small number declining treatment for other reasons. However, the majority of patients had previous admission dates that were cancelled during first wave and some with further cancellations as a result of the most recent increase in COVID pressures.

9.4 All patients on the RTT waiting list have a risk prioritisation category (P1-P6) assigned to indicate the most clinically appropriate timescale for treatment;

- P1(a/b) – within 24-72 hours
- P2 – within a month
- P3 – within 3 months
- P4 – 3 months or more
- P5 – patient deferred (COVID)
- P6 – patient deferred (other)

At the end of 2020 trusts were informed that only P1 and P2 admissions should proceed. This includes activity undertaken in the private sector. As a result, long waits (the most routine cases) are likely to increase until such time as P3 and P4 admissions are reinstated.

10 Cancer Waiting Times Performance

10.1 2 week wait (85.5%) and 2 week wait breast symptomatic (50%) performance were both below the standard (93%) this month. There were slightly fewer 2 week wait referrals in December but there was a small increase in 2 week wait breast symptomatic pathways.

10.2 The majority of 2 week wait breaches were in Breast Surgery where performance was 50%. 20% of 2 week wait breaches were due to patient initiated delays. 8 (just under 10%) of the 2 week wait breast symptomatic breaches were also the result of patient initiated delays.

10.3 The Breast Service, with support from the SAC divisional management team, have been tasked with a review of current options (including some outsourcing models) to address the issue with a temporary increase in capacity which is required to deliver a compliant position against the waiting time standards.

10.3 All but one of the 31day standard targets were achieved this month. There are currently 3 breaches of the 31 day subsequent surgery standard (2 Urology, 1 Breast) which have affected performance which was below the target (94%) at 87% at the time of writing. It should be noted that December's total pathways (23) was the highest year to date.

10.4 Performance against the 62 day referral to first treatment standard is currently below the 85% target at 80.5% although the reporting period is still open and additional activity will be recorded which could affect performance either way. There are currently 19 breaches (LGI, Urology, Lung, Haematology, Breast, Head & Neck, Gynaecology) with 93.5 pathways in total, one of the highest this year.

10.5 Performance against the 62 day screening referral standard has is currently not compliant at 86.7% (target 90%). There was 1 breach (Lower GI) with 7 pathways in total.

10.6 A rolling 12 month summary of performance against the cancer waiting time standards is included in appendix 4.

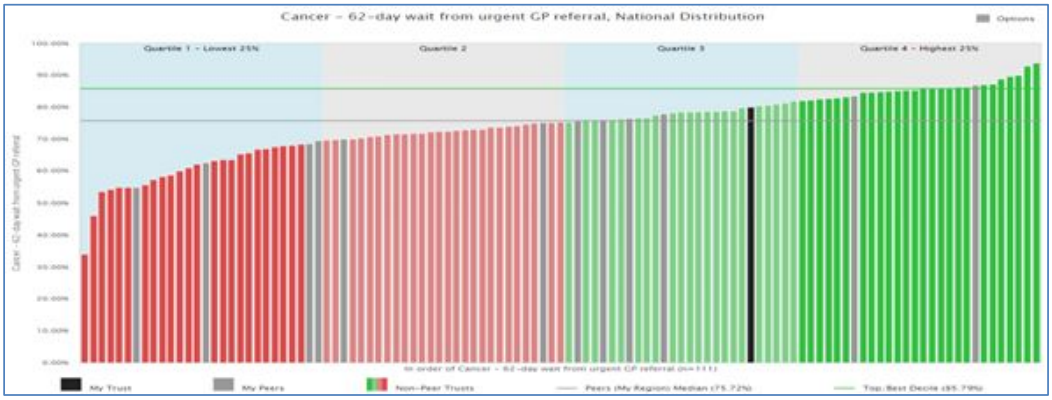
10.7 The Phase 3 recovery plan requires organisations to reduce the number of cancer pathways over 104 and 63 days. Good progress has been made to date, as shown in the table below.

September	>62 total	126
	>62 day with a diagnosis	20
	>104 total	39
	>104 with a diagnosis	3
October	>62 total	110
	>62 day with a diagnosis	23
	>104 total	34
	>104 with a diagnosis	8
November	>62 total	99
	>62 day with a diagnosis	21
	>104 total	28
	>104 with a diagnosis	8
December	>62 total	81
	>62 day with a diagnosis	22
	>104 total	17
	>104 with a diagnosis	4

10.8 Patients waiting over 104 days are reviewed at the weekly Access meeting and where pathways have failed to progress, actions are agreed to ensure bottlenecks are tackled. Patient choice or non-compliance is a factor, as are prolonged waits for diagnostics in some cases, delayed MDT discussions and pathway complexity. There are 2 further meetings each week to review the cancer waiting lists with escalations to clinicians where necessary. This approach has facilitated the reduction demonstrated above.

10.9 Model Hospital benchmarking (October 2020 performance at 80%) shows WHHT has moved back to the third quartile (the black bar) and is 34th of 111 providers. Performance was better than the national median of 75.3% and the regional median of 75.7%.

Model Hospital has not been updated to show December performance at the time of writing.



11 Diagnostic waiting times performance

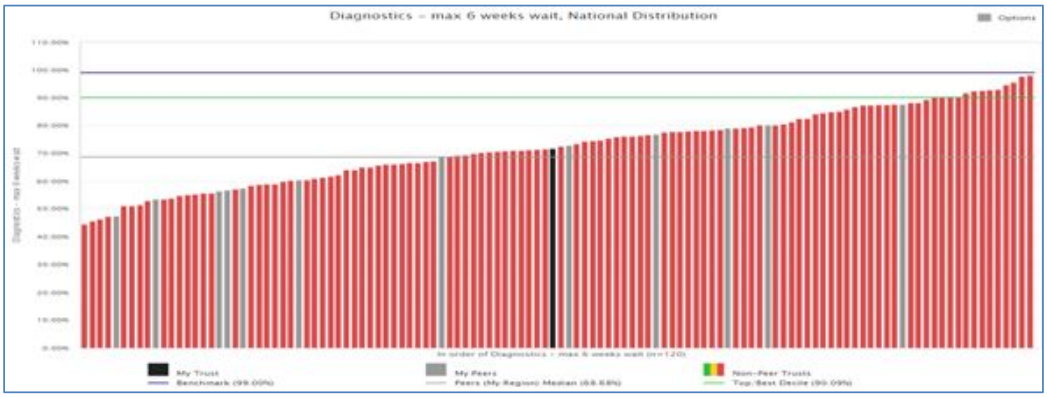
11.1 The standard for diagnostic waiting times was not achieved, and performance fell to 72.5% (from 74.3%). Most modalities' performance remains below the standard.

Diagnostic Waiting Times Performance	April	May	June	July	Aug	Sept	Oct	Nov	Dec
W01: Imaging - Magnetic Resonance Imaging	52.8	55.2	75.6	72.9	75.8	82.4	82.4	75.5	76.7
W02: Imaging - Computed Tomography	53.3	90	83.3	91.3	83.5	78.3	83.8	87.7	92.2
W03: Imaging - Non-obstetric ultrasound	23.6	39.8	88.5	92	82.7	66.9	58.5	65.5	58.3
W04: Imaging - Barium Enema	80	100	100	100	100	100	75	75	100
W05: Imaging - DEXA Scan	7.5	39.3	73.6	84	35.1	38.8	32	37.7	41.1
W06: Physiological Measurement - Audiology - Audiology Assessments			100	57.2	54.8	55.8	68.1	59.8	64.8
W07: Physiological Measurement - Cardiology - echocardiography	2.2	5.7	40	36.8	70.3	86.1	97.8	98.4	97.6
W08: Physiological Measurement - Cardiology - electrophysiology									
W09: Physiological Measurement - Neurophysiology - peripheral neurophysiology	50		100	85.5	100	100	100	100	95.3
W10: Physiological Measurement - Respiratory physiology - sleep studies									
W11g: Physiological Measurement - Urodynamics - pressures & flows (Gynae)	100	100	100	100	100	100	100	100	100
W11s: Physiological Measurement - Urodynamics - pressures & flows (Surgical)			100	77.8	90.5	66.7	65	100	100
W12: Endoscopy - Colonoscopy	46.9	28	50.7	69.7	69.8	79.5	75.8	82.3	76.5
W13: Endoscopy - Flexi sigmoidoscopy	40.1	32.8	40.6	50.5	62.9	81.3	91.7	86.8	84.3
W14: Endoscopy - Cystoscopy	35.1	38.6	47.7	55.6	60.3	69.2	71.1	57.6	49.7
W15: Endoscopy - Gastroscopy	22	19.9	41.8	61.8	54	53.1	69.5	75.9	68.5
Total	26.5	39.6	64.8	73.4	68.5	69.4	72	74.3	72.5

11.2 Additional capacity has been secured for MRI, CT and ultrasound at a local independent sector provider. Following the start of the contract in mid November, further capacity was agreed for MRI and ultrasound, coming on line in January 2021.

11.2 Model Hospital benchmarking (October 2020 performance at 71.8%) shows the Trust's (the black bar) position, which was slightly below the national median, 72.2% and the regional position at 68.6%. No organisation achieved the 99% standard, the highest being 98.1%.

Model Hospital has not been updated to show December performance at the time of writing.



12 Harm Reviews

12.1 Tracking the completion of harm reviews is now conducted using the main waiting list. A paper was presented to the Quality Committee in October outlining the harm review process. Each division has a different trigger point; Surgery 48 weeks; WACS Gynaecology 40 weeks, Paediatrics 25 weeks; Medicine 40 weeks. Analysis of the PTL on 31/12/2020 is shown below.

Surgery (Trigger: 48 weeks)	Total > 48 weeks	Harm Reviews	
		Completed	In progress or outstanding
GENERAL SURGERY	138	60.9%	39.1%
UROLOGY	118	81.4%	18.6%
TRAUMA & ORTHOPAEDICS	186	36.6%	63.4%
ENT	320	82.5%	17.5%
OPHTHALMOLOGY	232	81.9%	18.1%
ORAL SURGERY	285	77.2%	22.8%
COLORECTAL SURGERY	2	0.0%	100.0%
BREAST SERVICE	35	62.9%	37.1%
UPPER GI SURGERY	11	63.6%	36.4%
VASCULAR SURGERY	39	74.4%	25.6%
ORTHODONTICS	18	88.9%	11.1%
PAIN MANAGEMENT	102	46.1%	53.9%
PAEDIATRIC UROLOGY	16	75.0%	25.0%
PAEDIATRIC OPHTHALMOLOGY	16	62.5%	37.5%
Total	**1518**	**70.2%**	**29.8%**

Medicine (Trigger: 40 weeks)	Total > 40 weeks	Harm Reviews	
		Completed	In progress or outstanding
GASTROENTEROLOGY	2	0.0%	100.0%
CARDIOLOGY	26	19.2%	80.8%
DERMATOLOGY	9	0.0%	100.0%
RESPIRATORY MEDICINE	30	0.0%	100.0%
NEUROLOGY	8	37.5%	62.5%
RHEUMATOLOGY	6	0.0%	100.0%
GERIATRIC MEDICINE	5	0.0%	100.0%
ENDOCRINOLOGY	3	33.3%	66.7%
CLINICAL HAEMATOLOGY	5	0.0%	100.0%
HEPATOLOGY	3	0.0%	100.0%
Total	**97**	**9.3%**	**90.7%**

WACS (Trigger: Gynae 40 weeks Paed Cardio 35 weeks Paeds 25 weeks)	Total > 40/35/25 weeks	Harm Reviews	
		Completed	In progress or outstanding
GYNAECOLOGY	7	28.6%	71.4%
PAED GASTROENTEROLOGY	0	NA	NA
PAED CARDIOLOGY	0	NA	NA
PAEDIATRIC EPILEPSY	3	0.0%	100.0%
PAEDIATRICS	4	0.0%	100.0%
Total	**14**	**7.1%**	**92.9%**

The volume of pathways triggering the harm review process has increased very significantly and as a result services have been struggling to manage the volume of reviews required. Additional resource has been identified to support the non-clinical elements of harm reviews but some changes have been required to systems to enable this and as a result a backlog has arisen. This is now being addressed and the position will improve going forward.

12.2 Some changes are being made to the oversight of harm reviews within the Surgical divisional governance structure to ensure full visibility of any harms identified. Work is underway to validate the current number of harms and an update will be provided next month.

12.4 Cancer 62 day harm reviews are tracked by the MDT Co-ordinator team. CWT guidance puts responsibility for completion of a harm review on the treating provider. Although WHHT have undertaken reviews on pathways with onward tertiary referrals, input from the treating organisation is sometimes difficult to obtain although there has been progress with Head & Neck pathways, with East and North Herts trust agreeing to undertake the harm reviews for patients treated at The Lister Hospital. However, there is still some further work to do to develop a similar level of collaborative working with other tertiary providers.

Period covered: Mar-Nov 20	Tracking		Reviews completed
Tumour Site	Total reviews required	Total reviews in progress	
Urology	61	1	60
Colorectal	50	1	49
Head & Neck	22	16	4
Upper GI	17	3	14
Breast	12	0	12
Gynaecology	13	2	11
Lung	30	14	16
Haematology	20	1	19
Dermatology	3	0	3
Sarcoma	1	1	0

13 Risks

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

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

14 Recommendation

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

Jane Shentall
Director of Performance
28 January 2021

Appendix 1 - Elective Recovery – Actual vs Plan vs Target

Activity type+B3:M51			Sep	Oct	Nov	Dec	Jan	Feb	Mar	Update / Comment
Diagnostics	CT	Trust plan	103%	102%	102%	102%	102%	102%	102%	**Diagnostics** CT activity is above target, but MRI activity is lower than in teh previous month. Additional independent sector capacity has been secured from January 2021 **Endoscopy** The impact of hte bowel scope screening suspension continues to affect overall recovery rates. Flexible cystoscopy has been repatriated to HHGH from Spire. COVID sickness has resulted in the loss of some sessions. **Outpatients** Referrals overall are at 75% of the previous year although Cancer referrals have returned to 100%. Approximately 10% of referrals are reviewed via Advice & Guidance and Referral assessment services (RAS). Some of this activity would have converted to outpatient activity previously and accounts for some of the gap between target/plan and actual. In additional, the increased demand from urgent and emergency care pathways including COVID have resulted in the suspension of some clinic activity so that staff can be released to support ward and virtual hospital work. **Elective Day Case & Inpatient** The effects of COVID on staffing has resulted in the suspension of activity at SACH so that staff can be redeployed to support WGH wards and ITU, resulting in a drop in activity. **Indepdent Sector** Negotiations with a number of independent sector providers has been ongoing, with plans to send activity to a number of BMI sites and Spire Bushey. Patients (diagnostic and Orthopaedic LA cases) are also being sent to a locally commissioned provider. As this provider is not on the national framework there is a financial implication for the trust, but this activity is being undertaken within the agreed allocated funding.
		Target	90%	100%	100%	100%	100%	100%	100%	
		Actual	90%	91%	100%	109%				
		Gap to plan	-13%	-11%	-2%	7%				
		Actual vs target	0%	-9%	0%	9%				
	MRI	Trust plan	113%	102%	104%	104%	102%	108%	106%	
		Target	90%	100%	100%	100%	100%	100%	100%	
		Actual	75%	75%	89%	85%				
		Gap to plan	-38%	-27%	-15%	-19%				
		Actual vs target	-15%	-25%	-11%	-15%				
	Endoscopy	Trust plan	55%	81%	100%	100%	100%	100%	100%	
		Target	90%	100%	100%	100%	100%	100%	100%	
		Actual	60%	79%	73%	71%				
		Gap to plan	5%	-2%	-27%	-29%				
		Actual vs target	-30%	-21%	-27%	-29%				
Outpatients	All Outpatients	Trust plan	75%	90%	90%	90%	90%	90%	90%	
		Target	100%	100%	100%	100%	100%	100%	100%	
		Actual	77%	82%	80%	81%				
		Gap to plan	2%	-8%	-10%	-9%				
		Actual vs target	-23%	-18%	-20%	-19%				
	All non face to face	Actual	39%	38%	43%	45%				
		Target	25%	25%	25%	25%	25%	25%	25%	
		Gap	14%	13%	38%	20%				
	F/Up non face to face % of all non face to face	Actual	63%	65%	67%	69%				
		Target	60%	60%	60%	60%	60%	60%	60%	
		Gap	3%	5%	7%	9%				
Electives	Day Case	Trust plan	98%	94%	94%	95%	95%	94%	94%	
		Target	80%	90%	90%	90%	90%	90%	90%	
		Actual	51%	74%	70%	69%				
		Gap to plan	-47%	-20%	-24%	-26%				
		Actual vs target	-29%	-16%	-20%	-21%				
	Inpatient	Trust plan	79%	89%	89%	89%	89%	89%	89%	
		Target	80%	90%	90%	90%	90%	90%	90%	
		Actual	87%	76%	95%	76%				
		Gap to plan	8%	-13%	6%	-13%				
		Actual vs target	7%	-14%	5%	-14%				

Appendix 2

The Access standards

- 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- Less than 1% of patients should wait 6 weeks or more for a diagnostic test, measured against 15 key diagnostic tests (see below).
- More than 92% of patients on incomplete (open) pathways should have been waiting no more than 18 weeks from referral.
- A maximum of 2 weeks
  - from urgent GP referral for suspected cancer to first outpatient appointment – 93% operational standard
  - from referral or any patient with breast symptoms (where cancer is not suspected) to first hospital assessment – 93% operational standard
- Maximum one month (31 days)
  - from decision to treat to first definitive treatment – operational standard of 96%
  - decision to treat/earliest clinically appropriate date to start second/subsequent treatment where the treatment is surgery (operational standard 94%), drug treatment (operational standard 98%), radiotherapy (operational standard 94%)
- Maximum two months (62 days) from
  - urgent GP referral for suspected cancer to first treatment – 85% operational standard
  - urgent referral from NHS Cancer Screening Programme (breast, cervical, bowel) for suspected cancer to first treatment – 90% operational standard

The 15 key diagnostic tests

1. Imaging - Magnetic Resonance Imaging
2. Imaging - Computed Tomography
3. Imaging - Non-obstetric ultrasound
4. Imaging - Barium Enema
5. Imaging - DEXA Scan
6. Physiological Measurement - Audiology – Audiology Assessments
7. Physiological Measurement - Cardiology - echocardiography
8. Physiological Measurement - Cardiology - electrophysiology
9. Physiological Measurement - Neurophysiology - peripheral neurophysiology
10. Physiological Measurement - Respiratory physiology - sleep studies
11. Physiological Measurement - Urodynamics - pressures & flows
12. Endoscopy - Colonoscopy
13. Endoscopy - Flexi sigmoidoscopy
14. Endoscopy - Cystoscopy
15. Endoscopy – Gastroscopy

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf

Appendix 3

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

Description	Total	Less than 18 Weeks	18 Weeks Plus	% Under 18 Weeks	Change since last month
GENERAL MEDICINE	11	11	0	100.0%	↔
OTHER	1	1	0	100.0%	↑
ANAESTHETICS	2	2	0	100.0%	↔
PAEDIATRIC GASTROENTEROLOGY	21	21	0	100.0%	↑
PAEDIATRIC ENDOCRINOLOGY	32	32	0	100.0%	↔
PAEDIATRIC CLINICAL HAEMATOLOGY	11	11	0	100.0%	↑
MEDICAL ONCOLOGY	21	21	0	100.0%	↔
GYNAECOLOGICAL ONCOLOGY	35	35	0	100.0%	↔
ORTHOTICS	87	86	1	98.9%	↑
PAEDIATRICS	375	369	6	98.4%	↑
CLINICAL ONCOLOGY	39	38	1	97.4%	↑
BREAST SURGERY	314	305	9	97.1%	↓
GASTROENTEROLOGY	1252	1210	42	96.7%	↓
DIABETIC MEDICINE	85	80	5	94.1%	↓
PAEDIATRIC CARDIOLOGY	49	46	3	93.9%	↑
DERMATOLOGY	2049	1920	129	93.7%	↓
CLINICAL HAEMATOLOGY	186	173	13	93.0%	↓
RESPIRATORY MEDICINE	790	732	58	92.7%	↑
ENDOCRINOLOGY	289	267	22	92.4%	↓
NEUROLOGY	821	757	64	92.2%	↓
PAEDIATRIC DERMATOLOGY	62	57	5	91.9%	↓
GYNAECOLOGY	772	705	67	91.3%	↑
NEPHROLOGY	34	31	3	91.2%	↓
CARDIOLOGY	1730	1558	172	90.1%	↑
RHEUMATOLOGY	523	458	65	87.6%	↓
PAEDIATRIC EPILEPSY	24	21	3	87.5%	↓
HEPATOLOGY	55	47	8	85.5%	↑
GERIATRIC MEDICINE	42	33	9	78.6%	↓
UPPER GASTROINTESTINAL SURGERY	348	273	75	78.5%	↓
UROLOGY	1629	1264	365	77.6%	↑
COLORECTAL SURGERY	410	315	95	76.8%	↓
TRAUMA & ORTHOPAEDICS	2147	1507	640	70.2%	↑
PAEDIATRIC OPHTHALMOLOGY	150	101	49	67.3%	↑
PAEDIATRIC UROLOGY	172	115	57	66.9%	↓
OPHTHALMOLOGY	1454	960	494	66.0%	↑
VASCULAR SURGERY	190	119	71	62.6%	↑
GENERAL SURGERY	1256	785	471	62.5%	↓
ENT	1267	735	532	58.0%	↑
ORAL SURGERY	891	487	404	54.7%	↑
PAIN MANAGEMENT	753	390	363	51.8%	↑
ORTHODONTICS	30	0	30	0.0%	↔
Total	**20409**	**16078**	**4331**	**78.8%**	↑

Appendix 4
Cancer waiting times performance – update (at 29/1/21)

Standard	Target	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 YTD (latest)
2ww	93.0%	96.8%	97.0%	97.6%	98.0%	95.1%	99.0%	97.7%	98.6%	96.4%	97.1%	96.9%	95.6%	85.5%	95.6%
2ww 28 day FDS	75.0%	76.8%	75.8%	84.7%	77.0%	68.8%	85.6%	82.1%	80.3%	81.7%	78.1%	83.6%	79.2%	81.4%	80.9%
2ww breast	93.0%	98.4%	94.2%	98.6%	98.5%	100.0%	87.9%	87.9%	98.1%	96.2%	97.1%	98.7%	88.1%	50.0%	88.4%
31 day 1st	96.0%	99.4%	96.3%	97.2%	97.1%	98.5%	92.1%	97.2%	96.5%	96.6%	96.4%	94.3%	97.2%	100.0%	96.5%
31 day surgery	94.0%	100.0%	100.0%	100.0%	100.0%	93.3%	87.5%	100.0%	89.5%	70.0%	83.3%	100.0%	94.7%	88.0%	90.6%
31 day drug	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%
31 day palliative	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 day	85.0%	82.9%	84.8%	80.1%	83.1%	70.3%	76.9%	86.4%	76.9%	86.6%	85.5%	82.0%	85.9%	80.5%	81.7%
62 day screening	90%	100.0%	72.0%	80.0%	92.0%	85.7%	64.3%	100.0%	0.0%	66.7%	66.7%	66.7%	92.3%	86.5%	71.4%

NB: Performance is provisional at the time of writing and until the quarterly reporting period closes.

Trust Board Meeting
4 February 2021

Title of the paper	**Integrated Performance Report** ***(January 2021 reporting period – December 2020 data)***
Agenda Item	11/87
Presenter	**Sally Tucker** **Chief Operating Officer**
Author(s)	**Jane Shentall** **Director of Performance**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary	**Best Care / Great Team – COVID-19 snapshot** • Significant increase in all COVID-19 patient indicators: positive inpatients continues, with 372 (was 119), and a rise (from 5) to 21 ITU COVID-19 positive patients (slide 3, 28-30) • Staff absence indicators have also risen dramatically with COVID-19 sickness at 457 (from 208) and 276 staff self-isolating (previously 117) (slide 3) • 4 Hospital definite and 6 hospital probable nosocomial infections were reported • 1 indeterminate and 3 community nosocomial infections were reported (slide 3, 30) • PPE RAG rating indicates that there was a good supply of items, all of which were green in terms of days' supply (slide 3, 29) **Safe Care & Improving Outcomes** • Mortality indicators: SHMI has improved further to 97.9 (99.4 last period), HSMR has risen (from 82.4) to 88.8 (slides 4, 25) • There were no hospital apportioned clostridium difficile cases (previous month 2) with a year to date total of 18 (slides 4, 26) • The overall C-section rate is higher at 34.7% (previously 32.5%) and remains above (worse than) target (28%); the elective rate has increased at 16.9% (was 14.2%) and is above the local target (11%), and the emergency rate (target 15%) is lower at 17.8% (was 18.2%). The year to date rate for all C-sections is 33.8% (slides 4, 32). • Reporting for safe care, nursing shift fill, remains suspended as a result of the COVID-19 pandemic (slides 4, 34) • There were 15 serious incidents and patient safety incidents that are harmful has increased to 19% (previous month 11.9%) and year to date 10.4% (slides 4, 34) • 2 Never events were reported in the month (slides 6, 38) • Safety thermometer new harms remains suspended as a result of the COVID-19 pandemic (slide 4, 35) • VTE risk assessment compliance is better (higher) than target (95%) at 96.8% and year to date the rate is 96.2% (slides 4, 37) • Stroke indicators: Admission to the unit within 4 hours is below target (90%) at 14% (previously 26.1%); 76.3% (was 86.2%) of patients spent 90% of their admission on the unit (target 80% (slides 4, 38)

Caring & Responsive Services

- Ambulance turnaround delays increased drastically with 388 (was 347) between 30 and 60 minutes with an increase in delays over 60 minutes, at 514 (was 148) (slides 5, 39)
- ED 4 hour performance was lower than the previous month (83.4%) at 68.4% with a year to date position of 82.1% (slides 5, 39)
- Reporting requirements for delayed transfers of care (DToCs) remain suspended as a result of the covid-19 pandemic (slides 5, 41)
- Friends & Family testing has also been paused for COVID-19
- Complaints response times were below (worse than) target (80%) at 66.7% with 6 reactivated complaints received in the month (slides 5, 44)
- RTT (incomplete) performance continues to improve (from 78.4%) to 78.8% (ytd 62.9%). There were 1131 x 52 week breaches (previously 1112) (slides 5, 46)
- Diagnostic waiting times performance remains below the standard (99%) at 72.5% (was 74.3%) (slides 5, 46)
- 2 week wait performance (85.5%) is below (lower than) target (93%) (slides 5, 47)
- 2 week wait breast symptomatic is non-compliant with the standard (93%) at 50% (slides 5, 47)
- 28 day faster diagnosis standard (2ww) performance is compliant at 82.7% (slides 5,47)
- 31 day first performance is currently better than the standard (96%) at 100%
- 31 day subsequent surgery performance is below the standard (94%) at 87%
- Performance against the 62 day urgent referral to first treatment is currently below target (85%) at 80.5% (slide 5, 49)
- 62 day screening performance is non-compliant at 86.7% (target 90%) (slides 5, 49)
- Short notice appointment cancellations have reduced but are above (worse than) target (5%), at 6.6% (slides 5, 50)
- Outpatient DNA rates are worse than target at 8.7% (year to date 7.9%) (slides 5, 50)

Workforce & Finance

- 12 month turnover rate is stable at 12.6% (previously 13%) and is just below (better than) target (13%); the vacancy rate is improved at 9.1% (was 9.6%) and is better than target (10%) (slides 5, 51)
- Sickness absence rates have remained above (worse than) the target (3.5%) at 5.2% (slides 6, 51)
- All staff appraisals are at 85.8%, worse than target (90%) (slides 5, 52)
- Mandatory training is compliant at 90.7% (slides 5, 52)
- Bank pay is in line with the 12% monthly target. (ytd 11%). Agency pay is also within the monthly 4.8% target (slides 6,17)
- For this month (9) the trust reported a position that was in line with our updated forecast. Expenditure of £37.9m was £0.8m higher than the £37.1m of income received. As we've been breaking-even for the past eight months, the year to date position also shows a deficit of income over expenditure of £0.8m (320.9m income and £321.7m costs). This position is in line with our NHSEI agreement to incur a deficit no greater than £4.2m by the end of the year.
- As per the revised plan, the trust was expected to achieve £0.3m worth of efficiencies in month. This was met and £0.8m has been delivered year to date. The revised full year target for efficiencies is £2m.
- The sensitivity of the forecast ranges from a £5.6m deficit in the worst case, a £4.2m deficit in the likely case and a £3.5m deficit in the best case.
- A range of activity counts are now included for information (slide 6):
  - → Referrals are lower than the previous month
  - → A&E attendances are lower than the previous month
  - → Elective inpatient spells are better than plan

	Activity RAG ratings are shown in the context of the minimum income contract where the primary objective is to match capacity to demand. Therefore, non-elective activity above plan/expectations would be rated red. Births are classified as non-elective activity and so activity below plan is rated green. Elective spell underperformance against expectations is rated red in the context of waiting list management. *NB: Data correct at the time of reporting – 29/1/2021*
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: Trust Management Committee — Date: 27 January 2021 Committee/Group: Finance & Performance Committee — Date: 28 January 2021
Action required	The Committee is asked to receive this report for information, assurance and discussion.

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

January 2021

Reporting Period: December 2020

Trust Board: 4th February 2021

Performance data updated on: 29th January 2021

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

How Are we Doing?

Safe Care & Improving Outcomes	Caring & Responsive Services	Workforce & Finance
Safety Thermometer New Harm Free Care Suspended Target 95%	**Complaints response times** 66.7% Target 80%	**Mandatory Training** 90.7% **Appraisal Rates** 85.8% Target 90%
Clostrioides Difficile cases 2 Target 3	**ED 4 hour standard** 68.4% Target 95%	**Agency pay** 4.7% Target 4.8%
VTE assessment 96.8% Target 95%	**RTT 52 week waits** 1131 Target 0	**Vacancy rate** 9.1% Target 10%
Inpatient Friends & Family positive scores Suspended Target 95%	**CWT - 62 day referral to first treatment** 80.5% Target 85%	**I&E forecast** (Full year) -£4,200 **I&E actual** (YTD actual & BAU plan) -£850 Target -£ 950

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West Hertfordshire Hospitals NHS Trust

COVID-19 SNAPSHOT – 15th January 2021

BEST CARE

GREAT TEAM

INPATIENTS

C-19 positive **312**	C-19 suspected **9**	ITU C-19 positive **21**
C-19 result awaited **47**	C-19 negative **215**	ITU C-19 negative **7**

STAFF VACCINATION & TESTING

1st Vaccination % to date **79.2%**	
C-19 positive **15**	C-19 negative **29**

PATIENT TESTING

Non-elective C-19 positive **18**	Non-elective C-19 negative **28**
Elective C-19 positive **0**	Elective C-19 negative **1**

STAFF ABSENCE

C-19 sickness absence **457**	C-19 household contact **159**
C-19 symptomatic **181**	C-19 test and trace **117**

NOSOCOMIAL INFECTIONS

Hospital definite **4**	Hospital Probable **6**
Hospital indeterminate **1**	Community **3**

PPE ESTIMATED STOCK DURATION (DAYS)

Fluid resistant face masks **19 (Green)**	FFP3 face masks **15 (Green)**
Gloves **16 (Green)**	Gowns **20 (Green)**

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Essential Measures – Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Lower than previous month and within the "as expected" range	SHMI 97.9 HSMR 88.8	**Complaints response times** Below target (80%) and lower than previous month	66.7% YTD 76.9%	**All staff appraisal** Better (higher than) previous month Below target (90%)	85.8% YTD 86.3%
Infection Control – clostrioides Difficile (hospital & healthcare) 0 Cat1 and 2 Cat2 cases this month	2 (Cat1: 0 Cat 2:2) YTD 30	**Inpatient Friends & Family Test** Positive scores mainly compliant but variable, ED just below target (95%)	Suspended	**Mandatory training** Consistently achieved (target 90%) and stable	90.7% YTD 92.2%
Serious incidents & Never Events (NE) Variable – 15 SIs in reporting period	SI 15 YTD 35 NE 2 YTD 3	**Mixed sex accommodation** None in reporting period but usually low number when breaches occur	Suspended	**Turnover at 12 months** Just below (better than) target (13%) Similar to previous month	12.9% YTD 13.6%
Patient safety incidents which are harmful Higher than previous month	19.0% YTD 10.4%	**Outpatient DNA rates** Higher (worse than) target (8%) and higher than previous month	8.7% YTD 7.5%	**Income & Expenditure** Position is in line with the revised plan	(£0.81)m YTD (£0.85)m
Combined Caesarean Section Standard (28%) not achieved and worse (higher) than previous month	34.7% YTD 33.8%	**ED waiting times** Worse than previous month Target (95%)	68.4% YTD 82.1%	**Capital Spend** £2.5m Capital spend in December	(£2.49)m YTD (£13.71)m
VTE assessments Better (above) than target (95%) Similar to previous month	96.8% YTD 96.2%	**RTT waiting times** Lower than the target (92%) Increase in 52 week waits	78.8% YTD 67.0% 1131	**CIP Efficiency** YTD achievement of £0.9m 1.9m if expected to be delivered	YTD £0.90m FY £1.9m
Stroke Indicators Admission to Stroke Unit within 4 hrs – target (90%) not achieved 90% admission spent in the Stroke Unit – target (80%) not achieved	4 hr 14.0% YTD 26.0% Adm 76.3% YTD 75.1%	**Cancer waiting times** 2ww below target 62 day below target (85%) Worse than previous month	2ww 85.5% YTD 95.6% 62 day 80.5% YTD 81.9%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 0 Elec 2788 vs 3959.81 Non-Elec 3527 vs 5089.99
Reporting Sub-Committee **Quality Committee**		**Reporting Sub-Committees** **People, Education & Research Committee** **Finance & Performance Committee**		**Reporting Sub-Committees** **People, Education & Research Committee** **Finance & Performance Committee**	

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West Hertfordshire Hospitals NHS Trust

COVID19 – SNAPSHOT - Indicator Summary

Domain	Theme	Trend Month on Month	Nov-20	Dec-20	Jan-21
COVID 19 Snapshot	**Inpatients**				
	C-19 positive	Worsening	67	119	312
	C-19 suspected	Worsening	9	15	9
	C-19 result awaited	Improving	85	86	47
	C-19 negative	Worsening	471	405	215
	ITU C-19 positive	Worsening	5	5	21
	ITU C-19 negative	Worsening	9	9	7
	Staff Testing				
	1st Vaccination % to date		N/A	N/A	79.2%
	C-19 positive	Worsening	2	13	15
	C-19 negative		248	107	29
	Patient Testing				
	Non-elective C-19 positive	Worsening	6	13	18
	Non-elective C-19 negative	Worsening	54	73	28
	Elective C-19 positive	Stable	0	0	0
	Elective C-19 negative	Worsening	4	3	1
	Staff Absence				
	C-19 sickness absence	Worsening	234	208	457
	C-19 household contact	Worsening	114	93	159
	C-19 symptomatic	Worsening	95	71	181
	C-19 test and trace	Worsening	25	44	117
	Nosocomial Infections				
	Hospital definite	Worsening	0	2	4
	Hospital probable	Worsening	0	2	6
	Hospital indeterminate	Improving	1	2	1
	Community	Worsening	1	3	3
	Estimated duration of PPE stock (days)				
	Fluid resistant face masks	Stable	18	19	19
	FFP3 face masks	Stable	18	15	15
	Gloves	Stable	16	16	16
	Gowns	Stable	20	20	20

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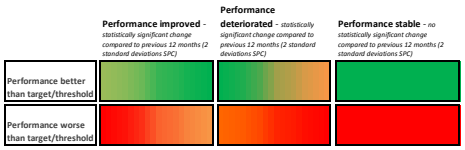
Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Oct-20	Nov-20	Dec-20	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Safe care & Improving Outcomes	Safe	**Quality of Care: Mortality Indicators**												
		SHMI (Rolling 12 months)	27	100	Performance improved and better than target	100.5	99.4	97.9			Jul-20	National	100	Jul-20
		HSMR - Total (Rolling three months)	27	100	Performance deteriorated but better than target	83.9	82.4	88.8			Sep-20	National	100	Sep-20
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	29	n/a		2	3	0	18		Dec-20	National	n/a	
		Clostridioides Difficile - Healthcare associated (Cat 2)	29	n/a		2	1	2	12		Dec-20	National	n/a	
		Clostridioides Difficile - Hospital and Healthcare associated Total	29	3	Performance stable and better than target	4	4	2	30	25	Dec-20	National	n/a	
		Hand Hygiene Compliance	30	95%	Performance stable and better than target	95.9%	97.1%	96.5%	97.3%	95%	Dec-20	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	34	4.9%	Performance stable and better than target	3.8%	5.2%	4.3%	4.4%	4.9%	Jun-20	National	4.9%	Jun-20
		30 Day Emergency Readmissions - Emerg *	34	14.1%	Performance stable and better than target	12.6%	12.2%	12.4%	12.4%	14.1%	Jun-20	National	14.1%	Jun-20
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	35	28.0%	Performance stable but worse than target	34.5%	32.5%	34.7%	33.8%	28.0%	Dec-20	Local	28.0%	2017/18
		Caesarean Section rate - Emergency*	35	15.0%	Performance stable but worse than target	18.5%	18.2%	17.8%	17.3%	15.0%	Dec-20	Local	16.0%	2017/18
		Caesarean Section rate - Elective*	35	11.0%	Performance stable but worse than target	16.0%	14.2%	16.9%	16.5%	11.0%	Dec-20	Local	12.0%	2017/18
		Patient Safety												
		% nursing hours (shift fill rate)	37	95.0%	Performance stable and better than target	suspended		97.3%	99.9%	95.0%	Dec-20	National	n/a	
		Serious incidents - number*	38	0	Performance deteriorated and worse than target	5	5	15	35	0	Dec-20	National	n/a	
		Serious incidents - % that are harmful*	38	0.0%	Performance stable but worse than target	50.0%	100.0%	93.3%	81.3%	0%	Dec-20	National	n/a	
		% of patients safety incidents which are harmful*	38	0.0%	Performance deteriorated and worse than target	10.0%	11.9%	19.0%	10.4%	0%	Dec-20	National	n/a	
		Never events	38	0	Performance deteriorated and worse than target	0	0	2	3	0	Dec-20	National	n/a	
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	-	95.0%	Performance improved but worse than target	Suspended				95.0%	Dec-20	National	93.7%	Mar-20
		Safety Thermometer % New Harm Free Care (acquired within Trust)	-	95.0%	Performance improved but worse than target					95.0%	Dec-20	National	97.8%	Mar-20
		Category 4 pressure ulcers - New (Hospital acquired)	40	0	Performance deteriorated and worse than target	0	0	1	1	0	Dec-20	Local	n/a	
		Category 3 pressure ulcers - New (Hospital acquired)	40	0	Performance stable and better than target	0	1	0	2	0	Dec-20	Local	n/a	
		VTE risk assessment*	42	95.0%	Performance stable and better than target	96.6%	97.1%	96.8%	96.2%	95.0%	Dec-20	National	95.3%	Q3 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	43	90.0%	Performance deteriorated and worse than target	18.8%	26.1%	14.0%	26.0%	90.0%	Dec-20	National	59.3%	Sep-20
		Stroke patients spending 90% of their time on stroke unit	43	80.0%	Performance stable but worse than target	80.0%	86.2%	76.3%	75.1%	80.0%	Dec-20	National	84.3%	Sep-20

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



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Indicator Summary

NHS
West Hertfordshire Hospitals

Domain		Theme	Page	Target	Trend	Oct-20	Nov-20	Dec-20	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Caring & Responsive Services	Effective	**Patient Flow: Emergency Department**												
		Ambulance turnaround time between 30 and 60 mins		0	Performance deteriorated and worse than target	372	347	488	2923	0	Dec-20	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance deteriorated and worse than target	99	148	514	1194	0	Dec-20	National	n/a	
		% Patients admitted through A&E - 0 day LOS		n/a		27.1%	30.5%	24.9%	27.6%		Dec-20	National	n/a	
		Patient Flow: In hospital flow												
		Discharges between 8am and 12pm (main adult wards excl AAU)		33.0%	Performance stable but worse than target	18.1%	17.7%	17.7%	16.1%	33.0%	Dec-20	National	n/a	
		Mixed sex accommodation breaches	45	0	Performance stable and better than target	suspended				0	Dec-20	National	59 Trusts breaching	Feb-20
		LOS > 21 days	46	65	Performance stable but worse than target	67	62	84	84	65	Dec-20	National	n/a	
		Delayed Tranfers of Care (DToC) beddays used in month	46	n/a		Suspended				n/a	Dec-20	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	46	n/a						n/a	Dec-20	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	-	95%	Performance stable but worse than target	suspended				95%	Dec-20	National	85.0%	Feb-20
		Inpatient Scores FFT % positive	-	95%	Performance improved but worse than target					95%	Dec-20	National	95.9%	Feb-20
		Daycase FFT % positive	-	95%	Performance improved but worse than target					95%	Dec-20	National	n/a	
		Maternity FFT % positive	-	95%	Performance stable but worse than target					95%	Dec-20	National	96.9%	Feb-20
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	47	80%	Performance stable but worse than target	86.5%	85.4%	66.7%	76.9%	80%	Dec-20	National	n/a	
		Reactivated complaints	47	0	Performance deteriorated and worse than target	1	0	6	15	0	Dec-20	National	n/a	
		Patient Experience: End of life care												
		New indicators to be included in Q4												
	Responsive	**Access to Services**												
		ED 4hr waits (Type 1, 2 & 3)	44	95.0%	Performance deteriorated and worse than target	83.4%	82.1%	68.4%	82.1%	95.0%	Dec-20	National	80.3%	Dec-20
		Referral to Treatment - Incomplete*	49	92.0%	Performance stable but worse than target	74.8%	78.4%	78.8%	67.0%	92.0%	Dec-20	National	68.2%	Nov-20
		Referral to Treatment - 52 week waits - Incompletes	49	0	Performance deteriorated and worse than target	1075	1112	1131	5816	0	Dec-20	National	192169 (all Trusts)	Nov-20
		Diagnostic (DM01) <6 weeks		99.0%	Performance stable but worse than target	72.2%	74.3%	72.5%	65.3%	99.0%	Dec-20	National	72.5%	Nov-20
		Cancer												
		Cancer - Two week wait *	50	93.0%	Performance deteriorated and worse than target	96.9%	95.6%	85.5%	95.6%	93.0%	Dec-20	National	88.1%	Q2 20/21
		Cancer - Breast Symptomatic two week wait *	50	93.0%	Performance deteriorated and worse than target	98.7%	88.1%	50.0%	87.6%	93.0%	Dec-20	National	81.9%	Q2 20/21
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	50	75.0%	Performance stable and better than target	84.4%	80.2%	82.7%	81.7%	73.9%	Dec-20	National	n/a	
		Cancer - 31 day *	51	96.0%	Performance stable and better than target	94.3%	98.3%	100.0%	96.8%	96.0%	Dec-20	National	94.7%	Q2 20/21
		Cancer - 31 day subsequent drug *	51	98.0%	Performance stable and better than target	100.0%	100.0%	100.0%	99.1%	98.0%	Dec-20	National	99.2%	Q2 20/21
		Cancer - 31 day subsequent surgery *	51	94.0%	Performance stable but worse than target	100.0%	94.7%	87.0%	90.7%	94.0%	Dec-20	National	87.5%	Q2 20/21
		Cancer - 31 day subsequent radiology *	51	94.0%		-	-	-	100.0%	94.0%	Dec-20	National	96.1%	Q2 20/21
		Cancer - 62 day *	52	85.0%	Performance stable but worse than target	81.8%	85.9%	80.5%	81.9%	85.0%	Dec-20	National	76.9%	Q2 20/21
		Cancer - 62 day screening *	52	90.0%	Performance stable but worse than target	66.7%	92.0%	85.7%	73.7%	90.0%	Dec-20	National	64.0%	Q2 20/21
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	53	5.0%	Performance stable but worse than target	8.7%	7.4%	6.6%	15.5%	5.0%	Dec-20	Local	n/a	
		DNA rate	53	8.0%	Performance stable but worse than target	8.0%	7.9%	8.7%	7.5%	8.0%	Dec-20	National	n/a	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Oct-20	Nov-20	Dec-20	YTD actual	YTD target	National / Local / Trust	Bench-marking	Bench-marking period
EMERGENCY CARE PATHWAY KLOEs	SAFE	% nursing hours (shift fill rate)	37	95%	Performance stable and better than target	101.2%	99.8%	97.3%	99.9%	95%	National	N/A	
		Patient Safety Incidents which are harmful	38	0%	Performance stable but worse than target	50.0%	100.0%	93.3%	81.3%	0%	National	N/A	
	EFFECTIVE	Occupancy - Adult G&A (including critical care) (on 15th)	N/A	92%	Performance stable and better than target	89.3%	89.4%	92.3%	92.3%	92%	National	N/A	
		Occupancy - C19+ve (including critical care) (on 15th)	N/A	N/A		5.8%	10.2%	19.5%	N/A	N/A	National	N/A	
		Patients medically fit for discharge (on 15th)	N/A	N/A		57	49	54	N/A	N/A	National	N/A	
		C-19+ve patients medically fit for discharge (on 15th)	N/A	N/A		0	4	14	N/A	N/A	National	N/A	
		C-19+ve bed days used (including critical care)	N/A	N/A		877	2041	4486	16666	N/A	National	N/A	
		Long LOS > 21 days	46	65	Performance stable but worse than target	67	62	84	84	65	National	N/A	
		Surge capacity bed days used	N/A	N/A		668	674	1341	5106	N/A	National	N/A	
	RESPONSIVE	A&E type 1 attendances	N/A	95%	Performance stable but worse than target	67.3%	65.7%	42.5%	68.7%	95%	National	TBC	
		Ambulance turnaround - delays over 60 minutes	N/A	0	Performance deteriorated and worse than target	99	148	514	1194	0	National	N/A	
		A&E Type 1 admitted pathway performance	N/A	95%	Performance deteriorated and worse than target	56.4%	53.6%	25.5%	53.4%	95%	National	TBC	
		A&E 12 hour waits (arrival to departure)	N/A	0	Performance deteriorated and worse than target	120	160	716	1524	0	National	N/A	
		A&E 12 hour breaches (decision to admit to departure)	N/A	0	Performance deteriorated and worse than target	0	0	21	21	0	National	N/A	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Oct-20	Nov-20	Dec-20	YTD actual	YTD target	Data period	National / Local / Trust	Bench-marking	Bench-marking period
Workforce and finance	Well led	**Recruitment & Retention**												
		Staff turnover rate (rolling 12 months)	54	13.0%	Performance improved and better than target	13.3%	13.0%	12.9%	13.6%	13.0%	Dec-20	National	15.0% (Beds and Herts orgs)	Q1 19/20
		% staff leaving within first year (excluding medics and fixed term contracts)	54	n/a		18.1%	15.5%	15.5%	16.3%	n/a	Dec-20	National	n/a	
		Vacancy rate	54	10.0%	Performance stable and better than target	10.7%	9.6%	9.1%	9.7%	10.0%	Dec-20	National	11.1% (local survey)	Q1 19/20
		Sickness rate	54	3.5%	Performance stable but worse than target	4.2%	4.2%	5.2%	5.2%	3.5%	Dec-20	National	3.7% (EoE orgs)	Q1 19/20
		Developing Staff												
		Appraisal rate (Total)	55	90.0%	Performance stable but worse than target	87.0%	82.2%	85.8%	86.3%	90.0%	Dec-20	National	n/a	
		Mandatory Training	55	90.0%	Performance deteriorated but better than target	91.1%	90.7%	90.7%	92.2%	90.0%	Dec-20	Local	91.0% (local survey)	Q1 19/20
		Essential Training	55	90.0%	Performance improved but worse than target	0.0%	0.0%	0.0%	90.8%	90.0%	Dec-20	Local	n/a	
		Finance overview												
		Financial Risk Rating	15-25	0	Performance improved and better than target	0.00	0.00	0.00			Dec-20	Local	n/a	
		Income & Expenditure Actual	15-25	-£537	Performance stable but worse than target	£12	£23	-£814	-£850	-£950	Dec-20	Local	n/a	
		Income & Expenditure forecast	15-25	£850	Performance stable and better than target	£12	£36	-£4,200	-£4,200	£850	Dec-20	Local	n/a	
		Cash balance at the end of the month	15-25	£3,422	Performance stable and better than target	£44,730	£42,896	£50,025	£50,025	£3,422	Dec-20	Local	n/a	
		Capital expenditure	15-25	-£2,008	Performance stable and better than target	-£1,388	-£3,740	-£2,489	-£13,710	-£18,067	Dec-20	Local	n/a	
		CIP delivery against plan	15-25	£0	Performance improved and better than target	suspended		£900	£900	£8,068	Dec-20	Local	n/a	
		% Bank Pay**	15-25	12.0%	Performance stable and better than target	11.6%	12.7%	11.8%	11.0%	12.0%	Dec-20	Local	n/a	
		% Agency Pay**	15-25	4.8%	Performance stable and better than target	5.1%	4.7%	4.7%	4.2%	4.8%	Dec-20	Local	7.3% (local survey)	Q1 19/20
		Activity (chargeable)												
		GP referrals		8,027	Performance stable and better than target	7,010	5,894	5,980	43,570	72,243	Dec-20	National	n/a	
		A&E attendances		15,595	Performance stable and better than target	11,933	10,674	10,722	93,786	131,294	Dec-20	National	n/a	
		Elective spells (overnight)		470	Performance stable but worse than target	410	476	384	2,746	4,252	Dec-20	National	n/a	
		Elective daycase		3,490	Performance stable but worse than target	2,031	2,655	2,404	14,316	31,575	Dec-20	National	n/a	
		Total elective spells		3,960	Performance stable but worse than target	2,070	3,131	2,788	16,320	35,827	Dec-20	National	n/a	
		Non-elective spells		5,090	Performance stable and better than target	3,901	3,798	3,527	31,672	44,989	Dec-20	National	n/a	
		Births		333	Performance improved and better than target	360	340	257	3,160	2,943	Dec-20	National	n/a	
		Outpatient attendances		20,505	Performance stable but worse than target	11,185	11,648	10,108	88,894	185,520	Dec-20	National	n/a	

* No official cash target
** Straight line target

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

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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Safe Care & Improving Outcomes

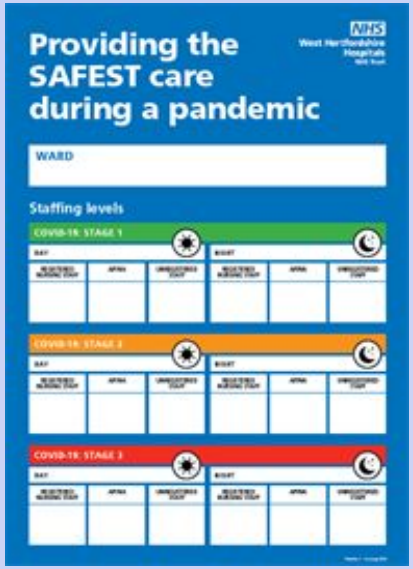
Chief Medical Officer

As seen across the UK, we have had a significant rise in the number of patients infected with Covid, and in order to manage patients safely and efficiently, the zoning system has been re-introduced. Our ITU has had to expand significantly, and has managed to meet demand with capacity. The Ethical committee has restarted on a 7/7 basis providing guidance and pastoral support to colleagues, and once again consists of a senior physician, senior nurse, and a lay person experienced in counselling. The Virtual Hospital team has been expanded to deal with rising demand, and has been vital in reducing admissions. A daily senior clinician led review of all “medically fit for discharge” patients is occulting every weekday in order to reduce length of stay and improve patient flow. Finally, the vaccination project is forging ahead, and the feedback from staff his highly complementary of the efficiency and pathway that has been set up.

Chief Nurse

During December with the increased rise in covid infections this has impacted on workforce and we have continued to focus on providing the safest care in a pandemic. This has entailed a review of covid templates and monthly table top reviews of these alongside several daily reviews of clinical staffing. This has been supported by the instigation of weekly harm reviews and, the development of posters for all ward areas on providing the safest care in a pandemic to aide staff communication.

Reducing nosocomial infections continues to be a focus and the plastic curtains have now been put in place for further separation and segregation of bed spaces and hepa filters for increased ventilation in a number of ward areas. A round table review with the CCG/NHSE, PHE and the medical examiner led by our infection control team was undertaken in December to identify further learning.
In addition Microbiological genomic testing has been undertaken on 20 random COVID-19 specimens across the organisation and this has illustrated that 85% of cases were identified as the new variant in December, strongly suggesting that the recent identified outbreaks are likely to have been largely made up of this variant.



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West Hertfordshire Hospitals NHS Trust

Key messages for the Board

Caring & Responsive Services

Chief Nurse

The spiritual and pastoral care team have continued to support patients and staff across the trust during this phase of the pandemic. The spiritual and pastoral care centre continues to be used for prayer, counselling, wellbeing and quiet space.

The family liaison line (FLL) has now expanded across over 12 wards and is undertaking over 1200 calls to relatives and carers a week.

The end of life coordinator is now in post and developing the 'Rose Volunteers' working with the palliative care team, who have supported an increased number of patients requiring end of life care. The team have been offering essential support to staff across the trust in the delivery of end of life care.

Margarida Pacheco has joined us as the Lead Nurse for Patient Experience.

Chief Operating Officer

During December and early January 2021 the Trust saw a significant upward trend in ED attendances, admissions and COVID+ve patients.

The impact of this was further expansion of those wards assigned for COVID patients and the execution of ITU's surge plan which saw the partial use of Endoscopy and Theatres recovery.

During this period ED experienced significant pressures with an increased level of ambulance conveyances and high volumes of patients in the department. Mitigation came in the form of mutual aid as a result of EEAST ambulance service 'load levelling' to neighbouring Trusts who were under less pressure and the instigation of a 'support pilot model' by EEAST providing paramedic workforce to support the co-horting of patients in order to release crews to respond to the increased levels of 999 calls. During this period the Trust made daily declarations of an OPEL 4 status, this being the highest level of capacity constraint declaration. Regrettably this resulted in a number of patients breaching the 12 hour Decision to Admit performance standard.

In terms of capital initiatives, replacement of the Cardiac Cath Labs is ongoing. Phase 2 of EAU's expansion continues with an anticipated completion date being late February 2021.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief People Officer

Vaccinations - In January we launched our vaccination programme which has been run out of Watford FC. The programme initially focused upon vaccinating Trust staff with priority given to Clinically Extremely Vulnerable colleagues. Since then we have expanded the target audience or this facility with other NHS workers and social care staff using the facility. Thus far we have vaccinated over 7,220 NHS/social care staff which is significantly more than had originally been anticipated. The facility is now being geared up to continue vaccinating NHS/social care staff for the foreseeable future. The feedback we have had from staff using this facility has been extremely positive.

Lateral Flow Testing – We have issued over 3,500 Lateral Flow Test kits (LFT) to our staff, with each kit being sufficient for approximately three months of testing. The distribution process has gone well, but more work needs to be done to ensure that staff are recording their test results. A plan is in place to address this issue.

Disciplinary Policy – In light of the tragic death of Amin Abdullah and the shared learning from Imperial College Healthcare we have recently reviewed our approach to the management of disciplinary issues. The review aims to ensure that our practices are inclusive, compassionate and person-centred, with an overriding objective as to the safety and wellbeing of colleagues and our NHS people.

Working from home – In light of the new variant COVID we have moved to even greater remote working for those colleagues not absolutely required to work on site.

Supporting our staff – We are continuing to offer psychological and wellbeing support for our staff and have expanded our on-site counselling service. In addition we are grateful both to Watford FC and our local Chamber of Commerce for their assistance in offering additional expanded lunch time facilities.

Staff absence – During the last two months we saw a sharp increase in the number of staff who were absent due to illness or self-isolating, with this figure peaking at 11.9%. It is pleasing to see a significant decrease in absence levels which now stand at around 7.5%.

Overseas nurse recruitment – We continue to recruit from overseas with 30 new starters in November and 21 in December.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief Finance Officer

For this month (9) the trust reported a position that was in line with our updated forecast. Expenditure of £37.9m was £0.8m higher than the £37.1m of income received. As we've been breaking-even for the past eight months, the year to date position also shows a deficit of income over expenditure of £0.8m (320.9m income and £321.7m costs). This position is in line with our NHSEI agreement to incur a deficit no greater than £4.2m by the end of the year. However, although the overall result was in line with our forecast, this compliant position was due to higher than forecast COVID-10 costs and lower than expected 'elective activity recovery' costs. When compared to the business as usual (BAU) financial plan (set before the start of the pandemic) our £321.7m of costs were £6.4m higher than the £315.3m BAU plan. It's important to note that £19.7m of our costs were due to COVID care therefore without COVID related costs our spending would have been significantly lower than the BAU financial plan. The lower spend is due to the significant shortfall in patient numbers not related to COVID.

The majority of services have now restarted and until November (M8) there was a clear upward trajectory in the numbers of patients treated. This trend did not continue for the month of December unsurprisingly due to the steep rise in the numbers of COVID positive patients. The value of patient activity
In comparison to the original plan is summarised below:

- Elective admissions were 63% of the original plan in month, 49% year to date.
- Outpatient attendances were 77% of the original plan in month, 67% of plan for the year to date.
- A&E attendances 77% of plan for the month, compared to a 74% year to date.

The Trust spent £2.5m on buildings and equipment assets in December. The year to date capital spend stands at £13.6m. The total capital expenditure programme for 2020/21 now exceeds over £50m including starting works related to a new multi-story car park, the development of a new electronic patient record, new complex imaging equipment including replacing our cardiac catheter labs, fire safety and critical infrastructure improvements and the business case for the major redevelopment of Watford General Hospital.

Cash flow continues to be healthy through advance block payments and this is supporting the trust's efforts to pay suppliers as quickly as possible.

More detailed plans are being developed for the next financial year, although it is likely that the financial regime in place for 2020/21 will continue for the first 3 months of 2021/22. In addition to other capital spending developments the Trust expects to complete the business cases related to the Trust redevelopment, complete construction of a new multi-storey car park, outsource pathology services, implement the electronic patient record system, relocate many corporate functions away from the Watford General site and complete refurbishment of Watford operating theatres.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Corporate - ICT

Chief Information Officer

The December headline metrics show a stable position when looking at technology provision in the round but identify a couple of areas that continue to be a challenge.

Metric	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Priority 1 incidents	4	7	2	3	3	1	1
Priority 2 incidents	17	20	21	10	12	8	8
Incident backlog	350	415	416	417	458	469	400
First time fix rate	87%	91%	92%	91%	91%	84%	86%
Customer satisfaction score	7.2	6.6	6.8	6.9	6.5	7.0	4.9
Network availability	100%	100%	100%	100%	100%	100%	100%

The broad perspective is that the infrastructure improvements made over the last 18 months have given the Trust a more reliable technology platform and with the mass rollout of the new Windows 10 devices now underway an increasing number of end users benefitting from improved performance.

However, the one area where we have not invested in the infrastructure, Pathology, led to a very challenging month for both the ICT team and end users with multiple small failures across the software and hardware that supports the pathology team. This was particularly difficult for the organisation given the reliance on the swift transference of COVID-19 results for discharge and bed planning.

The deterioration in the customer service metric is disappointing, and though this month it is based on a very small sample size (57 users) it is reflective of the one area of the Atos contract that has for some time not shown the improvements evident in the remainder of the contract. We continue to work with Atos on the interaction between the service desk, Bates, the in-house team and the end user. We see the W10 deployment as a key opportunity to improve our end user engagement and to obtain some more informed opinion.

In more strategic news, the Trust signed the ten-year contract with Cerner for the EPR programme on the 23rd Dec with programme activities moving at great pace. Reports on the progress of the EPR programme go at regular intervals to the Great Place Programme Board, the Great Place Committee and the Executive team meeting as well as many of the Divisional meetings across the organisation. The Planned go-live date for the EPR programme at this point is 27th November 2021, just ten months from now.

We continue to make progress on the replacement of our printer estate, scheduled for the end of May, the Outsourcing of our Medical Records service, both of which should bring business cases to board next month and the gradual upgrade to Microsoft 365 which is being deployed alongside the W10 programme.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Income and Expenditure December 2020

			In Month (£000's)				YTD			
Trust Definition	**Expense Type**	**Annual Budget**	**Budget**	**Actual**	**Variance**		**Budget**	**Actual**	**Variance**	
Income	Divisional Income	81,730	7,320	10,099	2,779	Bii	61,423	75,418	13,995	Fii
	NHS Revenue	336,416	28,311	27,012	(1,299)	Bi	252,938	245,494	(7,444)	Fi
	Income Unallocated CIPs	0	0	0	0		0	0	0	
Income Total		**418,147**	**35,631**	**37,111**	**1,480**	**B**	**314,361**	**320,912**	**6,551**	**F**
Pay	Medical Pay	(81,974)	(6,784)	(7,074)	(290)		(61,605)	(62,511)	(907)	
	Non-Clinical Pay	(61,114)	(5,169)	(4,349)	820		(44,809)	(38,031)	6,778	
	Nursing Pay	(80,758)	(6,871)	(6,948)	(77)		(60,541)	(59,585)	956	
	Other Clinical Pay	(30,851)	(2,578)	(2,740)	(162)		(23,112)	(23,789)	(676)	
	Scientific, Technical & Profes	(27,350)	(2,276)	(2,392)	(115)		(20,507)	(20,911)	(404)	
	Pay Unallocated CIPs	9,386	1,083	0	(1,083)		5,415	0	(5,415)	
Pay Total		**(272,661)**	**(22,596)**	**(23,503)**	**(907)**	**C**	**(205,160)**	**(204,827)**	**332**	**G**
Non Pay	Clin Supp Serv	(31,291)	(2,597)	(2,653)	(56)		(23,499)	(21,048)	2,451	
	Drugs	(21,424)	(1,778)	(1,612)	166		(16,089)	(14,524)	1,565	
	OTHER (NON CLIN)	(81,881)	(7,414)	(8,791)	(1,377)		(61,319)	(69,059)	(7,740)	
	Non Pay Unallocated CIPS	5,654	669		(669)		3,167		(3,167)	
Non Pay Total		**(128,941)**	**(11,121)**	**(13,055)**	**(1,935)**	**D**	**(97,740)**	**(104,630)**	**(6,890)**	**H**
Recharges	Recharges	0	0	0	0		0	0	0	
Recharges Total								**0**	**0**	
Financing Charges	Depreciation	(10,948)	(913)	(901)	12		(8,208)	(8,196)	12	
	Trust Debt Redemption	(5,570)	(464)	(468)	(4)		(4,184)	(4,123)	61	
	Unwinding Discount	(27)	(2)	2	4		(20)	14	35	
Financing Charges Total		**(16,545)**	**(1,378)**	**(1,367)**	**11**	**E**	**(12,412)**	**(12,305)**	**107**	**I**
Total		**0**	**537**	**(814)**	**(1,351)**	**A**	**(950)**	**(850)**	**100**	**J**

The performance to plan was worse than plan by £1.3m. An actual deficit of £814k was reported for the month of December. The performance against plan shown, represents the pre-covid business as usual plan.

B- The overall income position saw an over performance in month of £1,480k.
Bii – With the interim reimbursement arrangements in place, key points to note within divisional income include reduced PSF and car parking income within the month. This was mitigated by the top up payment and claims for additional covid related costs which are captured on slide 11.
Bi- NHS Revenue generated a total of £27,012k in month. This represented the ongoing temporary block arrangements with all CCGs, regardless of activity performance. This guarantee of income saw an underperformance against the business as usual plan. This is where block arrangements did not cover our original expectations of the activity to be performed in December. The underperformance was £1,299k in month. Operationally, all points of delivery saw underperformances in month as a result of the Covid-19 situation. However, prior to December and the second wave of Covid, actual activity levels saw an increase in volume.

C – The overall pay bill for the month was £23,503k which was £907k overspent. Within the pay position, an additional £1,013k was spent in relation to covid-19 and is offset by income. After allowing for these items, the residual underspend is due to reduced activity levels in month .

D – The non pay position reported an overspend of £1,935k. This includes an additional £1,300k spent in relation to covid-19 . This has partially been offset by income.

E – Financing charges underspent in month by £11k. This was in relation to a year to date adjustment reflecting the actual effect of depreciation.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Finance overview dashboard

Financial Overview 31st December 2020

Month 9 Income & Expenditure

£m	Plan	Actual	Var
Surplus / (Deficit)	0.5	(0.8)	(1.4)

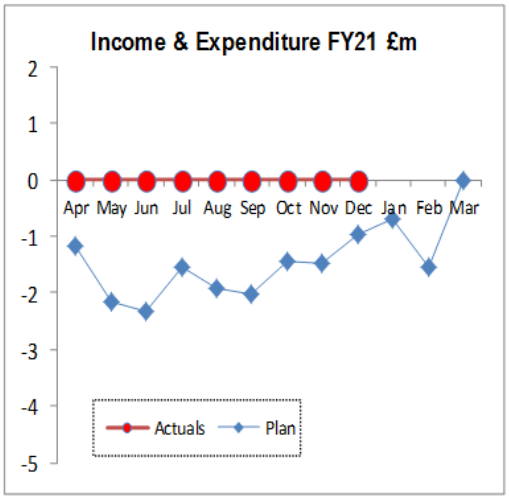
£m	YTD 20/21		
Surplus / (Deficit)	(1.0)	(0.9)	0.1

Statutory / Regulatory Duties

Breakeven	The trust achieved break even year to date and has a break even plan for FY21.	G
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 31/12/20 equated to £50m.	G
BPPC	Month 9 performance - 91.2% on number, 97.1% on value (95% target)	A

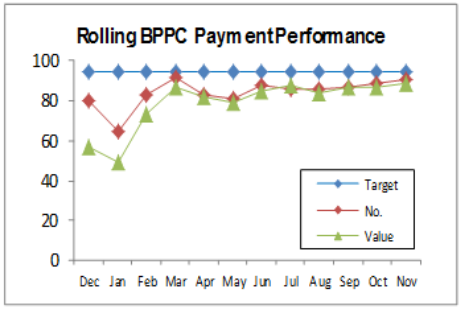
Financial Risk Rating	FY21	2

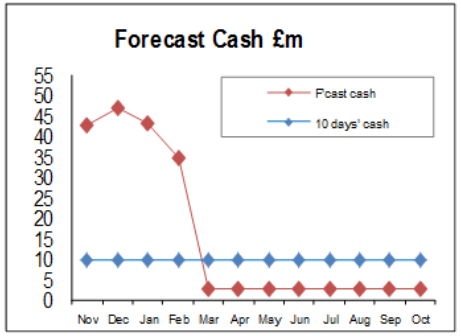
Risk rating on a scale of 1 to 4, with 1 being best and 4 being worst.

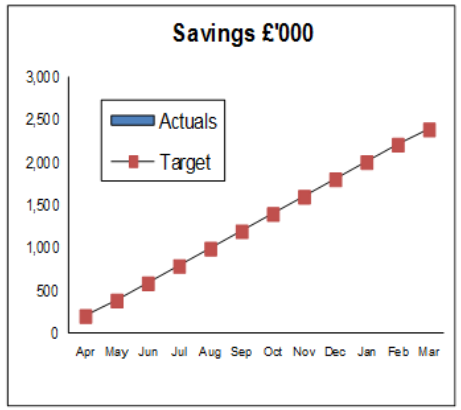


YTD Variance by Division £m

Medicine	13.5
Unscheduled Care	8.8
Surgery	21.1
Women's	5.3
Clinical Support	4.6
Estates & Facilities	1.8
Corporate	1.8
Other	(56.9)
Total	**(0.1)**







Commentary

- See earlier pages for I&E detail.
- The Better Practice Payment statistics for December show 91.2% by value and 90.7% by number.
- The cash balance at the end of December was £50m.

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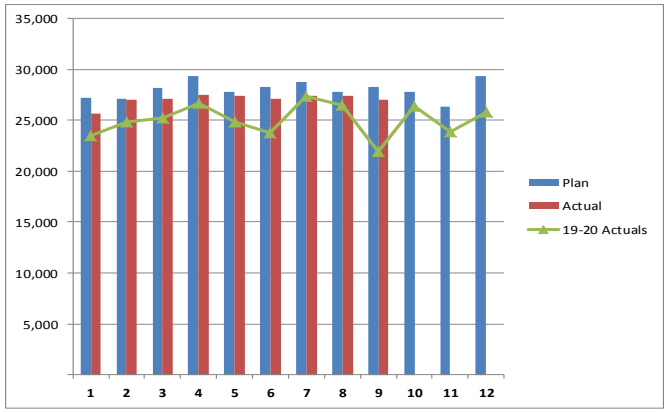
West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Income – December 2020

NHS Revenue: Performance by Month (£s)

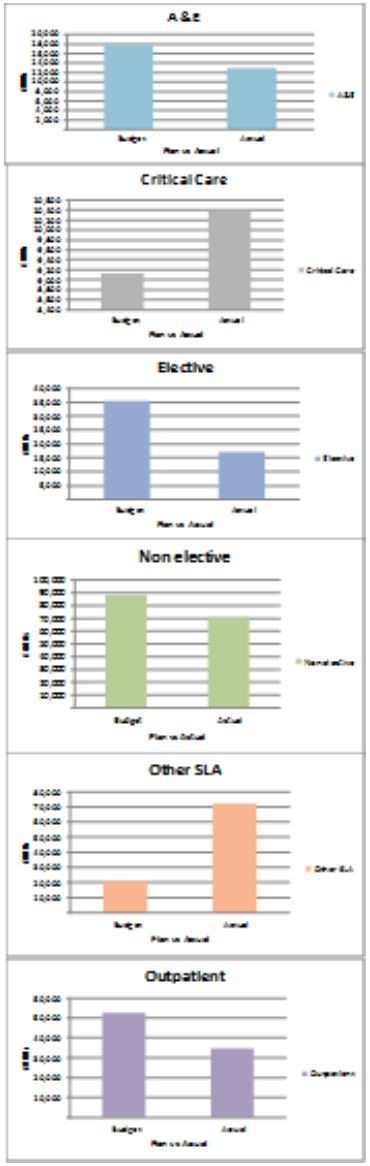


NHS revenue continues to be set at a block amount of £27.1m for the month of December. This resulted in an underperformance against the business as usual plan.

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

Despite increases in activity in recent months, A&E continues to underperform against plan by £0.5m
In December, Critical care broke even in month. This was linked to the number of covid patients requiring critical care facilities.
The reduction in Elective cases continues to drive a monthly underperformance of £1.6m. This is predominately within the Surgery division.
For Non Elective the in month position showed under performance of £2.2m.
Despite an increase in virtual interactions, the overall fall in Outpatient attendances meant performance was £1.5m away from plan.

The adverse variances above were offset by other SLA income being favorable to plan by £4.5m. This reflects the block reimbursement arrangements.



In Month Performance (£s)

			In Month (£000's)		
Expense Type	POD	Annual Budget	Budget	Actual	Variance
NHS Revenue	A&E	26,486	2,244	1,723	(522)
	Critical Care	13,664	1,153	1,177	24
	Elective	53,207	4,416	2,789	(1,627)
	Non elective	132,024	11,213	9,030	(2,183)
	Other SLA	32,315	2,724	7,265	4,541
	Outpatient	78,721	6,561	5,028	(1,532)
	NHS Rev Unallocated CIPs				
NHS Revenue Total	Total	336,416	28,311	27,012	(1,299)

In Month Performance (spells)

			In Month (Activity)		
Expense Type	POD	Annual Budget	Budget	Actual	Variance
NHS Revenue	A&E	186,835	15,868	11,249	-4,619
	Critical Care	14,579	1,238	1,179	-59
	Elective	47,706	3,960	2,825	-1,135
	Non elective	64,358	5,466	3,816	-1,650
	Other SLA	3,774,708	313,316	266,934	-46,382
	Outpatient	479,834	39,863	30,973	-8,890
NHS Revenue Total	Total	4,568,020	379,711	316,976	-62,735

Divisional Income

Divisional income delivered a £2.8m surplus in month. Reduced PSF and car parking income was mitigated by the covid top up payment. In addition to this the Trust received £1.5m worth of claims for additional covid related expenditure. This is included within the position.

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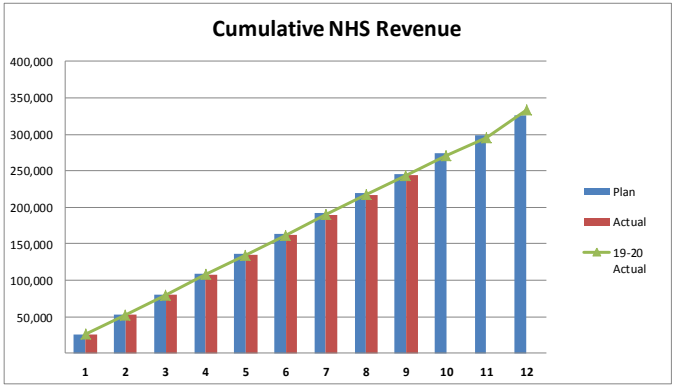
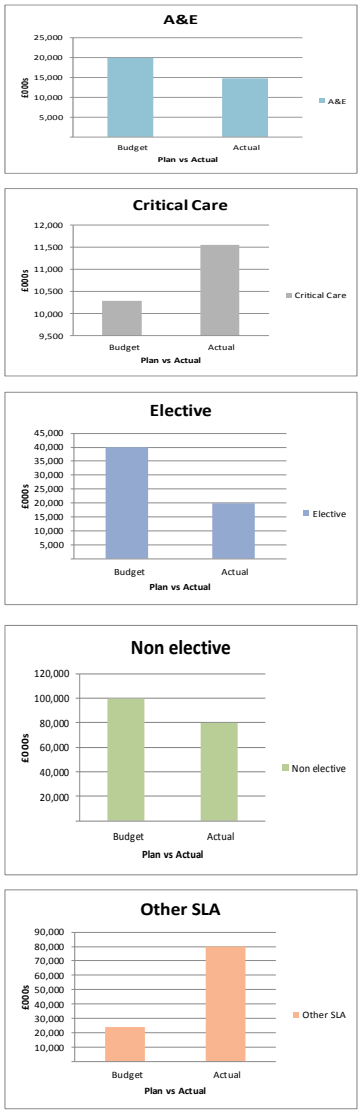
Workforce & Finance : Year To Date (YTD) – Trust Income

NHS Revenue: Performance by Month (£s)



Month 9 YTD shows Income under performance of £7.4m. £245.5m has been generated against plan of £252.9m.

A&E has a YTD under performance of £5.2m which is linked to a price and volume variance.
Critical care is £1.3m better than plan and has seen an average occupancy rate of 80%. The increase is linked to the Covid-19 pandemic.
Elective performance is £20.1m away from the YTD plan. This is mostly driven by underperformances across the Surgery division linked to a reduction in the volume of procedures performed and a reducing complexity of procedures.
Non Elective activity has a deficit against plan of £19.7m. This is predominately centred around the Emergency division and is linked to a reduction in emergencies throughout the pandemic.
YTD Outpatient performance shows £19.4m worth of under performance.
Other SLA income is £55.6m above plan. This is driven by a central adjustment to take into account the impact of the block reimbursement structure.



YTD Performance (£s)

	YTD (£000's)		
POD	Budget	Actual	Variance
A&E	19,944	14,739	(5,204)
Critical Care	10,278	11,553	1,275
Elective	39,958	19,829	(20,129)
Non elective	99,470	79,836	(19,634)
Other SLA	24,142	79,821	55,679
Outpatient	59,146	39,716	(19,430)
NHS Rev Una			
Total	**252,938**	**245,494**	**(7,444)**

YTD Performance (spells)

	YTD (Activity)		
POD	Budget	Actual	Variance
A&E	124,898	87,449	-37,449
Critical Care	9,746	10,085	339
Elective	31,867	15,330	-16,537
Non elective	43,023	31,198	-11,825
Other SLA			
Outpatient	320,531	204,008	-116,523
Total	**530,065**	**348,069**	**-181,995**

Divisional Income

The YTD divisional income position is now better than plan by £14m. This is driven by claims for Covid -19 revenue reimbursement from the centre.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Pay December 2020

Trust Pay Performance

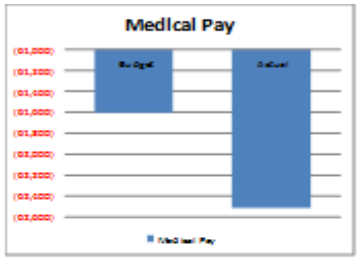
Expense Type	Annual Budget	In Month (£000's)			WTE		
		Budget	Actual	Variance	Budget	Actual	Variance
Medical Pay	(81,974)	(6,784)	(7,074)	(290)	717.93	747.50	-30
Non-Clinical Pay	(61,114)	(5,169)	(4,349)	820	1,259.20	1,242.06	17
Nursing Pay	(80,758)	(6,871)	(6,948)	(77)	1,648.22	1,684.16	-36
Other Clinical Pay	(30,851)	(2,578)	(2,740)	(162)	1,045.99	1,065.51	-20
Scientific, Technical & Profes	(27,350)	(2,276)	(2,392)	(115)	513.99	543.80	-30
Pay Unidentified CIPs	9,386	1,083		(1,083)	0.00	0.00	0
Total	**(272,661)**	**(22,596)**	**(23,503)**	**(907)**	**5,185.33**	**5,283.03**	**-98**

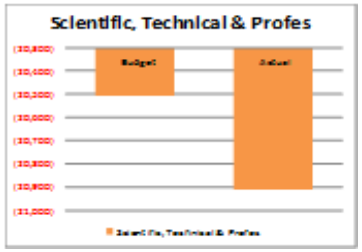
The Trust reported an in month overspend of £0.9m. £1.1m worth of cost captured in relation to Covid-19.

Key areas to note include;

Medical pay was £0.29m overspent, this is linked to operational changes in dealing with the covid-19 outbreak.
Non Clinical Pay- was underspent by £0.8m. This represents unspent growth reserves across divisions.
Nursing and other clinical pay showed a combined overspend against plan of £0.24m. This was driven by shifts booked in relation to covid.
Agency premium to cover scientific and professional vacancies across clinical support, theatres and cardiology resulting in the £0.1m overspend in month.
Expected pay efficiencies in month were not achieved and this caused a £1.1m adverse movement against the business as usual plan.

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





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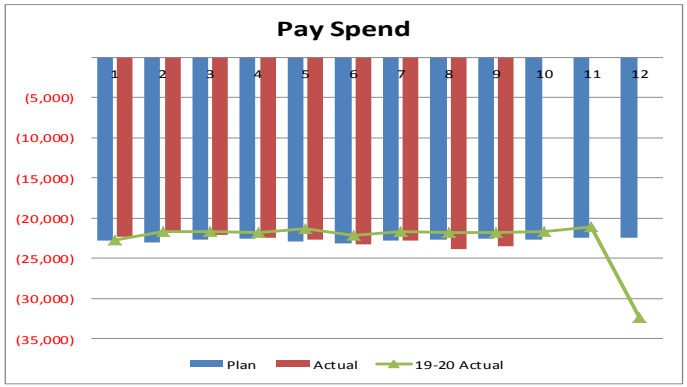
West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Trust Pay December 2020



The year to date reported position shows an underspend of £0.3m.

Key year to date themes to note are:

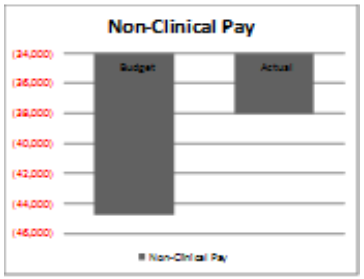
Medical pay – is showing a £0.9m overspend. This reflects operational changes made during the covid-19 pandemic.

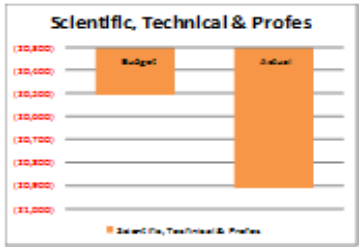
Nursing and other clinical pay has a combined underspend of £0.28m YTD. This is driven by a lower bank and agency fill rate and operational changes made to deal with Covid-19 (zonal deployment).

Scientific & therapeutic agency premium to cover vacancies across clinical support, theatres and cardiology are causing £0.4m YTD overspend.
The above overspends are buffered by unutilised growth monies sitting on the non clinical pay line.

Unachieved CIPs due to the temporary suspension of the efficiency programme account for a £5.4m overspend.

Total Pay costs which have been spent in relation to the Covid-19 pandemic total £7.9m.





YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(81,974)	(61,605)	(62,511)	(907)
Non-Clinical Pay	(61,114)	(44,809)	(38,031)	6,778
Nursing Pay	(80,758)	(60,541)	(59,585)	956
Other Clinical Pay	(30,851)	(23,112)	(23,789)	(676)
Scientific, Technical & Profes	(27,350)	(20,507)	(20,911)	(404)
Pay Unallocated CIPs	9,386	5,415		(5,415)
	(272,661)	**(205,160)**	**(204,827)**	**332**

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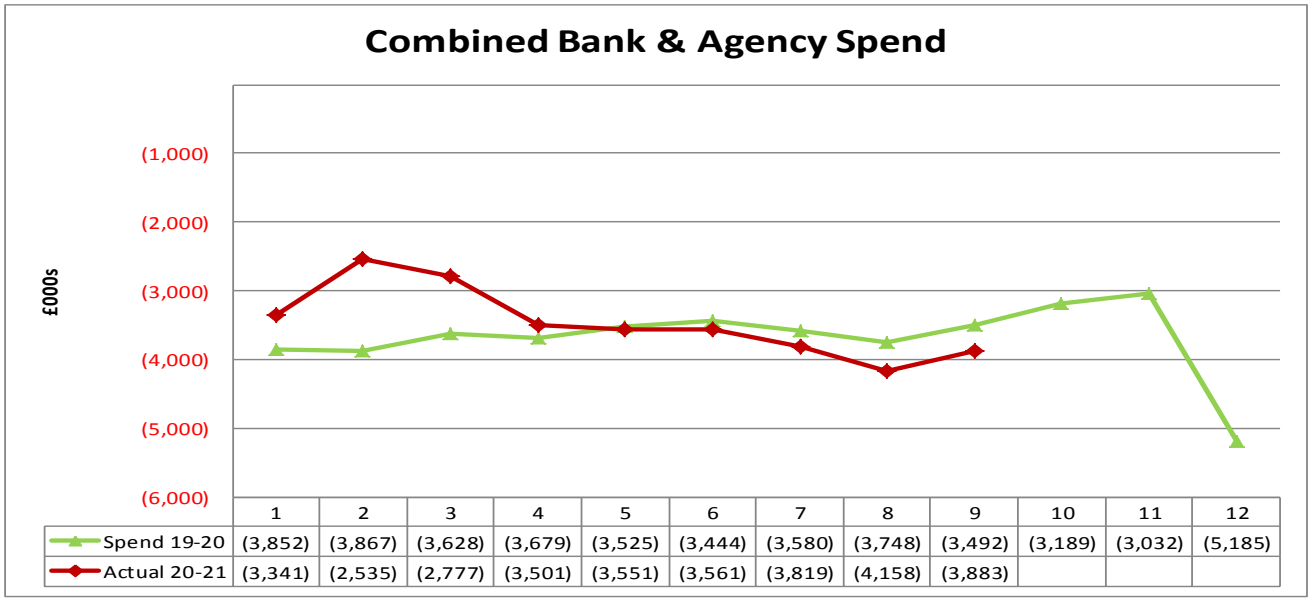
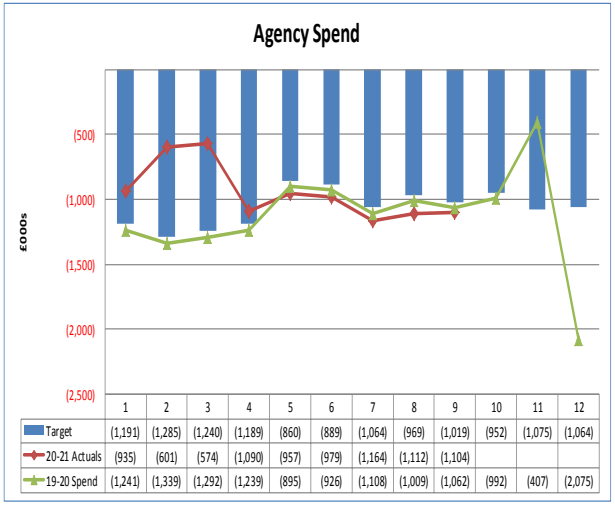
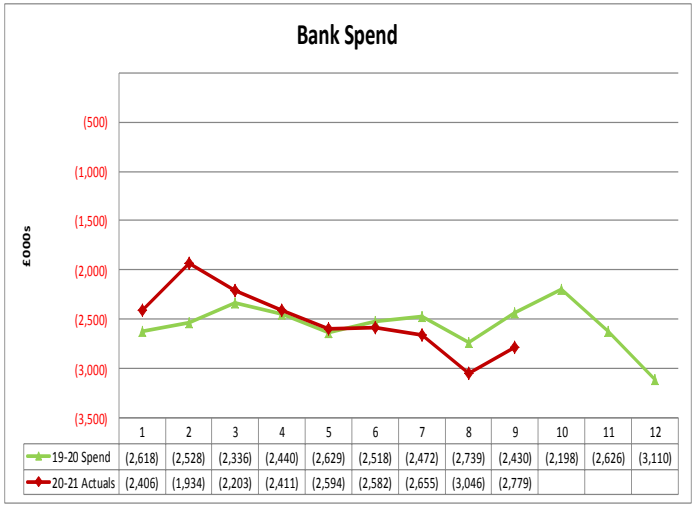
Workforce & Finance: Bank & Agency Spend December 2020



	1	2	3	4	5	6	7	8	9	10	11	12
Spend 19-20	(3,852)	(3,867)	(3,628)	(3,679)	(3,525)	(3,444)	(3,580)	(3,748)	(3,492)	(3,189)	(3,032)	(5,185)
Actual 20-21	(3,341)	(2,535)	(2,777)	(3,501)	(3,551)	(3,561)	(3,819)	(4,158)	(3,883)			



	1	2	3	4	5	6	7	8	9	10	11	12
Target	(1,191)	(1,285)	(1,240)	(1,189)	(860)	(889)	(1,064)	(969)	(1,019)	(952)	(1,075)	(1,064)
20-21 Actuals	(935)	(601)	(574)	(1,090)	(957)	(979)	(1,164)	(1,112)	(1,104)			
19-20 Spend	(1,241)	(1,339)	(1,292)	(1,239)	(895)	(926)	(1,108)	(1,009)	(1,062)	(992)	(407)	(2,075)



	1	2	3	4	5	6	7	8	9	10	11	12
19-20 Spend	(2,618)	(2,528)	(2,336)	(2,440)	(2,629)	(2,518)	(2,472)	(2,739)	(2,430)	(2,198)	(2,626)	(3,110)
20-21 Actuals	(2,406)	(1,934)	(2,203)	(2,411)	(2,594)	(2,582)	(2,655)	(3,046)	(2,779)			

Agency

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

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

Agency expenditure in the month totalled £1.1m. This remained consistent with last month.

Of the £1.1m in-month spend, £0.24m was spent in relation to covid.

Year to date Agency spend stands at £8.8m. This is within the £9.7m YTD target. At year end, the Trust expects to meet the original agency target of £12.8m.

Bank

Bank spend for December was £2.8m. This is consistent with the patterns of spend seen in previous months.

Of the £2.8m spend, £0.5m was spent in relation to covid.

When comparing to the same month last year, the Trust has spent £0.4m more on temporary staffing.

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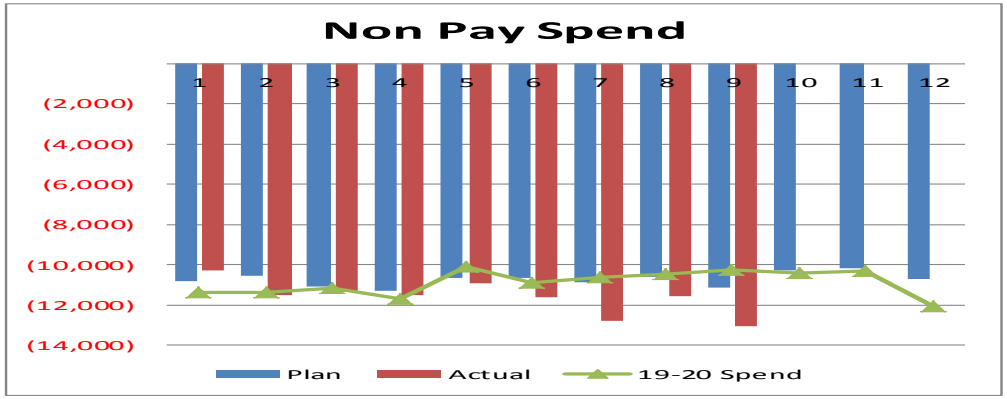
Workforce & Finance: Non Pay December 2020

West Hertfordshire Hospitals NHS Trust

Non Pay Performance

Expense Type	Annual Budget	In Month (£000's) Budget	Actual	Variance	YTD Budget	Actual	Variance
Clin Supp Serv	(31,291)	(2,597)	(2,653)	(56)	(23,499)	(21,048)	2,451
Drugs	(21,424)	(1,778)	(1,612)	166	(16,089)	(14,524)	1,565
OTHER (NON CLIN)	(81,881)	(7,414)	(8,791)	(1,377)	(61,319)	(69,059)	(7,740)
Non Pay Unallocated CIPS	5,654	669		(669)	3,167		(3,167)
Total	**(128,941)**	**(11,121)**	**(13,055)**	**(1,935)**	**(97,740)**	**(104,630)**	**(6,890)**



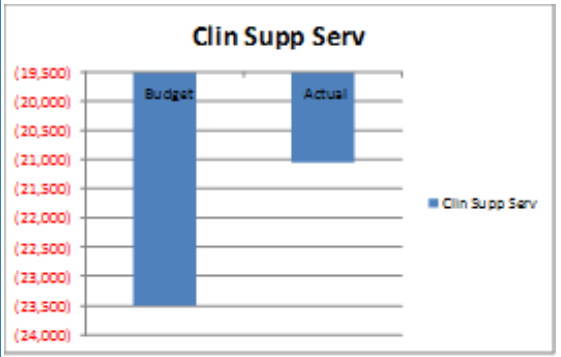
The in month non pay position (excl finance charges) reported an overspend of £1.9m. Actual Spend was £13.6m against a budget of £11.1m.

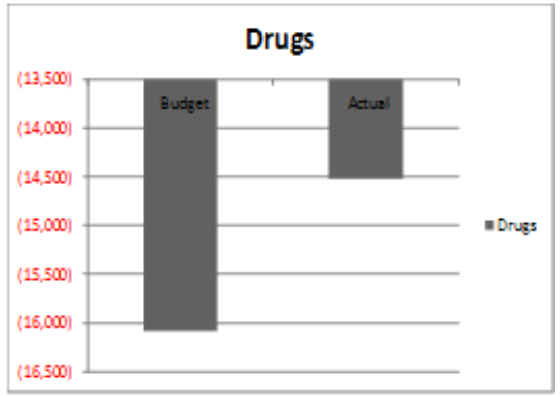
The main drivers of the position include:

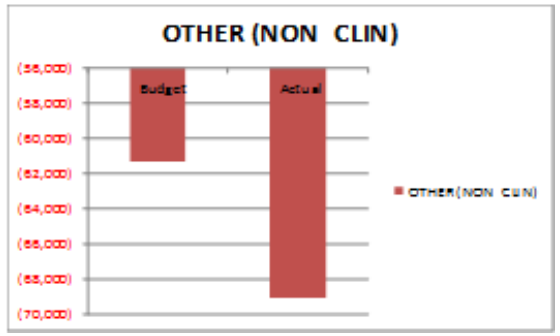
Clinical supplies were £0.06m underspent in month. This was linked to the number of elective procedures performed in month.
Drugs were underspent by £0.16m. This is linked to the overall levels of patients seen in month.
Other non clinical supplies were overspent by £1.4m. The majority of this relates to covid related infrastructure costs.
The position includes a total spend of £1.35m in relation to covid-19 in month.

YTD the position is £6.9m overspent. This includes total YTD covid non pay costs of £11.8m.

YTD Performance







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Workforce & Finance: Covid-19 Cost Capture December 2020

Principles

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

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

Month 9

In month 9 the following costs have been captured:

£1,124k pay
£1,354k non-pay

This has been offset with £1,505k worth of central income for the month plus a further £700k worth of retrospective allocations.

Major equipment purchases will be largely non-recurrent, while staff costs will be ongoing.

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Pay	Medical Pay	368	2402
	Non-Clinical Pay	117	1458
	Nursing Pay	351	1916
	Other Clinical Pay	145	854
	Scientific, Technical & Profes	143	1236
Pay Total		**1,124**	**7,866**

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Non Pay	Bedding & Linen		1
	Cleaning supplies & materials	17	540
	Computer expenditure		65
	Consultancy	151	422
	Drugs		202
	Estates expenditure	110	1292
	Fuel & power	-4	12
	Furniture & office equipment		13
	Healthcare from other NHS Bod	-71	41
	Laboratory expenses	407	2440
	Medical & Surgical Equipment	11	1143
	Other non-pay	413	4118
	Printing & stationery	1	57
	Provisions		-38
	Rates	-6	18
	Other non-pay (misc)	323	1502
	Telephones	5	5
	Travel & subsistence		3
	Depreciation	-5	14
Non Pay Total		**1,354**	**11,848**
Grand Total		**2,478**	**19,714**

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Workforce & Finance: Efficiency Programme

WHHT - FY21 CIP Efficiency Covid 19 impact

FY21 Efficiency Strategy Themes Covid 19 impact (as of 18.11.20)

	Suspended						FY21 Target						
Strategy Theme	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	Total £000
Pay efficiencies - establishment review									30	30	30	30	120
Non-Pay Procurement initiatives							143	143	143	204	204	204	1,041
Income - efficiency opportunities							115	145	145	145	145	145	840
Total	0	0	0	0	0	0	258	288	318	379	379	379	2,001

WHHT FY21 CIP Efficiency Divisional Target

	Suspended						FY21 Target						
Division	April M1 £000	May M2 £000	June M3 £000	July M4 £000	Aug M5 £000	Sept M6 £000	Oct M7 £000	Nov M8 £000	Dec M9 £000	Jan M10 £000	Feb M11 £000	March M12 £000	FY21 Total £000
Clinical Support							23	25	28	33	33	33	175
Corporate							31	35	38	46	46	46	241
Medicine							56	62	69	82	82	82	431
Surgery & Anaesthetics							68	76	84	100	100	100	529
Emergency Medicine							27	31	34	40	40	40	213
Womens & Childrens							28	31	35	41	41	41	219
Environment							25	28	31	37	37	37	193
Total	0	0	0	0	0	0	258	288	318	379	379	379	2,001

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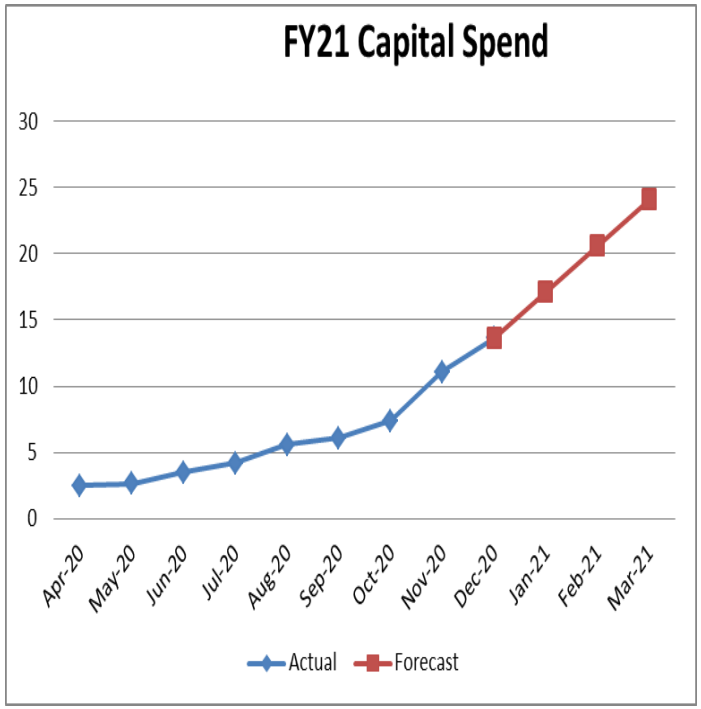
Workforce & Finance: Capital Expenditure December 2020

Month	Scheme	Spend (£m)
1	Your Care Your Future	**0.3**
1	LED Lighting	**0.2**
1	Medical Equipment	**0.6**
1	Backlog maintenance	**0.1**
1	Covid-19 related projects	1.3
	Month 1 Total Spend	**2.5**
2	Your Care Your Future	0.06
2	Covid-19 related projects	-0.49
2	Fire Safety	0.31
2	Backlog maintenance	0.25
	Month 2 Total Spend	**0.13**
3	Your Care Your Future	0.08
3	Medical Assessment Unit	0.31
3	Endoscopy Equipment	0.29
3	Replacement of Pharmacy Robot	0.06
3	Theatre Project	0.08
3	WAN Infrastructure- IT	0.03
	Month 3 Total Spend	**0.85**
4	Covid-19 related projects	0.02
4	Medical Assessment Unit	0.18
4	Multi Storey Car Park (MSCP)	0.03
4	Fire Safety	0.41
4	Estates projects	0.07
	Month 4 Total Spend	**0.71**
5	Fire Safety	0.14
5	Your Care Your Future	0.33
5	Medical Assessment Unit	0.05
5	Multi Storey Car Park (MSCP)	0.07
5	Sundry Estates	0.07
5	Covid-19 related projects	0.74
	Month 5 Total Spend	**1.40**

Month	Scheme	Spend (£m)
6	Fire Safety	0.04
6	Your Care Your Future	0.14
6	Medical Assessment Unit	0.04
6	Security Improvements	0.03
6	IT LAN Remediation	0.06
6	Cardiac Catheter Lab	0.16
6	Sundry Estates	0.03
6	Covid-19 related projects	0.01
	Month 6 Total Spend	**0.51**
7	Fire Safety	0.10
7	Your Care Your Future	0.6
7	Medical Assessment Unit	0.1
7	X-Ray rooms	0.1
7	EPR	0.20
7	Sundry Estates	0.1
7	Covid-19 related projects	0.1
	Month 7 Total Spend	**1.30**
8	Fire Safety	0.1
8	Your Care Your Future	0.3
8	MRI/CT Enabling - SACH	0.2
8	CT/MRI Home Reporting	0.2
8	EPR	0.2
8	Windows 10	0.1
8	MSCP	2.3
8	Covid-19 related projects	0.3
	Month 8 Total Spend	**3.70**
9	Your Care Your Future	0.4
9	Endoscopy	0.2
9	EPR	0.2
9	MSCP	0.9
9	Cardiac Catheter Lab	0.1
9	Theatres	0.2
9	Other sundry	0.4
9	Covid-19 related projects	0.1
	Month 9 Total Spend	**2.50**
	YTD Spend	**13.60**

YTD Capital spend by Scheme



West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

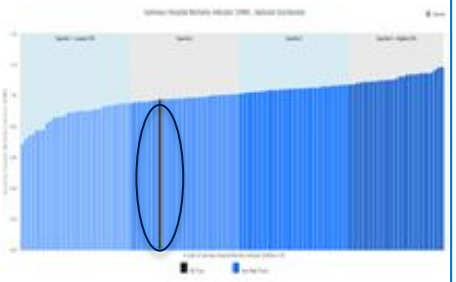
In this reporting period:
The latest available Summary Hospital Mortality Indicator (SHMI), October 2019 to September 2020, is 97.85 and within the 'as expected' range (band 2). The Trust's HSMR of 100.6 is also within the 'as expected' range. HSMR and SHMI have increased slightly as COVID-19 infection rates continue to rise. Although COVID-19 infection is mapped to 'viral infections' and is not part of the primary diagnostic groups bundle which contribute to HSMR, it does affect the metric indirectly .

Quantitative aspects of Mortality :
A case note deep dive review is undertaken for each 'outlying' primary diagnostic SMR group with a speciality or senior trust consultant and the coding manager. This process is consistent and has not highlighted any lapses of care to date in those outlying groups. The current outlying groups are septicaemia except in labour and other infections including parasitic, which is a new alert. The Trust has recently received the sixth and final bespoke report from Dr Foster specifically examining COVID-19 mortality and patient characteristics / demography.

Qualitative aspects of Mortality:
Monthly specialty/departmental mortality review meetings take place, but it has been necessary to suspend the structured judgement review (SJR) process on account of reduced consultant reviewer availability, a consequence of increased ward demands, along with staff sickness and isolation. The level tier 2 work for judgements of potential avoidability of death has also been temporarily suspended.

Performance stable
Better than target/threshold

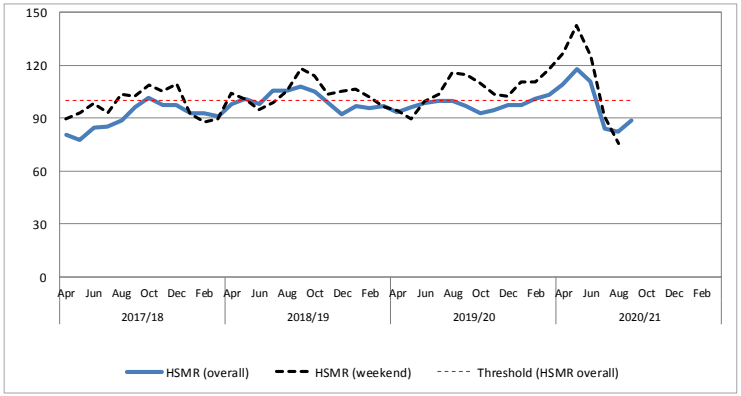
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



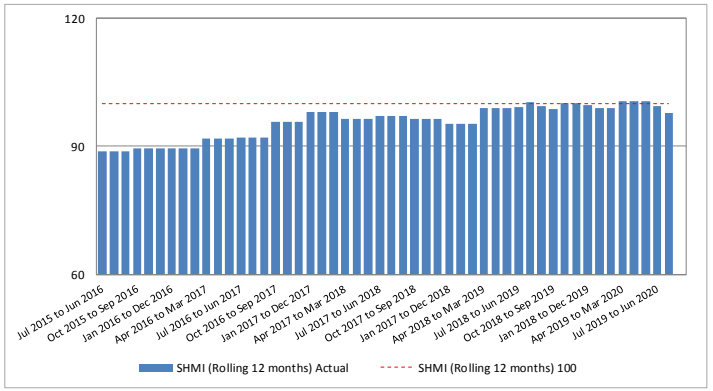
Period: Jan 2021

WHHT 0.98 **Sector: 1.01**

HSMR – rolling 3 months



SHMI – rolling 12 months



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

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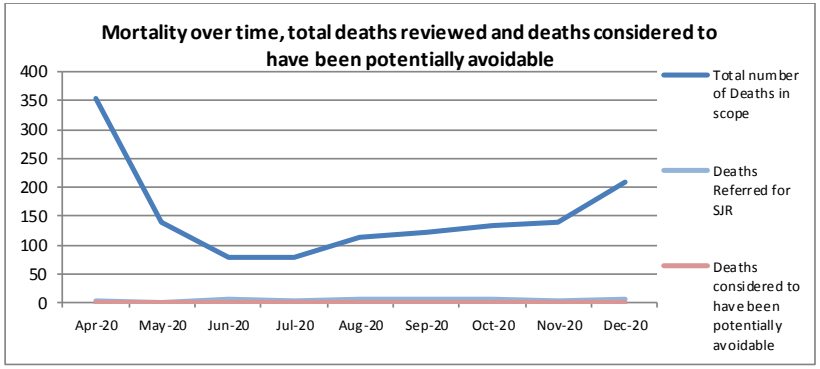
Safe Care & Improving Outcomes: Learning from deaths dashboard

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

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

Total Number of Deaths in Scope *based on date of death		Total Deaths Referred in for SJR **based on date of review		Total that were Tier 2 reviewed		Total Number of Deaths considered to have been potentially avoidable (RCP <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
209	140	8	4	3	5	2	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
484	317	18	17	13	14	3	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1376	1652	48	137	27	32	5	2



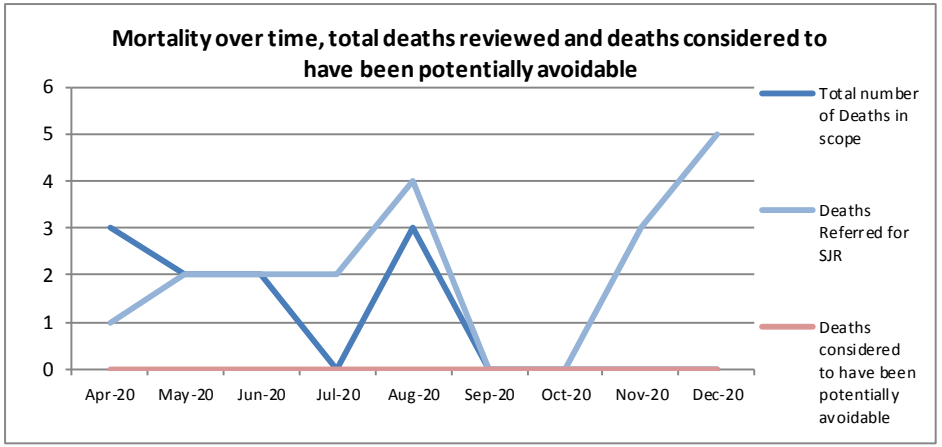
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable		Score 2 Strong evidence of avoidability		Score 3 Probably avoidable (more than 50:50)		Score 4 Probably avoidable but not very likely		Score 5 Slight evidence of avoidability		Score 6 Definitely not avoidable	
This Month	0	This Month	0	This Month	2	This Month	0	This Month	0	This Month	1
This Quarter (QTD)	0	This Quarter (QTD)	0	This Quarter (QTD)	3	This Quarter (QTD)	5	This Quarter (QTD)	0	This Quarter (QTD)	5
This Year (YTD)	0	This Year (YTD)	1	This Year (YTD)	4	This Year (YTD)	10	This Year (YTD)	4	This Year (YTD)	8

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

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

Total Number of Deaths in Scope *based on date of death		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of Deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	5	3	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	3	8	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	23	19	23	0	0



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

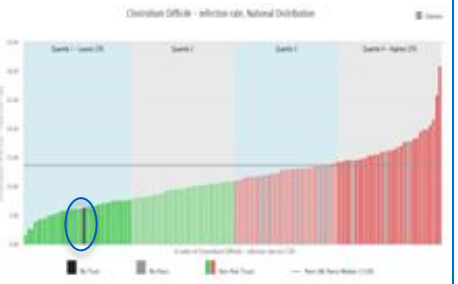
In this reporting period:
Clostrioides difficile Infection (CDI) objectives for 2020/21 are based on criteria commenced on 1 April 2019: Hospital onset healthcare associated – cases detected 2 days or more after admission (CAT1). Community onset healthcare associated – cases that occur in the community that have had a hospital admission/inpatient in the previous 4 weeks (CAT 2). Community onset indeterminate association – cases detected in the community when a patient has had an admission or been an inpatient in the previous 12 weeks but not the most recent 4 weeks (CAT 3). Community associated – cases that occur in the community when the patient has not had an admission or been an inpatient in the previous 12 weeks (CAT 4). Objectives for acute providers are based on the first 2 categories and the Trust trajectory of no more than 34 cases with identified lapses in care for the full year continues in 20/21. In Dec 2020 2 cases of C diff infection were attributed to the Trust (x2 cat 2) . Total number of Trust apportioned cases April to Dec is 30 (removal of x1 case in August by PHE). RCA's have been completed in all cases up to end of July, from Aug to Dec data obtained and further detailed reviews planned . No links have been identified with any of the cases during Dec or any cases earlier in the year. The IPC team are working with divisions to ensure standards of IPC practice and management of cases continues to be of a high standard.

MRSA bacteraemia (MRSAb): There is no formal target set for MRSAb, a zero tolerance approach is in place. 0 cases of MRSAb identified Dec. The PIR on previous identified post 48 hour case in Nov has been completed and discussed with CCG, findings suggest sample probable contaminate. Learning will be shared with divisional governance and disseminated to clinical staff .

Hand hygiene (HH): Hand hygiene compliance for the month of Dec is above the 95% target across the trust. HH training on ward visits is routine, staff now reminded of importance of washing to the elbow in clinical areas. IPC undertakes daily clinical visits to observe and provide support to ensure compliance with hand decontamination and PPE compliance.
Water Management, Ventilation and Decontamination: The Trust has groups in place to monitor all of these areas. Water Safety Group meetings have been undertaken, and issues identified with maintenance of temperature has led to higher counts of Legionella in recent water sampling. PHE have been in attendance at review meetings, and a full estates action plan with mitigating actions including filters on outlets in PMOK have been undertaken. Ventilation and decontamination are also included in discussed as part of the COVID governance structure.

Performance stable
Better than target/threshold

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

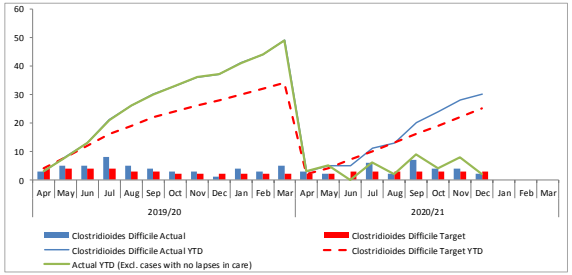


Period: to March 2019

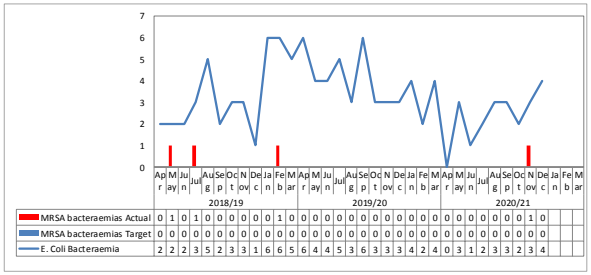
WHHT 6.42 Peer 13.68
National 11.11

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

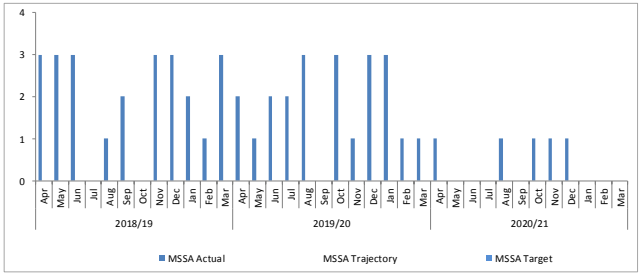
Clostrioides Difficile Infection (CDI)



MRSA



MSSA



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

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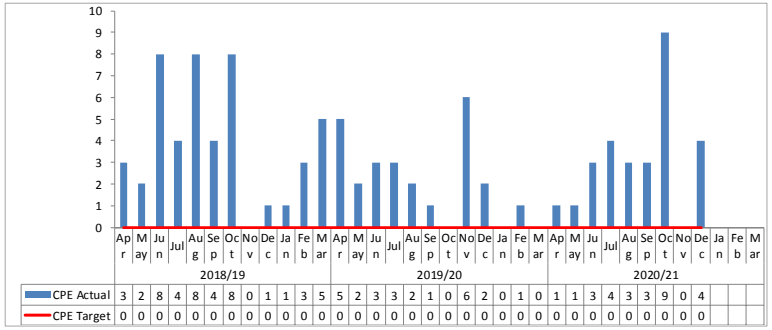
Safe care & Improving Outcomes: Infection Control (2 of 2)

In this reporting period:
E. Coli bacteraemia (E colib):
There was 4 post-48hr cases and 14 pre-48 hour cases (non-trust) reported in Dec 2020. There is no externally set target for the trust but the national target is to deliver a 25% reduction by 2021 and 50% by 2024; this is reflected in the quality indicator which is monitored by the CCG. Thematic data is gathered for post-48 hour cases and reviewed alongside microbiology review of the pre-48 hour cases. Work around this is to be recommenced as part the recovery plan.

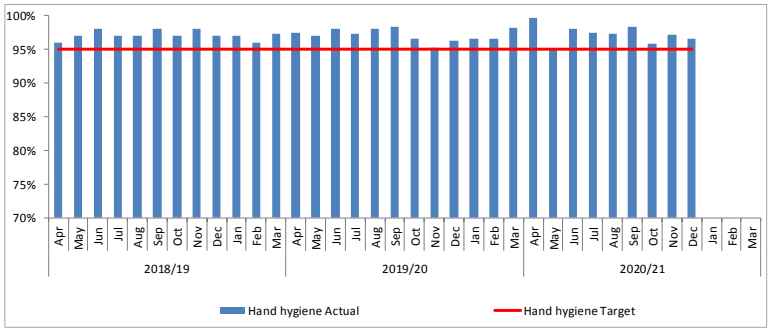
Methicillin-sensitive Staphylococcus aureus (MSSAb):
There was 1 post-48 hour case and 7 pre-48 hour cases of MSSAb in Dec 2020. Each case is usually reviewed by a microbiologist using an RCA tool to identify and share learning .

Carbapenemase-producing Enterobacteriaceae (CPE):
The trust routine management and compliance process for CPE continues, including screening, enhanced cleaning and isolation. Clusters of cases have been identified across the division of medicine during Oct to Dec , further microbiological data suggests the same typing and evidence of some me transmission in ward areas. Immediate actions including enhanced cleaning and isolation of patients has been undertaken, along with screening of all contacts. Further epidemiological investigations have been undertaken to identify and possible transmission and target actions.
IPC Progress Update: The IPC Code of Practice (CoP) audits have been reviewed to incorporate COVID19 IPC guidance & the BAF. Divisions and wards have recommenced their CoPs audits in their departments, and IPC Team are supporting. During Dec work to support clinical areas and operational teams in the safe management of the rising number of COVID -19 patients has been the priority. Spot check audits have also been developed to provide assurance and highlight areas requiring support . There is continued monitoring of water quality, ventilation, decontamination, antimicrobial stewardship and cleaning across the trust. Also ongoing discussion from IPC with Facilities, Estates, Mitie and the clinical team to ensure we work together to continue to maintain a high standard of cleanliness of the environment which is fundamental in the prevention of Nosocomial infections in COVID.
Next steps: continued support for teams to safely manage the ongoing high numbers of patients identified with COVID-19, including support in PPE and placement of patients being a priority.

Carbapenemase-producing Enterobacteriaceae (CPE)



Hand hygiene compliance



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

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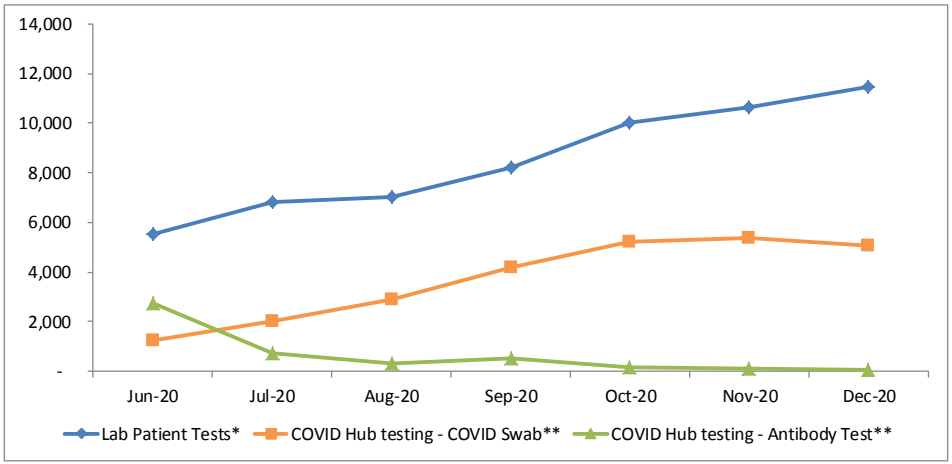
Safe care & Improving Outcomes: COVID-19 (Slide 1 of 3)

Laboratory and COVID Hub testing – Staff and patient volumes

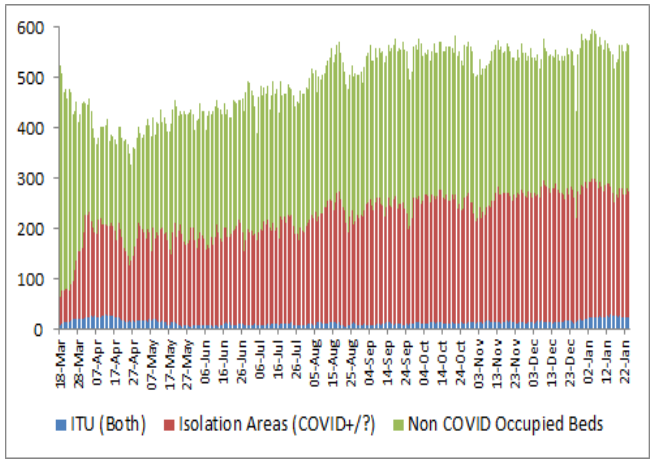
Tests/Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Lab Patient Tests*	5,516	6,816	7,022	8,195	10,030	10,664	11,473
COVID Hub testing - COVID Swab**	1,251	2,029	2,907	4,165	5,216	5,385	5,084
COVID Hub testing - Antibody Test**	2,735	742	281	537	154	119	58

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

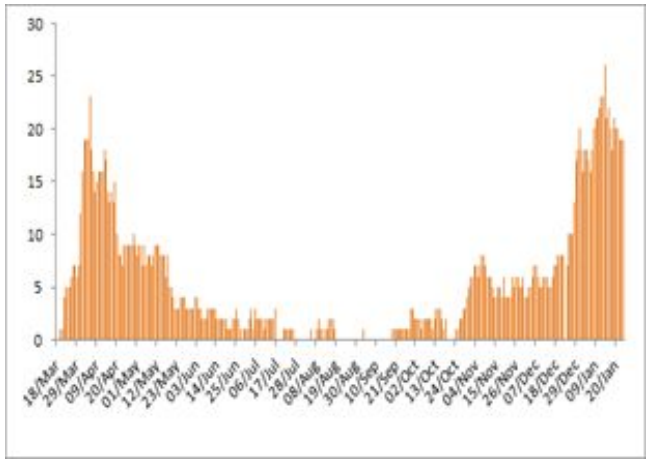
**(includes WHHT/bank/agency/mitie/household - based on appt date)



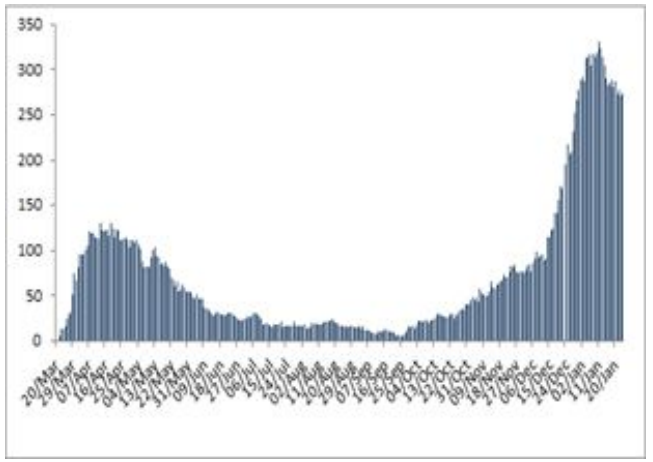
Occupied beds all areas at 0800



COVID-19+ve patients in ITU at 0800



COVID-19+ve patients in other beds at 0800



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

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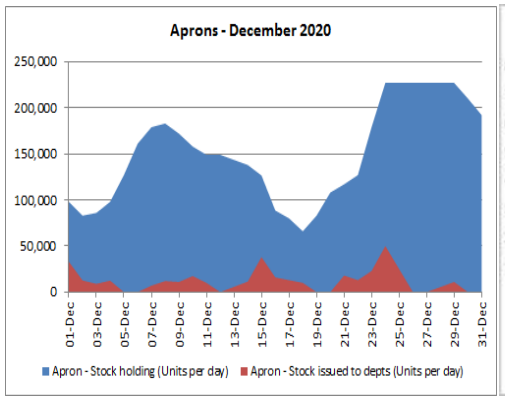
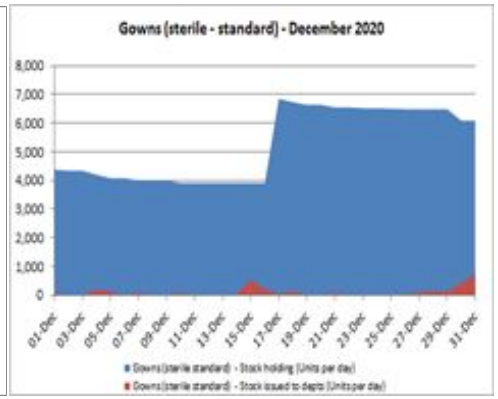
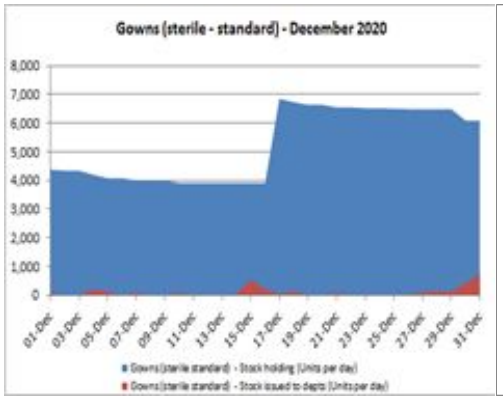
Safe care & Improving Outcomes: COVID-19 (Slide 2 of 3)

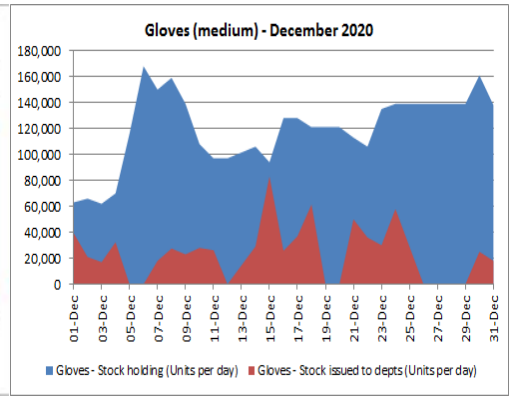
PPE

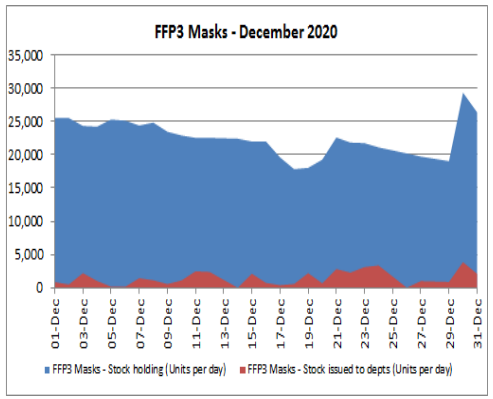
- Central DHSC control of supply and delivery of items from the National Pandemic stock continues.
- The graphs below show at a summary level usage (red block) has remained below stock level although during May stock levels for gowns were under pressure.
- The main current concern remains that National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

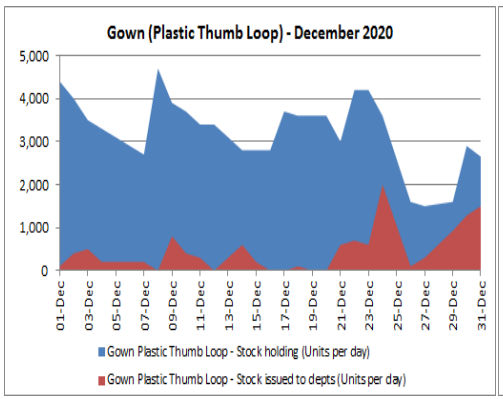


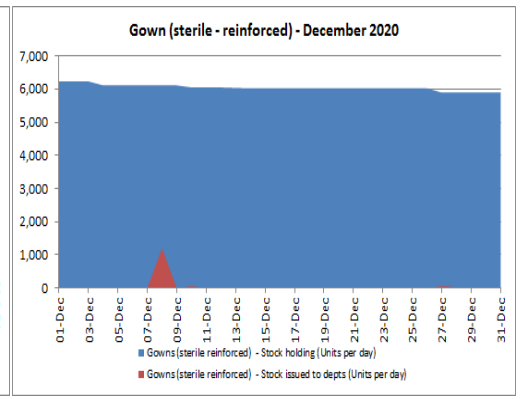












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Nurse & DIPC	Quality Committee	1b / 2a / 2b / 2c / 3a

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

Nosocomial infection cases

COVID19 positive inpatient cases are reviewed each day at a joint IPC meeting. The 4 categories of Nosocomial Infection are based on date of patient's sample in relation to their date of admission. The 4 categories are 0-2 days (Hospital-onset community Healthcare-Associated), 3-7 days (Hospital-onset indeterminate Healthcare-Associated), 8-14 days (Hospital onset probable Healthcare-Associated) and 15+ days (Hospital-onset definite Healthcare Associated). All cases are reported to NHSE and RCAs/themeatic reviews undertaken. During Dec there has been increased numbers of patients with COVID-19 management and prevention of nosocomial infection has continued to be a priority.

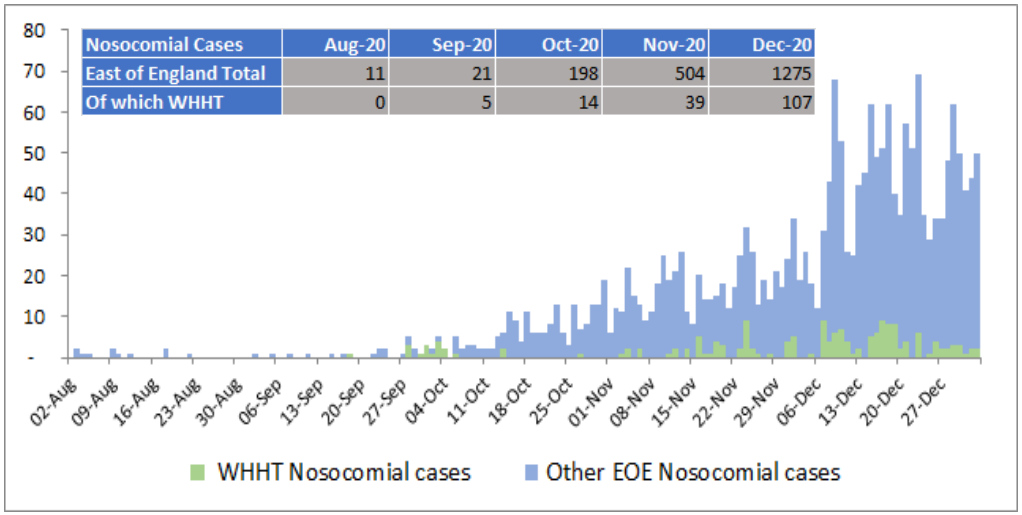
Following nosocomial outbreaks in Oct/Nov 2020 and the identification of a new variant strain of COVID-19, (with a high rate of transmission associated), the Trust has undertaken reviews including visits from NHSE/CCG IPC representatives. Feedback from the reviews was positive but suggestions included: increased screening that has been implemented for both patients and staff (including Lateral flow testing fro clinical staff). In addition a Table top in-depth case review has been undertaken on 3 cases identified as part of Tudor/Castle outbreak and this included CCG, NHSE and PHE representation and was led by IPC with input from the Medical Examiner. Learning from this is planned to be shared with the clinical teams as part of education and support.

In addition Microbiological genomic testing undertaken on 20 random COVID-19 specimens across the organisation has illustrated that 85% were identified as the new variant, strongly suggesting that the recent identified outbreaks are likely to have been largely made up of this variant.

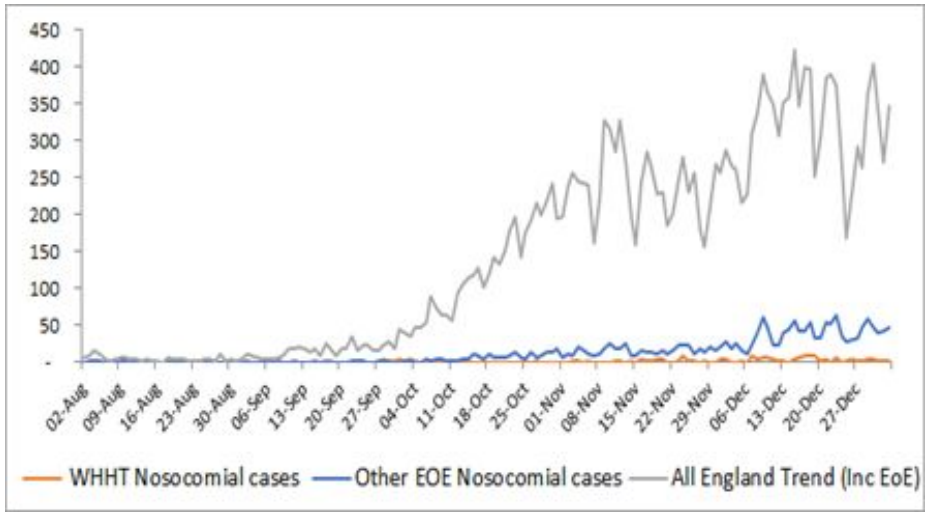
The IPC team supports the management of the COVID-19 Pandemic through support and advice in the safe management of patients with covid including patient placement and PPE use. Spot check audits are undertaken to identify and areas of concern to target support.

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

Nosocomial Cases	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
East of England Total	11	21	198	504	1275
Of which WHHT	0	5	14	39	107



All England – Trend + WHHT and EOE - including 8-14 days and 15+ days.



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

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Safe care & Improving Outcomes: Emergency Readmissions

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

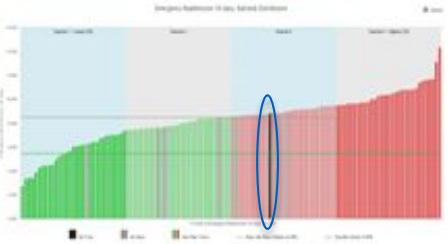
There has been an increase in the emergency readmissions rate to 12.4%, which is 1.7% lower than the national average of 14.1%.

Factors / Themes:
Combined readmission rates (emergency and elective admissions), includes all patients with more than one admission to the hospital within a period of 30 days, regardless of whether the second admission was related.

Latest available data June 2020

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Readmission 30 days

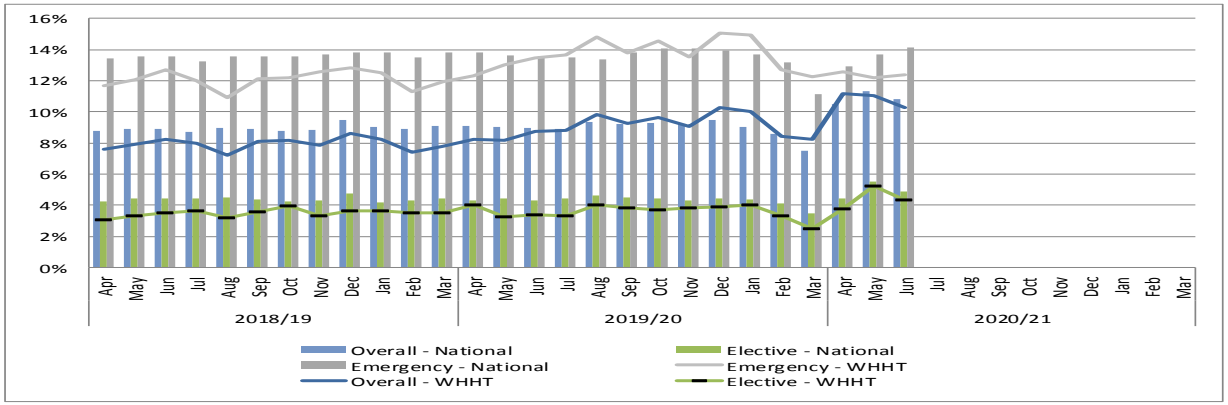


Period: Q2 2020/21

WHHT 8.82% Peer 8.49%
National 8.58%

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

Emergency Readmissions



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

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Safe care & Improving Outcomes: Caesarean Section rates

C-section rate
The elective and emergency combined rate is 34.7% (Emergency 17.8%, Elective16.9%).

Women's choices for mode of birth are facilitated as per the NICE guidance which influences the elective rate.
C-sections have been reviewed daily by the incoming teams on call and decision making is reviewed and discussed with the outgoing team. All maternal requests for C-sections are reviewed by the booking team and referred to the birth options team.

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

The foetal monitoring masterclass , an in house once a month study day is held on a virtual platform regularly to improve understanding of foetal physiology and electronic foetal monitoring. A competency based assessment test is conducted following the class..

Operative delivery is increasingly consultant led/supervised .
The upcoming operative vaginal delivery study day is planned for in April 2021 to improve skills in safe operative delivery.

Performance stable
Better than target/threshold

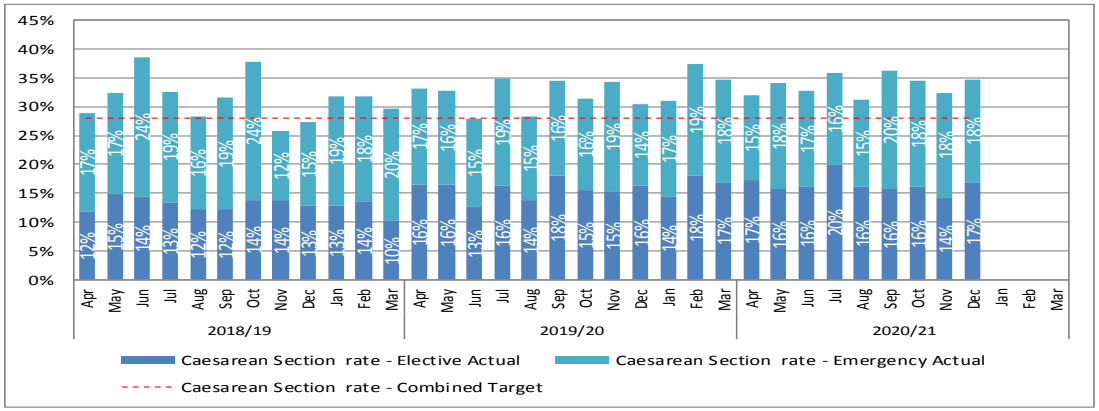
Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate

Period: October 2020

WHHT 20.94% Peer: 16.25%
National: 18.12%

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

Caesarean section rates



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

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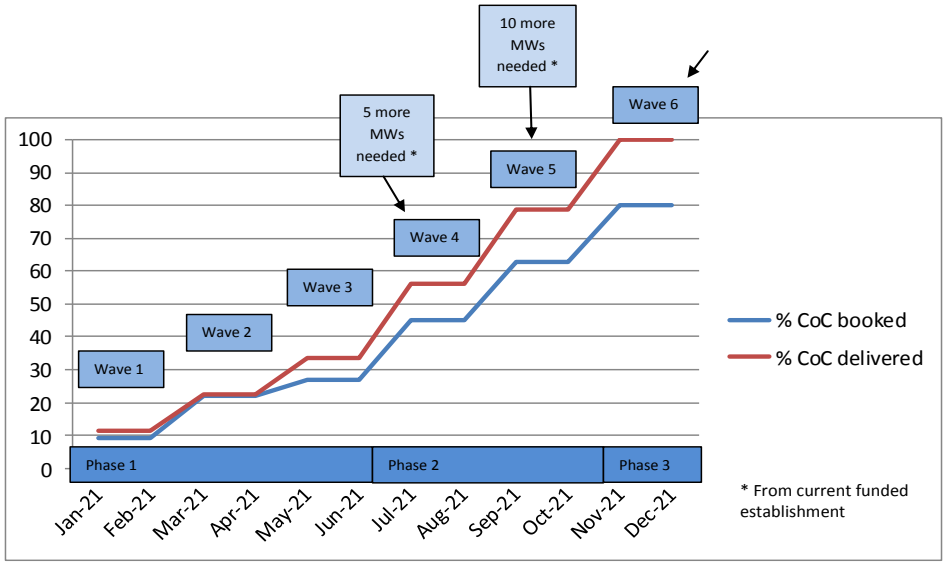
Safe care & Improving Outcomes: Maternity – Continuity of Carer

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

In October 2020 it has been requested nationally that we resume implementation and the expectation of recovering the **35%** ambition as quickly as possible and at least by 31 March 2021 has been set. At the same time, we will be specifically looking at the proportion of Black and Asian women and those from the most deprived neighborhoods are placed onto a continuity of carer pathway meets and preferably exceeds the proportion in the population as a whole.



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

- Review CoC staffing template based on funded establishment- Due early February
- Orchid Team launched on 18/1/21. This team is based within WD post codes realigned to BAME women and deprivation indices.
- LMNS funding was released in January to fund start up costs (computers, phones, equipment).
- The Ockenden report (December 2020) requires that all Trusts fund to the Birthrate Plus recommendation which is 1:22 (2018), a business case will be presented to TCM in February 2021.
- The COVID-19 pandemic has had an impact on staffing availability.
- Better Births Project Midwife - LMNS funded post recruited to in December 20
- Networking with other local hospitals that had successfully implemented the COC to learn good practice.
- Implementation of COC remains on divisional risk register
- Local Maternity Neonatal System (LMNS) BAME working group – action plan in place
- CoC working group monthly meetings with Executive & NED Maternity safety champions.
- Further HEE training sessions planned across the LMNS January 21
- Engagement with key stakeholders to ensure co-production e.g. senior leaders, staff, student midwives/universities, service users- in progress
- Training needs analysis of all staff, PDM support & supernumerary time for up-skilling
- Recruitment of staff to Trust & CoC teams- vacancy currently 19% with recruitment pipeline in place.

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

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Safe care & Improving Outcomes: Workforce and CHPPD

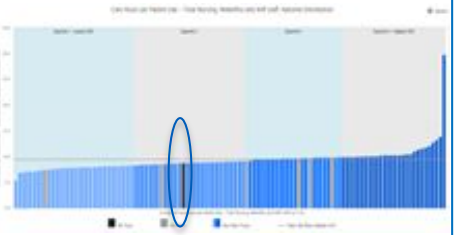
In this reporting period:
Nursing and Midwifery staffing is reviewed as part of the daily operational site meeting and at the workforce safe staffing hub at 08.30 and 14.30, where senior nursing staff support, guide and amalgamate workforce resources using patient dependency, acuity information and professional judgement. During December the overall fill rate was 97.3% (91.2% registered / 99.6% unregistered). Due to the increase in demand a number of surge areas continued to be opened throughout December, this led to an increase in demand for staffing. The Trust operated under Business Continuity from 8-17 December and from 28 December through until January. In addition a number of areas were also closed due to COVID positive patients / contacts. Throughout December there has been significant challenges around nursing and midwifery staffing resulting in a professional discussion and decision with senior nursing leaders that clinical areas would continue to operate under COVID Phase 2 templates. In maternity there were challenges in staffing for ABC and Delivery suite often with requirements for redeployment of staff to support acuity and demand. Overall 61.9% shifts were RAG rated green, a decrease of 8.9% from last month. 27.4% were RAG rated amber, an increase 8.6% from last month and 0.7% were RAG rated red. Clinical areas log an incident via datix for any red shifts or red flags related to staffing. A number of areas had not recorded dependency and acuity for their patients so an incident was also logged to reflect this and the mitigations taken. Ward leaders' supervisory time was 66.4%, of the 33.6% lost (15.6 % was due to annual leave, 18% due to redeployment to support safe staffing and the junior workforce). The preceptorship programme was paused to support safe staffing and the vaccine programme and has been added to the risk register. The team continue to support staff out in practice. There continues to be an increased demand for temporary staff to meet service demand and substantive staffing challenges. A total of 92,772 hours were requested (4,055 more than last month). The over all fill rate is 74.1 % (72.7% registered and 75.7% unregistered), NHSP 61.8%, 12.3% agency. There were 25.9% unfilled. At the workforce meetings chaired by the Deputy Chief Nurse, we continue to encourage rosters to be completed 12 weeks in advance to achieve better bank fill of vacant duties and for staff health and wellbeing. CHPPD rate is 8.8 a decrease of 0.1 from last month (Model Hospital data October 2020, peers 8.4 National 9.1). Enhance care redeployment accounted for 286 shifts (46 day and 240 night).

Factors/Themes

- Ongoing challenges with safe staffing due to increase in number of COVID positive patients, demand and acuity
- Continue to go out to bank and agency to support clinical areas including surge
- Table Top Safe Staffing Review of Templates held with Chief Nurse
- COVID staffing is on the risk register (risk 4273), at a 12 – currently being reviewed.
- Operating in COVID amber templates since 24 November to date.
- ITU operating over 4 phases(main ITU, Endoscopy and Recovery) Staffing as per National Guidance 1:2
- Due to ITU demand we are using Thornbury agency which is not on framework
- Staff are supported out of hours (including BH and weekends) by band 7 bleep holders and by a Senior Nurse. In addition, a senior night sister role has been added until March 2021.
- EWTD and Sickness rules currently switched off on e-roster, next review 28 January 2021
- V11 eroster now fully operational
- In patient wards establishment Reviews due to COVID 19 paper went to TMC December 2020
- Preceptorship programme paused in December to date on the risk register
- Vaccination programme commenced 4 January 2021

Performance stable
Better than target/threshold

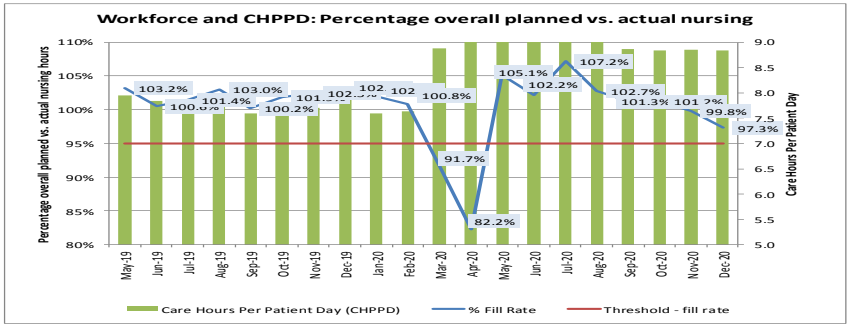
Benchmarking: MODEL HOSPITAL
Care hours per patient day – total nursing & midwifery staff



Period: October 2020

WHHT: 8.8 **Peer: 9.5**
National: 9.1

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



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

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Safe Care & Improving Outcomes: Patient Safety

In this reporting period – December 2020:

Never events
There were two Never Events reported in December 2020;
- Wrong Implant – part of hip replacement
- Retained object– a missing drill bit

Serious Incidents
15 serious incidents (SIs) were declared in December 2020. Of these, eight were reported by Women and Children Division arising from the decision to upgrade all incidents being managed by the HSIB to SI status; and the clinical harm review of all incidents which were previously being managed as Divisional RCA. At the end of December 2020, the Trust had six incidents being investigated by the HSIB.

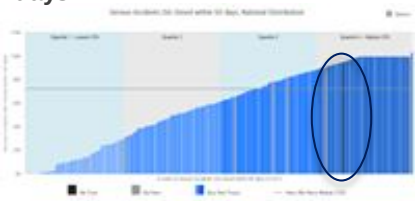
% of patient safety incidents which are harmful *
62.5% (168) of the incidents reported in December 2020 were recorded as causing "moderate or higher" level of harm to patients. This compares adversely with 47.9% (81) recorded in November 2020. This demonstrates a disproportionate increase in the percentage of incidents reported as harmful in December 2020 in comparison with the number of incidents reported in November 2020. Of the 168 incidents reported as causing moderate harm or higher, 129 are related to Covid-19.
(*Harmful incidents are those rated as low , moderate , severe harm level or death).

The number of incidents rated as "death/catastrophic and severe" was higher in December (9 incidents) compared with (5 incidents) reported in November 2020.

There were four incidents reported in December 2020 with a harm level rated as "death/catastrophic".

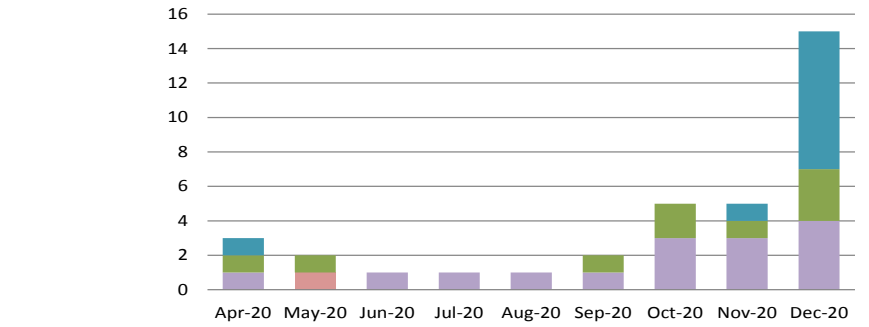
Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



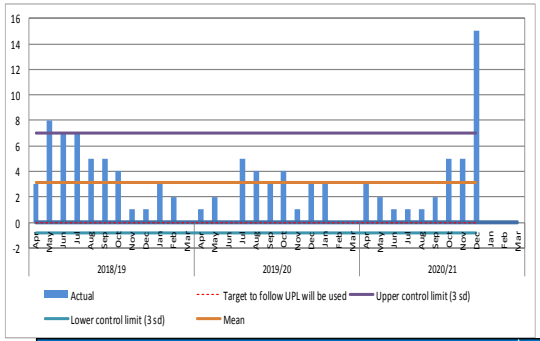
Period: 2018/19
WHHT 95% **Peer: 72%**
National: 61%

Serious Incidents by division

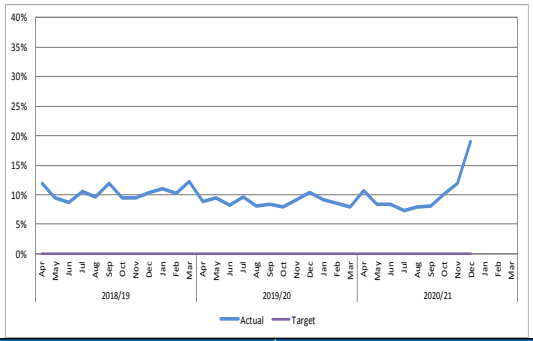


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Paeds	0	0	0	0	0	0	0	0	0
Maternity	1	0	0	0	0	0	0	1	8
Gynae	0	0	0	0	0	0	0	0	0
Surgery	1	1	0	0	0	1	2	1	3
Medicine	1	0	1	1	1	1	3	3	4
Emergency Medicine	0	1	0	0	0	0	0	0	0

Serious Incidents



Safety incidents (% harmful)



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

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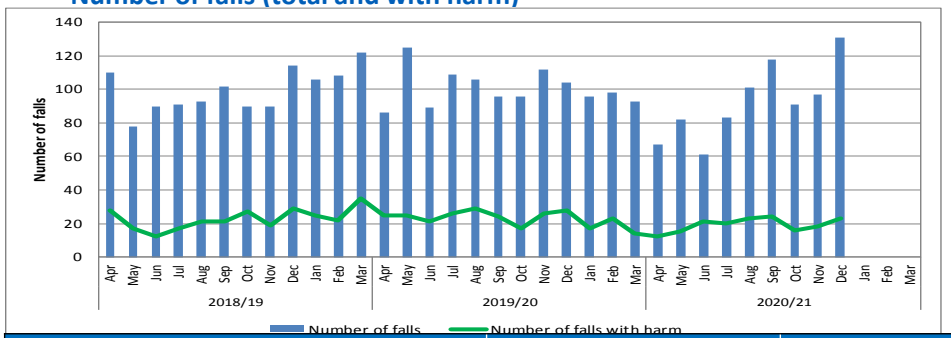
Safe Care & Improving Outcomes: Falls & Falls with harm

In this reporting period:
In December there were 125 inpatient falls. 22 falls with low harm; 1 with moderate harm and 3 with severe harm two of which resulted in a Neck of Femur fracture. For falls with harm 13 (72%) were suspected (unwitnessed) and 5 (28%) were witnessed, 9 (50%) occurring during the night and 9 (50%) during the day. Of the falls with harm, 8 (33%) were linked to a cognitive impairment; however none of these were patients with a known Dementia.
Of the 125 falls reported in December , 99 (79.2%) occurred around the bed space, 77 of which were in a bay and 18 (14.4%) in the toilet. 21 (16.8%) of the falls reported were recurrent fallers.
The clinical areas reporting the highest number of falls were A&E (including Resus and CDU) with 12 falls (4 witnessed, 8 suspected; 9 within the patient's bed space) and Tudor /Castle Ward with 16 (2 witnessed, 14 suspected; 15 within the patient's bed space). Aldenham Ward, Sarratt Ward also reported 7 falls during December.
Ongoing QI project on Croxley Ward to highlight patients at falls risk using an assessment tool and application of patients deemed at high risk of falls. This is subject to ongoing monitoring to review the accuracy of the intervention to provide more precise data to be able to establish the presence of an causal relationships between the intervention and falls numbers. The new 'tag-in tag-out' system was introduced prior the Christmas period through the implementation of rapid PDSA cycles however due to staffing shortages and a COVID outbreak on the ward, it is difficult to establish the success of this introduction. The project has been suspended.
Introduction of separation of exact location of falls on the ward to establish differences of falls in side rooms and falls in bays to more precisely measure factors implicated in inpatient falls in the Trust's current environment.

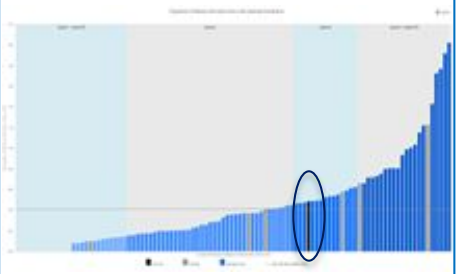
Actions:
- Complete weekly review of falls numbers to gain a more detailed understanding of monthly trends to allow for a more tailored approach to falls prevention support
- Contact Matrons to increase visibility of falls prevention support for ward staff and promotion of falls practitioner support on weekly e-update with the reporting of falls with harm directly to practitioner
- Develop SOP for time related initiation of falls care plan in ED
- Liaise A&E team to explore whether specialist falls support is needed due to sharp increase in falls during December. As part of Harm-free care team, support A&E with review of documentation whilst using corridor as a surge area.
- Review cognitive impairment as an impact on falls and how this correlates with provisions for ECW staff. Review of ECW staffing to explore impact of declined ECW's on falls and tailor support on wards to assist with alternatives to 1:1 as included in falls training
- Meet with SI team regarding data for occurrence of fractured neck of femur resulting from inpatient falls
- Ongoing falls awareness, prevention and management sessions for clinical staff development and student nurses

Number of falls (total and with harm)



Performance stable
Better than target/threshold

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



Period: December 2019

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

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

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

39

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Safe Care & Improving Outcomes: Pressure ulcers (HAPUs)

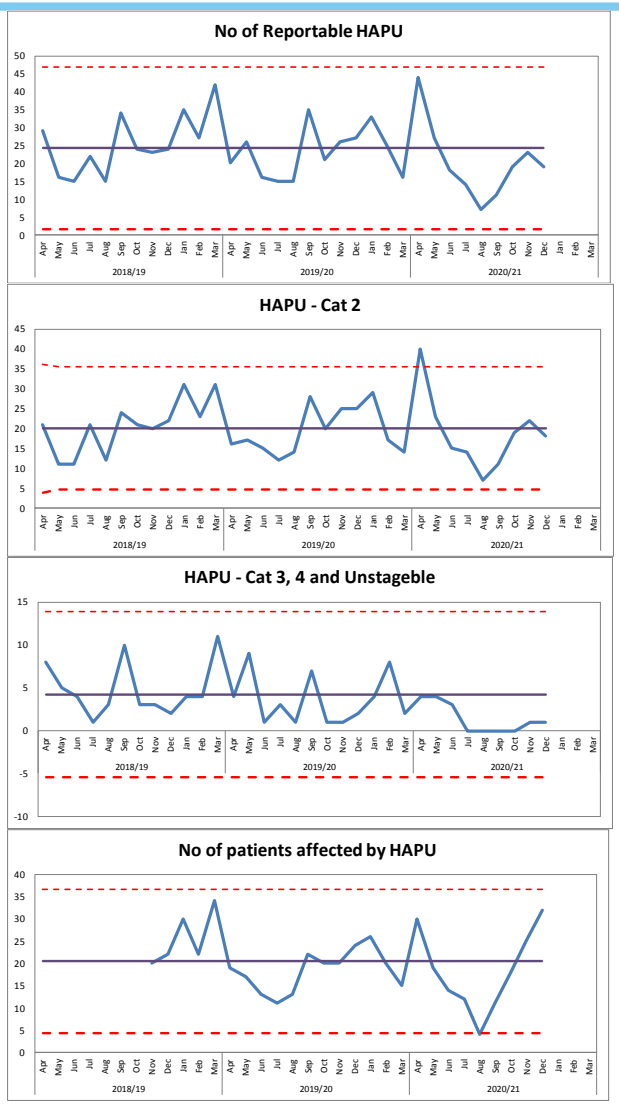
In December 2020 there were 19 reportable HAPU's, a decrease from 23 in November (17.4%). Despite this decrease, there was one category 4 (d) pressure ulcer, this was related to a specific medical device. Actions were formulated after a learning discussion to reduce the risk of recurrence.

There were 5 MDRPU reported in December, compared with 13 in November. Out of 5 reportable MDRPU, 4 patients were associated with use of CPAP(80%).

There were 39 reported cases of moisture associated skin damage (MASD) via the tissue viability system in December. This is similar to November. 34 of the 39 (87%) were reported on Medical wards. 5 of the MASD were initially reported as Cat 2 HAPU were re-categorised to moisture lesions.

The data shows common cause variation.

Reportable HAPU (December 2020)			
Categories	HAPU	MDRPU	HAPU Total
Category 2	14	4	18
Category 3	0	0	0
Category 4	0	1	1
Unstageable (possibly category 3 or 4)	0	0	0
Total reportable	14	5	**19**
Non-Reportable HAPU			
Category 1	10	1	11
Suspected deep tissue injury (SDTI)	11	2	13
Total non- reportable	21	3	24



Actions/developments for Pressure Ulcer management:

1. Continue to use the wards safety huddles to raise awareness of:
 * the importance of timely effective repositioning, robust and timely reassessment of skin of patients at risk and documentation in accordance with the Trust guidelines.
 * Use Skin Champions to initiate projects on their wards to raise awareness around the need for precautionary and preventative approaches to MDRPU.
* Work closely with NIV practitioner and NIV manufacturer to explore best solution for device related pressure ulcers.
2. TVN to provide weekly ward based 'bite-sized training' with virtual and other electronic forms of training around assessment, classification, prevention & treatment of pressure ulcers, throughout the Trust.
3. Continue to work with Continence CNS to deliver divisional bite sized power training both virtually and/or face to face, around Continence management and prevention of Moisture Associated Skin Damage.
4. Initiative started on AAUL1 (all 4 areas) and Granger Suite- Nurses using iPad to photograph cat 2 and above HAPU.
5. Harm free care team to work with wards completing reviews of skin assessment accuracy to ensure standards maintained during busy periods. Assisting nurses with reviews of accuracy of BESTSHOT paperwork .
6. Review usage data with NIV practitioner to explore potential relationships with medical device related pressure areas.
7. Develop SOP for time related initiation of care plan in ED.
8. Review data for time spent in ED to explore relationships with hospital acquired pressure areas.
9. Lead wards in trialling movement of paperwork to the end of the bed to assist ward staff in completion starting with Granger Suite.
10. Supporting medical wards with regular reviews of skin carried about by the harm free care team to support staff in meeting ongoing standards despite increased pressures and reduced staffing.

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

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Ward Scorecard – Combined Safety and Process Alert Summary

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

One Month

Emergency Medicine	**29**
AAU Y1	14
AAU B1	5
AAU P1	5
AAU G1	3
A&E	1
UCC	1
MIU	0
Medicine	**88**
Red	13
Bluebell	10
Winter	9
Croxley	9
Winyard	8
CCU/ P/G 3	8
AAU B/Y 3	7
Sarratt	4
Aldenham	4
Oxhey	4
Heronsgate & Gade	4
Tudor	3
Stroke	2
Cassio	2
Simpson	1
Frailty	0
Surgery	**21**
Cleves	8
ICU	3
Elizabeth	3
Flaunden	3
Ridge	2
Letchmore	2
DLM	0
Langley	0
Grand Total	**138**

Three Months

Emergency Medicine	**85**
AAU Y1	36
A&E	14
AAU P1	12
AAU B1	11
AAU G1	10
UCC	2
MIU	0
Medicine	**225**
Red	29
Winyard	27
Bluebell	18
AAU B/Y 3	18
CCU/ P/G 3	16
Oxhey	15
Croxley	15
Winter	15
Tudor	13
Heronsgate & Gade	13
Aldenham	12
Cassio	11
Sarratt	11
Stroke	11
Simpson	1
Frailty	0
Surgery	**74**
Cleves	19
Flaunden	14
ICU	11
Elizabeth	9
Letchmore	8
Ridge	7
Langley	6
DLM	0
Grand Total	**384**

Six Months

Emergency Medicine	**154**
AAU Y1	66
A&E	28
AAU P1	20
AAU B1	17
AAU G1	14
UCC	9
MIU	0
Medicine	**423**
Red	50
Heronsgate & Gade	42
Winter	39
Winyard	37
Oxhey	35
AAU B/Y 3	30
Aldenham	28
Bluebell	26
Cassio	24
Sarratt	24
Tudor	23
CCU/ P/G 3	22
Croxley	22
Stroke	20
Simpson	1
Frailty	0
Surgery	**162**
Flaunden	36
Cleves	30
Letchmore	23
Elizabeth	23
ICU	20
Ridge	15
Langley	13
DLM	2
Grand Total	**739**

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Safe care & Improving Outcomes: VTE risk assessment

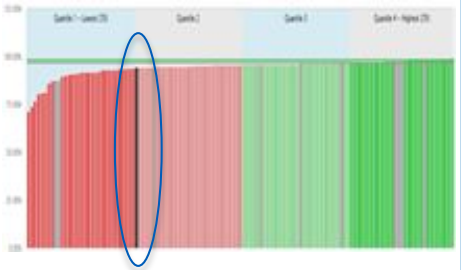
In this reporting period:
The target was achieved this month.

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

Next steps:
- Regular reporting is being provided to all wards where VTE risk assessments are below threshold
- Focused awareness and training sessions in AAU Level 1.
- VTE prevention specialist nurse to target these areas and to visit Safety Huddles as well as liaise with senior sisters.
- VTE learning is part of Doctors' and nurses' mandatory training

Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
VTE assessment

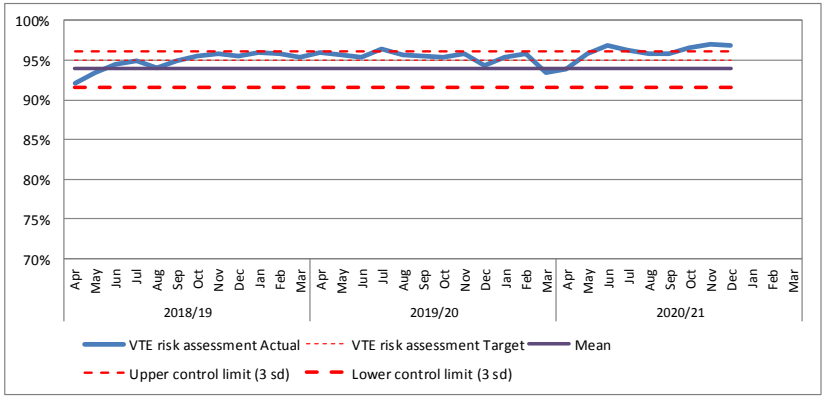


Period: Q3 2019/20

WHHT 94.38% Peer: 94.43%
National 95.99%

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

VTE risk assessment



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

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Safe Care & Improving Outcomes: Stroke

In this reporting period:

Admission to Stroke Unit within 4 hours – 14.0%

Meeting the performance standard has become difficult to achieve as patients admitted to the Trust require COVID swabs prior to any planned ward transfer and therefore wait in a holding ward until the swab results are available, resulting in the inability to admit to the Stroke unit within 4 hours. However during the time in the holding areas, patients are reviewed by the Stroke team and continue to receive specialist care and input whilst awaiting transfer to the Stroke unit.

Patients who are given intravenous thrombolysis are prioritised for transfer to a side room on the Stroke unit for monitoring whilst the COVID swab results are awaited. Positive COVID stroke patients are not admitted to the stroke ward but still receive stroke specialist input. Furthermore there has been COVID outbreak on the unit attributing bed closures and reduction in the stroke bed capacity.

90% stay on Stroke Unit 76.3 % (target 80%)

Compliance on this standard has been not achieved , contributory factors are the constraints described above.

Thrombolysed within an hour 16.7 % (SSNAP target 55%)

Achievement of the target is variable, depending on several factors but mainly the complexity of cases seen. A total of 6 patients were thrombolysed of which 1 was within 1 hour.

Performance stable
Better than target/threshold

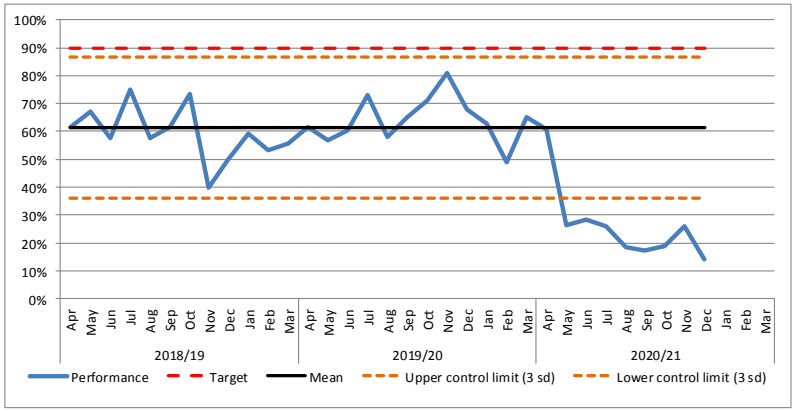
Benchmarking: SSNAP

Period: July to September 2020

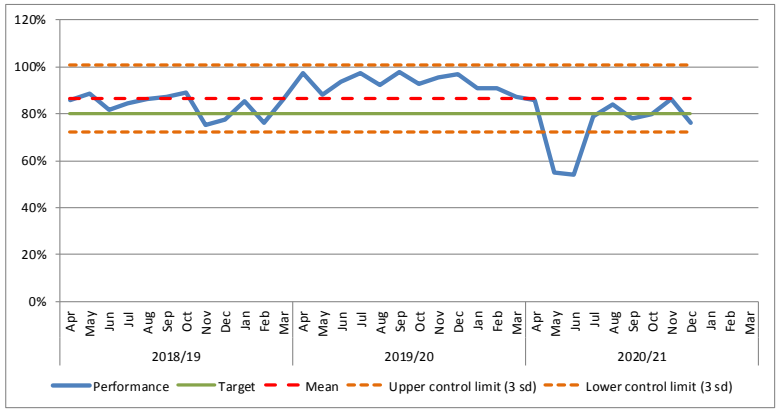
Admission within 4 hours: 59.3%

90% admission on Stroke Unit: 84.3%

Stroke: Admission within 4 hours



Stroke: 90% of admission on Stroke Unit



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

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Caring & Responsive Services: Emergency Department

In this reporting period:

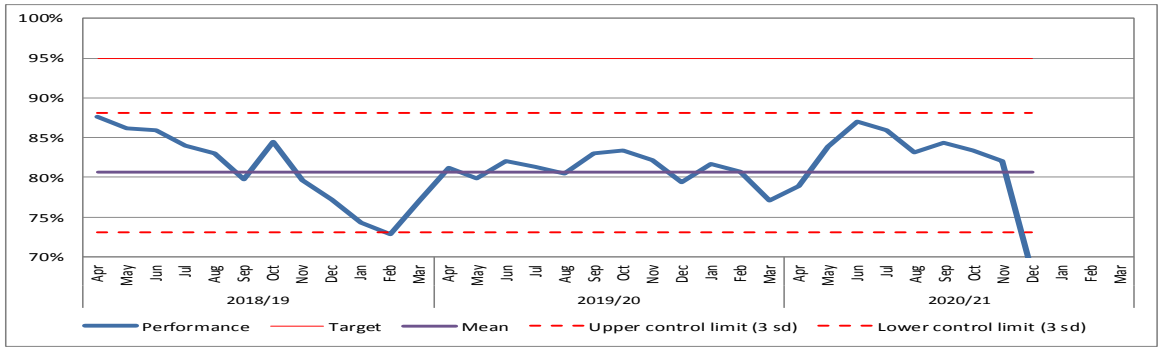
At 68.4%, overall Trust performance decreased on the previous month's performance of 82.1%. This is as a result of the 2nd wave of covid. Compliance with the 95% standard was maintained at HH UTC (99.9%). Performance at the WGH UTC was 98.6%. COVID hinders established assessment pathways, staffing is a considerable constraint and admitted pathways are disrupted. Hemel UTC attendances have continued to reduce falling by 2% on the previous month. MIU remains closed. The DOS for UTC was switched off at WGH to enable ED capacity. Total Trust attendances including attendances at the UTC remained static from the previous month. 21 twelve hour breaches were incurred in December due to ED and bed capacity constraints.

In December the average ambulance handover time increased from 26 minutes to 50 minutes. Conveyances continue to increase with a 6.5% rise from the previous year in comparison to a decreasing trend across the region. The number of over 60- minute offload delays rose to 512 in December with corridor care enacted. In partnership with EEAST, crews were on site 24/7 to support with corridor care which reduced offload delays. Patients were offloaded in clinical priority and assessment cubicles were ring fenced for initial assessment.

Next Steps:

- Continue to work with EEAST to support offload delays
- Ensure safest care in ED with corridor care SOP in place and active cohorting from EEAST.
- Harm reviews on patients who breach 12 hour DTA standard and those who are cared for in the corridor.
- We aim to improve flow with the addition of the Fracture Clinic surge plan. This space supports our COVID escalation plans.
- The regular check in meetings between the service team and Executive colleagues have restarted.
- The monthly programme board meetings oversee the ambulance work stream with a joint action plan between EEAST and the Trust – this continues.
- Consultant recruitment – successful Consultant recruitment was achieved in November with one consultant appointed. Further interviews are scheduled for April 2021. This success is following the approval of a recruitment and retention package approved in September 2020.
- SMART has been limited due to the new COVID pathway, a Virtual SMART commenced in September 20.
- The new EAU opened in August which has increased the number of patients being seen through the assessment area. An expansion is planned for this area by February 2021.

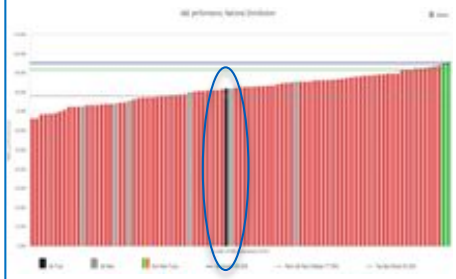
A&E: Attendances within 4 hours



Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL

% of patients admitted or discharged within 4 hours of arrival



Period: November 2020

WHHT: 82.06% Peer: 77.93%
National: 95.0%

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

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

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Caring & Responsive Services: Mixed sex accommodation breaches

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

Submission suspended

Performance stable
Better than target/threshold

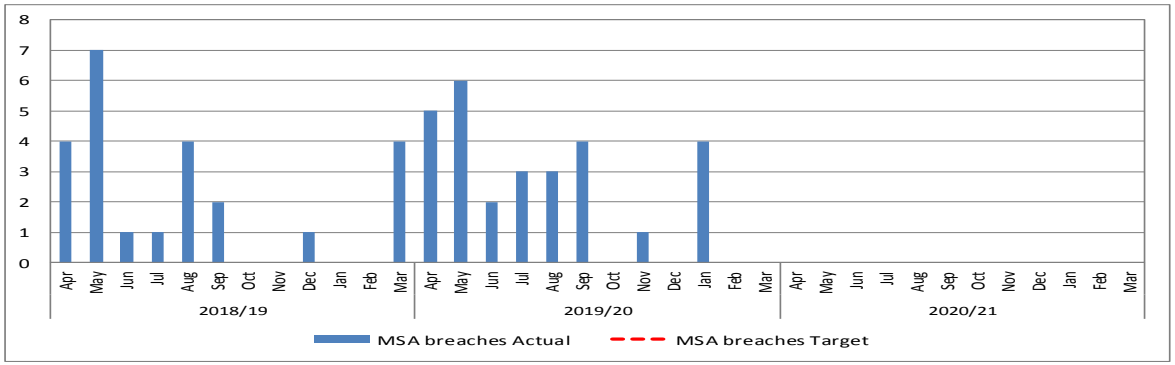
Benchmarking:

Not currently available

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

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

Mixed sex accommodation breaches



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

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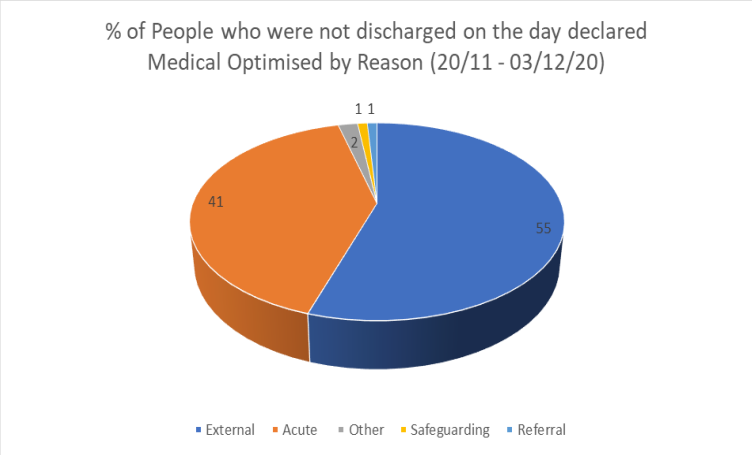
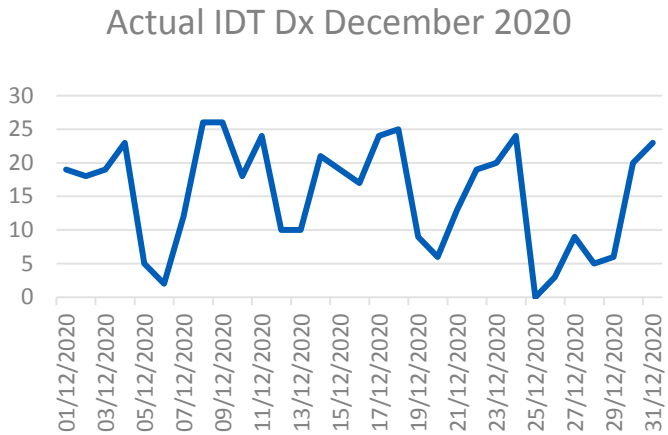
Caring & Responsive Services: Delayed Transfers of Care

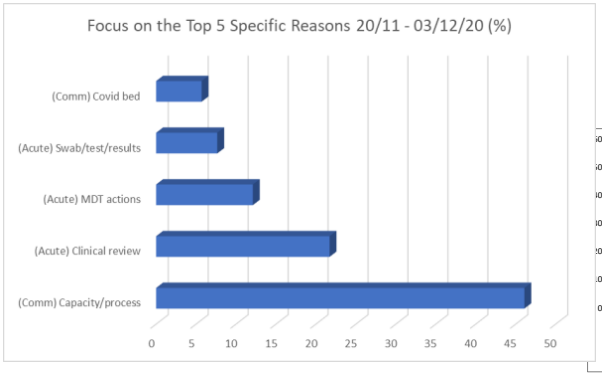
In this reporting period:
The chart below shows the percentage of beds occupied by medically optimised patients delayed due to external reasons for the start of December but is indicative of the challenges throughout the month. There is less people delayed compared to the previous reporting reasons for internal reasons. Where internal delays do occur these still tend to be due to change medical status, the completion of MDT activities or awaiting swab results. Reviewing the detail of the data external capacity remains the most significant issue whilst this does relate mostly to home care, bed base rehab and CCG Complex Care pathways. This is not capacity alone but the ability of that capacity to accept COVID + and Contact patients. IDT during Dec 20 discharged on average 15 people per day but unlike previous festive periods activity decreased as the month went on, showing a challenging trend line between Christmas and new year. day.





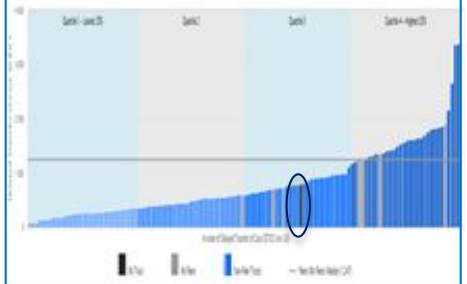
Key areas of focus for IDT and the Trust need to be:
More consistency of medical decision making and referral making across 7 days.
Introduction and roll out of the new referral process to support DTA.
Accuracy of clinical decision making and embedding the DTA Action Cards
Staff resource is identified and provisioned at the right level for the transformed pathways.
Maintain people's level of function during the acute part of their stay.

Externally IDT will be working with partners to:
Address deficits in care capacity which tend to be localised
Maintain flow through transitional pathways supported by wrap around therapy services.
Address increase requirements around COVID + pathways.
Adopting new discharge to care home guidance across the system



Performance deteriorated
Worse than target/threshold

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

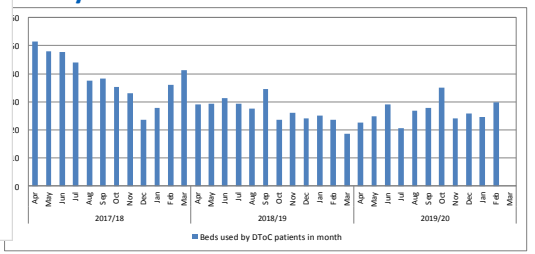


Period: December 2019

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

Submission suspended

Delayed Transfers of Care



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

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Caring & Responsive Services: Complaints

In this reporting period:
67% of complaints were responded to within the required time in December (target 80%)
26 new complaints were received as follows:

- 31% (8) relate to Surgery, Anaesthetics and Cancer (SAC)
- 23% (6) Medicine
- 19% (5) Women's & Children's (WACs)
- 23% (6) Emergency Medicine
- 4% (1) CSS

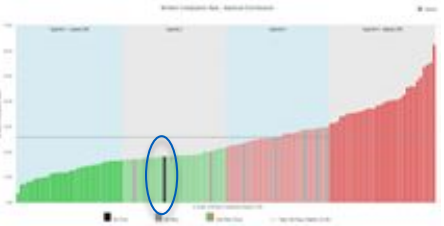
At month end there were a total of 47 live complaints (up by 2 compared to previous month).
28 complaints were closed in the month. No complaints were re-opened in December 2020

Improvement plan:
One complaint is older than 3 months (within EM) and of 47 open complaints, 10 were overdue at the end of the month (7 in Medicine and 3 Emergency Medicine), this has not been assisted due to the impact of the second peak of the pandemic on both Divisions and the Trust overall. This is reflected within Medicine especially where performance for the month was at only 36%. Regular weekly meetings are held with Medicine and EM to seek to reduce outstanding complaints.

Factors/Themes:
Trust wide, common themes remain all aspects of clinical care (incl. clinical care and treatment) at 62% (16); attitude of staff and communication at 19% (5), Admissions/Discharge 11% (3), and 8% (2) other. Communication remains a consistent factor throughout all complaints received which aligns with restricted visiting during the pandemic.

Performance improved
Better than target/threshold

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

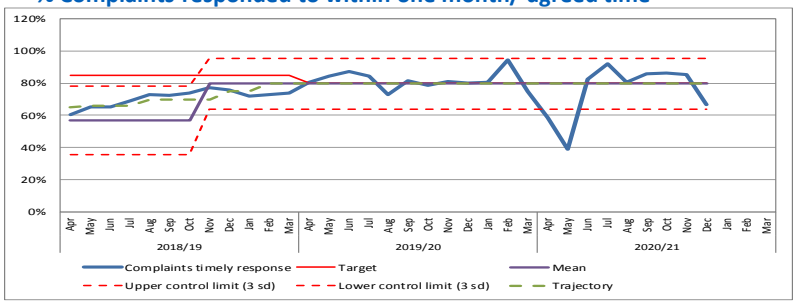


Period: December 2019

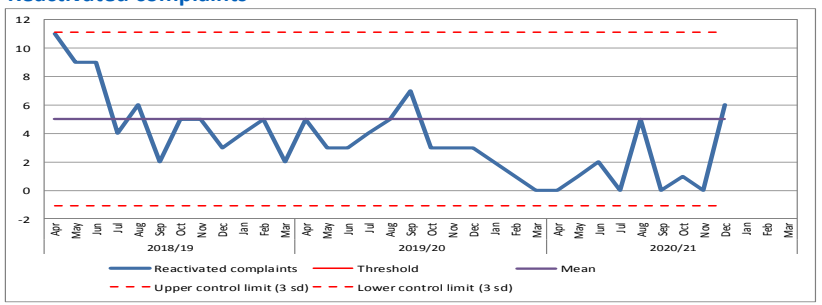
WHHT 18.36 Peer 25.90
National 21.95

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

% Complaints responded to within one month/ agreed time



Reactivated complaints



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

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Caring & Responsive Services: End of life care

In this reporting period:

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

Referrals to Specialist Palliative Care

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

In December 2020, **158** referrals were made to the Trust Specialist Palliative Care Team. This is a significant increase compared to previous months and reflects the current situation within the hospital . Of the patients with capacity to make decisions about PPD and where it was appropriate, 100% had an identified PPD.

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

There were **4** patients in December 2020 who died in a setting that was not their preferred place of death (PPD). For the 2 patients wishing to be at home ,1 of them had physical symptoms that did not permit their transfer home and 1 died suddenly. There were 2 patients who wished to die in a nursing home, but were unable to be transferred due to being too unwell.

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

Of the 10 patients whose deaths were reviewed in December , 4 patients were on the IPCD. 1 patients was excluded from the audit as they died suddenly. There were 5 patients who **did not** have an IPCD and it was deemed that it **would** have been appropriate to use in 3 of these patients. Learning from the audit will be fed back to ward areas to support the identification of patients appropriate for an IPCD.

Treatment Escalation Plans (TEP)

Treatment Escalation Plans ensure that every patient's care is reviewed, individualised and their levels of care are considered, in line with the Trust's guidelines.

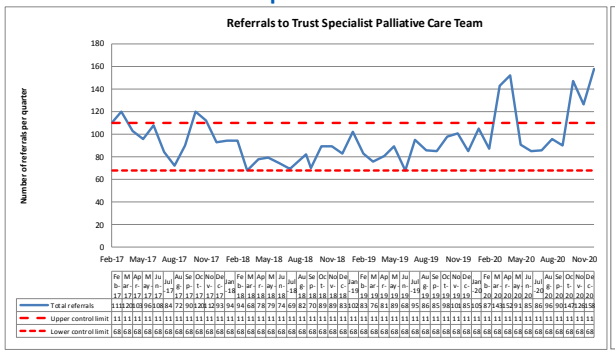
Of the 10 patients whose notes were reviewed, who died in December 2020, **6** patients had a TEP in place; however only 4 of those patients had had their TEP appropriately reviewed. There were 4 patients who did not have a TEP in place at the time of their death. We continue to provide ongoing education on the importance of TEPs across the Trust.

Stable

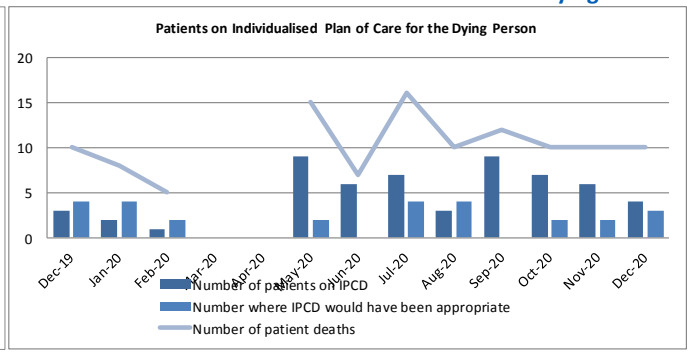
Benchmarking:

Not currently available

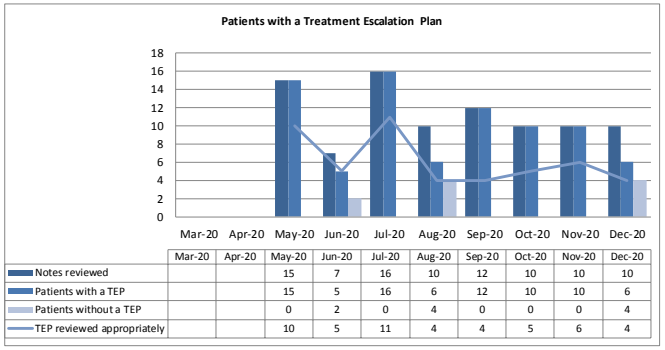
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Notes reviewed			15	7	16	10	12	10	10	10
Patients with a TEP			15	5	16	6	12	10	10	6
Patients without a TEP			0	2	0	4	0	0	0	4
TEP reviewed appropriately			10	5	11	4	4	5	6	4

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

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Caring & Responsive Services: RTT Open pathways

In this reporting period:
Improved open pathway performance is on-going with further reduction in the over 18 week backlog, although there were fewer referrals. This month 78.8% of pathways were under 18 weeks (previous month 78.4%)

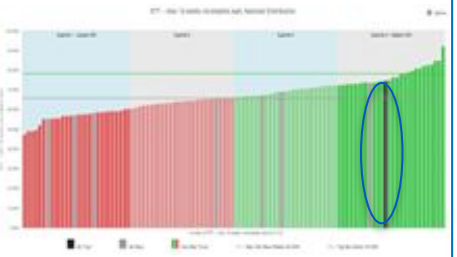
The median waiting time at WHHT (i.e. the weeks half the patients on an RTT pathway were waiting) was better than the national position (7.1 vs 10.4 weeks) but the 92nd percentile wait time was worse (46.7 vs 45.1 weeks).

The increase in 52 week waits continues however, and at the end of the month there were 1131 patients whose waiting time exceeded 52 weeks wait, the majority remaining in Oral Surgery 20%, ENT 22%, Ophthalmology 12%. 318 pathways over 52 weeks were closed in the month (350 in previous month).

Diagnostics
Performance has decreased as a result of increasing pressures from urgent and emergency care demand with a drop to 72.5% (from 74.3%).

Performance improved
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

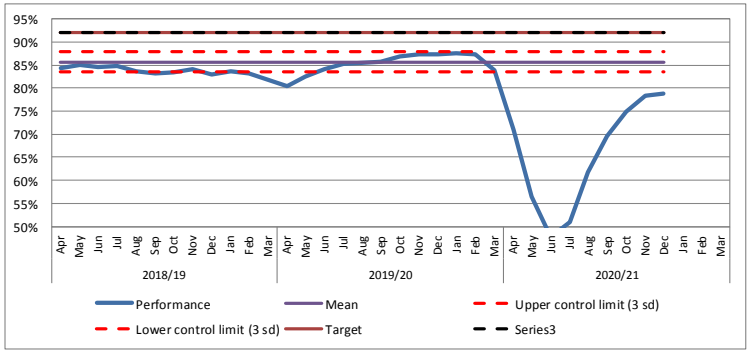


Period: October 2020

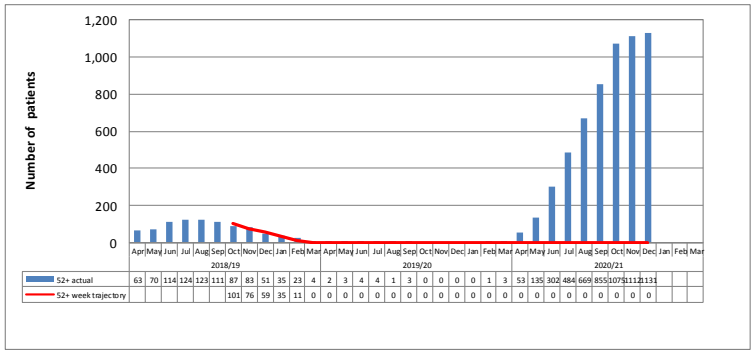
WHHT: 74.84% Peer: 65.90%
National: 66.52%

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

RTT - % within 18 weeks



Number of 52 week waits



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

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

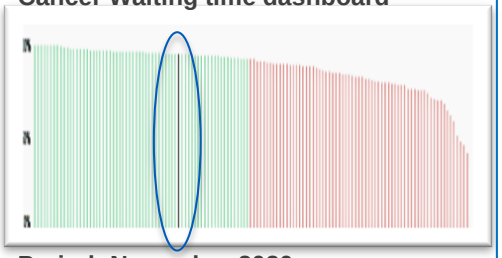
2 week waits:
The provisional position for December is non-compliant at 85.5 % with 1460 referrals of which 212 were seen beyond 14 days. Of the 212, 178 x breast 1x gynae, 6 x H&N, 6 x LGI, 1 x lung, 2 x skin, 16 x UGI, and 2 x urology
In December the Trust received 100 % of the 'number of 2ww taken' from January 2020 which is the Trust's baseline month.
The Trust are monitoring the referral numbers and the numbers of patients diagnosed with cancer. Currently the Trust's conversion rate is lower than usual at 3.8% in December compared with a baseline figure of 6.9 %.In January 2020.

2 week wait breast symptomatic:
The provisional position for December is non-compliant at 50 %.
There were 150 referrals, an increase on the previous month of 15 Of these 75 patients were seen beyond 14 days. This was on account of a particularly high number of referrals in October and November which had an influence on clinic availability in December.

28 day Faster Diagnosis Standard achieved (target 75%):
- 2ww - 82.1%
- Breast Symptomatic – 90.9%
- Screening –50% - 6 patients with 3 Breaches (2 x LGI 1 x gynae)

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

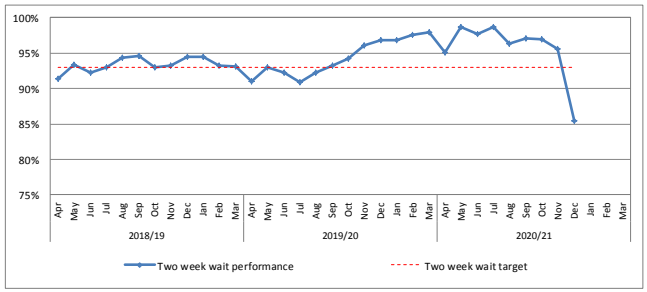


Period: November 2020

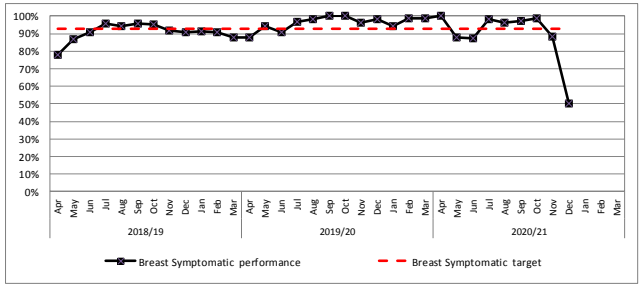
WHHT: 95.6% **Peer: 85.9%**
National: 87.0%

(Peers = East of England region)

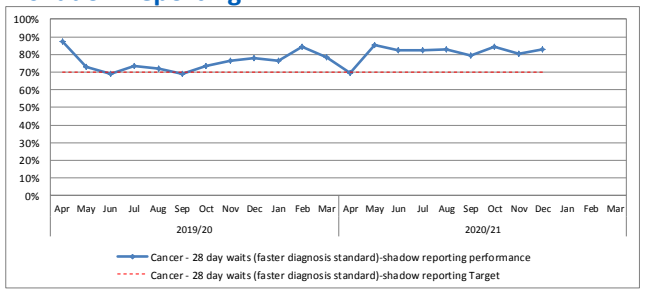
Two week waits: % within target time



Breast symptomatic patients: % within target time



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



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

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Caring & Responsive Services: Cancer 31 day

In this reporting period:

31 day referral to first definitive treatment
The position for December is provisionally compliant at 100 % with 154 pathways

31 day subsequent surgery
The provisional position for December is non-compliant at 87%, there were 23 pathways with 3 breaches (1 x breast 2 x urology)

31 day subsequent Drug
The provisional position for December is compliant with 100%. There were 27 pathways

31 day subsequent palliative and other
The provisional position for December is compliant at 100 % with 11 pathways

Next steps:
Continue to review the influence of COVID on cancer pathways

Performance improved
Better than target/threshold

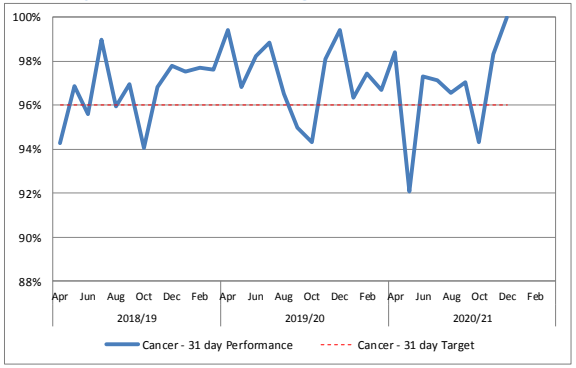
Benchmarking: NHSI Analytics Hub

Period: November 2020
31 day first:

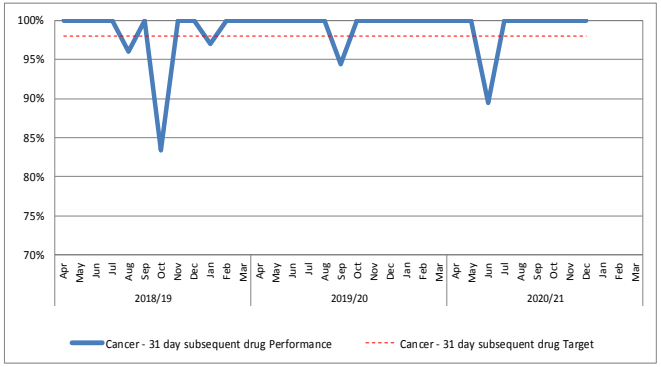
WHHT: 98.9% **Region: 94.9%**
National: 95.2%

31 day surgery:
WHHT: 94.7% **Region: 86.7%**
National: 87.7%

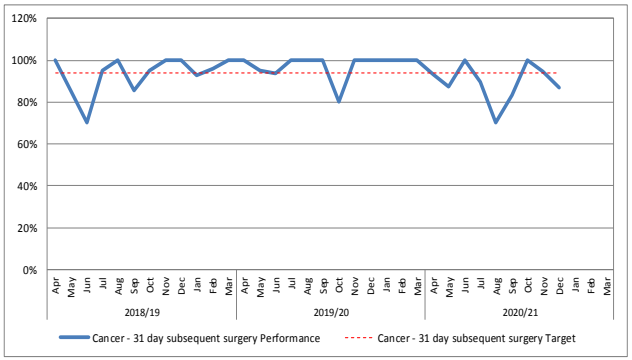
31 day first: % within target time



31 day subsequent drug: % within target time



31 day subsequent surgery: % within target time



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

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Caring & Responsive Services: Cancer 62 day urgent GP referral

62 day referral to first definitive treatment – The position for December is non-compliant at 80.5%
Provisionally there are 92.5 treatments (105 patients) with 18 breaches (22 patients). This includes 2x breast, 4x gynae , 4x haematology , 2 x LGI , 2x lung , 2 x head and neck , 6 x urology

A review of the breaches indicates a range of reasons for delays: including patients requiring MDT discussion in more than one tumour site MDT, patients becoming unwell during the pathway, delays in booking tests, particularly re-booking tests that require a repeat, change in plans as to where the patient requires surgery following POA and delays in getting the results of tests and biopsies.

62 day screening referral to first definitive treatment –Performance for December is provisionally non-compliant at 85.7% 7 with pathways (8 patients) with 1 breach (1 x LGI)

62 day consultant upgrade –The provisional December position is 88.5% with 13 pathways (14 Patients) with1.5 breaches (2 patients) 1x urology, 1 x LGI

.

104 day breaches open pathways: Open : In December's submission of open pathways over 104 days, there were 17 patients of which consisted of 2x breast, 2 x gynae , 3 x haem 5 x head &neck 2 x LGI, 2 x lung , 1x UGI and 4 x urology. These long pathways are being actively managed in 2 forums a week with clinical input where necessary this includes from all types of pathways: 62 days, 31 day, CU and screening patients. This also includes patients with a TCI date.
Closed:– In December the Trust closed 5 patient pathways after 104 days from date of referral. This includes from all types of pathways: 62 days, 31 day, CU and screening patients

Performance improved
Better than target/threshold

Benchmarking: MODEL HOSPITAL
62 day wait from urgent GP referral

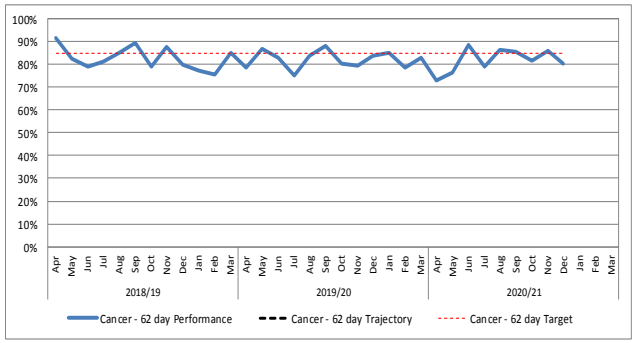
Period: October 2020
WHHT: 80.00% Peer: 75.77%
National: 75.39%

Peers = Nightingale Group – acute multi-site trusts

Benchmarking: NHS Analytics Hub
Period: November 2020
WHHT: 83.1% Peer: 75.1%
National: 75.5%

Peers = East of England Region

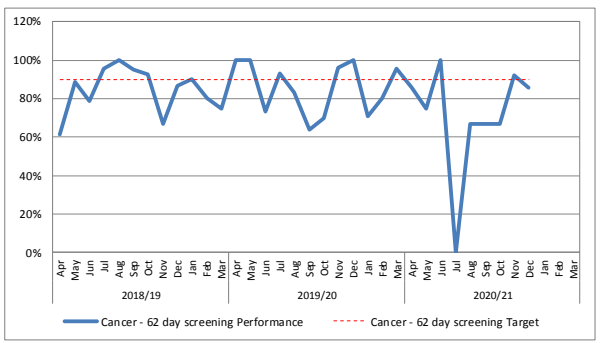
62 day GP: % within target time



62 day GP: Tumour Site

Tumour type	October	November	December	Q3 (provisional)
Breast	100	95.5	90.2	94.3
Gynaecological	100	100	63.6	91.5
Haematological	75	60	25	53.8
Head and Neck	50	0	0	28.6
Lower Gastrointestinal	37	30.8	62.5	39.6
Lung	50	75	55.6	58.8
Skin	100	100	100	100
Upper Gastrointestinal	83.3	63.6	100	77.3
Urological	87.5	88.5	75	83.4
Testicular	100	0	0	100
Other	0	0	100	66.7
Sarcoma	0	0	0	0

62 day screening: % within target time



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

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Caring & Responsive Services: Outpatients

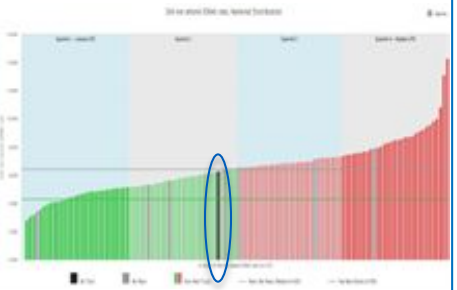
In this reporting period:

- Majority of re start work completed – focus of the group and work plan is now Outpatient Transformation
- Data pulled which identifies redundant clinic templates and clinic codes.
- Appointment letter for attend anywhere revised and to be re launched to teams
- Structured Conversation Template and rationale shared with Operational Recovery Group (ORG) and Divisional Managers. Dates being booked in with ADMs
- Draft framework of work plan for Attain and WHHT Outpatient Transformation team has been submitted and meeting plan in place.
- Neurology Service attended ICS PIFU workshop
- 2nd Wave COVID 19 SOP agreed for cancellation/re-structuring (non-face to face wherever possible) outpatient appointments
- Trial of new phone completed and plan for install now in place.
- 218 Clinic Revision received and completed
- Cancellation letter uploaded to Infoflex and draft sent to outside supplier
- OUG re-established

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

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Did not attend rate

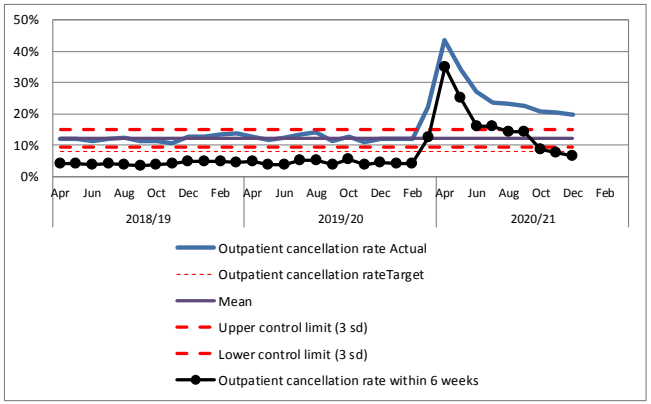


Period: Q2 2020/21

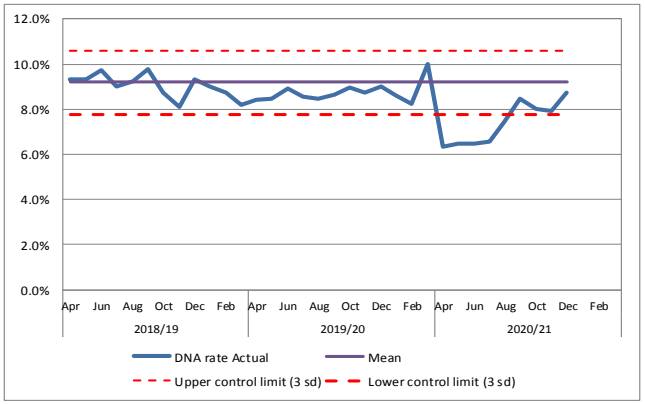
WHHT 6.30% Peer: 6.42%
National: 6.54%

(Peers = Nightingale Group – acute multi-site trusts

Outpatient cancellation rate



DNA rate



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

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Workforce & Finance: Recruitment & Retention

In this reporting period:
Contracted wte staff in post is 4,717 (4,688) wte last month (+28wte over the last month, +166wte over the last 12 months. The increase in staff is largely due to planned recruitment from abroad for nursing staff.
Vacancies (the difference between the ledger establishment and contracted wte on ESR) is 470 wte or 9.1% of the establishment (9.6% last month). The target rate is 10%. There has been little change in the funded establishment over Dec. Nursing Band 5 vacancy rates are now under 2%. Following the intake of nurses from abroad, and nurse retention has fallen to the lowest rate we have recorded since 2015.

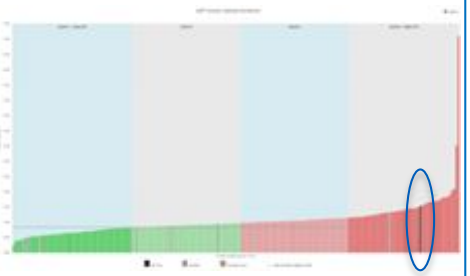
Sickness –the Sept rate is 4.7% against a target of 3.5%. The 12 monthly sickness rate averages 4.9%. The monthly figure was 4.2% last month, and over 11% for April, the highest rate recorded over the last 10 years. The sickness rate a year ago was 3.9%. **The absence rate including sickness, and covid self isolating was 8.9%.**

Labour Turnover –This is 12.9% (last month 13.0%). The target is 13%, so that the Trust has continued to achieve this. Rates over the last 6 months have been the lowest rate recorded since October 2013, All TUPE related leavers have been excluded from the calculations, as have staff who were on fixed term contracts or have re-commenced working for the Trust. The voluntary rate (excluding retirements / dismissals etc) is 10.3% (10.6% last month). The rolling 3 monthly turnover rate is around 13.5%, which suggests that are relatively low short term pressures for staff leaving. Turnover rates for Band 5 nurses is 13.1%.

Next steps –
There are positive developments looking forward at the trajectory for recruitment for both Health Care Assistants as well as Nursing and Midwifery staff. Regarding HCAs, we continuing to hold recruitment sessions twice a week, and have funding from HEE to support recruitment and retention for these staff, with skills training mentoring and pastoral support.
For the registered nursing & midwifery workforce we have recruited 84 overseas nurses since August 2020, and there are a further 31 (adult acute nursing) awaiting to commence at the Trust over Jan / early Feb. 59 nurses have passed their OSCE exams and a further 20 are awaiting the outcome. There will 45 third year students also joining the Trust on a temporary basis as organised by HEE. The NMC are also contacting overseas nurses who are currently awaiting their PIN to invite them to join the NMC temporary register.

Performance stable
Worse than target/threshold

Model Hospital benchmarking:
Proportion of staff leaving each month

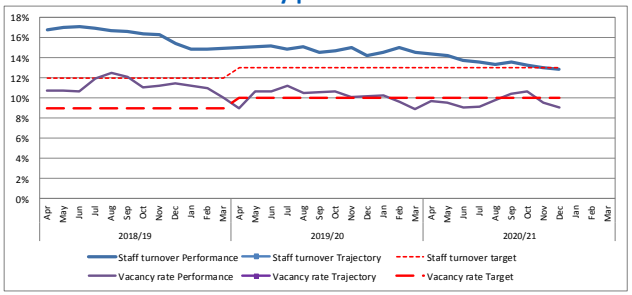


Period: October 2019

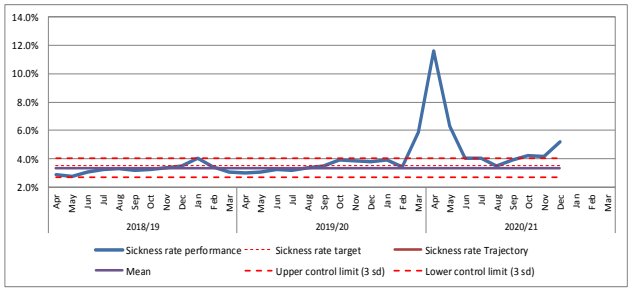
WHHT: 1.54% **Peer: 0.83%**
National: 0.98%

Peers = Nightingale Group – acute multi-site trusts)

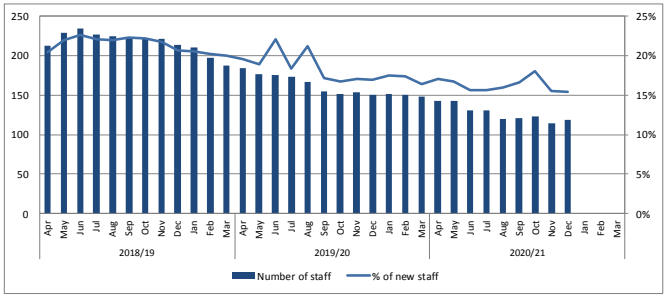
Staff turnover and vacancy performance



Sickness absence performance



Number of staff leaving within first year



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

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Developing Staff

In this reporting period:

Appraisals

Appraisal rates are currently 86%, just below the 87% achieved before the first wave of COVID where the compliance rates were held until this month. Over the last few months, the Divisions have been working to a recovery plan with HRBPs in order to achieve as close to compliance as possible. The figures include medical staff (apart from Deanery training grade medical staff).
Over March to November, the rate was maintained at 87% for reporting purposes, while appraisals were undertaken where possible and so thatt there would be no disruption to services. In addition, incremental grade progression is continuing to be applied automatically, and this will continue to be applied to March 2021.

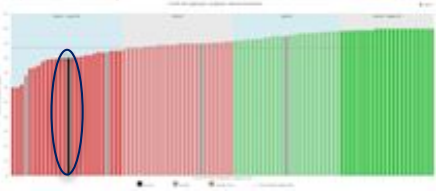
Mandatory / Essential training
The all Trust mandatory training rate remains above target at **91%.** Compliance in the low 90's has now been consistently maintained since November of 2018. Compliance is now measured for one single set if mandatory training, rather than separating into mandatory and essential. As always the "all-Trust/all targets" figures does mask some areas of low compliance in specific subjects, staff groups and/or departments; although all divisions overall are at, over or (at the very least) close to 90%.

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

For local benchmarking for training compliance, within Herts Beds and Essex Trusts, the Trust ranks 6/15 local Trusts (Q2, 20/21)

Performance improved
Better than target/threshold

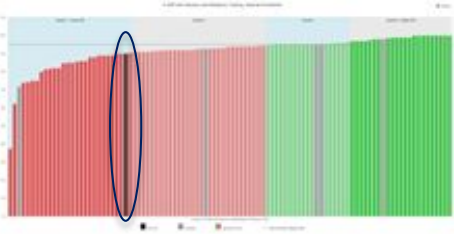
Benchmarking: Model Hospital
Trust staff with appraisal completed by the required date



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

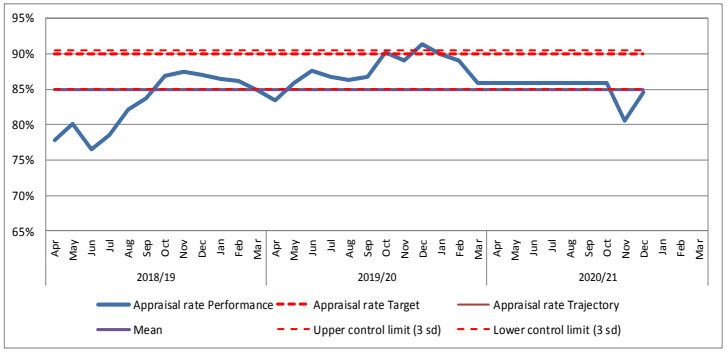
Performance stable
Better than target/threshold

Benchmarking: Model Hospital
Statutory & Mandatory training compliance rate

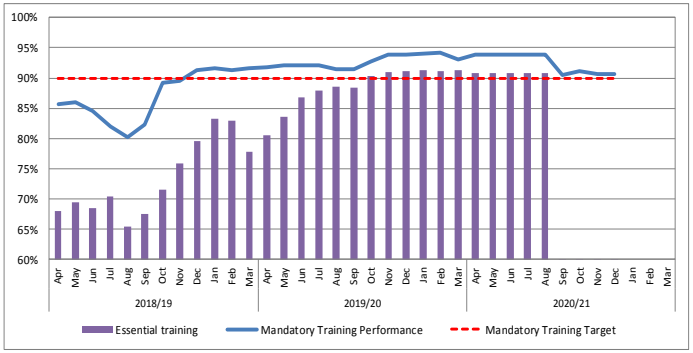


Period: 2018/19
WHHT 90% **Region 95%**
National 94%
Peers = Nightingale Group – acute multi-site trusts)

Appraisal performance



Essential training and mandatory training performance



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Workforce & Finance: Maternity Training Compliance Report

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
FETAL MONITORING TRAINING PROGRAMME (TARGET 90%)	MIDWIVES OVERALL K2 COMPLIANCE	92%	90%	90%	90%	86%	84%	85%	91%	82%	91%	98%	98%	96%
	MIDWIVES OVERALL STUDY DAY COMPLIANCE													
	MIDWIVES PROVIDING INTRAPARTUM CARE													
	MIDWIVES ON DELIVERY SUITE K2 COMPLIANCE	100%	100%	100%	100%	98%	100%	98%	100%	86%	94%	100%	100%	98%
	MIDWIVES ON ABC K2 COMPLIANCE	100%	97%	100%	100%	98%	98%	98%	100%	88%	94%	100%	100%	97%
	OVERALL COMPLIANCE K2 + STUDY DAYS											98%	98%	96%
	DOCTORS OVERALL COMPLIANCE	93%	93%	93%	85%	79%	82%	84%	86%	88%	80%	100%	100%	97%
	DOCTORS OVERALL COMPETENCY COMPLIANCE	97%	93%	93%	92%	83%	82%	87%	80%	86%	80%	100%	100%	97%
MATERNITY EDUCATIONAL DAYS (TARGET 90%)	MED 1 MIDWIVES OVERALL % COMPLIANCE	92%	91%	87%	82%	82%	68%	74%	72%		72%	63%	65%	64%
	MED 2 MIDWIVES OVERALL % COMPLIANCE	92%	91%	85%	80%	80%	68%	71%	69%		70%	62%	61%	62%
	MED 3 MIDWIFE OVERALL % COMPLIANCE	93%	93%	92%	80%	79%	64%	66%	63%		58%	53%	56%	58%
Obstetric Emergency Training (Skills & Drills, MST and PROMPT - NHS Resolution Target 90%)	MIDWIVES			92%		83%	92%	66%			58%		56%	58%
	OBSTETRIANS			40%		100%	88%	23%			26%		55%	55%
	ANAESTHETISTS			58%		87%	87%	16%			22%		33%	34%
	THEATRE STAFF			59%		32%	68%	0%			0%		0%	0%
	HCA			74%		21%	61%	15%			14%		11%	8%
	TNA/ NN			68%		44%	84%	14%			14%		0%	0%
	STAFF OVERAL % COMPLIANCE			65%		41%	83%	52%			34%		38%	

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Workforce & Finance: Developing Staff

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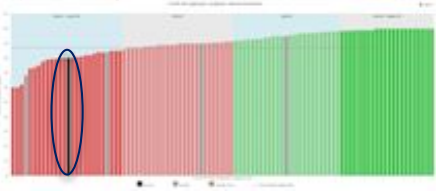

Period: 2018/19
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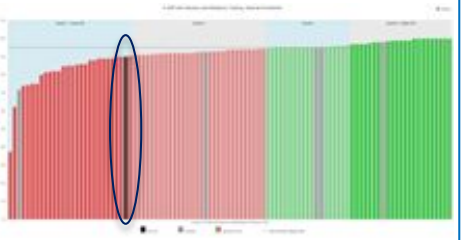
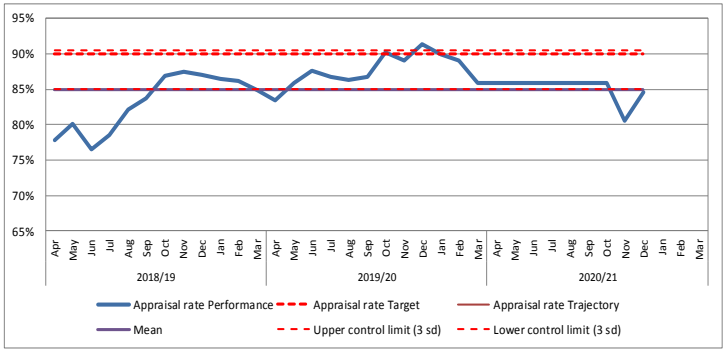
Performance stable
Better than target/threshold

Benchmarking: Model Hospital
Statutory & Mandatory training compliance rate

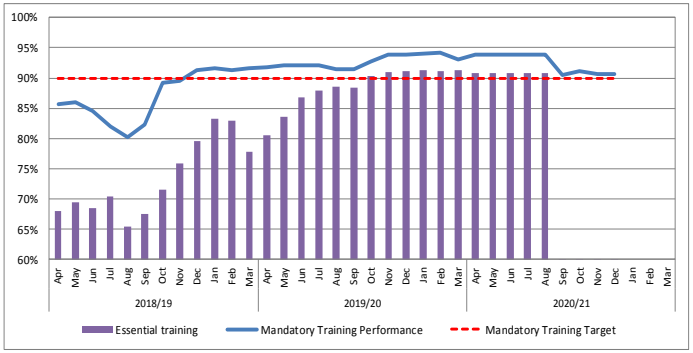


Period: 2018/19
WHHT 90% **Region 95%**
National 94%
Peers = Nightingale Group – acute multi-site trusts)

Appraisal performance



Essential training and mandatory training performance



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Workforce & Finance: Workforce BAF scorecard

The Board Assurance Framework shows key workforce indicators in the context of current performance, performance 12 and 3 months ago, Trust workforce targets, the distance to these targets and a RAG rating based on 5 scales. It also has benchmarking data taken from NHS healthcare providers in the Hertfordshire and West Essex and Bedford, Luton and Milton Keynes STPs. The RAG rating is based on distance to targets – if current performance is within 0% to 20% (or exceeds) its target then the RAG rating is green. If performance is within 60% – 80% of target then the rating is yellow. This is repeated at 20% intervals for amber and brown until performance is over 80% from the target when the RAG rating is red. If 2 indicators are rated red, then the overall rating is red. If all indicators are rated green, or one is amber then the overall rating is green. Any other combination is amber.

The BAF performance indicators reflect core areas of the workforce that we are monitoring. These include B5 nurse vacancies and turnover, reflecting the focus on recruitment and retention of these staff in conjunction with NHSI. These areas are identified as the Trust's highest workforce risk factors. B5 Nurse Turnover rates are 13.1% currently, about half their rates 3 years ago. The Trust is now consistently below its 16% target. For B5 Nurse vacancies, the rate is currently under 2% for ward based nurses, much reduced from 11.5% two months ago. Over 100 B5 nurses have either started or are planned to start between now and the end of January 2021 - since mid-August we have increased our deployment of overseas nurses and we have planned groups of 24 arriving each month. For the registered nursing & midwifery workforce we have recruited 84 overseas nurses since August 2020, and there are a further 31 (adult acute nursing) awaiting to commence at the Trust over Jan / early Feb.

Combined appraisals rates were held at their pre-covid rates of 87%, just below the compliance requirement of 90%. From November, the rates stated are the actual compliance figures, and these are currently 86%. The HRBPs are working with Divisions to progress towards 90% compliance. The overall rate for medical staff (97%) includes all medics apart from Deanery posts. Mandatory training compliance is 91%, and is now consistently above the 90% target..

The Nov monthly Trust sickness rate is 5.2% against a 3.5% target, and so is above target. The 12 month sickness figure is 4.9%, above the 3.5% target and reflecting high COVID related sickness over Spring 2020 and the last few months. It is anticipated that sickness will remain relatively high over Winter months.

The current agency pay bill percentage is 4.7%. The overall target rate for 2020/21 is 4.7%, reflecting the reduced agency cost target envelope.

The 12 month turnover rate is 12.9%, the lowest rate we have recorded since 2013, and means that the Trust has achieved the 13% target set 3 years ago. The Trust is ranked 9 / 16 nearby NHS organisations.
FFT scores have been suspended during COVID. The staff survey for 2020 is covered in slide 27.

Workforce Indictors - Progress Table

Progress against target - Dec 2020

KPI	Benchmark average	Performance 12 months ago	Performance 3 months ago	Current performance	Target	Distance to target	Better / worse than 3 months ago	Remaining Progress to target needed (%)
Vacancy	11.1%	10.2%	10.4%	9.1%	10.0%	-0.9%	↘	-9%
Band 5 Nurse Vacancy		4.6%	10.6%	1.3%	9.0%	-7.7%	↘	-86%
Headline Turnover	13.7%	15.0%	13.6%	12.9%	13.0%	-0.1%	↘	-1%
Band 5 Nurse Turnover	16.3%	17.0%	14.9%	13.1%	16.0%	-2.9%	↘	-18%
Total Sickness	3.6%	3.8%	3.9%	5.2%	3.5%	1.7%	↗	49%
Non-Medical Appraisal	54%	90.0%	87.0%	84.0%	90.0%	-6.0%	↘	7%
Medical Appraisal		97.0%	97.0%	97.0%	90.0%	7.0%	→	-8%
Core Skills Framework	89%	94.0%	91.0%	91.0%	90.0%	1.0%	→	-1%
Agency as a % of Paybill	7.1%	5.1%	4.9%	4.7%	4.7%	0.0%	↘	0%
Friends and Family Test (Work)		53.9%	52.2%	52.2%	66.0%	-13.8%	→	21%
Overall Summary								

Key	
Achieving 80% of the target	
Achieving 60% to 80% of the target	
Achieving 40% - 60% of the target	
Achieving 20% to 40% of the target	
Achieving Under 20% of the target	

Overall Scoring Key	
Red	2 or more indicators Red
Green	One amber indicator, all other indicators Green
Amber	All other combinations

Data sources

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Source	Executive lead	Lead	Board IPR	Quality IPR	Patient Experience IPR	Divisional IPRs
Safe care & Improving Outcomes	Safe	**Quality of Care: Mortality Indicators**							
		SHMI (Rolling 12 months)	Dr Foster	MD		✓	✓	✗	✓
		HSMR - Total (Rolling three months)	Dr Foster	MD		✓	✓	✗	✓
		Quality of Care: Infection Control							
		Clostridioides Difficile - Hospital associated (Cat 1)	WHHT	CN		✓	✓	✗	✓
		Clostridioides Difficile - Healthcare associated (Cat 2)	WHHT	CN		✓	✓	✗	✓
		Clostridioides Difficile - Hospital and Healthcare associated Total	WHHT	CN		✓	✓	✗	✓
		Hand Hygiene Compliance		CN		✓	✓	✗	✓
		Quality of Care: Emergency Readmissions							
		30 Day Emergency Readmissions - Elective *	Dr Foster	MD		✓	✗	✗	✓
		30 Day Emergency Readmissions - Emerg *	Dr Foster	MD		✓	✗	✗	✓
		Quality of Care: Caesarean Section rates							
		Caesarean Section rate - Combined*	WHHT	MD		✓	✓	✗	✓
		Caesarean Section rate - Emergency*	WHHT	MD		✓	✓	✗	✓
		Caesarean Section rate - Elective*	WHHT	MD		✓	✓	✗	✓
		Patient Safety							
		% nursing hours (shift fill rate)	WHHT	CN		✓	✓	✗	✓
		Serious incidents - number*	WHHT	MD		✓	✓	✗	✓
		Serious incidents - % that are harmful*	WHHT	MD		✓	✓	✗	✓
		% of patients safety incidents which are harmful*	WHHT	MD		✓	✓	✗	✓
		Never events	WHHT	MD		✓	✓	✗	✓
		Safety Thermometer Harm Free Care (acquired within and outside of Trust)	WHHT	CN		✓	✓	✗	✓
		Safety Thermometer % New Harm Free Care (acquired within Trust)	WHHT	CN		✓	✓	✗	✓
		Category 4 pressure ulcers - New (Hospital acquired)	WHHT	CN		✓	✓	✗	✓
		Category 3 pressure ulcers - New (Hospital acquired)	WHHT	CN		✓	✓	✗	✓
		VTE risk assessment*	WHHT	MD		✓	✓	✗	✓
		Patients admitted to stroke unit within 4 hours of hospital arrival	SSNAP	MD		✓	✓	✗	✓
		Stroke patients spending 90% of their time on stroke unit	SSNAP	MD		✓	✓	✗	✓

Data sources

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Source	Executive lead	Lead	Board IPR	Quality IPR	Patient Experience IPR	Divisional IPRs
Caring & Responsive Services	Effective	**Patient Flow: Emergency Department**							
		Ambulance turnaround time between 30 and 60 mins	East of England Ambulance Service	COO		✓	✗	✗	✓
		Ambulance turnaround time > 60 mins	East of England Ambulance Service	COO		✓	✗	✗	✓
		% Patients admitted through A&E - 0 day LOS	WHHT	COO		✓	✗	✗	✓
		Patient Flow: In hospital flow							
		Discharges between 8am and 12pm (main adult wards excl AAU)	WHHT	COO		✓	✗	✗	✓
		Mixed sex accommodation breaches	WHHT	COO		✓	✗	✗	✓
		LOS > 21 days	WHHT	COO		✓	✗	✗	✓
		Delayed Tranfers of Care (DToC) beddays used in month	Integrated Discharge Team	COO		✓	✗	✗	✓
		Delayed Tranfers of Care (DToC) beds used in month	Integrated Discharge Team	COO		✓	✗	✗	✓
	Caring	**Patient Experience: Friends & Family Test**							
		A&E FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Inpatient Scores FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Daycase FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Maternity FFT % positive	Meridian	CPO		✓	✓	✓	✓
		Patient Experience: Complaints							
		Complaints responded to within target/agreed timescale	WHHT	CN		✓	✓	✓	✓
		Reactivated complaints	WHHT	CN		✓	✓	✓	✓
		Patient Experience: End of life care							
		New indicators to be included in Q4	WHHT	CN		✓	✓	✓	✓
	Responsive	**Access to Services**							
		ED 4hr waits (Type 1, 2 & 3)	WHHT	COO		✓	✗	✗	✓
		Referral to Treatment - Incomplete*	WHHT	COO		✓	✗	✗	✓
		Referral to Treatment - 52 week waits - Incompletes	WHHT	COO		✓	✗	✗	✓
		Diagnostic (DM01) <6 weeks	WHHT	COO		✓	✗	✗	✓
		Cancer							
		Cancer - Two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - Breast Symptomatic two week wait *	WHHT	COO		✓	✗	✗	✓
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent drug *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent surgery *	WHHT	COO		✓	✗	✗	✓
		Cancer - 31 day subsequent radiology *	WHHT	COO		✓	✗	✗	✓
		Cancer - 62 day *	WHHT	COO		✓	✗	✗	✓
		Cancer - 62 day screening *	WHHT	COO		✓	✗	✗	✓
		Access to Services: Outpatients							
		Outpatient cancellation rate within 6 weeks^	WHHT	COO		✓	✗	✗	✓

Data sources

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Source	Executive lead	Lead	Board IPR	Quality IPR	Patient Experience IPR	Divisional IPRs
Workforce and finance	Well led	**Recruitment & Retention**							
		Staff turnover rate (rolling 12 months)	WHHT	CPO		✓	✗	✗	✓
		% staff leaving within first year (excluding medics and fixed term contracts)	WHHT	CPO		✓	✗	✗	✓
		Vacancy rate	WHHT	CPO		✓	✗	✗	✓
		Sickness rate	WHHT	CPO		✓	✗	✗	✓
		Developing Staff							
		Appraisal rate (Total)	WHHT	CPO		✓	✗	✗	✓
		Mandatory Training	WHHT	CPO		✓	✗	✗	✓
		Essential Training	WHHT	CPO		✓	✗	✗	✓
		Finance overview							
		Financial Risk Rating	WHHT	CFO		✓	✗	✗	✓
		Income & Expenditure Actual	WHHT	CFO		✓	✗	✗	✓
		Income & Expenditure forecast	WHHT	CFO		✓	✗	✗	✓
		Cash balance at the end of the month	WHHT	CFO		✓	✗	✗	✓
		Capital expenditure	WHHT	CFO		✓	✗	✗	✓
		CIP delivery against plan	WHHT	CFO		✓	✗	✗	✓
		% Bank Pay**	WHHT	CFO		✓	✗	✗	✓
		% Agency Pay**	WHHT	CFO		✓	✗	✗	✓
		Activity (chargeable)							
		GP referrals	WHHT	CFO		✓	✗	✗	✓
		A&E attendances	WHHT	CFO		✓	✗	✗	✓
		Elective spells (overnight)	WHHT	CFO		✓	✗	✗	✓
		Elective daycase	WHHT	CFO		✓	✗	✗	✓
		Total elective spells	WHHT	CFO		✓	✗	✗	✓
		Non-elective spells	WHHT	CFO		✓	✗	✗	✓
		Births	WHHT	CFO		✓	✗	✗	✓

Trust Board
4 February 2021

Title of the paper	COVID-19 Briefing Report
Agenda Item	12/87
Presenter	Tracey Carter: Chief Nurse & Director of Infection, Prevention and Control
Author(s)	Alison Fuller: Interim Associate Chief Nurse
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: *x*
Executive Summary	The purpose of this report is to provide the Trust Board with an overview of organisational reported activity that has arisen in response to the management of patient safety, operational services and acting on national and local guidance or regulatory compliance during the COVID-19 pandemic. Executive scrutiny and assurance is managed on a day by day basis in partnership with divisions and specialties, escalation as appropriate is also received into the Incident Management Team (IMT), Operational recovery group and the Clinical Decision Panel (CDP) where risks are assessed as appropriate. All identified risks have been managed in line with Trust policies and procedures and have remained within the existing organisational governance arrangements. All risks are reviewed via the divisional governance arrangements or directly raised with the lead executive director. The Risk Review Group chaired by the Chief Medical Officer (CMO) continues to review and accept risks onto the corporate risk register as appropriate. The group is currently sitting every two months and last met in January 2020. The range of risks recorded within the divisional and corporate risk registers, have all been separately coded to indicate they are as a direct result of, or have been influenced by COVID-19 pandemic. This approach supports the monitoring of risks across the whole organisation as well as aligning to the divisions and specialities.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** – ***Objectives 1-4***: *x* **Aim 2 Great team** – ***Objectives 5-8***: **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

<table>
<tr><td></td><td>support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☐How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Quality Committee</td><td>28 January 21</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Trust Board is asked to receive this report for information and assurance of the management of the current phase of the COVID-19 pandemic.</td></tr>
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Agenda Item: 12/87

Trust Board – 4 February 2021

Presented by: Tracey Carter: Chief Nurse & DIPC

1. Purpose

1.1 The purpose of this report is to provide the Trust Board with an overview of organisational reported risks that have arisen in response to the management of patient safety, operational services and acting on national and local guidance or regulatory compliance during the Covid-19 pandemic.

2. Background

2.1 NHS England and other national regulatory bodies have over the past month, issued a range of targeted directives and essential guidance that focus on the delivery of patient safety and operational activity within healthcare in response to COVID-19 pandemic.

2.2 The Trust has in response continued to implement the Clinical Decision Panel which was originally convened in the first wave of COVID-19 (March 2020 and aims to provide rapid, senior clinical and executive overview and scrutiny to all national and local changes.

2.3 All identified risks are managed in line with Trust policies and procedures and have remained within the existing organisational governance arrangements.

2.4 All risks are reviewed via the divisional governance arrangements or directly raised with the lead executive director. The Risk Review Group chaired by the CMO continues to review and accept risks onto the corporate risk register as appropriate. The group is currently sitting every two months and is next scheduled for June 2020.

2.5 Executive scrutiny and assurance is managed on a day by day basis in partnership with divisions and specialties, escalation as appropriate is also received into the Incident Management Team (IMT) and risk assessed as appropriate.

2.6 The range of risks recorded within the divisional and corporate risk registers, have all been separately coded to indicate they are as a direct result of, or have been influenced by COVID-19 pandemic. This approach supports the monitoring of risks across the whole organisation as well as aligning to the divisions and specialities.

3. Analysis/Discussion

3.1 Ethical Review Panel

The Ethical Panel has been re- established due to the increasing pressures and hospital admissions of patients with COVID-19.

The existing terms of reference have been reviewed, revised and agreed at the Clinical Advisory Group on 6th January 2021.

The changes and additional responsibilities of the panel reflect the lessons learnt from the first wave as well as the intensity of this second wave resulting in even more operational pressures and further reduction of inpatient bed capacity.

The changes include consideration of ethical decisions outside of ITU, facilitation of decision making of treatment escalation to ITU, the acknowledgement and signposting of clinicians for emotional support and the review and risk assessment of postponement of surgical procedures in elective surgical patients with cancer who are likely to require postoperative support in ITU and balancing this with the risk of acquiring COVID-19 within the hospital environment.

In summary there are two operational aspects of the panel which differ from the first wave.

A 24 hour on call rota of 3 professionals (Consultant, senior Nurse and lay representative) and a weekly Teams meeting to discuss the elective cancer patients is now in place.

3.2 England of East (EEAST) Ambulance Service

Supporting and delivering 'treat and transfer', the Trust has been in discussion with EEAST. The intention is to undertake STARR / initial assessments using available cubicles within the UTC for those patients that do not require majors. This means that STARR cubicles are specifically assigned for assessment and the 'back of the ambulance' assessment would not be required. However, should there be no available capacity and the patient must be located onto the corridor following initial assessment it is suggested that as part of the governance arrangements the emergency department section of the Escalation Policy will be updated to include an 'exceptional black' section and the use of the ambulance to 'hold' patients. This is currently being evaluated and will be received through the Trusts governance arrangements.

To manage patient safety and ongoing monitoring of the patient all observations and associated documentation for those patients still under the care of EEAST will be undertaken by the allocated healthcare assistant within STARR. However, this has the potential to create an impact on the emergency department available staff against the activity at the time within STARR. Consequently, discussions are in place with EEAST to seek support, using them to take and record all observations in line with the corridor management model. This model will align to the COVID-19 Act principles and will be supported by a standard operating policy.

3.2 Reconfiguration into Zones on the Watford General Hospital site

The burden of COVID-19 has again fundamentally altered the framework of the hospital bed base, the provision of elective services, the availability of staff and the clinical needs of patients. Consequently, the Trust has revised the zoning reconfiguration to adapt to these pressures and the delivery of clinical care. Recognising clinical demand and patient numbers, the main hospital is divided into a configuration of A-F zones (Appendix 1)

In association with the zoning framework all the teams work to the following principles of deployment for all ward duties and on call:

- Each team takes full clinical responsibility for their zone.
- Every patient must be reviewed every day by a consultant (preferably in the morning).
- During the week: 2 consultants to provide 'cover' against the afternoon sessions for clinical questions, communication with relatives. The remainder should contribute to specialty work as defined by their clinical lead/department.
- Each team will have a zonal lead.

- The zone lead will organise the team and coordinate input on all COVID-19 related Sitreps/O2 analysis.
- The existing general medicine after hour's rota will continue for all Non-COVID-19 medicine clinical advice 2100-0900.
- 1 Respiratory consultant will assume responsibility for NIV/CPAP calls 2100-0900, seven days per week.
- When on call, consultants performing post-take duties must clearly allocate every patient to the correct zone. To aid accurate identification and bed management a colour code should be allocated based on the patient type.
- The division will review bed-base and consultant availability on daily/weekly basis and reserve the right to move consultants around to balance work demands.
- In the first instance dermatology, neurology and haematology consultants will not provide on call input.

Evaluating the zoning and staff allocation is reviewed daily by operations and discussed within the Clinical Advisory Group (CAG) and Clinical Decision Panel (CDP).

3.3 Elective Care Cancellations and Governance

The rapid increase in demand associated with the latest wave of COVID-19 admissions began to impact the trust's ability to maintain safe services and following discussions between the Chief Medical Officer, Chief Nurse, Chief Operating Officer and senior divisional management teams a decision was made in mid to late December to stand down non urgent inpatient activity at SACH to facilitate the release of staff for redeployment at WGH.

The position has deteriorated further and has impacted some urgent and cancer admissions, which have been cancelled on the day or in the days leading up to admission where there has been staffing, theatre capacity or bed availability constraints.

Guidance has been issued to divisions to ensure outpatient activity is reviewed with a view to cancelling all non-urgent activity, where appropriate face to face appointments to be converted to virtual consultations and where face to face is essential for this to be moved to either HHGH or SACH outpatients, through to the end of January in the first instance.

Where there has been a need to stand down cancer clinics, clinical leads have been fully involved in the decision-making process. In Dermatology, for example, the WGH lists have been cancelled and activity re-provided at HHGH and SACH. In Respiratory Medicine, clinics have been merged to ensure cancer capacity remains intact.

The Clinical Decision Panel has been re-established and will consider requests from divisions where there is a need to suspend whole service(s) delivery.

3.4 COVID 19 Reported Risks

To address the rapid changes in delivering services the Trust response has been to ensure that for each identified area appropriate and timely risk assessments have been undertaken in accordance with the Trust Risk Management policy and procedures. The following provides a summary of all risks reported from December 2020 related to COVID -19. All risks are reviewed monthly and presented to the Risk Review Group which last met January 2021 and is chaired by the Chief Medical Officer with executive and divisional attendance.

Risk Register Reference	Description of Risk	Division	Risk Rating
4363	Due to workforce challenges to provide safest care during a pandemic may have the potential to impact on patient assessment and the consistency in patient centred assessment to manage preventable harm e.g. pressure ulcers and moisture lesions, falls, UTIs, VTE; and the promotion of optimal nutrition	Corporate Services	15
4355	Managing the Trusts approach to support staff in the wearing of FFP3 masks and gowns for procedures that do not involve AGP procedures	Corporate services	9
4356	The ability to treat by surgical intervention patients with a diagnosis of cancer within national guidance and in safety during	Corporate services	20
4362	Appropriate cohorting of all COVID-19 contact patients using a pre and post 7 day exposure timeframe	Corporate services	20
4353	Clinical Waste - Shortage of bins and limited collections nationally	Environment	16
4359	Ability to provide an increase in Mitie Cleaning requirements - during COVID	Environment	16
4360	Shortages of Patient Linen and Nursing Scrubs during COVID	Environment	16
4357	Ability to deliver safe care against the current increase in patients testing COVID 19 positive and requiring NIV/ respiratory management	Environment	20

3.5 Patient Harm Review Panel and Delivering Safest Care

Unprecedented times during COVID 19 pandemic present the Trust with the challenge to provide the safest patient care possible. This comes at a time when there has been significant depletion of our nursing workforce with coronavirus symptoms, self-isolation, general sickness absence and vacancies.

The NMC (January 8 2021) states 'as demonstrated since the start of the pandemic, our professions will need to continue to respond flexibly, including potentially working outside our normal roles or places of work.'

It is important to set out what is the **safest** approach to care in a pandemic and what the risks are. The pandemic needs a different approach according to the circumstances and allows for that flexibility and risk where required.

In response, the Chief Nurse has introduced a process using the principles of *'check and challenge'* to understand the impact in providing safest care during a pandemic. Supported by a standard operating procedure we are now triangulating the use of COVID red and amber templates (nurse staffing establishment during COVID 19 pandemic) with the number of reported preventable patient harms e.g. Pressure ulcers, falls, nutritional events and infection prevention / line sepsis.

Adopting this approach brings together the monthly Desktop Safer Staffing Review, divisional clinical patient harm review and the recently convened Harm Review Panel. The following provides an overview of each process:

a) The Desktop Safer Staffing Review is chaired by the Chief Nurse with support from the Deputy Chief Nurse, HON, work force and other delegated attendees. The main function is to provide a level of overview and scrutiny to deliver safest nursing care during a pandemic and is responsive to the function and findings from the daily staffing review, divisional and specialty reported experiences.

b) Divisional review is led by the respective head of nursing (HON) and quality governance facilitator (QGF). All reported patient harms e.g. pressure ulcers, falls using Datix incident reporting arrangements are reviewed, validated against the harm grading system and collectively cross referenced against safest staffing COVID 19 red and amber templates according to the day they were reported. Immediate mitigation plans are put in place and escalated concerns raised through the divisional and corporate governance arrangements.

c) The Harm Review Panel (HRP) oversees the clinical review of patients who have sustained 'harm' graded moderate or above and prospectively those incidents that still require final grading by the speciality or division and cross referencing with the COVID 19 staffing templates. This panel is held weekly and is chaired by the Chief Nurse with the Deputy Chief Nurse, heads of nursing (HON), quality governance facilitators (QGF) and other delegated members. The panel supports, but does not replace, appropriate specialty, divisional or corporate clinical governance management arrangements.
The HRP will makes recommendations against individual cases or where there are identified trends and themes, triangulate with risk and quality improvement methodology and initiatives.
The findings will be reported to the Quality Committee through the COVID 19 briefing during the pandemic and monitored through the risk management arrangements (risk register entry 4363).

3.6 Clinical Decision Panel Update

The panel continues to meet weekly and focus on cross cutting clinical issues, clinical prioritisation and guidance.

Two areas of risk were discussed:

a) Transfers of patients from Watford ITU to Papworth ITU.
An agreement with Papworth has been agreed with the network that where there is a surge in the ITU to maximise the available bed base that patients can be transferred out. Three patients had been transferred out. The panel discussed the associated triggers and risks that would support the decision to transfer a patient The Chief Medical Officer (CMO) is the identified lead director.

b) ITU Surge Capacity
Implementing the surge plan has required ITU to use the theatre recovery area. The panel discussed surging into theatres 3 and 4, and what staffing challenges including oxygen provision this would create. The CMO is seeking clarification from the regional medical director and network against increasing capacity.

4 Risks

Not having an overview of risks that are COVID 19 related when the recovery phase commences.

5 Recommendation

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

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

Appendix 1

Reconfiguration into Zones on the Watford General Hospital site

Site		Wards/Zone	NOTES	TEAM	BED NUMBERS	Colour code
WGH GRANGER+	**A**	RED,BLUEBELL, WINYARD, WINTER, AAU L3	COVID with full TEP and patients for CPAP/Optiflow SUPPORTED BY ICU TEAM/OUTREACH	Interventional Medicine	140	
WGH	ITU	PMOK L6 ITU/RECOVERY	COVID	ITU	25	
WGH	ITU	Endoscopy ITU	Non-COVID	ITU	10	
WGH PMOK L5+	**B**	LETCHMORE(C)/ESAU (Nanayakkara), CLEVES (NC) FLAUNDEN (holding) (EL-SAFI),RIDGE(NC/C)/ LANGLEY(NC) (RANJITH),ELIZABETH (Surgery NC)	Non-COVID surgery/Medical surge(Cleves/ridge/Langley circuit/Elizabeth) Letchmore/Flaunden/ ESAU circuit: CONFIRMED COVID/CONTACTS with TEP limited to O2/supportive care Ceiling of care Nasal spec O2 for ESAU	Surgery + Medicine	123	
WGH PMOK L4+	**C**	ALDENHAM, STROKE HERONSGATE, SARRAT, CROXLEY,GADE, OXHEY,	NON-COVID MED/CVA IN STROKE WARD NON-COVID DEMENTIA IN OXHEY YOUNG COVID (Aldenham) COVID/CoE with TEP limited to O2 and supportive care	Care of the Elderly	173	
WGH PMOK L3+/ SHRODDELS	**D**	ELIZABETH (medicine), CASSIO, TUDOR, CASTLE, AMPOD (weekdays)	NON-COVID MEDICINE in ELIZABETH COVID with TEP limited to O2 and supportive care COVID on palliative pathways (TUDOR/CASTLE)	Specialist Medicine Palliative care	84	

WGH AAU+	**E**	AAU L1, EAU, PAU	COVID SUSPECTED [AAU L1 B, PAU] COVID [AAU L1Y] NON-COVID-holding wards [AAU L1 G/P] NON-COVID MEDICINE [EAU]	Emergency Medicine	78
CATH LAB	**F**	AAU L2	NON-COVID CARDIOLOGY	Cardiology	

Trust Board
4 February 2021

Title of the paper	Ockenden report and assurance framework
Agenda Item	13/87
Presenter	Colette Mannion, Director of Midwifery and Gynaecology & Nursing William Forson, Divisional Director, Women and Children's Division
Author(s)	Colette Mannion, Director of Midwifery and Gynaecology & Nursing
Purpose	*Please tick the appropriate box* *For approval*: ☐ *For discussion*: ☐ *For information*: X
Executive Summary	The purpose of this report is to provide assurance to the Trust Board that the recommendations from Ockenden's first report: *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust* (December 2020) have been reviewed to ensure that maternity services are compliant and any areas for improvement are identified and mitigated. The report was presented to the Quality Committee on 28 January 2021. The Assurance Assessment Tool provided by NHS England and NHS Improvement with seven Immediate and Essential Actions has been reviewed and completed with the relevant minimum evidence requirements agreed with the national team. A gap analysis of the remaining recommendations has also been undertaken which will inform a quality improvement action plan. The Assurance Assessment Tool should also be reported through the LMS and shared with regional teams in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards. The Quality Committee received a paper in December 2020 to provide assurance that the original Morecambe Bay (2015) recommendations have been reviewed to ensure that the Trust's maternity services are compliant and any areas for improvement are identified and risks mitigated. A comprehensive Maternity Quality deep dive accompanied the paper which highlighted performance against national maternity safety and quality indicators, areas for improvement and identified areas of challenge and the associated mitigations. This has been shared with the Regional Chief Midwife, Director of Nursing, NHS England & NHS Improvement – East of England and Herts Valleys Clinical Commissioning Group Quality Assurance team. Following the Ockenden report Trust Boards were asked to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation. To support these discussions, NHSE/I are asking Trusts to complete and take to their Board the Assurance Assessment Tool, which draws together elements including: 1) All 7 IEAs of the Ockenden report, 2) NICE guidance relating to maternity, 3) compliance against the CNST safety actions, and 4) a current workforce gap analysis The Assurance Assessment Tool requires evidence that the Trust will implement the revised Perinatal Clinical Quality Surveillance Model (December

	2020). As part of the Trust's immediate response, the Women and Children's Clinical strategy has been updated to include this urgent and immediate action and will be presented at Trust Board in February 2021. The Board's attention is brought to the requirement for confirmation by the Trust that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety. In 2020/21 this was £1.2m for year 3 of the Maternity Incentive Scheme which was paused in 2020 in response to the COVID-19 pandemic and restarted in October 2020 with new guidance and submission date (July 2021). The Ockenden report has provided an opportunity for the Trust's maternity services to be reviewed in the light of the recommendations and any gaps in compliance identified and mitigated. Additionally, there is a renewed requirement for Board oversight of safety in the maternity services and financial investment based on ring-fencing refunds from the Maternity Incentive Scheme and increasing the midwifery workforce to meet Birthrate Plus recommendations. A responsive action plan will be developed and managed through the Divisional Governance process.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** — x **Aim 2 Great team** — ***Objectives 5-8*** — x **Aim 3 Best value** — ***Objective 9*** — x **Aim 4 Great place** — ***Objective 10-12***
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 WACS Divisional Governance meeting — 21 January 2021 Quality Committee — 28 January 2021
Action required	The Board is asked to: • Review and note the assurance provided by the completed Assurance Assessment Tool. The evidence base is available under separate cover. • To receive assurance that the maternity services have the required leadership, governance, transparency and quality improvement culture to ensure that any gaps in compliance will be managed. • To approve the completed Assurance Assessment Tool for national submission with our LMNS by the 15 February 2021.

Agenda Item: 13/87

Trust Board meeting – 4 February 2021

Title of paper -Ockenden report and assurance framework

Presented by: Colette Mannion, Director of Midwifery and Gynaecology Nursing
William Forson, Divisional Director, Women's and Children's Services

1. Purpose

1.1 The purpose of this report is to ask the Board to formally note the Trust's response to the publication of Donna Ockenden's first report: *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust* on 11th December 2020. NHS Trusts received a letter from NHS England and NHS Improvement (NHSE/I) setting out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally. Seven Immediate and Essential Actions (IEA) were identified to redouble efforts to bring forward lasting improvements in maternity services.

1.2 Trusts were advised that they should proceed to implement the full set of the Ockenden IEAs. However, NHSE/I identified 12 urgent clinical priorities from the IEAs which they requested confirmation of implementation by 5pm on 21st December 2020.

1.3 Further guidance was received in a letter dated 23 December 2020 from NHS England and NHS Improvement – East of England Regional Chief Midwife, Director of Nursing which clarified the minimum evidence that should accompany the Assurance Assessment Tool due to be submitted by 15th January 2021. On 11th January 2021 this date was extended to 15th February 2021 due to operational pressure owing to the COVID-19 pandemic.

1.4 Trust Boards were asked to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

1.5 NHSE/I requested that every trust providing maternity services review the report at their next public board. The Board should reflect on whether the assurance mechanisms within their Trust are effective and, with their local maternity system (LMS), they are assured that poor care and avoidable deaths with no visibility or learning cannot happen in their own organisation. To support these discussions, NHSE/I are asking Trusts to complete and take to their board the Assurance Assessment Tool, which draws together elements including:

1. All 7 IEAs of the Ockenden report,
2. NICE guidance relating to maternity,
3. Compliance against the CNST safety actions, and
4. A current workforce gap analysis

1.6 The Assurance Assessment Tool should also be reported through the LMS and shared with regional teams in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

1.7 This report contains the completed Assurance Assessment Tool (Appendix 1) the evidence base of which is available separately. A gap analysis of the Trust's position against the

remainder of the Ockenden recommendations is available under separate cover and informs the quality improvement work plan for Women's Services.

2. Background

2.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

2.2 The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families. This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

2.3 The total number of families to be included in the final review and report is 1,862. The original plan was to publish one complete report, when the reviews of all the cases had been completed. However, as numbers of affected families continued to grow, in July 2020 it was agreed with the Minister of State for Mental Health, Suicide Prevention and Patient Safety, that early learning from the review of cases so far be shared with the Trust and the wider maternity services this calendar year. This has led to the publication of this first report whilst work continues towards completion of the remaining cases.

2.4 Intermittent publicity regarding the work of the review led to a continual increase in families wanting their stories and voices to be heard and their questions and concerns answered. Between June 2018 and the summer of 2020 a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.

2.5 In addition, The Shrewsbury and Telford Hospital NHS Trust, supported by NHS Improvement and NHS England, undertook its own two-stage review of electronic and paper records of cases of ***stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3)*** and ***maternal deaths.*** Through these reviews, known as the 'Open Book', which first occurred in October 2018 as an electronic review and then in July 2020 with paper records included, the review team were notified by NHS Improvement and subsequently the Trust of over 750 cases of poor outcomes across these 4 categories in the period 2000 to the end of 2018. The review team were first able to make contact with these families in April and July 2020.

2.6 Direct contact from families together with the Trust's referrals led to the review team reporting in July 2020 that the review numbers had increased to encompass 1,862 families. It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019.

2.7 To carry out a review of this size and to give each case the attention it deserves will take some time. It is important that expert clinicians lead the process, ensuring that each case is considered carefully and consistently using a standardised methodology. With the review now at 1,862 families, the reviewing team anticipate a publication date for the second and final report in 2021.

2.8 To date, the review team have already identified emerging themes that should be addressed by the Trust and the wider maternity community across England as soon as possible. Therefore they have decided to publish this first report of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final

report, with the full support of NHS England and Improvement, the Department of Health and Social Care and the Secretary of State for Health and Social Care.

2.9 Over the years, the review team note, many important recommendations from previous national maternity reviews and local investigations which might have made a significant difference to the safety of mothers and babies receiving care at the Trust have either not been implemented or the implementation has failed to create the intended effect of improving maternity care. From this review of 250 cases they can confirm that there have been identified missed opportunities to learn in order to prevent serious harm to mothers and babies. However, they are unable to comment any further on any individual family cases until the full review of all cases is completed.

2.10 Having listened to families the review team state that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is their call to action. The review team state that expect to see real change and improved safety in maternity services as a result of findings from these 250 case reviews and their resultant **Local Actions for Learning** and **Immediate and Essential Actions** whilst they continue to work towards completion of the full and final report.

2.11 The NHS England and Improvement regional improvement team must ensure that they give appropriate support and oversight to the Trust. Regulators and professional bodies including the Care Quality Commission, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health must strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** in order that they translate into safer maternity care across England. To do nothing is not an option.

2.12 Repeatedly, families have told the review team of two key wishes. Firstly, they want questions answered in order that they understand what happened during their maternity care. Secondly, they want the system to learn, so as to ensure that any identified failings from their care are not repeated at the Trust or occur at any other maternity service in England. The scale of this review has reinforced their perceptions that their cases were not thoroughly investigated and that there may have been missed opportunities for learning and change and thereby a failure to prevent future harm.

3. Analysis/Discussion

3.1 As the review team have progressed with this review a number of apparent themes have emerged in the 250 cases and family interviews considered to date. These themes will be further scrutinised as they review the remaining cases, but the following are noted by the maternity review team at this early stage*:*

- Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory
- The CQC reports in 2015, 2018 and 2020 vary considerably
- MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)
- Clinical Commissioning Group (CCG) oversight of the Trust
- The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust
- Review of Maternity Services 2007- 2017
- The roles of midwives and obstetricians in the multidisciplinary maternity team
- Compassion and kindness
- Place of birth: Assessment of risk
- Clinical care and competency: management of the complex woman
- Escalation of concerns
- Management of labour: monitoring of fetal wellbeing, use of oxytocin
- Traumatic birth
- Caesarean section rates at The Shrewsbury and Telford Hospital NHS Trust
- Bereavement care

- Maternal Deaths (Between the years 2000 and 2019, there were 13 maternal deaths at The Shrewsbury and Telford Hospital NHS Trust)
- Obstetric Anaesthesia
- Neonatology

3.2 The Ockenden review team include these **Immediate and Essential Actions** because the Minister of State for Mental Health, Suicide Prevention and Patient Safety has expressly asked them, as part of this first report, to make recommendations which will help to improve safety in maternity services across England. The review team note they are aware that to date, there has been a mixed approach to implementing change from national safety reports and reviews into maternity services triggered by concerns relating to safety, such as this review.

3.3 Recommendations are of limited use if they are not implemented the review team state; indeed, had earlier recommendations been followed at The Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes the review team are investigating might not have occurred. Relying on the strength of the review team's collective clinical experience they have named their conclusions as Immediate and Essential Actions – i.e. these are things which the review team say must be implemented now if not already done so.

3.4 Many of the **Immediate and Essential Actions** are not newly developed; they are largely formed from recommendations made in previous reports and publications, to which they have referred. They state that they have formed their 'musts' from recurrent themes they have identified from investigating the selected 250 cases of concern referred to in this first report, with the objective being to positively impact safety in all maternity services across England.

3.5 Recurrent failings in maternity services and what action is needed to improve safety for mothers and babies is the focus of a new inquiry launched by the Health and Social Care Committee; https://committees.parliament.uk/work/472/safety-of-maternity-services-in-england (24 July 2020).The Safety of Maternity Services in England inquiry will examine evidence relating to ongoing concerns despite the substantial amount of work carried out in recent years. The Committee will build upon investigations that followed incidents at East Kent Hospitals University Trust and Shrewsbury and Telford Hospitals NHS Trust, as well as the inquiry into the University Hospitals of Morecambe Bay NHS Trust.

3.6 The Quality Committee received a paper in December 2020 to provide assurance that the original Morecambe Bay (2015) recommendations have been reviewed to ensure that West Hertfordshire's Hospitals NHS Trust maternity services are compliant and any areas for improvement are identified and risks mitigated. A comprehensive Maternity Quality deep dive accompanied the paper which highlighted performance against national maternity safety and quality indicators, areas for improvement and identified areas of challenge and the associated mitigations. This has been shared with the Regional Chief Midwife, Director of Nursing, NHS England & NHS Improvement – East of England and Herts Valleys Clinical Commissioning Group Quality Assurance team.

3.7 An external assurance visit was conducted by with the Regional Chief Midwife, Director of Nursing, NHS England & NHS Improvement – East of England on 10 December 2020 at the request of the Chief Nurse and Executive Maternity Safety Champion. There were a number of positive areas identified following a review of the documents submitted and interviews with a range of staff across the service. An action plan has been developed in response to the required areas for improvement which is being monitored for completion.

3.8 A maternity harm review meeting was undertaken on 22 December 2020 to review all HSIB, SI and RCA investigations conducted from January 2019 to December 2020. This was held to ensure the appropriate level of investigations occurred and the correct levels of harm were identified. 20 incidents were reviewed and assessed against the level of harm, level of investigation and Likert avoidability scale. Following this meeting, and subsequent executive review, 12 harm levels were amended and upgraded, 5 incidents have been re-graded and reported as SIs, and 4 incidents remained as RCAs but had their level of harm increased, one of which is already being investigated by HSIB, two divisional investigations

have been completed and escalated to the executive team prior to submission to the CCG. 3 were originally declared as divisional RCA learning reviews and are in process.

3.9 All incidents that fit the HSIB criteria should be declared SIs by the Trust. In a letter dated 18 December 2020 to the Trust's Chief Executive Officer, entitled *How HSIB can help you respond to the Ockenden Report's Essential and Immediate Actions to improve maternity safety,* the Trust responsibilities for reporting incidents was clarified:

- Undertake an immediate review (72-hour report) to identify urgent safety concerns.
- After this review, where an incident meets the HSIB criteria for investigation, this should be undertaken only by HSIB. Trusts should not be duplicating the investigation.
- Report all HSIB investigations as Serious Incidents (SIs) – this will ensure CCGs and NHSE/I remain fully informed of ongoing investigations.
- Where an incident does not meet our criteria, this would be referred back to the trust for them to investigate.

3.10 The Assurance Assessment Tool requires evidence that the Trust will implement the revised Perinatal Clinical Quality Surveillance Model (December 2020). As part of the Trust's immediate response, the Women and Children's Clinical strategy has been updated to include this urgent and immediate action as part of the Trust's Clinical Strategy 2121-26 and will be presented at Trust Board in February 2021.

3.11 An area of focus for the Trust is Principle 1 of the revised Perinatal Clinical Quality Surveillance Model which is entitled 'Strengthening trust-level oversight for quality' and sets out **six requirements to strengthen and optimise board oversight for maternity and neonatal safety** which are currently being addressed:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2 of the guidance, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

A range of further support measures are under consideration, including safety culture leadership training, access to a trust-level dashboard and access to an NHS Resolution developed annual maternity trust claims scorecard to help target interventions aimed at improving patient safety.

3.12 It should also be noted that Principle 5 in this document: 'Identifying concerns, taking proportionate action and triggering escalation' requires that wherever possible, oversight, action and response should take place at provider level with the support of the safety champions and trust board, and other trusts in the LMS. A range of sources of intelligence should be drawn on to appraise the board that the quality of care is not deteriorating, by adopting a curious approach. Based on discussions and sharing of insights, identified issues should prompt collective decision-making drawing on the views of representatives on the board or committee as to responsibility, accountability and action.

Examples of intelligence which should warrant further enquiry ahead of a decision to escalate include but are not limited to:

- Outlier status for perinatal and/or neonatal mortality
- Concerns identified through the trust, board, LMS or regional dashboard
- Thematic reviews identifying poor care as a contributory factor to outcomes
- Service user concerns, including themes from the CQC maternity survey
- Concerns raised by HSIB, NHS Resolution, through the Invited Review process, NMC, GMC and/or the deanery
- Concerns raised by CQC
- Themes from trainee or staff surveys
- Triangulated data which suggests a need for further enquiry

Action and support which may be considered when the need for additional intervention has been identified could include at Provider level:

- Discussion between frontline champions, MVP, board and non-executive lead to appraise, understand the issue, agree action, timeframes and follow-up.
- Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction.
- Issue discussed at the trust board and an action plan is agreed as a priority.
- Issue(s) discussed with LMS lead and regional chief midwife and action plan shared.
- LMS/ICS to support implementation of the action plan, escalating to regional teams if needed.

The perinatal quality surveillance model provides a framework for Trust oversight of maternal and neonatal quality and safety with clear escalation to LMNS and regional boards enabling a system-wide view of quality. This process is aligned to the national oversight where discussion on any additional action or support required and if criteria are met, entry into the Maternity Safety Support Programme. The criteria for entry into the Maternity Safety Support Programme are detailed below:

Inclusion criteria	**Exit criteria**
Maternity services which have: • an overall rating of Inadequate • an overall rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led, or an inadequate rating in a third domain • been issued with a CQC warning notice • dropped rating from a previously Outstanding or Good rating to Requires Improvement in the Safety or Well-Led domains • DHSC or NHS England and NHS Improvement request for a Review of Services or Inquiry • been identified to the CQC with concerns by HSIB	• CQC improves the rating by at least one in the Safe and Well-led domains

3.13 The Board's attention is brought to the requirement for confirmation by the Trust that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety. In 2020/21 this was £1.2m for year 3 of the Maternity Incentive Scheme which was paused in 2020 in response to the COVID-19 pandemic and restarted in October 2020 with new guidance and submission date In Birthrate Plus (July 2021).

3.14 A bi-annual midwifery workforce report is required to be discussed at Trust Board to meet the Maternity Incentive Scheme standards and to ensure Board oversight of the midwife to birth ratio. The report was discussed at Trust Board, Trust Management Committee and Quality Committee in 2020/21. The Birthrate Plus midwifery establishment review was undertaken in 2018 and recommended a ratio of 1:22, however there was no contractual or mandatory requirement to adopt the recommendation nationally and it was left to the Trust's discretion. The Trust agreed a midwifery establishment of **189.62 WTE** midwives required to maintain 1:26 midwife to birth ratio to deliver 4,400 births:

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

Following the Ockenden report NHSE/I requested that Trust Boards confirm to the Regional Chief Midwife that they have a plan in place to meet the Birthrate Plus (BR+) standard by 31 January 2021 confirming time scales for implementation. In Birthrate Plus there is a 10% allowance for skill mix with support staff (AfC band 3 and 4) for postnatal care specifically and therefore to achieve 1:22 in 2021/22 additional investment will be required. The LMNS have agreed to commission an updated Birthrate Plus review in 2021 and this will inform any further changes to investment based on acuity and dependency.

A business case will be developed to be presented at Trust Management Committee in February 2021 for funding for 9 midwives and 3.36 WTE band 3 Maternity Support Workers to meet the recommended 1:22 ratio and implementing a 10% skill mix for postnatal care. There are currently 33 WTE band 6 midwifery vacancies and the associated risks have been put on the WACS risk register. Previously a paper was presented to the Executive Directors to apply a number of recruitment incentives and the impact is being monitored.

3.15 The Ockenden report has provided an opportunity for the Trust's maternity services to be reviewed in the light of the recommendations and any gaps in compliance identified and mitigated. Additionally there is a renewed requirement for Board oversight of safety in maternity services and also financial investment based on ring-fencing refunds from the Maternity Incentive Scheme and increasing the midwifery workforce to meet Birthrate Plus recommendations. A responsive action plan will be developed and managed through the Divisional Governance process.

3.16 The Trust Board is required to provide a statement of commitment to sign up to the National Risk Assessment process when available later this year.

4. Risks

4.1 This report provides Committee assurance that WHHT maternity services have reviewed the Ockenden report and completed the required NHS Assurance Assessment tool and gap analysis to identify gaps in compliance and actions taken to mitigate risks. It provides the basis for action planning to implement the national changes required following Ockenden in the monitoring of maternity services and the urgent actions required by the Trust Board to ensure oversight, accountability, responsibility and escalation of safety issues. The Board should reflect on whether the assurance mechanisms within their Trust are effective and, with their local maternity system (LMS), they are assured that poor care and avoidable deaths with no visibility or learning cannot happen in their own organisation.

5. Recommendation

5.1 The Trust Board is asked to:

- Review and note the assurance provided by the completed Assurance Assessment Tool. An evidence repository is available for review of supporting documentation.
- To receive assurance that the maternity services have the required leadership, governance, transparency and quality improvement culture to ensure that any gaps in compliance will be managed.
- To approve the completed Assurance Assessment Tool for national submission with our LMNS by the 15 February 2021.

Name of Director: Tracey Carter
Title: Chief Nurse and Director of Infection, Prevention Control

28 January 2021

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months
Link to Maternity Safety actions: Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 2: Are you submitting data to the Maternity Services Dataset to the required standard? Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?
Link to urgent clinical priorities: (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
1.1 Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.						
The Hertfordshire and West Essex Local Maternity and Neonatal Systems Safety Forum established with ToR LMNS dashboard developed and circulated	The Hertfordshire and West Essex Local Maternity and Neonatal Systems Safety Forum will: • Provide assurance to the HWE LMNS on the provision of safe and high quality care to the population we serve • Act as the strategic group with responsibility for ensuring that HWE LMNS are aligned with the National Safety Agenda including: • Maternity Transformation National Planning Safety Deliverables 2020/21 • Patient Safety Metrics. • Provide a forum for developing strategy for the HWE LMNS as a result of	LMNS dashboard is a formal item on LMNS agenda Benchmarking against local organisations LSCS summit and action plan Triangulation of MOH, third degree tears and episiotomies with an action plan Review of audit programme Tripartite learning from HSIB investigation	To implement the Perinatal Clinical Quality Surveillance Model and strengthen Trust Board oversight New process for LMNS oversight to be agreed	Director of Midwifery and Clinical Director at WHHT LMNS Safety and Governance Midwife	The national maternity dashboard was launched in January 2021 and will need to embedded to gain maximum benefits.	Currently the maternity dashboard is collated across the LMNS and shared at the LMNS Safety Forum.

Senior LMNS Quality Safety Governance manager in post to coordinate across the LMNS foot print Inaugural meeting of LMNS SI oversight and scrutiny meeting held 25th January 2021with TOR and action log.	incidents reported through risk management, complaints or litigation claims • Monitor trends identified through risk management reports, share lessons learnt from incidents and ensure the Forum is taking appropriate action to minimize risk to service users and staff to prevent reoccurrence Identify practice development and training required to improve service delivery and clinical quality and safety across the LMNS	SI Themes and trends identified and sector wide solutions sought to achieve system wide change	To embed systems and processes for sharing learning from SI and HSIB across LMNS	Directors & Heads of Midwifery with LMNS	Sufficient leadership in place	Process in place and will evolve in maturity over 2021/22
To implement the Perinatal Clinical Quality Surveillance Model implementing-a-revised-perinatal-quality-s	Currently there is the Maternal & Neonatal health Safety Collaborative (MatNeo) & Beds, Herts & West Essex Local Learning System (LLS) Paper to be presented to WHHT Quality Committee detailing the requirements The revised perinatal quality surveillance model will be integrated within the Trust's clinical strategy and presented at the February 2020 Trust Board.	Published December 2020 and implications for the Trust being addressed- 6 requirements to strengthen and optimise board oversight for maternal and neonatal safety.	The revised perinatal quality surveillance model will provide clear lines for responsibility and accountability for addressing quality concerns at every level of the system.	Trust Board in February 2021 to approve Clinical Strategy which includes a commitment to implement the model.	To be presented to Trust Board by Director of Strategy	Currently under review by Chief Nurse, NED Maternity Safety Champions & Maternity and Neonatal Safety Champions

	Provider level responsibility for identifying , taking proportionate action and triggering escalation – to agree TOR and process		To implement the Perinatal Clinical Quality Surveillance Model and strengthen Trust Board oversight and the new process for LMNS oversight to be agreed LMNS and Regional Chief Midwife to agree ToR			
1.2 External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.						
External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	The Trust has utilised external clinical specialist opinion with a number of internal investigations, RCA's & SI's, from the LMNS and an independent consultant obstetrician and clinical risk lead, for transparency and independent clinical expertise. Staff undertaking comprehensive and concise investigations have undertaken Root Cause Analysis (RCA) training	Reports shared at Clinical Governance Findings inform audit cycle, guidelines and clinical practice.	To identify LMNS funding for this to reimburse clinicians across the LMNS. Consider allocation from CNST rebate or LMNS funds. Staff training numbers to be established and training organised to meet the need for new staff	LMNS partners	There is a cost implication which will need to be accounted for.	External clinical specialist with expertise available if required.

1.3 All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.						
All SI's are reported to the Trust Board through the Trust corporate Integrated Performance Report (IPR). The Quality IPR is reviewed at the Quality Committee bi-monthly and the Trust Board IPR is reviewed monthly. SI action plans are monitored at the Serious Incident Review Group. The LMNS ToR includes a system wide approach to maternity safety and learning, however maternity SIs are not discussed.	The Women's Governance meeting monitors learning from SIs and message of the week is circulated to staff for learning. Findings inform audit, guidelines and clinical practice .	Monitoring of all actions and assurances to ensure that they are embedded and audited as required Findings inform audit cycle, guidelines and clinical practice.	As of January 2021 to update the SI slide to show SI's in maternity and across the divisions. A detailed narrative SI report is also presented to the Trust Board bi-monthly giving a further overview of all SI's & HSIB cases including maternity. To include this requirement to the LMNS ToR	Chief Nurse, DOM and DD 01/01/2021 LMNS Maternity Transformation Programme Manager	Data analyst support.	Commenced 1/1/2021

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
-

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
2.1 Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.						
Currently there is no independent senior advocate role that reports to the Trust and the LMS Boards	Not in place currently, letter received from NHSE/I on 11/01/2021	Letter states: *To ensure consistency and equity across England, we are developing a national model for a network of advocates. Ensuring we get the right people into these roles is essential to improving maternity services in line with the Ockenden report. We know that the training, skills and credibility of the advocates will be key. We are therefore co-producing a framework, including a standard JD, training package and principles for establishing a network. We will develop a clear process so that women and families know how to contact the advocates. This will also include mechanisms for contracting advocates so they remain independent and how these will be funded.* *We know many of you are working at pace to introduce these recommendations. However, we believe the benefits of a sustainable national network of advocates will deliver the intent of this action.*		National guidance awaited	Funding to be agreed at national level	Advocacy services available through voluntary sector.

2.2 The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.						
As above	Not in place currently	Not in place currently	Develop a clear role profile for the ISA to ensure that they are available to support families at follow up meetings	National guidance awaited	National guidance awaited	Advocacy services available through voluntary sector.
2.3 Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.						
Non-executive director appointed	To work collaboratively with the Executive Maternity Safety Champion and maternity and neonatal safety champions.	Improvements in patient safety. A non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They work collaboratively with their maternity Safety Champions.	To implement the role as per the Perinatal Clinical Quality Surveillance model (Dec 2020)	Chief Nurse & Chairman	To review the national job description as part of the non-exec role.	Non-executive for quality committee and maternity safety within the committee.

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
3.1 Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.						
Systematic process in place to ensure that MDT training process in place and compliance monitored to meet NHSR criteria. Adopting the Core Competency Framework (maternity transformation programme)December 2020  A_core_competency_framework.pdf	Monthly training programme in place however paused April-June 2020 due to Covid-19. Met CNST standard 2019 with 90% compliance across all relevant groups. Training syllabus delivered locally and based on current evidence, national guidelines/recommendations, local audit findings, risk issues and case review feedback, using local charts, emergency boxes, algorithms and proforma.	Combined training provided via LMNS – Human Factors, CoC, Fetal monitoring 2019/20 High performing MDT teams working together to deliver high quality care for mothers and babies: Patient experience & Clinical outcomes Workforce metrics Culture Reputation External validation –CQC, CNST	Need to have external validation process agreed To add Gap and Grow training to the package To calculate the overhead required to ensure sufficient training allowance to meet requirements Funding for multiprofessionals in addition to midwifery educators for local training faculty	LMNS Lead Midwife for Education Lead Midwife for Education Divisional Manager & Clinical Director	Add to agenda and TOR of LMNS meeting Update TNA To identify an obstetric lead and anaesthetic lead for PROMPT 1PA per week Fund from CNST rebate or business case	MDT training virtually during COVID-19 pandemic WACS performance review monitors compliance monthly MDT training virtually during COVID-19 pandemic

3.2 Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.						
SOP developed and rota designed to allocate consultant to MDT ward rounds twice daily	Audit of compliance to confirm robust senior decision making for complex cases on Delivery Suite and antenatal and postnatal ward	To be added to the quarterly audit plan Findings inform audit cycle, guidelines and clinical practice.	To monitor audit results	Labour Ward obstetric lead and Clinical Director - Obstetrics	To review the anaesthetic rota to ensure adequate staff for twice daily ward rounds	Anaesthetist may not be available if in theatre or siting epidural. So escalation process to be followed.

Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team
Link to Maternity Safety Actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
4.1 Women with complex pregnancies must have a named consultant lead						
Guideline in place to ensure that women with complex pregnancies are referred to a named consultant: • Antenatal booking guideline (updated Jan 2021) • Diabetes in pregnancy • Fetal Medicine • Perinatal mental health • Preterm birth clinic (SBLCBV2) • Anaesthetic guideline • VBAC guideline • Twin pregnancy guideline	This ensures that there are robust pathways in place for managing women with complex pregnancies Audit of compliance to confirm that women are referred to the named consultant for January confirms 100% compliance	To be added to the bi-yearly audit plan Findings inform audit cycle, guidelines and clinical practice.	To review Consultant Obstetrician & Gynaecologists job plans to ensure that there is adequate workforce with the necessary specialist skills. The Obstetric Consultants names and specialities is in Antenatal Booking guideline – to be ratified and published Establish a forum whereby women and partners can join in management planning with the multidisciplinary team	Clinical Director & Divisional Director Chair of Women's Guideline group and Trust process Clinical Director-Obstetrics & Matron -ANC	To recruit substantively into locum consultant obstetricians posts-however 2 consultants on external secondment currently.	Sufficient workforce in post to enable a named consultant lead.

4.2 Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team						
Currently referral pathways to tertiary centres Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	Currently links are establish with UCLH, Cambridge & Imperial Audit of compliance	To be added to the bi-yearly audit plan Findings inform audit cycle, guidelines and clinical practice.	EOE maternal medicine network not finalised, awaiting clarification. The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians; Criteria for referral to be agreed and reflected in a SOP Establish a forum whereby women and partners can join in management planning with the multidisciplinary team	EOE leads	Funding to be agreed regionally	Currently links are established with UCLH, Cambridge, Imperial Healthcare, Chelsea & Westminster

Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture.
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
5.1 All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional						
Perinatal national notes have a section to formally record that a risk assessment has been completed. This will include a statement of commitment to sign up to the National Risk Assessment process when available. Women are booked for home birth, Birth Centre or Delivery Suite but this may change depending on evolving risk factors in pregnancy Recent audit showed poor compliance with risk assessment at	A % of women have risk factors at booking and this informs their birth options. Audit of clinical outcomes Maternity dashboard Monthly audit of ABC transfer rates and reasons BBA audit monthly Safeguarding audit PMRT Gap and Grow outcomes Fetal Medicine Metrics ANNBS	Audited quarterly Findings inform audit cycle, guidelines and clinical practice. Quality and safety metrics Perinatal outcomes ATAIN Benchmarking locally and nationally MATNEOSIP	Launch the new revised guideline to all staff groups	Matron Community Midwifery & Birth Centre Matron – ANC& MDAU and Inpatient Services Clinical Director-Obstetrics	Electronic Patient Record for maternity to facilitate real time data entry and audit. This project is currently on track with new system in 21/22.	Guideline updated to reflect Ockenden recommendation – awaiting ratification. Midwives and doctors informed of this requirement.

every AN contact. Action plan developed to raise awareness of mandatory requirement	Local guideline reviewed and amended, awaiting ratification					
5.2 Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture.						
Risk assessment of place of birth at each ANC visit not fully embedded due to lack of a electronic patient record that allows real-time monitoring. Maternity records held by the mother and not possible to assess on an ongoing basis.	Local guideline reviewed and amended, awaiting ratification	Audited quarterly, retrospectively findings inform audit cycle, guidelines and clinical practice.	Launch the new revised guideline to all staff groups Audit to be done on 50 cases following birth	Education team and Clinical Director & Matron Community /Birth Centre Matron Community /Birth Centre & Matron ANC/MDAU and Inpatients	Electronic Patient Record for maternity to facilitate real time data entry and audit. This project is currently on track with new system in 21/22. Workforce	All women on low risk pathway have a 36 week appointment to finalise place of birth. All contacts provide an opportunity to review place of birth.

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -** • **Improving the practice of monitoring fetal wellbeing –** • **Consolidating existing knowledge of monitoring fetal wellbeing –** • **Keeping abreast of developments in the field –** • **Raising the profile of fetal wellbeing monitoring –** • **Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –** • **Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.** • **The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.** • **They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •** **The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines**						
Consultant Obstetrician and lead midwife for fetal monitoring in post Nanda Shetty Consultant Obstetrician & Gynaecologist and CD-Obstetrics Judy Jackson Fetal Monitoring &	Supports best practice, learning and dissemination of information. MDT training includes: • K2 e-learning (FIGO, five modules) external provider for CTG masterclasses and monthly	Monthly monitoring of compliance and attendance. Monitoring of SI/RCA themes regarding fetal monitoring Findings inform audit cycle, guidelines and clinical practice.	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	LMNS Lead midwife and obstetric lead	Add to agenda and TOR of LMNS meeting Update TNA in line with core competency framework	MDT training virtually during COVID-19 pandemic WACS performance review monitors compliance monthly

Wellbeing Lead Midwife 1WTE permanently funded post.	virtual fetal monitoring training • Weekly hour long MDT CTG training (virtual and face –to-face), reviewing all live cases. • Divisional monthly perinatal morality & morbidity meeting, that present SI/RCA investigations as a platform for MDT shared learning		To calculate the overhead required to ensure sufficient training allowance to meet requirements Review the job plan for the Obstetric Labour Lead who is the lead for fetal monitoring to ensure sufficient allocation of Pas.	Divisional Director	Funding PAs	Sufficient workforce in post to provide adequate cover

Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. **All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care** **Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care** **Women's choices following a shared and informed decision-making process must be respected**						
The Trust website has been reviewed and compares favourably with that of Chelsea and Westminster in layout and organisation, outdated information has been updated. 1. Trust Website https://www.westhertshospitals.nhs.uk/maternity/ 2. The LMNS have funded the Mum and Baby App for 3 years which facilitates informed choice Email to all staff.docx 3. Multilingual padlet for free download: https://padlet.com/charlotteeaston1/Bookmarks	Two padlets have been developed by the Better Births Midwife within the LMNS, one for English speaking mothers and the other is multilingual as a resource tool for women to gain quick and easy access to resources. Additionally the	Regular review and monitoring of the website and App, in conjunction with our LMNS and MVP colleagues Feedback from service users & MVP	To enable all guidelines to be available to service users on the maternity website. To expand the offer regarding choice of place of birth. To personalise the COVID-19 advice.	IT Midwife, Consultant Midwife-Normal Birth & PMA with Communications team	Project plan and project manager	Good range of resources available in the maternity services.

or https://bit.ly/HWE-MAT1 4. Herts & West Essex LMNS resource padlet  20 07 06 HWE LMNS padlet poster.pdf 5. Infant Feeding Resources  Infant Feeding Resources.docx https://padlet.com/kbarber14/dodfc42o4sla Birth Options clinics provided by Consultant Obstetrician and Consultant Midwife VBAC clinic held weekly by Consultant Midwife	LMNS have funded the Mum & Baby App for 3 years for free download to mothers. The Infant Feeding Specialist Midwife has designed And launched an Infant Feeding support padlet for free download.		To ensure that issues for BAME women are represented. To highlight the interpreting service and access Meeting the CoC teams as rolled out Add reduced fetal movement advice To co-produce with MVP			

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Biannual midwifery workforce report discussed at Trust Board and sub-committees with an cation plan to achieve 1:22 LMNS BR+ commissioned in 2018 to inform Better Births programme. WHHT requires midwife to birth ratio of 1:22. Currently funded for 1:26 with an additional 5.22 WTE for supernumerary Delivery Suite co-ordinator 2019/20	Achieved full compliance with NHS Resolution Maternity Incentive scheme 2019 KPI monitored – supernumerary status of DS co-ordinator @100% 1:1 care in labour @100% Red flag maternity staffing events Planned v actual midwives fill rate	Currently 1:26 ratio with 33 WTE band 6 vacancies. Business case to be developed to be presented at Trust Management Committee in February 2021 for 9 midwives and 3.36 WTE band 3 Maternity Support workers. Monitor recruitment and reduction in vacancies and effect of incentives agreed in 2020/21	Trust Board to agree to fund BR+ recommendation of 1:22 Recruitment and retention plan Roll out of CoC teams 21/22	Trust Management Committee DoM and Matrons DoM and Matrons	Allocation of funds 2021/22	CoC roll out delayed due to high vacancy rate Safer care and fill rate monitored and shortages mitigated Maternity Escalation process followed Midwifery vacancies put on the Divisional Risk Register.

Business case to be presented in February 2021 to fund additional 9 WTE midwives. 10% allowance in BR+ for skill mix for postnatal care with band 3 and 4 posts, current funding for 18.44 WTE against 21.80 WTE full effect (3.36WTE). Working towards national band 3 Maternity Support worker programme with separate business case required 20/21.	Bank and agency usage Recruitment and retention plan to fill vacancies Staff survey Harm reviews Maternal and perinatal quality and safety indicators Patient experience					

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Director of Midwifery and Gynaecology (8d) is responsible and accountable to the Chief Nurse & Director of Infection, Prevention Control.

360-D-5108-RA1_job description Director o

The seven steps to strengthen midwifery leadership benchmarking:

1 A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service	**Yes**
2 A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	N/A
3 More consultant midwives	Yes
4 Specialist midwives in every trust and health board	Yes
5 Strengthening and supporting sustainable midwifery leadership in education and research	N/A
6 A commitment to fund ongoing midwifery leadership development	Yes
7 Professional input into the appointment of midwife leaders	No

In addition there are two deputies (8b), one focusing on operational matters and the second on governance and assurance. There are two Consultant midwives (8b), one leading on Public Health and the second on Normal Birth. There are 3 Maternity Matrons (8a). There 1.6 WTE Quality and Risk specialist midwife, a band 7 Risk midwife and an 8A Lead Midwife for Education , also an 8A Safeguarding and Complex Social care midwife. Please see organisational chart in the Job description attached.

A number of specialist midwives are employed: Pregnancy Loss Specialist Midwife – band 7
Diabetes Specialist midwives band 7 and band 6
Antenatal and Newborn Screening Specialist midwife band 7
Practice Development midwives –band 7 -2.4WTE
Infant Feeding specialist band 7 1.4WTE
Gap and Grow project midwife band 7 0.5 WTE
Immunisation midwife band 6 1 WTE
Safeguarding and Perinatal mental health 4 WTE band 7
1 WTE PMA and sessional provided by 6 others

Midwifery leadership development available locally and nationally, including band 6, band 7 and Matron development programmes, also the aspiring Head of Midwifery and all programmes on the Leadership Academy. Also the Trust has booked RCM courses e.g. Labour Ward co-ordinators study days.

The Director of Midwifery appointment panel included Corporate and Divisional representation and the Trust will undertake to include a senior RCM representative in future appointments.

NICE GUIDANCE RELATED TO MATERNITY					
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.					
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**
Trust clinical guidelines are guidelines which have been developed for local use from an external source, e.g. NICE, Speciality college or existing international guidelines. According to NICE (accessed in August 2016) clinical guidelines recommend how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management.	All documents must include details of **how** compliance will be monitored. For example: this might be done through audits, surveys, performance management, and incident and complaints analysis. These will be monitored by the Quality Governance Team during any assurance visits. They will liaise with the Intranet Administrator to ensure that no policy is uplifted to the intranet which does not meet the required standard.	The table below identifies approval and ratification groups based on the content covered by the policy. If they are unclear about the appropriate approval/ratification route for their document, authors must seek advice from the Assurance Team	Review and update accordingly the ToR for the Maternity Guideline line group	The Quality Governance Team is responsible for keeping the Trust Documents Databases up to date and will undertake an annual audit of a sample of strategies, policies and Clinical Guidelines on the Trust's database to review compliance with this policy - a minimum of once a year. The audit will need to demonstrate that: ▪ standards for strategy, policy and clinical guidelines development as stated in this policy are adhered to ▪ committee minutes reflect the document's approval, as per the processes set out in	A range of resources are available in both the Quality Governance Team and maternity services.

				this document; ▪ the documents are registered and have a unique identification number; ▪ the documents database is up-to-date. ▪ The correct version of the policy is posted on the intranet	

Trust Board
04 February 2021

Title of the paper	**Strategic Priorities Update**
Agenda Item	14/87
Presenter	**Helen Brown, Deputy Chief Executive**
Author(s)	**Esme Walsh, Strategy Delivery Office**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	This paper provides an update to the Trust Board on the progress of the key strategic priorities for 2020-21.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care – ***Objectives 1-4*** ✓ **Aim 2** Great team – ***Objectives 5-8*** ✓ **Aim 3** Best value – ***Objective 9*** ✓ **Aim 4** Great place – ***Objective 10-12*** ✓
Links to well-led key lines of enquiry	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	n/a
Action required	The Trust Board is asked to note the delivery status of the strategic priority projects.

Agenda Item: 14/87

Trust Board – 04 February 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 2020-21 and provides an update on their development and delivery.

1.2 **Table 1: 2020-2021 Strategic Priorities**

WHHT 2020-21 STRATEGIC PRIORITIES - Reporting to TMC	BEST CARE	BEST VALUE	GREAT TEAM	GREAT PLACE
CLINICAL STRATEGY				
CLINICAL STRATEGY	✓	✓	✓	
REPATRIATING CHEMOTHERAPY	✓		✓	
HEAD & NECK PATHWAY	✓			
INTERVENTIONAL RADIOLOGY	✓			
EMBEDDING SMART AS BAU	✓	✓		
MOUNT VERNON CANCER CENTRE REVIEW	✓			
VASCULAR HUB	✓			
ICS / ICP DEVELOPMENT	✓			
INTEGRATED CARE JOINT QIPP				
TRANSFORMATION PLAN	✓	✓	✓	
UTCs WGH and SACH & HEMEL	✓	✓	✓	
CAPITAL PROGRAMME				
THEATRES	✓	✓	✓	✓
EMERGENCY DEPARTMENT	✓	✓	✓	✓
MAU EXPANSION	✓	✓	✓	✓
LOCAL AREA NETWORK / WINDOWS 10 (ETC.)	✓	✓	✓	✓
OFF SITE BACK OFFICE	✓	✓	✓	✓
HEALTH RECORDS BC	✓	✓	✓	✓
OTHER BACKLOG MAINTENANCE PROJECT				✓
MRI SCANNER (SACH)	✓			✓
CARDIAC CATHETER LAB	✓			✓
FIRE SAFETY SPEND				✓
£1M MISCELLANEOUS MEDICAL EQUIPMENT				✓
CT SCANNER (WGH)	✓			✓
MULTI-STOREY CAR PARK				✓
OUTSOURCING PATHOLOGY SERVICES				✓

2.0 Clinical Strategy

2.1 An engagement draft of the **Clinical Strategy** was submitted to January's TMC for discussion and approval to proceed with the acknowledgement that this is a draft that will be further developed following stakeholder engagement in the spring. The intention is to finalise the strategy for formal approval in the early summer.

2.2 Repatriating Inpatient Chemotherapy – No update to report this month. A progress update on this project will be provided in July 2021 as the service continues to develop and embed.

2.3 The **Interventional Radiology OBC** is being developed and had been expected to be submitted for approval at the December TMC, this is now scheduled for February. Estimated build, staffing and equipment costs, have been developed, though the timeline has been pushed back to allow for a more thorough review of activity and income with system partners.

The expected capital costs are circa £2m and conversations have begun with the Raise charity on supporting this work, with fundraising expected to begin following OBC approval.

2.4 Virtual **SMART (Senior Medics Assigning & Re-designing the Take)** – The Junior Doctors' concerns around clinical decision making were fed back to the Medical Education Team, who have suggested that further Junior Doctor meetings/engagement should be undertaken to agree mitigations. The feedback would then be collated and presented back, however due to clinical staffing priorities, this exercise has not yet been undertaken. Cardiology have stopped working SMART since moving onto the Covid rota and the Respiratory team are continuing to work the Virtual SMART model in the interim.

2.5 The **Vascular Hub Project** is at the impact assessment/OBC finalisation stage, though it is currently impacted by operational pressures. No further update to report.

2.6 December was a relatively quiet month for the **Integrated Care Partnership (ICP)** as our focus was on ensuring that our organisation and system were in the best possible place to manage the increasing numbers of Covid patients. However the Integrated Clinical and Care Advisory Group (ICAG) met in December and January, with a focus on both the immediate priority of extending the Covid virtual hospital to a wider range of conditions to help manage our current demand, and our future priorities including paediatrics and diabetes.

Katy Healy came into post on 4 January 2021 as Associate Director for ICP Development, and her immediate focus is on developing a clinical and care integration strategy and on revisiting the key strategic milestones for the ICP and updating the programme plan. There has been inevitable slippage in the ICP development during 2020 as a result of Covid, but we remain committed to formally setting up the ICP as quickly as possible.

We reported in December that NHSE/I had published an engagement paper on the future of Integrated Care Systems (ICSs). Responses to the four questions posed in the paper were due on 8 January. WHHT put in a response to the engagement, as did most other organisations within the ICS. A combined ICS response was also submitted. The WHHT response gave tentative support for the direction of travel but said that there needed to be more clarity regarding the implications for

providers, particularly in terms of governance and accountability for the ICS as a statutory organisation, before it could support the preferred option.

2.7 The Mount Vernon Cancer Centre (MVCC) Review process continues with an active programme of stakeholder engagement planned over the next period, following a key decision in December 2020 by the MVCC Programme Board on the shortlist of options to be taken forward for further consideration.

The MVCC Programme Board has supported the recommendation from the Clinical Group to pursue the option of a single specialist cancer centre on an acute site, in conjunction with enhanced local access (for example increased local delivery of chemotherapy, and local options for simple appointments such as blood tests). The alternative option considered was to move some services to an acute site, leaving some services at the current location.

The Programme Board noted that only one acute hospital site fully met the essential criteria it had previously agreed. These essential criteria concerned the availability of co-located clinical services and access for patients (travelling times by car and by public transport). Members considered these criteria along with views on location that had been expressed by patients, carers and staff, and agreed that the programme team should undertake a detailed exploration of the feasibility of developing a new Cancer Centre on the Watford Hospital site.

A joint clinical working group is being established. The group will develop a joint clinical operating model and work through in detail how our two clinical teams can work together to maximise the clinical benefits for patients of co-locating MVCC on the WGH site.

UCLH are leading work to develop a detailed business case and the Trust's acute redevelopment team will be working closely with the MVCC programme team to work through how best to accommodate MVCC services on to the WGH site, in the context of the Trust's overall redevelopment plans and timelines. Our preliminary assessment has shown that the needs of the Mount Vernon cancer services could be accommodated on the Watford General Hospital site. The timescales are different for the Mount Vernon move and our construction, with our plans being further forward. However, we are confident that we can incorporate the needs of Mount Vernon when its future location and funding is finalised without causing delay or difficulty on either side.

3.0 Integrated Care Joint QIPP (part of Transformation Plan)

3.1 Frailty progress remains on hold due to staffing pressures across the Trust, however this project will shortly move to business as usual for 2021 reporting. The new expanded EAU when it opens in March 2021 will provide a permanent base for the frailty service.

3.2 Outpatients Transformation continues to make progress and updates are shared with the Operational Recovery Group. There are no significant updates to report this month.

3.3 Watford General Hospital (WGH) Urgent Treatment Centre – Due to the impact of the Covid second wave some temporary adjustments have been made to the service provision of the UTC in order to support the WHHT Emergency Department. These include: waiting space for the use of

ED patients, a number of staff have been transferred to work in ED and the Directory of Services (DoS) has been adjusted to direct more patients to Hemel Hempstead Hospital UTC. The teams are working closely together to monitor impact.

3.4 **Hemel Hempstead Hospital UTC** – The procurement of service has been paused and will be reviewed later this month. No further update to report.

3.5 **St Albans City Hospital (SACH) Minor Injury Unit / Urgent Care development** - The MIU remains closed for the foreseeable future. WHHT and Herts Valleys CCG are working together to develop a plan for future urgent care provision for St Albans and Harpenden. This has been delayed due to Covid pressures but will be a priority to be progressed in early 2021.

4.0 Capital Programme

4.1 The **Emergency Department Development** project is currently at the detailed design stage in preparation for FBC, the target date to go to Trust Board is February 2021, although this may be impacted by operational pressures. Both the modular unit and the internal work are in a 1:50 scale design phase, following approval of general arrangement. The start date of work following Board approval will be dependent on regulator approval. Full go live expected in winter 2021, dependent on approvals.

4.2 **Emergency Assessment Unit (EAU) Expansion** The winter plan for 2020-21 is for a modular unit (big enough to accommodate 20 beds) to be placed in Shrodell's garden, to be linked to the current EAU. The business case was approved by TMC, with caveats on ensuring that benefits are monitored, along with clinical support impacts. Building work is progressing well, though the completion of the work has been slightly delayed (from January 2021 to February) due to unforeseen ground work. The Emergency Division is working to mobilise the service, with go-live planned for early March 2021.

4.3 The **WGH Theatres Reconfiguration Programme** is progressing as planned. The main project works have started with contractor hoardings in place on Levels 5 and 6. Of note, the Integrated Discharge Team (IDT) room is due to complete 25 January which will directly lead on to the second IDT room.

It has been noted that the impact of Covid on the adjacent ITU may necessitate temporary changes to the location of the clean corridor "red lines". This will be agreed between the clinical users and the Infection, Protection and Control team before determining any impact on the construction works.

4.4 As previously reported, the **Backlog Maintenance Programme** (BLM) comprises over 20 projects, all in different phases of preparation and procurement but in general project management terms, programme delivery is broadly in line with plan.

The tendering and procurement stage of the larger projects has progressed over December and into the New Year. Several of the larger, more complex projects have successfully passed through the procurement process and orders have been raised.

In particular, the **boiler replacement for Verulam Wards at Hemel Hempstead Hospital** is a welcome addition to this, as the existing boilers failed in the past week. The Estates Team have managed to implement a short term fix, but it is not a long-term solution. The start-up meeting for the replacement scheme has been held and the new temporary boilers will now be installed to ensure the heating supply improves before the main replacement works start.

Another project that has been procured is the **replacement of the Chillers at St Albans City Hospital.** Five out of the six existing chillers had gone past their useful life and are not performing. The replacements have been procured and will be installed in March, ensuring that the new equipment will be operational in advance of the warmer seasonal weather.

Surveys and subsequent repair designs for many of the **campus road and car parks** have been returned, reviewed, and are currently out to tender. The remaining procurement for the Backlog programme will continue through January, with most of the programme works being delivered throughout February and March.

Covid is likely to have an impact on some of the projects currently in delivery. For example, of the three **Instant Power Supply (IPS) / Uninterruptible Power Supply (UPS) packages** being delivered, two are likely to be delivered fully before the end of March. However, the third package, the upgrade to the service within the Paediatric Resus and the main Resuscitation area of Watford General is likely to be affected due to the current demand for beds. 80% of the infrastructure of the project is expected to be delivered before the end of March, and the final connections will be made once availability of the area is more feasible. On the converse side of the same issue, where Covid has closed some areas works have been accelerated. In the **St Albans Day Theatre Recovery area replacement flooring works** have been brought forward and have been completed whilst the area is vacant.

4.5 Fire Safety Improvements – The Planned Fire Door replacement programme continues to plan. For emergency lighting, a tender specification has been released for a retro-fitted new system for St. Albans and Hemel Hempstead to mirror that installed on the Watford site and bids are due to be received mid-February. The bids are expected to be of considerable value and therefore a phased priority based plan will be developed with a level of works achieved in the 2020-21 financial year.

For fire alarms, a tender has been released for replacements and improvements, primarily at the St. Albans site. Although the Tender release had slipped, works are still planned to commence at the end of February 2021.

Following consultation with the Fire Safety Committee, it has been agreed that part of the remaining investment in Fire Safety should be redirected to address the fire safety issues emerging from a survey reporting that the Moynihan Building could not effectively achieve horizontal evacuation in the case of fire. Works have now commenced.

4.6 The **Local Area Network (LAN)** project is now complete.

4.7 The **Windows 10 Deployment** continues at pace and on schedule. A further business case for upgrading key applications for Windows 10 environment is in final development and will be presented for consideration as part of the 2021-22 Capital Programme.

4.8 The business case for the **Off Site Back Office Project** (Administrative Staff project) was approved by the Trust Board and is an essential enabler for creating additional clinical capacity on the WGH site. The tender process has commenced with the pre-qualification stage, 11 contractors were invited and 6 are interested. The full tender process is currently being progressed.

There is a new issue in that the landlords are requesting a £200K deposit for the dilapidations at the end of the term. The Trust has offered a letter of comfort confirming that money will be prioritised from the relevant year's capital funds, however the landlords are not willing to accept this.

There has been some slippage on original programme dates due to Covid and the first choice of premises falling through. The revised handover of premises after works completed is scheduled for 30 July 2021 with staff due to move during August and September.

4.9 The TMC request for approval of the **Health Records Full Business Case (FBC)** has been delayed due to ongoing financial discussions. The FBC will now be presented and reviewed at the urgent TMC in mid-February.

Key milestones include:
- Ascertain TMC approval at TMC meeting in February
-Present FBC at F&P Committee meeting in February
-Present FBC at Trust Board meeting in March
-Prepare for initiation of programme activities

4.10 **MRI SACH** – The MRI scanner has been ordered and is expected to be up and running by the end of March 2021.

4.11 **CT WGH** – Works will commence late February 2021 with the new scanner scheduled to be installed by the end of March 2021.

4.12 Works on the **Cardiac Cath Lab** have commenced following the Christmas break. The timeline for completion of Cath Lab 2 remains on track for February 2021. Work continues around ensuring that the capital spend in monitored closely.

The team have requested the costs for vesting and storage for the new Siemens Artis system for Lab 1, as it will allow the remaining equipment to be transported to the UK and stored within the financial year, as the current timeline for the second operational Lab will be early June. Where possible, the team will endeavour to shorten this time line.

Communication between IT and the suppliers has improved and the team are closely managing the IT allocated budget.

The team continue to modify the lists as per the transition plan, however due to winter and Covid pressures the Cath Lab has been used as a surge ward over the last month. The Trust and Cardiology team are managing this closely in line with the Surge policy. From 11 January 2021 urgent electives have been sent to tertiary centres until the Cath Lab staffing issues have been resolved, along with the new contingency plan. The plan will involve creating a new recovery bay within one of the echo rooms for elective patients. This contingency plan has been approved at Clinical Decision Panel, which will allow the booking of 1 or 2 electives per day from 20 January (to allow for Covid swabbing).

4.13 A progress update and associated RAG rating on the **£1m Miscellaneous Medical Equipment** project is set out below:

Equipment	**£000**	**Progress Update**	**RAG Rating**
Anaesthetic machines (x7)	£312k	Order fully received	
Foetal Recorder CTG (x31)	£200k	Business case has been submitted to January CFPG. If approved the lead time for the delivery is 4-6 weeks	
Epidural Volumetric Pump (x25)	£60k	Business case has been submitted to January CFPG. If approved the lead time for the delivery is 4-6 weeks	
Tourniquet machines (x6)	£28k	This will be transferred to 2021-2022 and business case will be submitted by theatres team.	
Defibrillators (x108)	£400k	Order raised/delivery date 01 March 2021	
Total	£1000k		

4.14 **Multi-Storey Car Park (MSCP)** – the main build is to be delivered under a Design & Build contract. A preferred supplier has been nominated and work commenced on 1 November 2020 under Pre-Construction Services Agreement funded by Trust (at risk).

Key milestones:

- FBC approved by Finance & Performance Committee (FPC) under delegated powers from Trust Board in December 2020 and forwarded to NHSI for approval.
- Joint Investment Committee (JIC) approval scheduled for 28 January 2021.
- The main contract signature has been delayed to 12 February 2021.
- MSCP complete 26 March 2022.

4.15 Following an updated decision from DHSC and NHSEI, the project to **Outsource Pathology Services** for the Integrated Care System (ICS) continues in the form previously outlined. Following initial bids from independent sector providers, face to face dialogue meetings will commence in February. These are designed to ensure bidders fully understand the detailed ICS requirements and for the ICS to understand the limitations of what bidders are able to provide. These meetings will run through to April. Following the dialogues an invitation for a 'best and final offer' (BAFO) will be issued in June 2021 with a view to appointing the preferred bidder by September.

The bidder analysis will be incorporated into full business cases to be presented to all ICS organisations in October with a view to signing contracts with the preferred bidder in November 2021. NHSEI have agreed that they will work alongside the project team to support analyses and decisions as opposed to requiring that the business case is submitted for separate approval. The wider hospital redevelopment programme is ideally supported by vacating the WGH pathology building by the summer of 2022. However the feasibility of this will be outlined in bidder face to face dialogues.

4.16 The **Strategic Priorities list for 2021-2022** is being revised with a number of completed schemes being removed e.g. Frailty, WGH UTC and emerging priorities being added. The Clinical Strategy and Capital Programme are expected to add to this list before the end of the financial year. A draft list for approval is expected to be presented to TMC in March.

5.0 Recommendation

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

OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Trust Board Meeting
4 February 2021

Title of the paper	**Clinical Strategy – Engagement Draft**
Agenda Item	15/87
Presenter	Helen Brown, Deputy Chief Executive Clare Parker, Director of Strategy and Integration
Author(s)	Clare Parker, Director of Strategy and Integration
Purpose	*Please tick the appropriate box* *For approval* ✓ | *For discussion* | *For information*
Executive Summary	We have really brought our vision 'the very best care for every patient, every day' to life over recent years through the efforts and commitment of #TeamWestHerts. Huge progress has been made to improve services for our patients; we moved out of 'special measures', won a range of national awards, reduced our vacancies and have seen our staff morale continue to rise. To build on this, our Trust strategy 2020 to 25 sets out how we will continue our successful improvement journey and deliver national and local priorities for the NHS. This clinical strategy sets out how we propose to organise, deliver and develop our services over the next five years to meet these challenges and deliver against our key aim of best care. We will also describe how we see the delivery of care changing as we move into our new hospital in 2025, supported by excellent digital technology to improve outcomes and patient experience. We have established a framework setting out the core elements of the clinical transformation that we need to achieve in order to deliver against the commitments in the NHS Long Term Plan and to ensure that our services are fit for purpose before we move into our new hospital in 2025. 

	This strategy sets clear ambitions for how we will improve our services. To deliver the very best care for every patient, every day: • We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population • We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate • We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population • We will be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy • We will personalise the care we deliver through shared decision making, taking account of the goals of the individual 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 • We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation • 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 • We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer. To enable the delivery of our strategy, we will: • Support our staff to develop a culture of compassionate leadership, providing the necessary mentorship and coaching • Support high quality education to all clinical learners in the Trust including the support and development of new clinical roles, and providing training and development to all staff to meet the changing ways in which care is delivered • Use digital to enable effective and efficient service delivery that values the time of our patients and staff • Develop a diagnostics strategy in recognition of the fundamental and increasing role that diagnostics play in care pathways • Redesign our business processes to improve patient and staff experience and support the delivery of best care. This strategy sets out a wide range of ambitions for the next five years. During the engagement phase of the development of this strategy we will identify the priorities for the clinical strategy by year, including any financial and workforce

<table>
<tr><td></td><td>implications. This will enable the development of a clear milestone plan by year which will feed into the annual corporate objectives for the trust and divisional business plans.

The plan for formal engagement with stakeholders and the community on the clinical strategy, alongside the clinical brief for the redevelopment and the three site strategy, appears later on the agenda under the item Service Redevelopment Engagement Plan.</td></tr>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><td>Aim 1
Best quality care
 
Objectives 1-5</td><td>Aim 2
Great place to work
 
Objectives 6-8</td><td>Aim 3
Improve our finances
 
Objective 9</td><td>Aim 4
Strategy for the future
 
Objective 10-12</td></tr>
<tr><td>✓</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>Clinical Advisory Group</td><td>27/1/21</td></tr>
<tr><td>Trust Management Committee</td><td>27/1/21</td></tr>
</table>
</td></tr>
<tr><td>Action required</td><td>The Board is asked to approve the engagement draft of the clinical strategy</td></tr>
</table>

West Hertfordshire Hospitals NHS Trust

Clinical Strategy

2021 – 2026

Engagement Draft

Contents

Executive summary

We have really brought our vision 'the very best care for every patient, every day' to life over recent years through the efforts and commitment of #TeamWestHerts. Huge progress has been made to improve services for our patients; we moved out of 'special measures', won a range of national awards, reduced our vacancies and have seen our staff morale continue to rise. To build on this, our Trust strategy 2020 to 25 sets out how we will continue our successful improvement journey and deliver national and local priorities for the NHS.

Providing the very best care for every patient every day doesn't just mean providing great care for local people when they are ill and receiving treatment in one of our hospitals. We need to work to improve the health of our population, not just manage ill health. We also need to join up care and constantly ask ourselves whether we can redesign care with local health and care partners, including voluntary sector providers, to make it more responsive, person-centred and better coordinated. For people with complex needs or long term conditions we need to plan ahead more and actively support people to manage their own health conditions at home or in primary and community care settings, and by doing this, prevent - as far as possible - the need for hospital care. There are also real opportunities to improve outpatient care by 'making every contact count'.

This clinical strategy sets out how we propose to organise, deliver and develop our services over the next five years to meet these challenges and deliver against our key aim of best care. However best care cannot be delivered in isolation, and much of this strategy will also describe how we will contribute towards our aims of great team and best value, as well as how we work with other health and social care providers. We will also describe how we see the delivery of care changing as we move into our new hospital in 2025, supported by excellent digital technology to improve outcomes and patient experience.

The clinical strategy also sits within the wider strategic context of the Herts and West Essex Integrated Care System health and care strategy *A Healthier Future,* which brings together the challenges and opportunities faced by organisations in Hertfordshire and West Essex as they work together to improve health and wellbeing within the funds available.

Our starting point

The Trust provides a wide range of acute emergency and planned services, with emergency care primarily provided at Watford Hospital; planned surgical and outpatient services, including some cancer services at St Albans City Hospital; and outpatient, diagnostic and urgent care services provided at Hemel Hempstead Hospital. This three-site arrangement supports local care provision, though the configuration of services across sites is in part a result of history and so creates some fragmentation.

We have a strong foundation on which to build our clinical strategy. From an organisation in special measures in 2015 with a CQC rating of 'inadequate', we have strengthened our services, leadership and governance so that we are now rated 'good' on the effective, caring and well led domains.

Figure E1: CQC ratings

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Watford General Hospital	Requires improvement →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Requires improvement →← Jun 2020	Good →← Jun 2020	Requires improvement →← Jun 2020
St Albans City Hospital	Requires improvement ↑ Jun 2020	Requires improvement →← Jun 2020	Good →← Jun 2020	Good ↑ Jun 2020	Good ↑↑ Jun 2020	Requires improvement ↑ Jun 2020
Hemel Hempstead Hospital	Requires improvement →← Jun 2020	Good ↑ Jun 2020	Good →← Jun 2020	Good ↑ Jun 2020	Requires improvement ↑ Jun 2020	Requires improvement ↑ Jun 2020
Overall trust	Requires improvement →← Jun 2020	Good ↑ Jun 2020	Good →← Jun 2020	Requires improvement →← Jun 2020	Good ↑ Jun 2020	Requires improvement →← Jun 2020

2020 has been dominated by the Covid-19 pandemic, with very high patient numbers in both the first and second waves. This was very challenging and often traumatic for staff to manage. The need to focus on these patients has inevitably impacted on waiting times and access for our planned care patients, which we will need to address.

The NHS Long Term Plan was published in January 2019 and sets out the overall NHS strategy to improve health and health outcomes. It describes five key changes to the NHS care model:

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.
2. The NHS will **redesign and reduce pressure on emergency hospital services.**
3. People will get more control over their own health, and **more personalised care** when they need it.
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS.
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

This strategy will describe how WHHT will achieve the ambitions set out in the Long Term Plan.

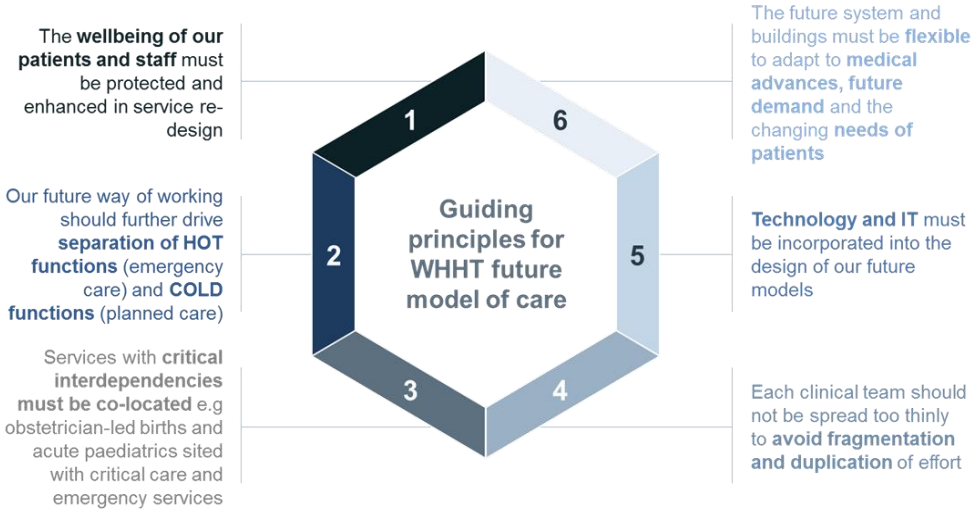
We are part of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS is working together in partnership to improve the health and wellbeing of the population of Hertfordshire and West Essex. The ICS has developed an integrated health and social care strategy, *A Healthier Future*, which all organisations have committed to delivering. The strategy is based on a 'population health' approach, which is a short-hand term to describe the aspiration of improving the overall health and wellbeing of a defined population – whether that's the whole population of a geographical area, such as Hertfordshire and West Essex, or a particular group of that population, such as children or frail elderly people.

To deliver the ICS strategy we have agreed to form an integrated care partnership (ICP) with the other NHS and local government organisations that commission or deliver care for the population of West Hertfordshire. These partners are Herts Valleys CCG, Central London Community Healthcare NHS Trust; Hertfordshire Community NHS Trust, Hertfordshire Partnerships NHS Foundation Trust and Hertfordshire County Council. This will require a shift in focus away from the traditional reactive NHS model of supporting people when they are ill, towards a more proactive approach that enables people to manage and improve their own health – while still providing best care to people when they need it.

The Trust fully supports the aims of the ICP and delivery of a population health management approach and expects to play a key role in its development. We are committed to working in different ways to meet the needs of our population; working to improve health and reduce health inequalities as well as meeting the acute health care needs of our patients.

Our current physical environment is not fit for the delivery of 21st century medicine, and our service configuration across our three sites is not optimal. We have been identified as one of the first group of trusts to receive capital funding through the Hospital Improvement Programme, and in parallel with this clinical strategy are working on the clinical brief and site strategy for the redevelopment. We have agreed 6 strategic underpinning principles for the clinical model which also underpin this strategy:

Figure E2: Strategic principles for the clinical model for the redevelopment



We have developed a 'clinical brief' for our redevelopment – this sets out what services we plan to deliver from each of our three hospitals and informs the detailed design work undertaken by our architect-led design team. We will publish our clinical brief as a separate document that compliments this clinical strategy. The clinical brief is a 'live' document which will continue to develop over the next five years.

It is not possible to specify now exactly how services will be delivered in 5, 10 or 20 years' time so we plan to design our new hospitals to be as flexible as possible and adapt as services change and develop over time.

We plan to engage widely with stakeholders over the coming months and years and will adapt our clinical brief to reflect the latest thinking as our planning work progresses.

Specifically the brief will be reviewed at full business case (FBC) stage, before we finalise designs for new facilities.

Our strategic ambitions

We have established a framework setting out the core elements of the clinical transformation that we need to achieve in order to deliver against the commitments in the NHS Long Term Plan and to ensure that our services are fit for purpose before we move into our new hospital in 2025.

Figure E3: clinical strategy framework

This strategy sets clear ambitions for how we will improve our services. To deliver the very best care for every patient, every day:

- We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population
- We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate
- We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population
- We will be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy
- We will personalise the care we deliver through shared decision making, taking account of the goals of the individual 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

- We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation
- 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
- We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer.

To enable the delivery of our strategy, we will:

- Support our staff to develop a culture of compassionate leadership, providing the necessary mentorship and coaching
- Support high quality education to all clinical learners in the Trust including the support and development of new clinical roles, and providing training and development to all staff to meet the changing ways in which care is delivered
- Use digital to enable effective and efficient service delivery that values the time of our patients and staff
- Develop a diagnostics strategy in recognition of the fundamental and increasing role that diagnostics play in care pathways
- Redesign our business processes to improve patient and staff experience and support the delivery of best care.

More detail on this enabling work is set out in our people strategy (2019) which includes education and training; our digital strategy (2020); our research strategy (2020) and our diagnostic strategy (in development).

Best Care

Our first priority is to provide consistent, high quality local acute services to our population. This means that when people need planned care we will see, diagnose and treat them as quickly as possible, and that when people need urgent or emergency care they will have rapid access to someone who can make an early decision about what treatment they need and ensure effective treatment is initiated as quickly as possible to optimise outcomes and reduce time spent in hospital. We also want to make the most of our strengths by identifying a subset of our services that go beyond the normal scope of services within a local hospital to create areas of excellence that offer a wider range of services to our

population, reducing the need for local people to travel into London and helping us to attract and retain more specialist clinicians.

Working in partnership to deliver new care models

We do not operate in isolation from other acute providers. In addition to our tertiary patient pathways to other providers, we are part of the Hertfordshire and West Essex integrated care system, which also includes East and North Hertfordshire NHS Trust and Princess Alexandra NHS Trust. We also have a clinical partnership with the Royal Free, through which we are working to standardise our clinical pathways through the clinical practice group programme, and we are part of several specialist networks such as maternity and cancer. These relationships give us the opportunity to work with key partners in a more strategic way to improve patient care and address shared problems such as workforce shortages through networked approaches.

In addition, we are a key partner in the West Herts Integrated Care Partnership (ICP), which is focused on improving health outcomes for the local population. There are many ways that we wish to work differently with our local partners going forward to improve the care that people receive from our services.

Integrated Care

When people need to use our services, their journey rarely starts and finishes at the front door of the hospital. People using elective services are normally referred by their GP or a community service, and are often followed up by the GP afterwards or between appointments. People using emergency services often attend the hospital by ambulance, and receive care from community providers or nursing homes after they are discharged. We need to remove the artificial walls between different parts of the NHS and social care so that our patients and carers experience seamless services.

The increasing number of people with long-term health conditions means that it is now vital for us to work with partners in primary, community and social care so that we understand and address the holistic needs of individuals, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care. We have adopted the definition of integrated (co-ordinated) care set out by National Voices in 2013 following extensive engagement work:

'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'

We will work with our partners in the ICP to implement integrated care models that reflect good practice and are targeted to the needs of our population.

Personalised Care

Personalised care is one of the five major service model changes in the NHS Long Term Plan. Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. It involves supporting people to talk about the outcomes that matter most to them; encouraging and enabling them to take on as much responsibility as they are able to manage their own care, health and wellbeing; and acknowledging them all as experts in their own care and lives. This shift represents a new relationship between people, professionals and the health and care system and provides a positive change in power and decision making that enables people to feel informed, have a voice and be heard. Working with our partners in the ICP, we will increasingly personalise the care that our patients receive.

As part of our approach to personalised care, we will give consideration to how inequalities impact on individual patients, and tailor our approach appropriately. This could include how we support reasonable adjustments for people with additional needs such as learning disabilities, how we support carers, or how we adjust pathways to take account of known variations in outcomes for particular population groups.

Consistent Care

The best performing hospitals in the country have developed really strong safety and quality improvement cultures which support and enable all staff to reduce harm, learn from mistakes and improve care. We have started this work and have many areas of good practice and pockets of excellence. Continuing to strengthen our quality improvement culture across all our services and improving how we use data and research to improve care is an essential element in delivering our 'best care' aim over the next five years.

We have an established partnership with the Royal Free London and partners to drive continuous improvement in care through the 'Clinical Practice Group' (CPG) programme. This brings clinicians together to design and systematically implement best practice 'care pathways' for common clinical conditions, continuously testing and improving design using in-depth monitoring and analysis. We will use this approach to develop a series of approximately 80 pathways managing the most burdensome health issues that are continuously evidenced as being the most efficient and effective way of managing that condition. This will improve efficiency and reduce costs, as well as underpin an approach of continuous improvement through the use of data to evidence best outcomes.

Our approach to consistent care will also ensure that we provide consistent access to specialist opinion through timely advice and guidance services, clinically effective use of virtual consultation models and seamless diagnostic and tertiary pathways.

Divisional and service strategies

Our clinical services are delivered by five clinical divisions; each division will be responsible for implementing the ambitions and commitments within this clinical strategy. Key priorities and plans at a service level have been reviewed as part of developing this strategy to ensure we have the most accurate information and assumptions about future need, new models of care, opportunities for integration and collaboration, and potential in terms of education and research. Section 5 of this strategy sets out the divisional and service level priorities that support the overall trust strategy.

Implementation and milestones for the next 5 years

This strategy sets out a wide range of ambitions for the next five years. During the engagement phase of the development of this strategy (February to June 2021) we will identify the priorities for the clinical strategy by year, including any financial and workforce implications. This will enable the development of a clear milestone plan by year which will feed into the annual corporate objectives for the trust and divisional business plans.

Ambition	Commitment	Trust Strategic Priorities			
		BC	BV	GT	GP
We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population	Implement the national '111 First' approach	■			
	Work with HVCCG to define the future model of urgent care for the St Albans and Harpenden population	■	■		
	Ensure people are seen quickly within our emergency department (ED), with rapid access to specialty opinion when needed so that decisions about their future care can be made promptly (SMART).	■	■	■	
	Further expand our emergency assessment unit capacity to bring together an integrated model to maximise same day emergency care across all specialties and provide a permanent base for our frailty service	■	■	■	■
	Develop and expand our virtual hospital model as our best practice standard	■	■	■	
	Review emergency surgical pathways and ensure we have enough ring-fenced emergency theatre capacity so that patients can receive timely care	■	■		■
	Adopt a 'getting it right first time' approach, to get the right patient to the right place for the care they need first time, reducing the number of times that a patient has to move within the hospital	■	■	■	
	Continue to work with system partners to improve discharge pathways out of the hospital.	■	■	■	
	Develop a more proactive understanding of needs, demand and capacity so that we can better respond to changes in demand and keep waiting times short	■			
	Increase planned surgery at SACH by improving utilisation of our theatres, increasing on-site diagnostic provision (MRI and CT) and providing an enhanced level of post-operative care so that patients with more complex needs can be treated there	■	■	■	■
	Modernise our patient communication and booking processes, innovating to improve and constantly talking to and learning from our service users and their carers to make the patient experience as good as possible	■	■	■	
	Make full use of emerging digital technology, with a culture that seeks and supports innovation	■	■		
	Review the activity volumes undertaken in our smaller specialties, with the intention of improving outcomes for our population by either developing a network approach with another provider to strengthen and support our service or to stop delivering the service altogether	■		■	
	Review those specialties where care is delivered by third party consultants to ensure they best meet the needs of our patients, and change the delivery model where required	■		■	
	Review all of our existing clinical pathways to other providers to rationalise them where this is in the best interests of patients	■			
	Explore where we can further develop strategic partnerships to improve outcomes or address workforce challenges.	■		■	

Ambition	Commitment	Trust Strategic Priorities			
		BC	BV	GT	GP
	Review the potential to work with partners to co-locate elements of cancer provision currently provided at Mount Vernon Cancer Centre onto the Watford General Hospital site as part of our redevelopment plans.				
	Review where there are opportunities to repatriate activity that currently is undertaken by London (or other out of area) hospitals but which could be effectively and safely delivered on one of our trust sites.				
	Expand and develop our care of the elderly service to better meet the needs of our patients, working closely with partners in the community to deliver care as close to home as possible				
We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate	Always seek to innovate and to use new technologies to continuously improve the care that we can provide in the lowest intensity clinical setting available				
	Provide people with a diagnosis on the day wherever clinically possible to reduce the period of uncertainty and anxiety				
	Increase the capacity of diagnostics available across our sites, including development of a rapid diagnostics centre at SACH				
	Remove same day multi-site pathways as quickly as it is clinically safe to do so.				
We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population	Implement continuity of care from antenatal to postnatal care, reflecting the recommendations of the national strategy *Better Births*.				
	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 and reflecting best practice				
	Integrate our new electronic patient record with primary, community, mental health and ambulance records so that information relating to the person's health is available to clinicians in all settings to support their decision making				
	Ensure all patients who require specialist input can access it quickly, enabling a clear care plan to be developed for their time in hospital and to allow early planning for their discharge should they be admitted				
	Integrate social care, community and mental health support into the emergency department model				
	Where applicable, ensure that patients are assessed for future care needs in their home or future environment not within the hospital				
	Improve our communication with the patient and their GP on discharge, to ensure that any additional support required in the community is put into place, followed up with a compassionate conversation within 24 hours				
	Working with partners fully implement the ICS-agreed model of care for frailty				
	As part of our work with the West Herts ICP, use data and risk stratification to identify people in their last phase of life, and use an integrated care planning approach to discuss and agree their goals with them				
We will be active leaders in our integrated care partnership, reaching outside of our traditional	Understand and reduce the health inequalities within our local population, working in co-production with communities to understand their needs and appropriately adapt our services to personalise care				

Ambition	Commitment	Trust Strategic Priorities			
		BC	BV	GT	GP
boundaries to help improve the health and wellbeing of our population and to keep people healthy	Through our ICP work with communities to address some of the causes of inequalities, and empower people to improve their own health and wellbeing				
We will personalise the care we deliver through shared decision making, taking account of the goals of the individual 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	Improve the information that we provide to patients to help them to understand their treatment options and support informed consent				
	Increase the understanding of patients about their condition and to build in reflection time before patients consent to procedures to enable them to consider and raise any questions or concerns that they may have				
	Give consideration to how inequalities impact on individual patients, and tailor our approach appropriately				
	Integrate our pathways for long term conditions with primary care, community and mental health to ensure that patients only have one care plan across all their providers and that it is jointly developed and shared				
	Implement patient initiated follow ups in all areas where it is clinically appropriate				
	Use our existing strategic partnerships to ensure that our population can access and benefit from advances in precision medicine				
We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation	Use the CPG approach to develop a series of approximately 80 pathways managing the most burdensome health issues that are continuously evidenced as being the most efficient and effective way of managing that condition				
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	Make timely advice and guidance services available to GPs across all our specialties				
	Maximise the clinically effective use of virtual consultation models				
	Redesign elective pathways to ensure that diagnostic tests are undertaken at the right point in the pathway to facilitate diagnosis without unnecessary tests being undertaken				
	Make our tertiary pathways seamless, and involve patients in multidisciplinary discussions about their care where they wish to be involved.				
	Consistently implement one stop clinics that enable test and diagnosis on the same day				
	Expand our range of multidisciplinary clinics, starting with the most common overlapping conditions, so that care is more joined up				
We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer.	Use and embed new technologies as an integral part of our building and new ways of working				

1. Introduction

We have really brought our vision 'the very best care for every patient, every day' to life over recent years through the efforts and commitment of #TeamWestHerts. Huge progress has been made to improve services for our patients; we moved out of 'special measures', won a range of national awards, reduced our vacancies and have seen our staff morale continue to rise. To build on this, our Trust strategy 2020 to 25 sets out how we will continue our successful improvement journey and deliver national and local priorities for the NHS. It describes our four key aims:

Figure 1.1: The 4 key aims from the WHHT Strategy 2020-2025

Our quality ambition is to match the highest performing NHS hospitals. In some areas our performance is comparable, for example, on mortality and harm-free care indicators. But there are others where we can improve, such as performance against waiting time standards. We want to ensure consistent high quality across everything we do, ensuring that our patients and their carers have a great experience of care.

Providing the very best care for every patient every day doesn't just mean providing great care for local people when they are ill and receiving treatment in one of our hospitals. We need to work to improve the health of our population, not just manage ill health. We also need to join up care and constantly ask ourselves whether we can redesign care with local health and care partners, including voluntary sector providers, to make it more responsive, person-centred and better coordinated. For people with complex needs or long term conditions we need to plan ahead more and actively support people to manage their own health conditions at home or in primary and community care settings, and by doing this,

prevent - as far as possible - the need for hospital care. There are also real opportunities to improve outpatient care by 'making every contact count'.

Along with the rest of the NHS and other healthcare systems, we are now facing a very difficult set of challenges – most significantly, the need to transform healthcare to meet the needs of many more people living longer and epidemic levels of chronic conditions such as diabetes and heart disease. The recent pandemic has also shown us how vulnerable we are to viruses in the increasingly global world we live in. At the same time, scientific and clinical innovation is hugely extending our ability to save lives and to improve people's quality of life through digital technology that allows people to manage their own care with reduced reliance on institutional settings.

We also have the challenge of delivering high quality care within a poor quality estate that is increasingly unfit for purpose. We have been lucky enough to secure capital funding to allow us to redevelop our sites, and we must ensure that we are able and ready to deliver 21st century care within our 21st century facilities by 2025.

This clinical strategy sets out how we propose to organise, deliver and develop our services over the next five years to meet these challenges and deliver against our key aim of best care. However best care cannot be delivered in isolation, and much of this strategy will also describe how we will contribute towards our aims of great team and best value. We will also describe how we see the delivery of care changing as we move into our new hospital in 2025, supported by excellent digital technology to improve outcomes and patient experience.

The strategy has been led by senior clinicians across the Trust and draws on detailed evidence and input from a wide range of sources. We have worked with staff, service users and our partner organisations including Herts Valleys CCG, our local clinical commissioning group to develop this draft strategy.

The clinical strategy is a core component of the Trust's wider strategy. Its development has been guided by our organisational vision and strategic ambitions; in turn, it is influencing the development of other Trust-wide strategies, such as those for estates, people and digital. Our clinical ambition is such that implementing the clinical strategy will require far-reaching transformation over the next five years, both within our own organisation and with our partners in primary care, community, mental health and social care.

The clinical strategy also sits within the wider strategic context of the Herts and West Essex Integrated Care System health and care strategy *A Healthier Future,* which brings together the challenges and opportunities faced by organisations in Hertfordshire and West Essex as they work together to improve health and wellbeing within the funds available.

2. Our starting point

2.1. Our Services

The Trust provides a wide range of acute emergency and planned services, with emergency care primarily provided at Watford Hospital; planned surgical and outpatient services, including some cancer services at St Albans City Hospital; and outpatient, diagnostic and urgent care services provided at Hemel Hempstead Hospital. This three-site arrangement supports local care provision, though the configuration of services across sites is in part a result of history and so creates some fragmentation.

Our future plans for our three hospitals are summarised briefly in section 2.12, and in more detail in our redevelopment 'clinical brief' which is being developed as an annexe to this strategy.

Our main commissioner is Herts Valleys CCG (HVCCG), with nearly 90% of our patients residing in the Herts Valleys area, with residents of North West London making up most of the rest of our patient base. We provide the majority of elective and non-elective acute care for this population but also have strong links and established referral pathways into London and neighbouring hospitals when our patients need more specialist care than we are able to provide locally.

Not everyone living within Herts Valleys CCG uses our services, particularly those who live in Hertsmere for whom Barnet Hospital (run by the Royal Free NHS Foundation Trust) is the closest acute hospital, and those living in Harpenden for whom Luton & Dunstable is the closest hospital.

These different flows are important in the context of the West Herts Integrated Care Partnership (ICP), which will be responsible for all people registered with a GP in Herts Valleys, not just those who use WHHT acute services. More information on the development of the ICP is set out in section 2.8.

2.2. Our population

Herts Valleys CCG has a registered population of over 600,000; 35-59 year olds are the largest proportion of the population. 18.9% of the population are aged 14 years or younger and 16.1% of the population are aged 65 years and over. 14.6% of the population are from BAME backgrounds, with the majority being Asian or British Asian. Watford has the highest proportion of people from BAME backgrounds with 28.1%.

Generally, areas within the CCG are affluent; of all the districts within the CCG Watford and Hertsmere have the highest deprivation scores. Areas within Borehamwood, Hemel Hempstead, and Watford have the highest proportion of children and young people, and older people living in poverty.

Life expectancy is similar to or higher than the average for England. Watford has the lowest life expectancy of the 5 districts within the CCG. Inequalities in life expectancy are highest Dacorum and Hertsmere for males, and Dacorum, Hertsmere and St Albans for females. Watford district has a higher than expected mortality rate for all cause, all age deaths. All age deaths are higher than expected for circulatory related, strokes, and respiratory deaths in Watford, and respiratory deaths in Hertsmere.

Hypertension (12.7%), depression (10.1%), obesity (8.3%), and diabetes (6.0%) have the highest prevalence within the population and 33.72% of the population in Herts Valleys CCG have multi-morbidity (two or more long term conditions).

The uptake of diabetic retinopathy screening, breast cancer and bowel cancer screening are above the target (or national average), but the uptake for cervical screening is below the national target. The uptake of the majority of childhood immunisations, and the flu vaccine in school aged children, people aged under 65 years with risk factors and pregnant women, and carers is below the national target.

A health needs assessment completed during autumn 2020 proposed the following areas of focus to improve health:

- Ante- and post-natal care
- Integrated lifestyle programme
- Long term conditions
- Falls prevention
- Mental health
- Communicable diseases
- Digital exclusion
- Population health management.

The West Herts ICP is currently developing a clinical and care integration strategy, which will use the health needs analysis as a starting point. We will ensure that there is consistency between this clinical strategy and the final ICP clinical strategy.

2.3. Performance & achievements

We have a strong foundation on which to build our clinical strategy. From an organisation in special measures in 2015 with a CQC rating of 'inadequate', we have strengthened our services, leadership and governance so that we are now rated 'good' on the effective, caring and well led domains.

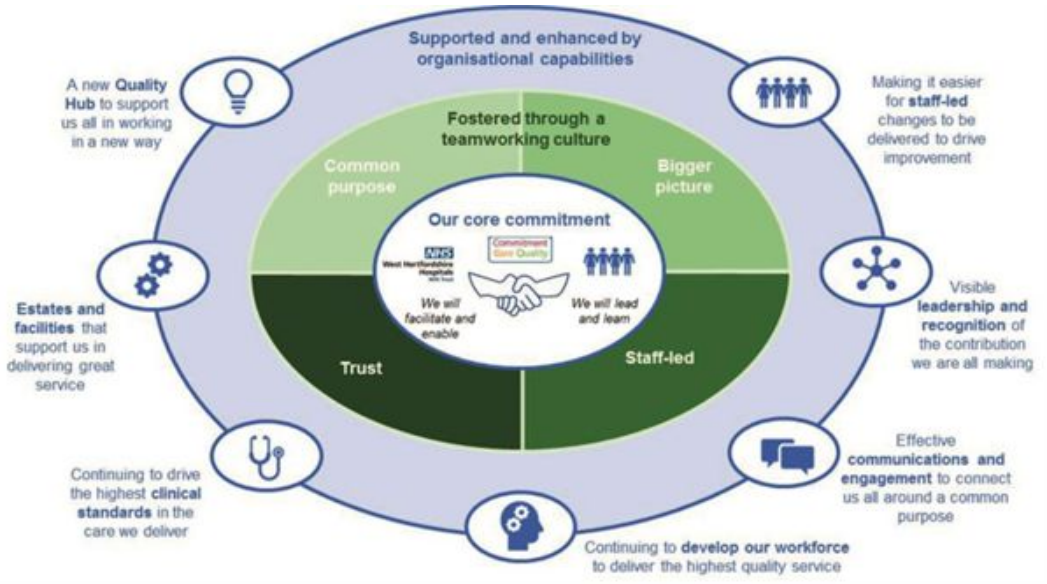
Figure 2.1: CQC ratings

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Watford General Hospital	Requires improvement ➔➔ Jun 2020	Good ➔➔ Jun 2020	Good ➔➔ Jun 2020	Requires improvement ➔➔ Jun 2020	Good ➔➔ Jun 2020	Requires improvement ➔➔ Jun 2020
St Albans City Hospital	Requires improvement ↑ Jun 2020	Requires improvement ➔➔ Jun 2020	Good ➔➔ Jun 2020	Good ↑ Jun 2020	Good ↑↑ Jun 2020	Requires improvement ↑ Jun 2020
Hemel Hempstead Hospital	Requires improvement ➔➔ Jun 2020	Good ↑ Jun 2020	Good ➔➔ Jun 2020	Good ↑ Jun 2020	Requires improvement ↑ Jun 2020	Requires improvement ↑ Jun 2020
Overall trust	Requires improvement ➔➔ Jun 2020	Good ↑ Jun 2020	Good ➔➔ Jun 2020	Requires improvement ➔➔ Jun 2020	Good ↑ Jun 2020	Requires improvement ➔➔ Jun 2020

We have a clear commitment to quality that is described in figure 2.2 and which supports a culture of teamwork driving continuous improvement in everything we do.

Figure 2.2: Our quality commitment



Historically we have not met emergency care or elective waiting times targets, but had made significant improvements before the Covid pandemic. Elective waiting times improved from 80% to 87% against the 90% target from April 2019 to February 2020, while a pilot project involving medical consultant input in the emergency department (SMART) helped to move the trust from 112th out of 134 reporting providers that had a type 1 facility in January 2019 to 42nd of 118 reporting providers in December 2019. Like all trusts our elective waiting times and our elective capacity have been affected by the need to prioritise

the treatment of Covid positive patients, and we will need to recover the ground lost as a key priority over the next two years.

2.4. Challenges

We identified a number of challenges for the Trust that also need to be considered in relation to the clinical strategy:

- Physical infrastructure: 57% of the Trust estate – and 80% of the WGH estate - is below Condition B, which is considered to be the minimum acceptable condition. We are currently developing the outline business case for our redevelopment and the clinical brief for how we will deliver services within the new hospital

- Electronic patient record: the Trust does not currently have an electronic patient record, meaning that records are paper based. This leads to significant inefficiencies in the delivery of care and prevents us from integrating our records with those of other providers such as primary care, meaning we have less information available when treating patients which can lead to sub optimal patient experience. We have approved a full business case to invest in an electronic patient record before we redevelop the hospital

- Workforce: we have made great progress in supporting and developing our workforce, as shown by significant reductions in nursing vacancy rates and improved scores in our staff survey. However, in common with the rest of the country we are experiencing recruitment challenges in areas where demand is growing such as radiography and radiology, and we have lower numbers of training doctors than some of our near neighbours in London which affects our longer term ability to recruit consultants. Covid has also had an impact on our staff, both from a direct health and wellbeing perspective and how we are able to engage them across a range of key trust priorities

- Patient and stakeholder engagement: We recognise that we need to do more to build two-way relationships with our patients, the local community and wider stakeholders, particularly as we embark on significant change. We have a vision for increased co-production with service users and have set up a co-production board and a redevelopment stakeholder reference group but there is more for us to do, particularly as Covid has also affected our ability to engage in face to face environments

- Funding: The NHS remains subject to significant funding pressures and WHHT has historically had a large deficit. Over the past three years, we have achieved over £40m of recurrent savings whilst meeting increased demand and improving quality and safety. In 2019/20, although we met financial targets set for us, our underlying

deficit was £50m. Changes in the financial regime as a result of Covid have increased our support funding from NHS Improvement to enable us to achieve a breakeven position. However, cost pressures are likely to outstrip NHS funding and we need to continue to deliver savings. Historically increases in funding have been at least 1% lower than general inflation. In addition NHS specific inflation and unfunded new service demands have necessitated an additional 3% per annum to maintain financial balance. If savings are made recurrently at 4% for the 2021/22 and 22/23 years the need for further savings at this level should fall. However the new hospital redevelopment will change the need for savings to finance the charges applicable to the capital investment

- Administration and management processes: As well as the lack of an electronic patient record, we have complex administration and management processes that reduce efficiency and impact on patient experience, such as multiple different places from which outpatient appointments are booked. We need to redesign our business processes as we change our digital and physical infrastructure.

2.5. Impact of Covid-19

The West Herts experience of the Covid-19 pandemic was similar to that of London. In wave 1 we saw very high patient numbers at an early stage of the incident, with numbers peaking at over 250 in the hospital during April. This was very challenging and often traumatic for staff to manage. The hospital estate is not well designed to deal with the challenges of separate patient pathways that need to be managed during an epidemic, and as we look to the new hospital we will be considering how we take our learning from Covid to influence the design. At the time of writing this strategy we are at the height of the January 2021 wave of Covid-19, with patient numbers reaching 350. The need to focus on these patients has inevitably impacted on waiting times and access for our planned care patients, as referenced in section 2.3.

However, we saw significant innovation and leadership from our clinicians as part of our response to the circumstances we faced, including much closer and very effective working with our partners in community and social care, as well as delivering more care virtually where it could be done safely. We were a national leader is developing a Covid virtual hospital which enables us to safely manage the care of people in their own homes, avoiding hospital admissions. This model has now been adopted nationally and more detail is given on page 32. This strategy will build on this experience to continue to innovate, to improve the integration of our services with partners, delivering more joined up care for patients; and maximise the use of new digital technologies to support delivery of care at home, reducing the need for local residents to attend hospital or be admitted for inpatient care.

2.6. The NHS Long Term Plan

The NHS Long Term Plan was published in January 2019 and sets out the overall NHS strategy to improve health and health outcomes. The plan describes how the NHS will be:

- more joined-up and coordinated in its care
- more proactive in the services it provides
- more differentiated in its support offer to individuals.

Demand for NHS services continues to grow. Some causes are either desirable or unavoidable:

- **our growing and ageing population**, inevitably increasing the number of people needing NHS care and the intensity of support they require;
- growing visibility and concern about areas of longstanding **unmet health need** (for example in young people's mental health services);
- **expanding frontiers of medical science and innovation**, introducing new treatment possibilities that a modern health service should rightly be providing (for example, new cell and gene therapies).

But some demand drivers are potentially modifiable by:

- action so that people get the right care at the right time in the **optimal care setting** (for example, providing better support to people living in care homes to avoid emergency hospital admissions; providing better social care and community support to slow the development of older people's frailty; and fundamentally redesigning outpatient services so that both patients' time and specialists' expertise are used more appropriately);
- improving **upstream prevention** of avoidable illness and its exacerbations. So for example, smoking cessation, diabetes prevention through obesity reduction, and reduced respiratory hospitalisations from lower air pollution. This can also be achieved through better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions.

The Long Term Plan describes five key changes to the NHS care model:

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.
2. The NHS will **redesign and reduce pressure on emergency hospital services.**

3. People will get more control over their own health, and **more personalised care** when they need it.
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS.
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

This strategy will describe how WHHT will achieve the ambitions set out in the Long Term Plan.

2.7. Hertfordshire and West Essex Integrated Care System

We are part of the Hertfordshire and West Essex Integrated Care System (ICS), which includes the following organisations:

- NHS commissioners: Herts Valleys CCG, East & North Herts CCG and West Essex CCG. The CCGs have a single management team and are planning to merge by April 2022
- Acute providers: East & North Herts NHS Trust and Princess Alexandra Hospital NHS Trust
- Community and mental health providers: Central London Community Healthcare NHS Trust; Hertfordshire Community NHS Trust; Hertfordshire Partnerships NHS Foundation Trust; Essex Partnership University NHS Foundation Trust
- Local authorities: Hertfordshire County Council and Essex County Council.

The ICS is working together in partnership to improve the health and wellbeing of the population of Hertfordshire and West Essex. Our approach is based on the principles of population health management, which is a way of targeting our collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services. Our key priorities are:

- Meeting people's health and social care needs in a joined-up way in their local neighbourhoods, whenever that's in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently as possible for as long as possible
- Adopting a shared approach to treating people when they are ill and prioritising those with the highest levels of need, reducing the variations in care which currently exist
- Placing equal value and emphasis on people's mental and physical health and wellbeing in all we do

- Driving the cultural and behavioural change necessary to achieve the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future

- Ensuring that we have the workforce, technology, contracting and payment mechanisms in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

The ICS has developed an integrated health and social care strategy, *A Healthier Future*, which all organisations have committed to delivering. The strategy can be found at https://www.healthierfuture.org.uk/sites/default/files/publications/2019/April/nm-summary-version-draft-hwe-integrated-strategy-executive-slide-deck-v71.pdf

2.8. West Herts Integrated Care Partnership

To deliver the ICS strategy we have agreed to form an integrated care partnership (ICP) with the other NHS and local government organisations that commission or deliver care for the population of West Hertfordshire. These partners are Herts Valleys CCG, Central London Community Healthcare NHS Trust; Hertfordshire Community NHS Trust, Hertfordshire Partnerships NHS Foundation Trust and Hertfordshire County Council.

The vision for the ICP is:

All partners working effectively together to reduce health inequalities and improve the health and wellbeing of people in Hertfordshire.

This means:

- *Local people are supported to stay well and live healthy lives in their communities*
- *People who need care and support will have the same opportunities for a good life as people who do not*
- *People and carers of all ages are empowered to take an active part in directing their own care and support*
- *People will receive their care and treatment in the right place, from the right people at the right time*
- *People will experience high quality, joined up services*
- *People will receive care in a financially sustainable system.*

Hospitals are, in the main, responsible for meeting the health needs of people who are ill and need specialist care and treatment. Payment has historically been on a case-by-case basis, but in an ICP model we will share responsibility with partners for preventing ill health, enabling earlier diagnosis and treatment and ensuring care is joined-up. The way we are funded is changing to reflect this, with a move towards 'fixed' or 'population' budgets.

2.9. Population Health Management

A 'population health' approach is a short-hand term to describe the aspiration of improving the overall health and wellbeing of a defined population – whether that's the whole population of a geographical area, such as Hertfordshire and West Essex, or a particular group of that population, such as children or frail elderly people.

The aims of population health are:

- Improving mental and physical health
- Improving people's experiences of services
- Reducing health inequalities (improving the health of those with the worst health, so that their health and wellbeing is more comparable with our healthiest residents)
- Lowering costs
- Improving the health and wellbeing of staff.

'Population health management' is an approach which enables us to target our collective resources where evidence shows there is the biggest problem and where we can have the greatest impact. Health and care partners in HWE have agreed to deliver joined-up services to defined groups of the population. In this way, we will prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points.

The Trust fully supports the aims of the ICP and delivery of a population health management approach and expects to play a key role in its development. We are committed to working in different ways to meet the needs of our population; working to improve health and reduce health inequalities as well as meeting the acute health care needs of our patients.

2.10. Royal Free clinical partnership

Complementing our local ICP relationships, we also have a clinical partnership with the Royal Free Hospital group, which includes work on the 'Clinical Practice Group' (CPG) programme. This brings clinicians together to design and systematically implement best practice 'care pathways' for common clinical conditions, continuously testing and improving design and reducing variation in care using in-depth monitoring and analysis.

Our work with the Royal Free on the CPG programme to reduce variation in care is a core element of our clinical strategy reflecting our commitment to deliver **consistent** high quality care for all our patients.

2.11. Digital transformation

We are also working with the Royal Free on a joint electronic patient record programme with an ambitious programme to roll out a full electronic patient record within the next 2

years. This is one part of our broader 'digital strategy' which sets out in detail how we plan to improve our IT infrastructure and develop our digital capability to support care delivery.

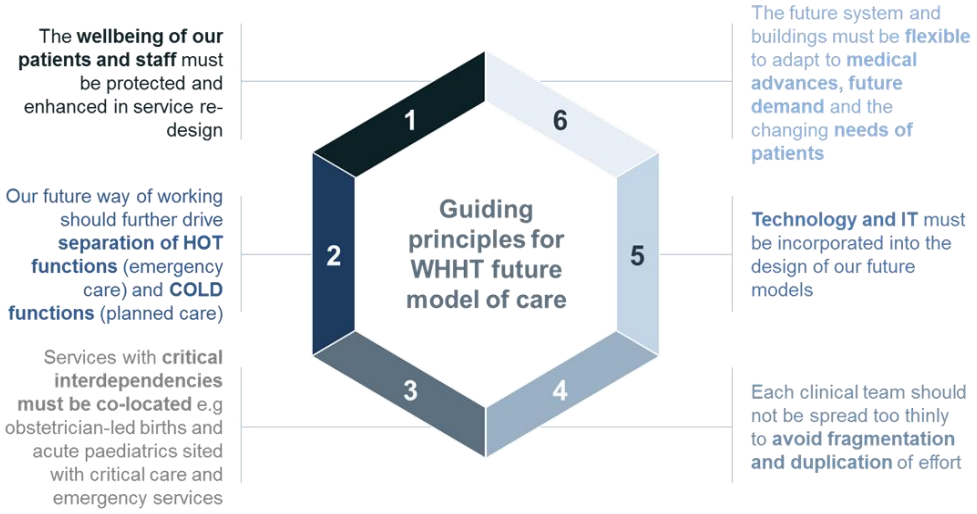
Our digital vision is that digital underpins every aspect of clinical innovation. We will provide the core digital foundation to empower the population of West Hertfordshire, support our staff to provide high-quality, safe, consistent and efficient care for every patient, every day. The digital strategy has 5 core themes, as shown in figure 2.3.

Figure 2.3: Core themes underpinning our digital strategy

2.12. Redeveloping our hospitals

Our current physical environment is not fit for the delivery of 21st century medicine, and our service configuration across our three sites is not optimal. We have been identified as one of the first group of trusts to receive capital funding through the Hospital Improvement Programme, and in parallel with this clinical strategy are working on the clinical brief and site strategy for the redevelopment. We have agreed 6 strategic underpinning principles for the clinical model which also underpin this strategy:

Figure 2.4: Strategic principles for the clinical model for the redevelopment



This strategy focuses on what we want to achieve clinically rather than on the location we expect to deliver it from, and the first five years of the strategy will be delivered in our existing estate ahead of the planned redevelopment. The strategy therefore links to and informs the redevelopment, but is independent of it.

We have developed a 'clinical brief' for our redevelopment – this sets out what services we plan to deliver from each of our three hospitals and informs the detailed design work undertaken by our architect-led design team. We will publish our clinical brief as a separate document that compliments this clinical strategy. The clinical brief is a 'live' document which will continue to develop over the next five years.

It is not possible to specify now exactly how services will be delivered in 5, 10 or 20 years' time so we plan to design our new hospitals to be as flexible as possible and adapt as services change and develop over time.

We plan to engage widely with stakeholders over the coming months and years and will adapt our clinical brief to reflect the latest thinking as our planning work progresses.

Specifically the brief will be reviewed at full business case (FBC) stage, before we finalise designs for new facilities.

3. Our strategic ambitions

3.1. Clinical strategy framework

We have established a framework setting out the core elements of the clinical transformation that we need to achieve in order to deliver against the commitments in the NHS Long Term Plan and to ensure that our services are fit for purpose before we move into our new hospital in 2025.

Figure 3.1: clinical strategy framework

To achieve our ambition of best care, we first need to be clear about what services we are best placed to provide and where we can achieve better patient experience or outcomes if care is delivered by other organisations or in alternative settings.

Secondly, we need to work with partners to develop our care model so that our services are better integrated, more personalised to the individual patient and their goals, and more consistent with less clinically unwarranted variation in care.

We then need to be clear how we ensure that we have the right people and infrastructure to enable us to be successful, as described through our enabling strategies.

The framework above summarises our approach and our ambition to provide consistently high quality services with areas of excellence, in line with our vision to provide 'the very best

care for every patient every day'. . It will also support us to deliver against the new model of care set out in the NHS Long Term Plan:

1. **Boost 'out-of-hospital' care** – while this is primarily about primary and community services, our focus on integrated care will support delivery of care outside of hospital
2. **Reduce pressure on emergency hospital services** through a focus on emergency care pathway redesign and on more proactive integrated care for people with more complex and / or multiple health conditions or in the last 2 years of life.
3. **More personalised care** and more active involvement of our patients in their own care through shared decision making and jointly agreed care plans
4. **Digitally-enabled outpatient care** supporting our focus on consistent care and improving access to our services.
5. **Population health** through our focus on integrated and personalised care and our joint work with partners in the ICP.

3.2. Our ambitions

We are setting clear ambitions for how we will improve our services. To deliver the very best care for every patient, every day:

- We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population
- We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate
- We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population
- We will be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy
- We will personalise the care we deliver through shared decision making, taking account of the goals of the individual 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

- We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation
- 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
- We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer.

To enable the delivery of our strategy, we will:

- Support our staff to develop a culture of compassionate leadership, providing the necessary mentorship and coaching
- Support high quality education to all clinical learners in the Trust including the support and development of new clinical roles, and providing training and development to all staff to meet the changing ways in which care is delivered
- Use digital to enable effective and efficient service delivery that values the time of our patients and staff
- Develop a diagnostics strategy in recognition of the fundamental and increasing role that diagnostics play in care pathways
- Redesign our business processes to improve patient and staff experience and support the delivery of best care.

More detail on this enabling work is set out in our people strategy (2019) which includes education and training; our digital strategy (2020); our research strategy (2020) and our diagnostic strategy (in development).

3.3. Our ambition for best care

We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population

We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate

Our first priority is to provide consistent, high quality local acute services to our population. This means that when people need planned care we will see, diagnose and treat them as quickly as possible, and that when people need urgent or emergency care they will have

rapid access to someone who can make an early decision about what treatment they need and ensure effective treatment is initiated as quickly as possible to optimise outcomes and reduce time spent in hospital. We also want to make the most of our strengths by identifying a subset of our services that go beyond the normal scope of services within a local hospital to create areas of excellence that offer a wider range of services to our population, reducing the need for local people to travel into London and helping us to attract and retain more specialist clinicians.

An early ambition to support this goal is to achieve teaching trust status during 2021.

3.3.1 Improving emergency care

Part of our core services and function for the local community is to provide care to people who require emergency treatment, accessed via the emergency department (ED). In 2019/20 approximately 105,000 people attended the WGH ED department, with a further 54,700 accessing urgent care via the urgent treatment centre at HHGH or the minor injuries unit at SACH. Of these, 48,000 people were admitted to the hospital for further same day or in patient care. This is an increase of 13% attendances and 15% admissions over the last 3 years.

The emergency care we provide is good, particularly for trauma patients where we see high volumes for a non-specialist centre. However as the number of people attending the hospital has increased, it has become harder to treat them within the national 4 hour target and our performance has consistently been below the national average, although we had seen some improvement before the Covid-19 pandemic began in 2020.

We have taken a number of steps to address this:

- We have opened an urgent treatment centre at WGH to manage people who do not require emergency treatment, freeing up our specialist ED consultants to focus on the most sick patients
- We piloted a new model during the winter of 2019/20 (SMART) that put Consultant respiratory physicians and cardiologists into the ED to provide early specialist input and assessment for people requiring admission to hospital. This both enabled some people to avoid admission and, by putting a care plan in place earlier in their stay, reduced the length of stay of people who were admitted
- We have increased the amount of same day emergency care that we are providing through an expanded ‘emergency assessment unit’ (EAU) so that those people who are able to be discharged on the day of their admission access the care they need to enable them to go home without an overnight stay

- We have introduced a paediatric assessment unit, which reduces the number of children who need to be admitted to the children's ward for an inpatient stay
- During the Covid pandemic, we introduced a Covid respiratory virtual hospital, that allowed us to safely monitor and care for people in their own homes instead of admitting them to hospital
- During Covid we also worked closely with partners to improve our discharge pathways out of hospital, which led to a reduction in the average length of stay.

West Herts Covid Virtual Hospital

In response to the COVID 19 pandemic we quickly developed and mobilised an integrated Covid virtual hospital, which uses a multi-disciplinary team approach including respiratory consultants, respiratory physiologists, nurses, healthcare assistants and allied health professionals to enable a specialist model allowing admission prevention, early supported discharge and identification of wider holistic needs. The service is led by WHHT.

The COVID virtual hospital aims to provide care for patients out of hospital with COVID, relieving pressures on the existing hospital services by:

- Reducing unnecessary admissions for patients who can safely be managed in the virtual setting, managing the care of patients diagnosed with COVID 19 out of the hospital setting
- Facilitating rapid discharges and where appropriate providing integrated care with our community partner CLCH supporting the patients with home oxygen and enhanced clinical reviews.

A web-based referral form enables easy referral from the acute hospital interface. Patients are then followed up for 14 days and provide the monitoring clinicians with pulse oximetry results supplemented with clinical narrative to facilitate home monitoring. The service is for patients who require close follow up after hospital attendance but are safe to be discharged to the virtual hospital.

To further improve our emergency and non-elective inpatient services, we will:

- Implement the national '111 First' approach to manage the number of people attending the hospital who don't require immediate emergency treatment, moving to a 'phone first' model with pre-booked appointments in our urgent treatment centres
- Work with HVCCG to define the future model of urgent care for the St Albans and Harpenden population in line with the requirements of the NHS long term plan

- Ensure people are seen quickly within our emergency department (ED), with rapid access to specialty opinion when needed so that decisions about their future care can be made promptly. This includes both medical and surgical opinion, delivered either in person or virtually if appropriate (building on our SMART and virtual SMART pilots).
- Further expand our emergency assessment unit capacity to bring together an integrated model for same day emergency care across all specialties and provide a permanent base for our frailty service, maximising the delivery of same day emergency care and avoiding inpatient admissions where possible
- Develop and expand our virtual hospital model as our best practice standard, including other conditions and specialties that are clinically appropriate to avoid unnecessary admissions and keep people safe within their own homes
- Review emergency surgical pathways and ensure we have enough ring-fenced emergency theatre capacity so that patients can receive timely care in accordance with agreed standards
- Adopt a 'getting it right first time' approach, to get the right patient to the right place for the care they need first time, reducing the number of times that a patient has to move within the hospital
- Continue to work with system partners to improve discharge pathways out of the hospital.

3.3.2 Improving planned care

We always strive to deliver high quality services, and we benchmark our outcomes against other hospitals and actively participate in the national 'getting it right first time' programme to support our approach to continuous improvement.

For most of our services we are justifiably proud of the care we provide to our patients, many of which are described further in section 3.3.3. However, we do have a number of challenges that we need to address:

- Our waiting times for treatment are longer than the national standard of 18 weeks in some specialties
- The two week wait for cancer referrals is met consistently but we do not consistently achieve the 85% target 62 day wait for commencement of treatment, and have a small number of breaches of the 104 day maximum

- Our processes for communicating with our patients are old fashioned, which often leads to a poor experience of our services, even when the care itself has been good. Poor communications is the main reason for complaints received by the trust
- Some specialties employ only a small number of consultants, which makes it hard to deliver out of hours care and makes them more vulnerable to sickness or vacancies
- In some specialties or sub specialties, the level of activity being undertaken each year is lower than the evidence would suggest is required to achieve and maintain the skills required to deliver the best outcomes
- In some specialties we are reliant on care being delivered by consultants from other providers
- We have clinical pathways with a wide range of other providers, some of which are historical rather than based on the best pathway for patients or effective strategic or clinical partnerships.

To address the challenges above, we will:

- Develop a more proactive understanding of needs, demand and capacity so that we can better respond to changes in demand and keep waiting times short
- Reduce outpatient waiting times by redesigning care pathways, maximising advice and guidance (where secondary care consultants provide advice to GPs to support them to manage patients with more complex needs), virtual clinics and expanding capacity where required
- Increase planned surgery at St. Albans City Hospital by improving utilisation of our theatres, increasing on-site diagnostic provision (MRI and CT) and providing an enhanced level of post-operative care so that patients with more complex needs can be treated at St Albans
- Modernise our patient communication and booking processes, innovating to improve and constantly talking to and learning from our service users and their carers to make the patient experience as good as possible
- Make full use of emerging digital technology, with a culture that seeks and supports innovation
- Review the activity volumes undertaken in our smaller specialties, with the intention of improving outcomes for our population by either developing a network approach with another provider to strengthen and support our service or to stop delivering the service altogether

- Review those specialties where care is delivered by third party consultants to ensure they best meet the needs of our patients, and change the delivery model where required
- Review all of our existing clinical pathways to other providers to rationalise them where this is in the best interests of patients
- Explore where we can further develop strategic partnerships to improve outcomes or address workforce challenges
- Review the potential to work with partners to co-locate elements of cancer provision currently provided at Mount Vernon Cancer Centre onto the Watford General Hospital site as part of our redevelopment plans. This is subject to the recommendations of the Mount Vernon Cancer Centre review currently underway and the outcome of a formal consultation on service change expected to be undertaken in 2021.

3.3.3 Areas of excellence

As stated above, we are justifiably proud of the services that we provide, and we have many strengths upon which we want to build and capitalise:

- Market leader for colorectal laparoscopic surgery
- Nationally leading Respiratory department offering a comprehensive range of respiratory services including the innovative Covid virtual hospital which provided the blueprint for the NHSE/I Covid VH program and the endo-bronchial ultrasound service (EBUS)and the associated interventional fellowship and national training program.
- Comprehensive range of urology services with opportunity to bring some services back to SACH that are currently delivered in North London
- Best practice medications safety huddles in paediatrics
- Nationally leading cardiology unit offering a wide range of cardiology procedures, often only seen in tertiary care facilities including ICD insertion, complex device implant, on-site EP procedures, cardiac MRI and cardiac CT. Further innovation includes the training of nurses to undertake angiography. Integrated diabetes service that has significantly improved outcomes for people with diabetic foot disease
- Integrated rheumatology services including shared care and rapid access for acute arthitides with 2-way flow of patients from and back into the community
- Nationally-leading JAG accredited gastroenterology department, with a complex diversified service and a large team of nurse-endoscopists.

- Large and high performing trauma unit
- Excellence in medical education award for support of medical students
- Extensive dermatology service.

Over time we have seen activity that has historically been undertaken in tertiary centres become more routine and able to be safely delivered locally. To build on our strengths and maximise the services that are locally available for our population, we will review where there are opportunities to repatriate activity that currently is undertaken by London (or other out of area) hospitals but which could be effectively and safely delivered on one of our trust sites.

We know that we have an ageing population, and that older people are the biggest users of our services. We will therefore expand and develop our care of the elderly service to better meet the needs of our patients, working closely with partners in the community to deliver care as close to home as possible.

3.3.4 Settings of care

Medicine has changed radically over the last 50 years and will continue to evolve as more technology becomes available. Surgeries that would previously have required several weeks' recovery in hospital can now be undertaken as day cases using keyhole surgery. Many procedures can now be undertaken safely in day case settings. These changes are more efficient for patients and staff and reduce the risk of post-surgery infections and complications.

Advances in telemedicine also enable people to be monitored in their own home, rather than needing to be in a hospital bed. The example of the Covid virtual hospital on page 30 shows how this can be better for the patient and reduce the need for hospital admissions.

As set out in section 4.3.2, we will redesign our services so that people only need to attend an acute hospital site if it is clinically necessary for them to do so, or if they are unable or do not wish to access virtual alternatives. We already deliver a high proportion of surgical procedures as day cases rather than inpatients and we will continue to shift care from inpatients to day cases and from day cases to outpatient procedures where it is safe to do so.

There are other ways in which we can improve people's experience of our services. As technology improves it becomes increasingly possible to undertake tests and provide diagnoses on the same day, reducing anxiety for patients. We also know that we have some pathways that require patients to attend more than one site on the same day, including on the day of surgery. We recognise that this is not a good experience for patients.

To deliver care as close to home as possible and to improve patient experience we will:

- Always seek to innovate and to use new technologies to continuously improve the care that we can provide in the lowest intensity clinical setting available
- Provide people with a diagnosis on the day wherever clinically possible to reduce the period of uncertainty and anxiety
- Increase the capacity of diagnostics available across our sites, including development of a rapid diagnostics centre at St Albans City Hospital
- Increase the availability of multi-disciplinary 'one stop' clinics
- Remove same day multi-site pathways as quickly as it is clinically safe to do so.

4. Working in partnership to deliver new care models

We do not operate in isolation from other acute providers. In addition to our tertiary patient pathways to other providers, we are part of the Hertfordshire and West Essex integrated care system, which also includes East and North Hertfordshire NHS Trust and Princess Alexandra NHS Trust. We also have a clinical partnership with the Royal Free, through which we are working to standardise our clinical pathways through the clinical practice group programme, and we are part of several specialist networks such as maternity and cancer. These relationships give us the opportunity to work with key partners in a more strategic way to improve patient care and address shared problems such as workforce shortages through networked approaches.

In addition, we are a key partner in the West Herts Integrated Care Partnership (ICP), which is focused on improving health outcomes for the local population. There are many ways that we wish to work differently with our local partners going forward to improve the care that people receive from our services.

4.1. Integrated care

We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population

We will be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy

When people need to use our services, their journey rarely starts and finishes at the front door of the hospital. People using elective services are normally referred by their GP or a community service, and are often followed up by the GP afterwards or between appointments. People using emergency services often attend the hospital by ambulance, and receive care from community providers or nursing homes after they are discharged. We need to remove the artificial walls between different parts of the NHS and social care so that our patients and carers experience seamless services.

The increasing number of people with long-term health conditions means that it is now vital for us to work with partners in primary, community and social care so that we understand and address the holistic needs of individuals, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care. We have adopted the definition of integrated (co-ordinated) care set out by National Voices in 2013 following extensive engagement work:

'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'

Herts integrated diabetes service

The Herts integrated diabetes service (HIDS) was established in 2018 in response to a range of challenges:

- A 3 tier service – primary, acute and community – meant that patient flow was often disjointed with many delays, duplication, poor communication, and a large variation in care in primary care
- We were an outlier with regard to minor and major amputation, lacking a NICE compliant multidisciplinary footcare team and in-patient podiatry
- Limited specialist service for complex patients
- Poor mental health provision and connection (strong correlation of depression and diabetes and poorer outcomes associated)
- Limited education opportunities for patients and primary care workforce.

HIDS is a partnership between WHHT, HCT and HPFT combining acute, community and mental health teams to deliver a joined up end to end pathway enabling a smooth transition across services for patients, including a single point of access.

The service has led to shorter waiting times for structured education and to see diabetes consultants and podiatry. Admissions where diabetes is the primary reason for admission have reduced by two thirds, and patient satisfaction has increased from 80% to 89%. People are able to access mental health support to manage any anxiety and depression associated with their condition.

4.1.1 Integrated elective pathways

For people receiving elective care, their pathway starts with a referral from their GP practice into either the trust or a community service that subsequently refers to the trust. Care can be episodic or long term, depending on the condition.

For people requiring episodic care, we will review our pathways into the trust from primary care as set out in section 4.3.2 below, so that people are able to access specialist opinion when they need it. We will also work with the community providers to identify where pathways cause unnecessary delays to treatment and change them so that they are patient rather than organisationally focused.

For pregnant women, we will implement continuity of care from antenatal to postnatal care, reflecting the recommendations of the national strategy *Better Births*.

The greatest opportunity to integrate elective pathways is for people with long term conditions who are in on-going contact with our services as well as with their GP and often with community, mental health and/or social care services too. Care is often fragmented, with insufficient sharing of information between organisations and a lack of co-ordination

between specialist clinicians dealing with different aspects of a person's health conditions such as diabetes and cardiovascular disease.

We already have examples of great practice such as the integrated diabetes service, and we will 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.

More widely, international evidence points to ways in which care for higher risk people can be better joined up. An example is Chen Med, a primary care service based in the south east of the United States which focuses on people over 65 who are in receipt of Medicare (state health funding). Primary care physicians are responsible for 400-500 people who are seen proactively on a regular basis (approximately monthly) in a multidisciplinary clinic setting. This means that there are specialists on hand to review patients when needed and to enable multidisciplinary conversations about and with patients to ensure optimum care. Observation trolleys are available if people are unwell, which often allows issues to be identified and addressed without the need for an ED attendance or hospital admission. People are educated in their disease so that they know which symptoms are a cause for concern, and know who to contact if symptoms occur. This enables issues to be managed early.

Evidence shows that the four elements that characterise good practice are:

- Self-empowerment and education
- Multi-disciplinary teams
- Care co-ordination
- Individualised care plans.

We will work with our partners in the ICP to implement integrated care models that reflect good practice and are targeted to the needs of our population.

4.1.2 Integrated urgent and emergency care pathways

As with elective care, some people require urgent and emergency care following an unexpected one off incident, while others require care as a result of an exacerbation of an on-going health condition. For all patients, we would seek to integrate the pathway through common changes:

- We will integrate our new electronic patient record with primary, community, mental health and ambulance records so that information relating to the person's health is available to clinicians in all settings to support their decision making. This includes supporting the ambulance crew to decide whether or not a patient should be conveyed to hospital

- We will ensure all patients who require specialist input can access it quickly, enabling a clear care plan to be developed for their time in hospital and to allow early planning for their discharge should they be admitted
- We will integrate social care, community and mental health support into the emergency department model
- Where applicable, we will ensure that patients are not assessed for future care needs within the hospital, and that they are discharged to be assessed within their own environment where a better understanding of their needs can be obtained and more appropriate care provided
- We will improve our communication with the patient and their GP on discharge, to ensure that any additional support required in the community is put into place, and we will follow this up with a compassionate conversation within 24 hours of discharge to address any questions or issues that the person may have.

For those patients whose care needs result from an on-going health condition, we will build on the pro-active model of integrated care described above which aims to identify people earlier so that they don't become as unwell. Our first priority population group is people with frailty, who are normally but not always over 65. Working with partners we will fully implement the ICS-agreed model of care for frailty, which will reduce admissions for this group and reduce length of stay through the use of rapid response services in the community.

4.1.3 Last phase of life

End of life care in the UK is ranked among the best in the world, but too many people still die in a place that is not of their choosing. A national survey identified that while 82% of people wanted to die in their own home, only 22% actually did so and 47% died in hospital. We want to shift the focus from considering end of life as the last few days or weeks to looking at the last 1-2 years of a person's life (last phase of life). The use of data to identify people in this phase, coupled with open and honest conversations about how their needs can be met, can improve their quality of life and reduce inappropriate admissions to hospital.

As part of our work with the West Herts ICP, we will use data and risk stratification to enable us to identify people in their last phase of life, and use an integrated care planning approach to discuss and agree with them how their needs will be met and what their goals are. This would include a shift away from more interventional medicine that adds limited value to the patient towards a more palliative approach that supports improved quality of life.

4.1.4 Improving health and addressing inequalities

Historically our focus has been within our hospitals, delivering care to the patient in front of us when they become unwell. However we now want to look wider than our traditional borders. Given that most of our patients live in west Hertfordshire, our ambition is to take a leading role within the west Hertfordshire Integrated Care Partnership (ICP), widening our responsibilities beyond the delivery of acute services to work with our ICP partners and the community to improve the health and health outcomes of our population. We want to move away from the current reactive system of care to a more proactive model that enables people to stay healthy by making changes to their lifestyle and taking an increased role in managing their own health.

The recent Covid pandemic has made everyone more aware of the inequalities that exist within our communities and the differential outcomes that people experience, whether this is due to deprivation, ethnicity, age or other issues. We will seek to understand these issues and adapt our services to reduce these inequalities, working in co-production with our local community to understand their needs and appropriately personalise care. Through our ICP we will also work with the community and a wider range of partners than we have traditionally worked with to address some of the causes of inequalities, and empower people to improve their own health and wellbeing.

4.2. Personalised care

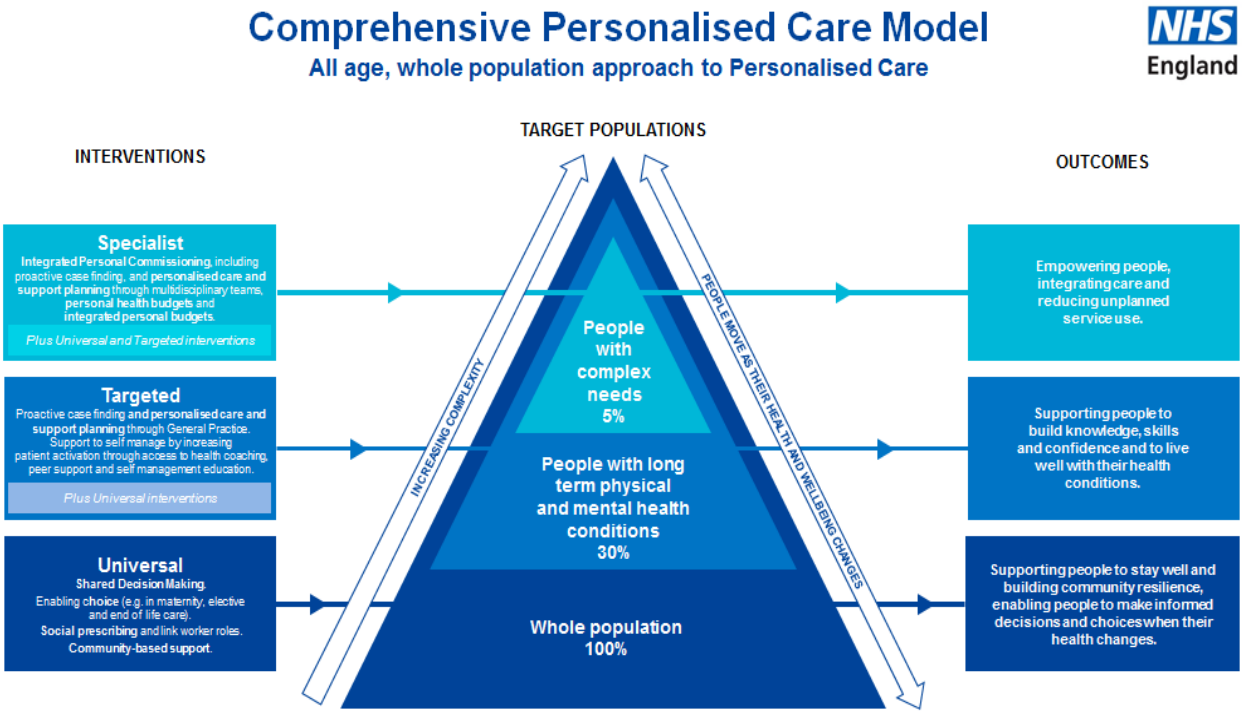
We will personalise the care we deliver through shared decision making, taking account of the goals of the individual and providing appropriate information and support to enable people to manage their own care more effectively and take informed decisions about the care they receive

Personalised care is one of the five major service model changes in the NHS Long Term Plan. Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. It involves supporting people to talk about the outcomes that matter most to them; encouraging and enabling them to take on as much responsibility as they are able to manage their own care, health and wellbeing; and acknowledging them all as experts in their own care and lives. This shift represents a new relationship between people, professionals and the health and care system and provides a positive change in power and decision making that enables people to feel informed, have a voice and be heard. Working with our partners in the ICP, we will increasingly personalise the care that our patients receive.

Figure 4.1 below shows the NHS England comprehensive personalised care model. It differentiates the type of intervention needed for different populations with differing health needs. These are:

- Universal – for the whole population
- Targeted – for the 30% of people with long term conditions
- Specialist – for the 5% of people with the most complex needs.

Figure 4.1: NHSE comprehensive personalised care model



4.2.1 Universal personalised care

The direction of travel over recent years has been to ensure that people are given sufficient information to enable them to make informed decisions about the treatment that they receive, and while the experience of this is variable there are many examples of excellent shared decision making within the trust, with patients fully enabled to participate and to ensure that their goals and needs are taken into account in the way care is delivered. We now need to embed this consistently across the trust.

As described in section 4.1.4, we want to increasingly support people to stay healthy and manage their own health and wellbeing. This means that we need to consider how we can use the many thousands of contacts between our staff and our patients to 'make every contact count', engaging in wider conversations about the choices that people are making to increase their understanding of how to improve their health and wellbeing.

We know that people who have had an unplanned inpatient stay with us often have questions after they have been discharged about their health and what they should be

doing. We have introduced 'compassionate conversations', where patients receive a phone call within 24 hours of their discharge to see how they are managing.

Compassionate conversations

In June 2019 a compassionate conversation post-discharge was introduced, delivered by ward managers, the nurse in charge or a designated registered nurse. This contact with patients was designed to be day 1 following discharge. The goals were to:

- Ensure that people have arrived safely home and are happy with their medication, management plan, and know who to contact for further advice if required.
- Enable early identification of any new symptoms
- Reduce readmissions
- Show compassion and closure for patients.

An advisory script enables a focused conversation that facilitates the sharing of meaningful information without being drawn into a full review of care that was provided.

In Feb 2020 the Trust reported that within a three month period, 3559 additional patient calls had been made. The majority of patients contacted praised the care they had received and were grateful for the phone call.

Feedback from the calls is discussed with wards, patient forums, the patient experience team and the new co-production board involving service users and actions implemented to improve our services in response to any areas of concern.

We will also improve the information that we provide to patients to help them to understand their treatment options and support informed consent. The report of the independent inquiry into the malpractice of Ian Paterson, a breast surgeon who carried out unnecessary invasive surgery on hundreds of women unchallenged by his colleagues or employer, was published in February 2020. We will learn from the report and its recommendations to increase the understanding of patients about their condition and to build in reflection time before patients consent to procedures to enable them to consider and raise any questions or concerns that they may have.

As part of our approach to personalised care, we will give consideration to how inequalities impact on individual patients, and tailor our approach appropriately. This could include how we support reasonable adjustments for people with additional needs such as learning disabilities, how we support carers, or how we adjust pathways to take account of known variations in outcomes for particular population groups.

4.2.2 Targeted personalised care

30% of the population have long term conditions, and targeted personalised care, through proactive case finding and the agreement of individual care plans, can help people to build the knowledge, skills and confidence to manage their condition effectively. While much of

this care planning will take place in or be led by general practice, many of these people will also be in regular contact with at least one specialist as a result of their condition. As described in section 4.1.1, we will integrate our pathways for long term conditions with primary care, community and mental health to ensure that patients only have one care plan across all their providers and that it is jointly developed and shared, with everyone working together.

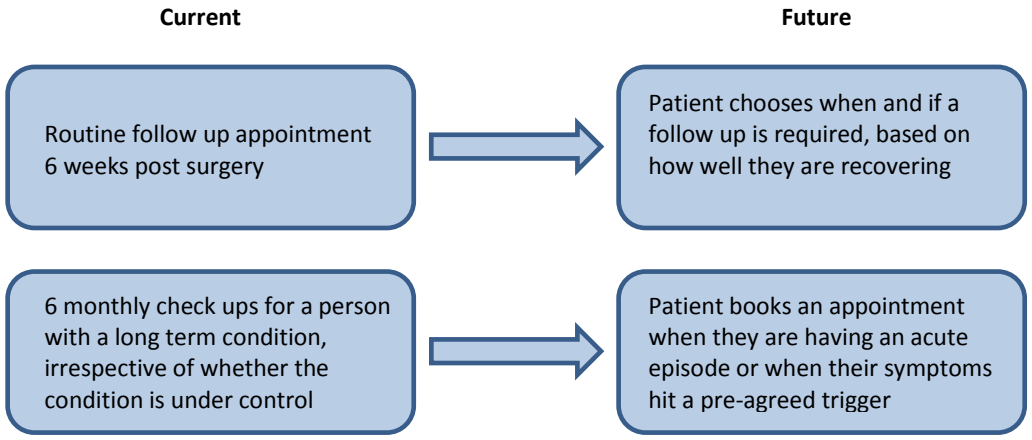
4.2.3 Specialist personalised care

For the 5% of people with the most complex needs, the targeted personalised care approach may be enhanced by giving them the ability to manage their own personalised health budgets. While this is again primarily led by general practice, these people will be in regular contact with secondary care and we will need to adopt a fully integrated approach to ensure that they are well supported.

4.2.4 Patient initiated follow up

There were approximately 329,000 follow up outpatient appointments across WHHT in 2019/20. Traditionally, follow up appointments are initiated by the doctor or nurse providing the appointment. Patient initiated follow-up (PIFU) describes when a patient (or their carer) can initiate follow-up appointments as and when required, e.g. when symptoms or circumstances change. Figure 4.2 shows how this could change care pathways:

Figure 4.2: how PIFU could change care pathways



We will implement patient initiated follow ups in all areas where it is clinically appropriate, working with patients to ensure that they are confident to manage their own condition and to know when they should request an appointment.

4.2.5 Precision medicine

Advances in precision medicine such as genomics also mean treatment itself will become increasingly tailored to individuals, and patients will be offered more personalised therapeutic options, particularly for cancer. The NHS Long Term Plan includes some specific commitments in this area:

- *From 2019, begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis and access to more personalised treatments*
- *We will focus targeted investment in areas of innovation that we believe will be transformative, particularly genomics. The NHS will be the first national health care system to offer whole genome sequencing as part of routine care. As part of the NHS' contribution to the UK government's broader aims to reach five million genomic tests and analyses over the same timeframe, the new NHS Genomic Medicine Service will sequence 500,000 whole genomes by 2023/24.*

This is a new area of medicine for WHHT. We will use our existing strategic partnerships, particularly with UCL Partners, to ensure that our population can access and benefit from advances in precision medicine, either delivered by us or available through our cancer network.

4.3. Consistent care

We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation

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

We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer

The best performing hospitals in the country have developed really strong safety and quality improvement cultures which support and enable all staff to reduce harm, learn from mistakes and improve care. We have started this work and have many areas of good practice and pockets of excellence. Continuing to strengthen our quality improvement culture across all our services and improving how we use data and research to improve care is an essential element in delivering our 'best care' aim over the next five years.

4.3.1 Clinical practice groups

We have an established partnership with the Royal Free London and partners to drive continuous improvement in care through the 'Clinical Practice Group' (CPG) programme. This brings clinicians together to design and systematically implement best practice 'care pathways' for common clinical conditions, continuously testing and improving design using in-depth monitoring and analysis. The rationale for this approach is that variation in clinical practice and process leads to worse patient outcomes at higher system costs, and consistently applied best practice pathways can reduce that unwarranted variation. In 2019, we began work on eight standardised best practice pathways and over the next five years we expect to implement at least another 40. This approach will be embedded in the design of our new electronic patient record system and the operation of our new hospital facilities.

The use of CPGs combined with rigorous use of clinical audit allows the data collected to demonstrate improvements in outcomes and challenge inconsistent practice. Pathways are advisory and can always be overridden by the clinician based on their own clinical judgement given the individual circumstances of the patient, as long as the reason for the alternative approach is documented. Over time this allows improvements in outcomes as a result of alternative practices to be agreed and embedded in the pathway, driving continuous improvement. However if data demonstrates worse outcomes as a result of non-compliance with the agreed pathway then this will be challenged and addressed.

We will use this approach to develop a series of approximately 80 pathways managing the most burdensome health issues that are continuously evidenced as being the most efficient and effective way of managing that condition. This will improve efficiency and reduce costs, as well as underpin an approach of continuous improvement through the use of data to evidence best outcomes.

4.3.2 Consistent access to specialist opinion

People are referred to the trust by GPs when they have symptoms that need more specialist review and diagnosis than the GP is able to provide. Nationally approximately one third of outpatient appointments do not result in any further diagnostic test or treatment, and in most cases the appointment could have been avoided if the GP had been able to request advice and guidance from a consultant. We have already redesigned the way in which outpatient care is delivered in several of our specialties, allowing GPs to request advice and guidance from consultants to better enable them to make the right decisions about the conditions that patients present with in primary care without the need for a face to face secondary care appointment. This model allows patients to access the advice or support that they require more quickly, reducing anxiety, and saves them the need to take time off work or to travel to a hospital site for an appointment.

Dermatology advice and guidance service

Each year around 24% of the population in England and Wales seeks medical advice for a skin condition, and approximately 6% of patients presenting with a skin problem are referred for specialist advice in secondary care. Tele-dermatology was the Trusts first and most well-established advice and guidance model. This uses GP initiated photos and associated clinical information, sent directly to the dermatologist, who will then give advice on diagnosis, investigations and management options within 72 hours. On average 70% of referrals that are made using tele-dermatology appropriately avoid an outpatient appointment.

Following the introduction of tele-dermatology advice and guidance the Trust carried out a survey of the clinical users of the service (mainly GPs) and the results showed that:

- 95% felt sufficiently informed about the service to explain it to patients when making a referral
- 90% were clear on what action to take when the tele-dermatology report was received
- 100% followed the guidance given
- 95% received the report within the target time
- 90% said the management plan provided would assist in managing patients with the same condition differently in the future.

We have also implemented virtual consultation models as a result of Covid, and have shown that across a wide range of specialties a virtual model (telephone or video) can provide a safe alternative to bringing people into a high risk clinical environment. While a virtual model will not be appropriate for everyone, and for some specialties and conditions there will always be a clinical need for face to face appointments, virtual consultations can be a convenient way for patients to speak to their consultant without needing to travel to the hospital or take time off work. They also offer an opportunity to improve the efficiency of clinical pathways, reducing the number of diagnostic tests required by improving the information available to the consultant.

At the other end of the patient journey, many of our patients go on to receive tertiary care at another provider where they require more specialist care than we provide, or require multidisciplinary team (MDT) input e.g. for some cancer pathways. The way patients experience these pathways is often disjointed, and they are often not included in the MDT conversations that determine the care they receive.

To ensure consistent access to specialist opinion, we will:

- Make timely advice and guidance services available to GPs across all our specialties
- Maximise the clinically effective use of virtual consultation models

- Redesign elective pathways to ensure that diagnostic tests are undertaken at the right point in the pathway to facilitate diagnosis without unnecessary tests being undertaken

- Make our tertiary pathways seamless, and involve patients in multidisciplinary discussions about their care where they wish to be involved.

4.3.3 One stop shops and multidisciplinary clinics

The current patient experience of care is not optimal and often involves multiple journeys to our sites and contacts with different staff in a way that is not joined up. While we have some pockets of excellent practice where people are able to attend single clinics to have tests undertaken and see a consultant for a diagnosis, too often people have to travel for a test on one or more days, and then to see a consultant in outpatients on a different day. This is both an inefficient use of patients' time and also increases anxiety as people have to wait for results. While it will not always be possible to get a diagnosis on the same day as a test for clinical reasons, we will seek to consistently implement one stop clinics that enable test and diagnosis on the same day.

Similarly, people often have multiple long term conditions and are under the care of several consultants in different specialties who do not always work together to best manage the holistic needs of the individual. We will expand our range of multidisciplinary clinics, starting with the most common overlapping conditions, so that care is more joined up.

4.3.4 Innovation, research and new technologies

We will always seek to consistently provide best practice care. This means that we will encourage and support the expansion of research across our services and the testing of innovative approaches to the delivery of care, supported by effective evaluation and use of data to ensure that we are achieving the best possible outcomes for our population. We will also seek to use new technologies wherever possible to improve care and reduce the intensity of the setting of care, allowing people to stay in their own homes wherever safe to do so with minimal disruption to their lives. Examples of the benefits of new technology include people with long term conditions who could have their condition monitored remotely to prevent unnecessary follow up appointments, or people who might otherwise need to be admitted to hospital for observation such as those successfully managed in the Covid virtual hospital. New technologies can also address poor business processes, improving efficiency for staff by automating routine administrative or clinical tasks and improving patient communications.

As we look towards the new hospital redevelopment, we will seek to use and embed new technologies as an integral part of our building and new ways of working.

5. Divisional and service strategies

Our clinical services are delivered by five clinical divisions; each division will be responsible for implementing the ambitions and commitments within this clinical strategy. Key priorities and plans at a service level have been reviewed as part of developing this strategy to ensure we have the most accurate information and assumptions about future need, new models of care, opportunities for integration and collaboration, and potential in terms of education and research.

5.1 Emergency Medicine

The Emergency Medicine division is responsible for the care of people requiring urgent or emergency attention and who either do not require admission or who stay in hospital for 48 hours or less. This includes the Urgent Treatment Centres (UTC) and Minor Injuries Unit (MIU); the Emergency Department (ED), the Children's Emergency Department (CED)and Clinical Decision Unit (CDU); the Ambulatory Care Unit (ACU); the Emergency Assessment Unit (EAU); and the short stay beds within the Acute Assessment Unit (AAU). The EAU is for medical and surgical patients and from March 2021 for orthopaedic, frailty and some gynaecology patients as well.

The division has a number of partnerships with other organisations. These are the partnership with Hertfordshire Partnerships Foundation NHS Trust (HPFT) who provide psychiatric liaison services within WHHT; Hertfordshire Urgent Care (HUC) who provide GP services to Hemel UTC and the out of hours service; the East of England Ambulance Service; the Integrated Discharge Team and Imperial College Healthcare NHS Trust, which runs the major trauma centre at St Mary's Hospital Paddington. Patients are also referred to other specialist providers depending on their needs.

The electronic patient record is a key enabler for the division, as early access to existing patient records (including primary care records) will facilitate decision making and the most appropriate management of patients. Recruitment is a key challenge, particularly to senior posts within the ED, for which a recruitment strategy has been agreed and commenced.

Integration

We will continue our joint working with HPFT and other system partners to provide specialist input and effective care pathways for people of all ages presenting with mental health needs.

The CDU will continue to allow time for relevant services and teams, such as the Clinical Navigators, physiotherapists and occupational therapists to work together to complete the

patient pathway within ED and initiate the ongoing care needs for discharge into the community.

Effective implementation and delivery of an integrated community and acute service for frail people will be critical to avoid unnecessary attendances and admissions, including an integrated health and social care team working to avoid unnecessary admissions where care needs can be met in the community.

Personalisation

Priorities for personalisation with emergency care services include:

- Improving how we care for vulnerable adults and children with additional needs including patients with mental health needs, dementia, learning disabilities or autism spectrum conditions, hearing difficulties and when English is not a first language
- Deliver a robust pathway for the transition of children to adult services in conjunction with the child and their family.

Consistent care

The Emergency Medicine division will continue to focus on improving pathways and operational processes to ensure all patients are seen, assessed and treated in a timely way, in line with current (and future) emergency care standards and GIRFT recommendations.[1]

The division will work to implement standardised best practice pathways (as part of the joint CPG programme with the Royal Free) for priority emergency care pathways.

5.1.1 Urgent treatment centres and the minor injuries unit

There is a UTC at WGH and HHGH, and a minor injuries unit (MIU) at SACH. The provision of the UTC service at WGH is currently subcontracted to a third party with expertise in urgent care. This is a new service that went live in July 2020.

- The requirements of the NHS Long Term Plan means that the SACH MIU cannot continue under its current service specification. During 2021 we will work with HVCCG to agree the future service model for St Albans
- In line with national policy, we have implemented the NHS 'Think 111 First' programme at all sites, with patients expected to call NHS 111 before attending the

[1] *emergency care access standards are expected to change during the lifetime of this strategy, once recommendations from a clinically led review of access standards are finalised following a pilot phase.*

UTC / ED, enabling an increasing proportion of attendances that are booked. This facilitates improved waiting times, reduces crowding and allows workforce/ demand models to be effective

- We will continue to work with the UTC provider to ensure the service at WGH is embedded to provide effective care within the UTC as well as ensuring pathways are effective from the UTC to other parts of the trust, or other services
- We will continue to work with third parties to ensure the good quality, effective service at Hemel UTC is maintained.

5.1.2 Emergency Department

The Emergency Department cares for patients of all ages with a high demographic of older adults and has an integrated Children's Emergency Department looking after patients below the age of 16 years. The ED receives a high volume of ambulance conveyances and sees a large number of complex, high acuity patients including a significant number of major trauma patients.

The department continues to have an ethos that supports development throughout the workforce delivering high quality training to doctors in training, Advanced Care Practitioners and nurses.

The delivery of care has changed during the Covid pandemic with the need for separate patient streams and social distancing within the department. The longer term implications of this will need to be considered as part of the planning for the redevelopment.

Recognising the challenges of the current environment an ED Redevelopment project is underway as an interim measure to support the safe delivery of patient care.

Priority areas where we will improve care over the next 5 years are:

- Deliver high quality care to patients attending the ED by working to meet current key performance indicators and new NHS access Standards and GIRFT measures
- Continue to work with system partners such as the North West London Trauma Network, HPFT and EEAST to continue to ensure high standards of care
- Ensure that the ED is a centre of excellence in terms of training, for medical, nursing and allied health professionals. This will ensure continued workforce recruitment and retention and allow us to continue to build a team that meets the needs of the population

- Work in partnership with specialty colleagues to develop pathways to ensure that all patients are seen by the right person at the right time including Same Day Emergency Care (SDEC)
- Implementation of the electronic patient record and the integration of the trust IT with other providers to enable access to patient records from other health and care providers (with appropriate patient consents).

5.1.3 Acute medicine

Same day emergency care

Adult same day emergency care provides a service where patients are assessed and treated on the same day by senior clinicians. The service is provided in the Ambulatory Care Unit and the Emergency Assessment Unit. They can be referred from a UTC, ED or primary care.

The service will continue to work with clinical colleagues from other divisions, to develop and embed the new multi-specialty EAU model and will ensure that the model operates effectively and efficiently in an integrated way.

It will continue to strengthen links with the community rapid response team to optimise the use of community based care.

In line with the national programme of T111F appointments will be booked to designated care pathways.

Acute Assessment Unit

The AAU is for patients who require admission for a short stay, usually less than 48 hours. Staff in this area also care for patients until a definitive specialty/ ward is identified.

The principles underpinning the AAU are that centralisation of acute medical admissions provides a focal point for early diagnosis and treatment of acutely unwell patients. Early involvement of the acute physician specialists supports clear patient pathways, prompt interventions and reduced length of stay. Patient care will follow evidence-based best practice and be protocol driven where appropriate. Engagement from the specialities at this early stage of the patient's journey will further support consistent and streamlined pathways.

The team will continue to work with partners to integrate community and social care services as a multi-disciplinary team. This approach to the more complex patients will facilitate sending people home with increased confidence in the package of care in place to support them.

5.2 Medicine

West Herts offers a wide range of medical specialty care and demand has grown in response to the changing demographics of the population. People are living for longer and are also developing more long term conditions such as diabetes or COPD, often as a result of lifestyle factors such as smoking or obesity. As a result, people can often be in long term contact with several consultants across multiple specialties, as well as seeing their GP regularly and using community or mental health services. For these older people, and for those with long term conditions, care needs to be better integrated.

High quality services

The largest demand for inpatient beds comes from people who are acutely unwell and who need general medical input as well as specialist expertise. Our top priority is to ensure that people who require admission receive the best possible care, which includes early access to specialist opinion to agree a management plan and getting the person into the right bed where they can best receive the care they need. We will achieve this by delivering the SMART front door model as standard across all specialties, delivered virtually where this is clinically safe and using networked approaches with partner trusts where a larger scale is needed to achieve effective clinical rotas.

There are also many opportunities to manage these people more proactively in the community to avoid admissions. In addition to increasing same day emergency care as set out in the emergency medicine section, we will expand the Covid respiratory virtual hospital model to manage a wider range of conditions and specialties until it becomes the standard way to manage people with escalating needs, using telemedicine to enable remote monitoring and keeping people safe in their own homes.

Advances in medicine also mean that more interventional medicine can be practiced, reducing the need for surgery. In these specialties (Cardiology, Gastroenterology, Respiratory) we already offer a wide range of interventions on site and have joint appointments with some specialist London providers that give us access to tertiary expertise. We will further expand these services, enabling more people to receive care locally.

Our strategy to deliver consistently high quality services is therefore:

- Incorporate IMT3 trained consultants into the medical take program to support exceptional quality acute GIM care as well as sub-specialty care
- Integrate care for people with long term conditions, working with our ICP partners to deliver a more proactive model that identifies escalating need earlier so that more

people can be managed at home or through ambulatory pathways and avoiding acute admissions where possible

- Improve and integrate care for older people, enabling independent living where possible and delivering care that is most appropriate for their needs and phase of life
- Repatriation of complex services locally to deliver exceptional care locally
- Diversify our consultant teams to include new specialities including Infectious Diseases and Renal Medicine
- Look for new opportunities to integrate with oncology services and develop one stop shop diagnosis and same day treatment services with positive impacts on key departments including haematology and rheumatology.

Integration

As set out above, integration will be a key theme for medicine. To better deliver care that is focused on the holistic needs of individual patients we will expand our multidisciplinary team working, focusing initially on common co-morbidities such as diabetes and cardiovascular disease. We will work with primary care to explore the opportunities to introduce models that bring together primary care with specialist expertise and voluntary sector input, focused on the needs of high risk patients and learning from best practice such as the ChenMed model. We will also review the care that the health and care system provides to people in their last phase of life, to ensure that their goals are understood and their needs met in the most effective way.

Personalisation

As set out above, we will implement a more integrated model that is better personalised to meet the needs of people with targeted or specialised interventions. Patient initiated follow ups will also be used effectively across the medical specialties to move away from people being regularly called back for follow up appointments when their condition is stable to a model whereby a person can book an appointment when there is an exacerbation in their condition that they need support to manage.

Consistent care

We are fully committed to the CPG approach to enable us to standardise pathways for common conditions and drive continuous improvement.

We already offer advice and guidance across several specialties and will expand this approach in line with the trust-wide strategy. We will work to redesign our outpatient care pathways to streamline care for patients, improve joint working with primary and

community care colleagues and ensure we make the best use of the skills of our specialist workforce.

5.2.1 Dermatology

The dermatology department is the 15th largest dermatology provider in the UK seeing 38,000 patients per annum, 40% more than the national average. It offers a comprehensive range of services including general dermatology, one stop two week wait skin cancer clinics, paediatric dermatology, path testing for contact allergy, minor surgery including day case surgery for flaps and grafts, phototherapy and photodynamic therapy. It also operates a range of joint clinics with vascular, urology and genitourinary medicine services. The dermatology department also supports emergency inpatient care with daily consultant led ward rounds and hot clinics for urgent cases. GPs access our services through innovative tele-dermatology, advice and guidance and referral assessment services.

The GIRFT review 2019 recognised the excellent standard of care and provision, and the department has been successful in recruiting and retaining staff when dermatology recruitment nationally is difficult.

Tertiary skin care pathways are mainly to the Royal Free and Lister Hospital. Plastic Surgeons at these hospitals and Oncologists from Mount Vernon Hospital join our local and specialist skin cancer MDTs. We also refer small volumes of micrographic surgery to St Thomas' Hospital.

Priority areas where we will improve care over the next 5 years are:

- The service at WHHT is substantially larger than the other trusts within the ICS and there is an opportunity to explore an HWE integrated care system wide hub and spoke model with WHHT as the hub
- We will explore the option of delivering more plastic surgery including Mohs Micrographic Surgery locally

5.2.2 Diabetes

The trust is the lead provider for an innovative integrated diabetes model in partnership with Hertfordshire Community Trust and Hertfordshire Partnerships NHS Foundation Trust, delivering services within community settings. There are already a range of multidisciplinary clinics through the integrated service, including psychologists, podiatrists and dieticians. This integrated model provides a potential blueprint for other integrated services.

Priority areas where we will improve care over the next 5 years are:

- Continue to work with partners to develop the west Hertfordshire Integrated Diabetes service (HiDs) including strengthening an integrated primary care led model with diabetic specialist input.
- Work with colleagues in other specialties to to further integrate care within the Trust through multidisciplinary approaches, particularly vascular surgery and obstetrics, the latter with combined ante natal clinics.
- Approximately one in 5 hospital inpatients have diabetes – we will review how we could enable the delivery of a consultant led in reach diabetes service across the hospital
- The latest GIRFT review identified that we are an outlier length of stay for patients for surgery for diabetes - we will review this regularly with a view to reducing the length of stay.

5.2.3 Endocrinology

Endocrinology is primarily an outpatient based service. There are a number of MDT networks, both with the local cancer network and with several London hospitals, the latter of which could be streamlined. The most recent GIRFT review identified many areas of excellent practice, including telephone advice and guidance to GPs, triage of all referrals, remote consultations, nurse led clinics and best practice pathways.

Priority areas where we will improve care over the next 5 years are:

- The service would like to further utilise technology to enable more shifts in the way that care is delivered and to explore the potential for a networked approach with other providers to support a virtual SMART model.

5.2.4 Neurology

The neurology department provides local general neurology outpatient services for all neurological conditions, as well as daily acute neurology in-patient liaison and neurology hot clinics at Watford General Hospital. Nerve conduction studies and electromyography are offered at Hemel Hempstead General Hospital and Watford General Hospital. The service benefits from several consultants having joint appointments with tertiary providers in London, where more complex neurological conditions are referred and managed.

Priorities for the next five years include:

Implementation of Advice & Guidance

- Developing a neuroradiology MDT

- Developing onsite electroencephalography (EEG)
- Specialist nurses (e.g. epilepsy, MS, PD) to provide additional patient support and facilitate the management of stable chronic patients through specialist nurse-led services, including the use of telemedicine and admission-avoidance advice lines
- Repatriation of procedures such as elective lumbar punctures and Botox injections for dystonia from tertiary centres
- Local delivery of MS disease-modifying therapies
- Improving the in-patient journey for patients presenting acutely with neurological disorders
- Working with community therapy and neuro-rehabilitation providers to improve continuity of care between secondary care and community settings.

5.2.5 Rheumatology

The rheumatology department manages a large proportion of complex diseases traditionally managed in tertiary care through a combination of local expertise combined with an award-winning regional virtual MDT conference network set up with Eastern Region tertiary care centres. A full range of complex immunosuppressive chemotherapies and biological therapies are administered through the support of this network and the chemotherapy unit at WGH.

The Rheumatology department also runs a comprehensive Osteoporosis service including dexa scanning, bone health counselling and pharmacotherapy advice and administers the latest innovative treatments for bone health maintenance. Unlike many DGH Rheumatology departments we are a training department with trainee SpRs, IMTs, CMTs SHOs, GP VTS and FY1s rotating through our Specialty department.

The department has developed good multidisciplinary working and has implemented new workforce roles to support care delivery. A biologic co-ordinator role has been developed in the last year to help facilitate and co-ordinate innovative and complex treatment regimes, and our current nurse led rheumatology helpline service is being developed into a full rheumatology therapeutic and support service through the addition of GP sessions to provide more holistic healthcare advice, including pharmacist sessions for drug advice and guidance. This type of initiative will help break traditional divides between primary and secondary care services and support better integration focused on the patient.

Other examples of existing integration both internally and externally are links with internal medicine to provide seamless inpatient and outpatient care and allow for management of

complex multisystem diseases; and working closely with locally commissioned community services such as the MSK soft tissue rheumatism and pain management service (Connect).

Key strategic priorities for the service are:

- To rationalise the elective service onto a single site in a centre for chronic disease management in order to improve staff cover, reduce inter site travelling and promote service development. This would include development of an infusion and treatment centre in order to facilitate complex treatment delivery and enrolment of our patients into trials of new innovative treatments and would also act as a hub for development of patient education programs and self-help groups for patients with chronic rheumatological diseases

- Continued work with primary and community services to create a seamless rheumatology service with free 2 way patient flow between community and hospital settings

- To use digital technology to facilitate remote patient care through:
  - virtual patient appointments
  - virtual networks to discuss complex patients
  - virtual 'on calls' to cover rheumatology emergency care in multiple hospitals
  - virtual rheumatology therapy support services (utilising GPWSI, pharmacists and nurses)

- To reduce follow ups of patients with chronic inflammatory diseases such as rheumatoid arthritis through use of patient initiated follow up or the development of stable patient follow-up services in the community

- To expand the current model of elective rheumatology care from the traditional outpatient clinic to a combination of clinics, MDT conferences (face to face and virtual) and a 'one stop shop' approach to managing multisystem disease.

Most traditional tertiary care rheumatology activity is kept in house however many patients with renal disease (especially vasculitis) are routinely transferred into London. There is an opportunity to manage this work locally with better local renal services.

Looking to the longer term, we anticipate a continued expansion of immunosuppressive treatment options for inflammatory diseases such as rheumatoid arthritis and novel treatments for diseases for which there has previously been little or no medical treatment options can be foreseen, e.g. disease modifying treatments that will slow the progression of Osteoarthritis are likely. The expansion of the clinical trials portfolio is envisaged.

Imaging technology for rheumatological disease is likely to improve and the provision of In house imaging such as MSK ultrasound during clinic appointments is likely to become the

standard of care. The department will need to keep pace with this, developing the expertise and procuring the relevant diagnostics.

5.2.6 Care of the elderly

Care of the elderly services are seeing increasing demand as a result of the ageing population and people living longer with chronic medical conditions, as such this will be a key focus for integrating services going forward in order to reduce the number of admissions for this population and provide better care in the community. The trust has developed a number of best practice services such prompt frailty assessment in the ED to prevent unnecessary admissions, a delirium recovery pathway, and a dementia friendly ward.

However the delivery of these has been inconsistent due to bed pressures, staffing challenges and the impact of Covid, and re-establishing these on a permanent basis will be critical. (The frailty service will be based in the newly expanded Emergency Assessment Unit from February 2021).

Priority areas where we will improve care over the next 5 years are:

- We will work closely with partners, particularly community, social care and ambulance services, to strengthen support to care homes and the delivery of rapid response services to people in their own homes to reduce conveyances to hospital
- There is an opportunity for admission-prevention clinics which could form part of the wider Chen-Med model that we want to explore
- The virtual hospital model introduced by the respiratory service could also provide a model to better support older people in the community, and the use of telemedicine and remote monitoring could help to reduce falls in high risk patients
- We will also work with our ICP partners to develop a model of care for people in their last phase of life as set out in section 4.1.3.

5.2.7 Stroke

The stroke service includes a hyper acute stroke unit (assessment and immediate treatment) and an acute stroke unit (on-going treatment and rehabilitation) on the WGH site. Key strengths of the service include multidisciplinary working with links to early supported discharge and neuro-rehabilitation services, and a 7 day stroke therapy service.

Thrombolysis is provided 24 hours a day with established links to a tertiary thrombectomy centre at Charing Cross hospital, though out of hours thrombolysis is dependent on the regional east of England telemedicine service. We also have a strong involvement in stroke research. During Covid we saw surprising success with virtual follow up appointments with

positive patient feedback, indicating the opportunity for a greater use of virtual technology in the future.

The key challenges for the service are recruitment given our proximity to London, a lack of access to digital resources for patients and a lack of specialist therapy equipment. In addition, the inpatient neuro rehab facility provided by CLCH has limited bed capacity.

The strategic priorities for the service are:

- Using digital technology to improve how we deliver stroke rehabilitation and follow up care
- Increasing the resources into early supported discharge
- Improving links with the voluntary sector and improving integration between acute services and those in the community more generally, with greater in-reach and out-reach of services and ensuring that after-stroke care enables people to self manage and maximise their independence
- Further development of joint Consultant positions with tertiary centres
- In the longer term, develop sufficient capacity to enable in house provision of out of hours thrombolysis
- Improving access to specialist therapy equipment.

5.2.8 Cardiology

The Cardiology service provides a full spectrum of diagnostic and interventional procedures including:

- Stress echo/ bike tests and transoesophageal echocardiograms
- Dedicated Coronary CT
- Dedicated Cardiac MRI
- Coronary intervention
- Complex pacing (implantable defibrillator and biventricular pacemaker service)
- Electrophysiology (EP) service
- Specialist Cardiac physiology team to support complex pacing/EP and imaging.

Six consultants are joint appointments with London tertiary centres which allows them to perform more complex procedures for West Herts patients within the tertiary settings

through a hub and spoke model. This provides high quality services locally with the sharing of good practice and protocols, and a good patient pathway for both elective and emergency services. The wide range of local services means we have been able to get Deanery support for 5 senior specialist registrar posts and encourages recruitment and retention of consultants. There is also a heart failure service provided in partnership with Central London Community Health (CLCH).

There are however challenges with the recruitment and retention of some other staffing groups, particularly nurses for the coronary care unit (CCU) and cardiac physiologists. We need to develop a clear recruitment and retention strategy to address this.

The current physical location of the CCU does not meet the minimum requirements for a level 2 unit. Upgrading the unit to level 2 would both increase the range of patients that could be safely managed and form part of the recruitment strategy to attract nurses.

Demand for cardiology is expected to grow in line with both demographic changes and shifting settings towards Cardiac CT, cardiac MRI and advanced imaging, which will drive increased demand for both increased staff and diagnostics capacity. There are opportunities to train nurse specialists to perform a range of procedures such as Linq devices, angiography and direct current cardioversion (DCCV).

Priority areas where we will improve care over the next 5 years are:

- Explore opportunities to expand the range of services provided at WGH, although this needs to be balanced against the capacity available to ensure there are no negative impacts on waiting times for current services
    - Subcutaneous ICDs
    - Expand EP service - AF cryoablations
    - Transcatheter aortic valve implantation (TAVI)
    - HIS bundle pacing
    - 7 day service for non-STEMI heart attacks.

- Further work to improve integration between the hospital and the community heart failure service, working with the community HF team to provide day care diuresis and reduce heart failure hospital admissions. Cardiac rehabilitation would be ideally suited for closer community collaboration

- Optimising the benefits of digital technology including:
    - Digital notes for pacemaker patients
    - Provide patients with pacemakers and implantable defibrillators with a remote monitor to allow scheduled remote follow up and allow early detection of arrhythmias of device malfunction by a digital alert based system (currently in excess of 5000 pacemaker checks per year)

- Electronic database of cardiology investigations.

5.2.9 Gastroenterology

Gastroenterology is a cohesive and forward thinking department that delivers an extensive range of specialist services, has a strong training and research capability and an excellent record for staff development and retention.

The unit is part of the East of England cancer network. The endoscopy unit is a JAG (Joint Advisory Group on GI endoscopy) accredited for service and national training and a regional centre for oesophago-gastro-duodenal and pancreatic endoscopic ultrasound and upper GI endoscopic mucosal resection. The department has trained and retained an exceptional number of nurse endoscopists and runs a high performing and commended bowel cancer screening service.

Outpatient services include a telephone assessment service for lower GI two week wait pathways and straight to test colonoscopy, and a range of nurse led and virtual delivery models alongside traditional face to face outpatients. Services for inflammatory bowel disease include an IBD helpline, nurse led services and multi-disciplinary teams, and specialist inpatient ward rounds. Hepatology and hepatobiliary services have close MDT links with the Royal Free Hospital and provide nurse led viral hepatitis and fatty liver service, and non-invasive chronic liver diagnostics (Fibroscan) as well as a providing a training position for an advanced endoscopy fellow.

The gastroenterology department has a wide range of links with other providers and tertiary centres, though few of these are formalised at present. Demand for services is expected to grow in line with demographic trends and the expansion of the national bowel cancer screening initiative.

Capsule endoscopy services are currently outsourced to St Mark's hospital and East & North Herts trust and there is an early opportunity to build a service and repatriate the activity. The service is currently participating in a national pilot for capsule endoscopy as part of the NHS Covid recovery plan.

Priorities and development opportunities for the next five years include:

- Workforce development and expansion in line with increasing demand
- Realise potential for additional specialist nurse roles in endoscopy, upper GI/nutrition, hepatology and IBD
- Further explore integration with surgical pathways to manage GI conditions and potential for multi-disciplinary clinics (for example in complex inflammatory bowel disease)

- Explore options to better integrate with primary care, community and mental health services, particularly in management of chronic health conditions, diatetics and improved psychiatric and psychological patient support
- Review learning from COVID – work with primary care to ensure appropriate referral pathways, continue with screening of referrals and use of telephone assessment clinics to ensure patients are streamed appropriately. Continued use of virtual appointments where clinically appropriate
- Developing a sustainable nutrition service (review options following the resignation of the long serving Consultant in GI medicine who previously provided this service)
- Further develop and embed capsule endoscopy service following pilot phase
- Work with system partners to integrate an assertive alcohol outreach service into the hepatology service
- Explore the opportunity for dedicated day case capacity to support infusions (biologics and iron), ascitic drainage, liver biopsy and management of day-case patients to offload the acute take and facilitate safer and earlier discharge
- Develop anaesthetist supported endoscopy lists to allow use of propofol for patients will not tolerate procedures under standard sedation, e.g. for complex procedures and patients with learning difficulties
- Become a regional endoscopy training academy and extend our research portfolio.

5.2.10 Respiratory medicine

Respiratory medicine is a high performing specialty providing a wide range of specialist services such as cancer, tuberculosis, asthma, COPD, bronchiectasis, pleural disease, sleep medicine, pulmonary nodule, cardio-pulmonary exercise test, exhaled nitric oxide (FeNO), Acute Respiratory Care Unit (ARCU - specialist unit for acute NIV), interstitial lung disease and a number of specialist MDTs (lung cancer, pulmonary nodule, pleural and ILD), and seeks to continually innovate and improve its services.

The interventional portfolio offered by Respiratory Medicine is exemplary for a District General Hospital and includes radial EBUS-guided lung biopsy, standard (linear) EBUS, EUS and EUS(B)-guided biopsy of metastases in the left lobe of liver, lower intra-abdominal lymph nodes and the left adrenal gland, endobronchial stenting for malignant indications, an advanced in-patient and out-patient thoracic ultrasound guided pleural service including medical thoracoscopy, indwelling pleural catheter (IPC - long term chest drain) and pleural vents for primary spontaneous pneumothorax. The endobronchial ultrasound (EBUS/EUS) service is supported by ROSE (Rapid On-Site Evaluation) enabling same day diagnosis of

service is supported by ROSE (Rapid On-Site Evaluation) enabling same day diagnosis of cancer; again singling our service out as an national exemplar. The department also runs a national training course for EBUS (one of only 7 centres in the UK) .

The inteventional portfolio also hosts a clinical fellowship program with senior specialty trainee (ST5+) and a research fellow working in additional to the standard Specialty Trainee (5) allocation from the East of England deanery.

The specialty also reaches into the community through an integrated community respiratory service for planned care. As well as providing integrated care pathways for asthma, COPD, and bronchiectasis, the community respiratory service also supports a domiciliary oxygen assessment service, admission avoidance and pulmonary rehabilitation.

The department has excellent links with 2 cardiothoracic services (The Brompton and Harefield Hospital for cancer and interstitial lung disease services and University College London Hospitals for non-malignant pleural disease and complex airway disease).

The Covid respiratory virtual hospital (CVH) model was developed by Respiratory clinicians early in WAVE 1 of the pandemic and was the first operational CVH service in the UK. The West Herts model has been used to develop a national blueprint now mandated by NHSE/I for all acute hospitals and a trust clinician now holds a regional leadership role. The CVH allows services to avoid unnecessary admissions and facilitate rapid (early) discharge. Collaboration with NHSX facilitated a more sophisticated model, incorporating the MedoPAd app and the integration of home monitoring.

The specialty is actively developing its research capacity and capability and is now collaborating with a range of partners across multiple studies. Recent publications include the development of a COVID risk stratification score for use in the Emergency Department (Thorax, Feb 2021), and the proportion of aspirated material used for ROSE at EBUS in suspected malignancy (Cytopathology 2021 . The team has also developed an evidence-based COVID pathway for acute management.

Priorities for the service are:

- To work with partners to review the model for the community respiratory service and opportunities to integrate its delivery with the wider delivery of the acute respiratory service. This includes an expanded ILD service, specialist asthma and sleep services
- Improve data sharing with community and primary care providers to improve the safety and handover of patients moving between settings of care

- To use innovation in digital medicine to expand the range of conditions treated through the virtual hospital model and to identify other virtual opportunities to better integrate care
- To develop a range of specialist diagnostic services including medical fluoroscopy in partnership with radiology, cryobiopsy and regular airway (anaesthetic) supported lists for more complex patients
- To join our gastroenterology colleagues to become a regional endoscopy training academy.

5.2.11 Clinical Haematology

Haematology provides a variety of clinical and non-clinical services and works across both the Medicine and Clinical Support Divisions within the Trust.

The Clinical Haematology service covers inpatient and outpatient work (including anticoagulation) across the Trust's three sites, Watford General Hospital (WGH), Hemel Hempstead General Hospital (HHGH) and St Albans (SACH).

Clinical haematology operates a busy day unit (The Helen Donald Unit) with more than 6,000 day unit admissions per year and nearly 2,000 cycles of chemotherapy per year (including intrathaecal chemotherapy). Apart from chemotherapy we administer biological treatment for other specialities patients, iron infusions, IVIg infusions. We provide supportive care with blood products for variety of haematology and non-haematology patients, central line care etc. Some of the haematology day case work (other than chemotherapy) is provided by CLCH the Community Treatment Unit at SACH. (transfusions, i.v. treatment etc.).

The haematology team provides specialist outpatient services at WGH and HHGH. These include 2 week suspected haematological cancer referrals, non-urgent referral pathways for variety of haematological conditions.

The Haematology team has inpatient beds on Tudor ward (shared with the Endocrinology team). Since August 2020 the service now offers inpatient chemotherapy services for appropriate patients.

Clinical haematology team provides 24/7 clinical and advisory consultant-delivered service for West Herts patients.

Priority areas where we will improve care over the next 5 years are:

- Further development of the inpatient chemotherapy service with intention to be the main provider of higher intensity chemotherapy service (chemotherapy for acute leukaemia or highly aggressive lymphoma patients) for the west Hertfordshire area.

(Most west Hertfordshire patients currently receive care at UCLH, development of a local service at WGH will improve patient experience through delivery of local care)

- Further development of Haematology Day Unit to be able to provide variety of chemotherapy, biologicals, targeted therapy for West Herts oncology patients
- To develop an out-reach chemotherapy service for certain haemato-oncology diagnosis/ age group patients in West Herts community
- Further development of nurse led clinics / virtual clinics for certain haematology diagnosis such as CLL/SLL, low grade B-NHL, MGUS, MPN. We provide this service for MPN patients already but there is a huge potential to increase this to other haematology diagnosis
- Successful completion of repatriation of SpR posts back to East of England and ability to recruit trainees into these posts in the long-term
- Work with Mount Vernon Cancer Centre (MVCC) and UCLH colleagues to review opportunities for integrating haemato-oncology services, linked to the potential relocation of MVCC cancer services to the WGH site (dependent on the outcome of the current MVCC clinical review).

5.2.12 Other specialist services – areas for development

We have identified two areas where developing a local service would significantly enhance the offering to the local population. These are renal services and infectious diseases.

Inpatients currently receive a renal service via an in-reach model provided by a consultant from Imperial College Hospitals Trust, who also provide dialysis services on the Watford site (dialysis at the St Albans site is provided by East & North Herts Trust). The in-reach service has limited capacity and our aim is to improve the support we can give to patients with renal disease by developing joint appointments between WHHT and one of the two specialist renal providers.

Similarly we do not currently have an infectious diseases service and we will produce a business case to develop a local service to address this gap.

5.3 Surgery and anaesthetics

West Herts delivers high volumes of surgical activity and is able to offer sub-specialty expertise across many specialties, enabling us to manage the majority of the needs of our patients locally. Our proximity to London means patients are able to access excellent tertiary care from the specialist London hospitals when it is needed.

Our key partnerships are the local cancer network (with East & North Herts NHS Trust and Luton & Dunstable NHS Trust, Mount Vernon Cancer Centre); Imperial College Healthcare NHS Trust for trauma and other specialist work; and Moorfields and the Royal National Orthopaedic Hospital for specialist ophthalmology and orthopaedic work. Tertiary referrals for complex pelvic recurrence and bowel failure patients go to St Mark's hospital.

High quality services

Most day case and elective activity is undertaken at SACH as the planned surgical site for WHHT. More complex surgery potentially requiring critical care support is undertaken at WGH. The future strategy as part of the redevelopment is to move the majority of elective surgery to the SACH site, supported by an enhanced 'high dependency' or 'extended recovery' care model to enable more complex patients to be managed safely. Waiting times for surgery vary, with some specialties easily achieving the 18 week maximum wait standard while others, particularly the larger specialties such as orthopaedics and urology, have longer waits. In the longer term the redevelopment will allow us to increase our theatre capacity to address the waiting list challenges and provide enhanced access to theatres in an emergency, but in the short term we will continue to use private sector capacity and additional weekend sessions to provide additional capacity. .

Getting It Right First Time (GIRFT) reviews and the application of GIRFT principles would indicate that in some areas the level of surgery being undertaken is below the level recommended to ensure the best outcomes. We will review all specialties over the next year to ensure they are clinically sustainable.

We have seen through the SMART pilot for medicine that increasing specialist support to the ED can improve decision making, reduce admissions and reduce length of stay. Medicine are piloting a virtual SMART model and surgery will learn from the experience of medicine to implement a SMART or virtual SMART model to support the ED. Where specialties are too small to offer either in hours or out of hours consultant cover, we will explore networked approaches with other local providers.

Integration

In common with other areas of the country, a number of community services have been introduced in recent years that manage low level problems that do not require surgical

intervention. In these specialties, referrals to the trust come via the community services rather than directly from GPs, other than for agreed exceptions such as suspected cancer pathways. While some of these services operate well, in others the patient pathway is less efficient and can cause avoidable delay for those people who need surgical intervention. As part of our new integrated care partnership, we will work closely with the community providers to improve the pathways and ensure that they are patient focused, efficient and effective.

Personalisation

The majority of the surgical care that we provide is episodic, in that people have a particular problem that can be remedied or mitigated by a surgical intervention. Unlike medical specialties, there are relatively few patients who have long term relationships with their consultants. This means that the main focus for surgery is on universal personalised care, and in particular ensuring that people have sufficient information to be able to make an informed choice about their care. We will build on our existing good practice relating to informed consent and consider how the lessons of the Patterson report can be applied both to complex surgery and more widely.

The other key opportunity is patient initiated follow up (PIFU), which can work very well post surgery for people whose recovery is in line with expectations. We will implement PIFU in all areas where it is clinically appropriate to do so.

Consistent care

The national GIRFT initiative began in orthopaedics and uses data to show how variations in practice and low surgical volumes drive unwarranted variations in patient outcomes. As referenced above, we will apply the outcomes of GIRFT reviews and the GIRFT principles to review our specialties and address unwarranted variations in outcomes. We will also work to reduce unwarranted variation in care by implementing best practice surgical pathways as part of the CPG programme with the Royal Free. Surgery has benefited from significant advances over the last 50 years, such as the introduction of laparoscopic surgery that enabled care to be shifted from inpatient to day cases. Technology continues to evolve, with robotic surgery and interventional radiology growing rapidly and being increasingly included in the standard training of new doctors. We will seek continuous improvement in the delivery of care, utilising new technologies where they lead to improved outcomes for patients.

Whilst most surgery is undertaken on a planned or semi-planned basis it is important that when emergency surgery is required that this is able to take place in a timely way in line with best practice guidance. We will review our theatre schedule and how we prioritise theatre capacity at Watford General Hospital to enable the creation of additional ring

fenced trauma and 'CEPOD[2]' theatre capacity and improve turnaround times for emergency surgery for priority pathways. This links to our plans to increase planned care activity at SACH as this will reduce the number of 'Watford only' elective surgical patients thereby freeing up theatre capacity for emergency surgery as well as reducing waiting times for patients with more complex needs.

5.3.1 Anaesthetics

The anaesthetics department provides a service to 7 theatres at WGH, 6 theatres at SACH and supports outpatient interventions requiring local anaesthetic. It is a flexible department with an emphasis on safety, and which provides good training and simulation opportunities. Workforce challenges within anaesthetics mirror the national shortfall and a robust and resilient workforce plan is required to address this. Recent initiatives have proven successful for staff grades but succession planning and continuation of the recruitment campaign is essential. Future opportunities to support the workforce include the development of non-medical anaesthetics associate roles. The EPR will improve safety, allowing access to the patient's previous anaesthetics records, and will support improvements in pre-operative assessment.

As more care shifts out of theatres into other settings, the need for anaesthetics input outside of theatres is likely to increase. The strategic direction for theatre provision lies in expanding elective services at the St Albans site. This involves an enhanced care model which started in 2018 but has the potential to expand. A comprehensive enhanced recovery suite with appropriate staffing levels and skill mix on the wards will allow for patients with more complex needs to receive their surgery on the elective site. This will significantly transform the service provision at SACH and reduce the demands on the Watford site.

5.3.2 Critical Care

The Critical Care Service at WHHT provides a 20 bedded Intensive Care Unit providing level 3, 2 and 1 critical care:

- Level 3 (advanced respiratory support with at least 2 organ system support)
- Level 2 (detailed observation including support for single organ)
- Level 1 care (Patients at risk of deterioration, whose needs are met on acute ward with critical care support or are ready for step down).

Patients requiring specialist care are promptly transferred out to our partner Trusts (Trauma: St Mary's Hospital; non-trauma neurology: Queen's Square Hospital; Renal: Hammersmith & Lister Hospitals).

[2] CEPOD (confidential enquiry into peri-operative deaths) – this is the term used to describe a ring fenced emergency theatre.

The Critical Care service also provides a nurse-led critical care Outreach 24/7 with daytime Consultant presence and a Hospital at Night service providing clinical advice and support to clinical teams. These services deliver care on our general acute wards in managing deteriorating patients and identifying patients who may benefit from admission to the critical care unit.

Key priorities for the service for the next 5 years include:

- Promoting the health and well-being of the critical care team, providing support and 'after-care' for staff traumatised by their experience of delivering care during the Covid pandemic
- Workforce development – recruitment and retention strategy and development of enhanced roles including Advanced Critical Care practitioners (ACCPs) to support delivery of level 2 and 3 critical care and Advanced Nurse Practitioner (ANPs) roles within the outreach service
- Further development of critical care support to enable more complex surgical case mix at St Albans City Hospital
- Joint work with medicine and surgical divisions to improve admissions pathways for critical care, ensuring that all patients who can benefit are identified, managed and transferred in a timely fashion
- Joint work with surgical division on opportunities for 'pre-optimisation' of patients undergoing emergency surgery
- Develop a Level one critical care facility incorporating speciality specific monitored beds for Respiratory medicine (ARCU) and Cardiology (CCU) patients.

5.3.3 Theatres

A refurbishment programme commenced for the Watford Hospital Theatre facility in 2020 and is due to complete by 2022. This will result in one additional theatre and a treatment room with a dedicated paediatric recovery area following recommendations from the CQC. This will create additional theatre capacity for minor operative procedures and dedicated Local Anaesthetic lists.

The longer term aspects of refurbishment are to upgrade all theatres with modern IT hardware which will improve data capture in real time.

The division is committed to maximising on the use of robotic technology to aid theatre productivity and clinical outcomes. The technology has applications in Urology, Colorectal Surgery and Orthopaedics and has demonstrated significant gains nationally and internationally.

5.3.4 Pain medicine

WHHT provides a pain service with a compliment of four consultants and one psychologist. The service focuses on the treatment of chronic pain disorders largely in an outpatient setting.

A comprehensive review of the pain service is required, working with colleagues within the integrated care system to create a system wide pathway for our patients.

5.3.5 Trauma and Orthopaedics

The orthopaedics department at WHHT sees high patient volumes but the British Orthopaedic Association has recognised WHHT has a relatively small number of surgeons for the size of the population. The current compliment of 16 consultants has sub specialty expertise including upper limb with hands, lower limb with foot and ankle and spine. The department has two dedicated trauma surgeons and 24/7 trauma provision with access to a dedicated trauma theatre. In common with most other providers, waiting times for orthopaedic services are a challenge and extensive demand and capacity modelling is required on an ongoing basis to manage the 18 week target.

Most tertiary links including cancer surgery are with the Royal National Orthopaedic Hospital at Stanmore, with linked MDTs for spinal patients. Elective paediatric orthopaedic surgery is provided at Stanmore as there is no service at WGH. The main trauma link is to the major trauma unit at St Mary's Paddington.

In line with GIRFT review findings and national standards the Trust implemented ring fenced orthopaedic beds on the Watford site in 2018. This has significantly reduced infection rates and improved the quality of care for all patients receiving surgery on the Watford site.

Nationally, Orthopaedics was the first specialty to be reviewed by GIRFT, and as a result national thinking is more advanced about the scale and organisation of services to achieve best outcomes. The national direction of travel is towards a hub and spoke model, with the most specialist activity being undertaken at a hub site to ensure sufficient activity volumes to drive the best outcomes. Under this model it is likely that WGH and SACH would be spokes with the hub at the RNOH, Stanmore. Most activity would continue locally but WHHT consultants would provide specialist surgery from the Stanmore site. WHHT consultants may in the future provide specialist surgery from the Stanmore site. There are also opportunities to collaborate on the delivery of orthopaedic services with the new north North Central London orthopaedic hub at Chase Farm Hospital.

Our priorities for the next five years include:

- Work within the Clinical Network to support developments with the Hub and Spoke model include workforce design and clinical pathway ratification

- In keeping with the lessons learnt within the COVID pandemic our medical staff model will be reviewed to deliver optimal care to both trauma and elective patients in line with the findings of direct consultant led virtual and face to face appointments
- Working to improve integration with community musculoskeletal pathways
- Improve pathways linked to the newly established MRI and CT provision at SACH
- Explore the opportunity to work collaboratively with the emergency medicine and medical divisions in the management of 'silver trauma' (patients over 65) to improve overall care and rapid discharge of this vulnerable group of patients
- Develop an integrated spinal surgery clinic with pain, rheumatology and neurology
- Work collaboratively within the ICS to develop a systems approach to the management of the acute sciatica pathway.

5.3.6 General surgery (Upper and Lower Gastro-intestinal surgery)

WHHT is nationally recognised as a centre of excellence for laparoscopic colorectal surgery. Clinical outcomes for patients treated within the trust lie within the top quartile nationally. In addition to this the Trust offers a standard range of services in general surgery including lower and upper gastro-intestinal surgery and cancer interventions. The lower GI surgeons form an active part of the bowel cancer screening service.

Pathways and partnerships are well established with more specialist London providers, where clinical expertise is concentrated and with local providers nearer to the population that we serve. Nationally, a hub and spoke model has been introduced for GI services. WHHT acts as a spoke to the central London hospitals to include the Hammersmith where WHHT consultants are an active part of the on-call provision for emergency upper GI surgery.

Improvements to general surgery will be enabled by the current theatre improvement programme which will provide improved facilities and free theatre time within main theatres. Over the next few years we would expect to see a shift towards more robotic surgery to replace current laparoscopic surgery in some areas. The GIRFT review for upper GI surgery recognises the need for provision of an acute service for emergency (hot) gallbladder patients. This will require the theatre refurbishment for additional theatre capacity as well as a dedicated on-call rota to provide provision of a surgical service.

Benchmarking against national peers indicates opportunity for improving patient pathways and workforce via specialist nurse provision. Extended scope practitioners would undertake independent clinics to free consultants for surgical activity, in particular the gall bladder service, and support waiting times.

GI services work collaboratively with the division of Women and Children (obstetrics and gynaecology) in the selection of patients for discussion in a joint MDT. This allows services to establish cases that should be undertaken by multiple teams in a single setting to improve the quality of surgery delivery. There is scope for further improvement in the multidisciplinary approach to patient interventions and care which will be implemented drawing on national examples of excellence.

Our priorities for the next five year include:

- Improving the hot gall bladder pathway
- Workforce redesign to develop specialist nurse / extended practitioner roles to improve pathways, reduce waiting times and free up consultant time for additional theatre sessions
- Further development of multi-disciplinary care model with obstetrics and gynaecology services.

5.3.7 Urology

This is a well-regarded department, offering a broad range of services across all three sites. The Urology service sees a high volume of patients and manages all activity in house. Established partnership arrangements are in place for cancer patients with E&NHT. A nationally supported review of the Mount Vernon cancer service is underway and may impact the partnership arrangements and patient pathways within urology in the future.

Priorities for the next five years include:

- Develop a day surgery brachytherapy service which will improve our patient experience and outcomes along with reducing length of stay
- Integrate with community partners, providing more telemedicine and community diagnostics as well as joint work to improve catheter care, with particular reference to difficult catheterisations
- Detailed review of Urology medical staffing model and implementation of an appropriate on-call rota in line with British Association of Urological Surgeons recommendations
- There is an aspiration to create a urology one stop centre at SACH. This would streamline the patient pathway, enhance the patients experience and reduce waiting times. This would create an opportunity for WHHT to be the adrenal centre for the region.

5.3.8 Vascular surgery

Vascular surgery offers a standard range of district general services with 24/7 on-call provision for the increasing emergency admissions. The service is provided across the WGH and SACH sites and includes interventional radiology, a vascular lab providing one stop clinics and a regional AAA screening programme.

The relocation and expansion of the vascular laboratory on the Watford site in 2020 helps future proof this service and enables it to absorb the growing demand, particularly for patients with DVTs, inpatients with diabetic feet and those requiring carotid diagnostics.

The complex nature of this patient group and frequent comorbidities such as diabetes provide opportunities for greater levels of integration. Through working closely with the medicine division we will improve patient pathways and service provision to match the growing demand within the diabetic, frail, elderly population with vascular disease.

A combined hub hosted by East and North Herts Trust (ENHT) has been agreed with specialist commissioners and is designed to manage complex and emergency surgery, with the latter achieved through a treat and transfer model. All arterial surgery will move to ENHT, with less complex surgery retained by WHHT. Working closely within the ICS, we will be establishing the clinical pathways and operational processes to enact this ICS priority.

Priorities for the next five years include:

- Working with partners to implement the vascular hub and spoke model
- Working with the medicine division to improve pathways and meet growing demand within the diabetic, frail, elderly population with vascular disease.

5.3.9 Breast surgery

The department offers a comprehensive range of services standard to a district general hospital with some elements of enhanced care that are well regarded by primary care colleagues and the local population. Examples are the fast track genetic urgent referrals managed by advanced nurse practitioners and the advisory MDT breast meetings for patients six weeks post-operation that include physiotherapy, lymphoedema and specialist nursing services.

Strong networks and partnerships are established across the London hospitals and more locally. The current patient pathway is geographically varied and wide ranging. The service is linked with Beds and Herts Breast Group within the East of England Cancer Clinical Network, Mount Vernon oncology, Royal Free plastics and NW Thames Regional Genetics Service. The service will determine whether by rationalising these pathways it would be possible to improve on the existing arrangements.

There is opportunity to improve the surgical pathway which would improve the patient experience and outcomes. The aspiration is to have a one stop service at the SACH but this requires infrastructure changes that are dependent on the hospital redevelopment.

Other plans to improve the current service include:

- introduction of patient initiated follow up
- upgrading of IT facilities for weekly multidisciplinary meetings and improved access to radiology reports for clinicians to allowed off site access in emergency situations
- Adoption of enhanced models for pre-operative preparation to ensure more accurate procedures using modern localisation technique (LOCalizer radiofrequency probe)
- Review of workforce model for oncoplastic surgery with the potential to create posts attracting dual trained clinicians in oncology and plastic surgery
- local delivery of level 4 clinical psychological therapy currently offered from Mount Vernon
- Collaborative working with partners to create an enhanced community model allowing improved tissue viability and wound care support to primary and community care.

5.3.10 ENT

Ear, nose and throat services manage high patient volumes, seeing circa 13,000 patients and operating on 1,500 patients yearly and working closely with audiology services. The department provides primarily elective surgeries and adopts latest specialty practices.

The department has a stable experienced workforce and patients report high levels of satisfaction in patient surveys. Consultants operate a shared rota with ENT consultants at E&NHT, with out of hours care and emergency surgery performed at the Lister hospital. Good partnership arrangements are in place with both E&NHT and the wider cancer network including LNWH and L&D for head and neck cancers.

Opportunities exist to repatriate some surgery locally, particularly thyroid surgery and benign head and neck surgery. This would be subject to confirmation that activity levels meet the recommended minimums per the GIRFT approach.

5.3.11 Ophthalmology

Ophthalmology is a relatively small service for the size of the local population, and is currently delivered across the SACH and WGH sites. Like many providers, WHHT have

historically struggling with waiting times for ophthalmology both for new and follow up outpatients and surgery. Emergency services are provided in hours, with emergency patients transferred to other providers out of hours although there are no formal arrangements to underpin this.

Priorities for the next five years include:

- Better integration of pathways with community and primary care providers
- Developing 'one stop' cataract clinics
- Introducing virtual optical coherence tomography imaging to enable diagnosis
- Creation of a vitreoretinal service locally.

The service will be reviewed to ensure that it is clinically sustainable over the medium to long term and to consider how expansion, networked approaches or other ways of delivering the service would support this. This review will include services for children, which are currently only delivered by one consultant. Key areas of focus include consideration of whether a 24/7 emergency service can be provided and / or how out of hours provision can be strengthened and whether there are additional services that should be provided locally.

5.3.12 Oral Surgery

The oral surgery service combines dental and orthodontics services provided by trust clinicians with a maxillofacial service provided by consultants from Northwick Park supported by trust nurses. The dental and orthodontics services are outpatient based. The maxillofacial service on site is relatively small though with high demand for both children and adults and comprises lymph node biopsies under local anaesthetic and extraction under deep sedation. Head and neck oncology services are provided at Northwick Park. Out of hours patients are transferred to Northwick Park for treatment as there is no on call service, and patients requiring an overnight stay are also treated at Northwick Park. Improvements to the physical environment in which the service is provided would improve patient and staff experience and improve flow within the clinic.

Working within the ICS, a detailed review of the dental service provision is required drawing on national learning and evidence of best practice care models. Through this it could be feasible to move the dental service into a community setting and to look at alternative methods of providing the maxillofacial service, including different providers or different sites. The aim would be to improve patient experience, reduce waiting times and improve the clinical sustainability of the service.

5.3.13 Paediatric Surgery

The majority of paediatric surgery is undertaken as day cases at WGH with approximately 500 procedures a year and is mainly focused in ENT, general surgery, dental, urology and orthopaedics. Emergency complex activity goes into London, with the provider dependent on the nature of the emergency and bed availability. Emergency neurosurgery and urology goes to Great Ormond Street Hospital, and emergency orthopaedics for multi-trauma and septic arthritis in the under 2s goes to St Mary's. Emergency ENT goes to East & North Herts Trust in common with adult ENT.

We will explore the potential to agree clear pathways for paediatric emergencies with a central London network.

The Trust recognises the provision of paediatric recovery in the general recovery areas is not sufficient, as highlighted by the CQC. The theatre refurbishment programme, which is due to complete in 2022, will therefore create a dedicated paediatric recovery area.

5.4 Women's and Children's

The women's and children's (WACS) division provides paediatrics (including neonatal), obstetrics, midwifery and gynaecology services. Paediatric services are a mixture of episodic care provided to mostly healthy children and long term specialist care for children with serious health conditions or physical disabilities. For the latter, personalised care throughout their childhood with a clear and effective transition into adult services is a top priority. There are also significant opportunities to integrate care for these children with community, primary care, mental health and social care services.

Similarly, women are in on going contact with trust services during pregnancy and after birth. In line with the national maternity strategy we will improve the continuity of care and the perinatal mental health support provided to women to ensure better outcomes for both the woman and her child.

5.4.1 Paediatrics

The paediatrics team delivers the majority of care for children aged 0 to their 16th birthday within the trust. As well as our acute cover to the Children's Emergency Department (CED) the paediatric ward, and a large general paediatric outpatient clinic service, we cover almost all the medical specialities including: allergy, behavioural paediatrics, cardiology, endocrinology, gastroenterology, haematology & oncology, neurology, nephrology and respiratory. We liaise closely with our colleagues in tertiary care; at Cambridge University Hospitals, Great Ormond Street Hospital and other London specialist centres. There is also a Safeguarding Children team supporting the department and wider hospital with social care issues for the children in the service. We work with our colleagues in surgery, especially urology, orthopaedics, ENT and general surgery, to support the acute admissions to the Children's Ward.

The Children's Emergency Department (CED) is run by the emergency medicine division but nursing staff are provided by the WACS division. A Paediatric Assessment Unit (PAU) was introduced in 2019 which enables children who would otherwise have had a short inpatient admission to be managed safely in an ambulatory way, reducing their time in hospital.

There are many opportunities to work differently with primary care clinicians and community services to avoid the need for children to attend hospital. We have implemented advice and guidance for GPs across our service to better meet the needs of the 40% of children who are discharged following a first outpatient appointment. We have introduced virtual appointments where it is safe to do so and continue to work with community providers to enable the delivery of services such as blood tests and IV antibiotics outside of the hospital.

A key priority is to improve transitional care for adolescents as they move from paediatric to adult services. Paediatric services currently serve children up to the age of 16, with children 16 years and over seen in adult settings (ED, outpatients and wards). An in-reach service for 16-18 year olds on adult wards is provided, but our ambition is to deliver a best practice model across all hospital services that considers the personalised needs of each child as they transition to adult services.

We run a level two paediatric oncology shared care unit, the only unit of this level located in a district general hospital within the North Thames Children's cancer Network. This includes full inpatient supportive care and day-care bolus and infusional chemotherapy. Our ambition is to achieve level two 'enhanced' status during 2021. Achieving level two 'enhanced' will allow the unit to deliver inpatient chemotherapy, reducing the need to travel into London for this specialist treatment. Additionally we have been invited to be a pilot centre for the launch of the new Acute Lymphoblastic Leukaemia trial (ALLTOGETHER). Leukaemia patients account for 50% of our oncology patient cohort and so we will absorb new patients from other surrounding units who have not been invited to open this trial, thereby opening growing the service. To achieve this aim, implementing electronic prescribing for chemotherapy is an essential priority.

Along with the East of England network we are also members of the Northwest London Hospitals Allergy Network and have been involved with active participation and hosting of regional meetings promoting better standardised practice and allergy education, including for primary care practitioners. We run a full skin prick testing, Serum IgE and oral food challenge service enabling assessment and diagnostic work up for children referred from the local area, and increasingly, the surrounding area. As the service expands, we are doing more complex work, linking closely with the WHHT paediatric respiratory, gastroenterology and dermatology teams to ensure that patient care remains closer to home. Aspirations to support low risk drug allergy assessment and immunotherapy for aeroallergen sensitisation remain 5 year aims.

There are challenges in recruiting junior doctors in paediatrics and there are opportunities to address this through increasing the training opportunities for Advanced Clinical Practitioners and Physician Associates.

The Paediatric team have been involved in the CPG programme to implement consistent best practice care including implementation of a 'wheezy child' pathway in CED. The service is committed to the principles of the CPG programme and will continue to work with RFL partners on rolling out additional best practice pathways.

Our priorities for the next five years include:

- Implementing advice and guidance as part of redesigning our outpatient pathways and ensuring specialist expertise if focused on children with the most complex needs

- Work with HCT to improve access to home based care to reduce the need for hospital admission (e.g. IV antibiotics)
- Continue to improve transition arrangements for young people into adult services
- Achieve level 2 'enhanced' status for our Paediatric Oncology Shared Care Service
- Workforce redesign – create additional advanced clinical practitioner roles
- Implementation of CPG pathways to support consistent delivery of best practice care.

5.4.2 Neonatal Services

Woodland Neonatal Unit is a designated Local Neonatal Unit (LNU) within the East of England Operational Delivery Network. It currently provides 24 cots, though this may change in future following ongoing regional review of neonatal services. Our service provides short term intensive care, high dependency, special care for babies born >27 weeks of gestation and birth weight > 800 grams or completed 28 weeks for multiple births.

The service also has 6 dedicated transitional care beds within the postnatal ward. The purpose of this unit is to give supportive care to babies (34-36 weeks gestation) who are well enough to be with their mothers but still require clinical surveillance.

The unit caters for around 800 admissions per year (second largest LNU service in the region) and prides itself in less invasive care practices in line with current evidence. This approach to care has helped unit achieve positive outcomes in the short and long term as shown in the National Neonatal Audit Programme metrics.

The immediate priority for the service is to sustain levels of good quality care and invest more in the less invasive care philosophy.

- Ensure unit complies with various recommendations in Better Births and Saving Babies Lives Care Bundle v2 (SBLCBv2) care bundle - Right Place of Birth (RPoB) for extreme pre-terms, optimisation of antenatal interventions e.g. magnesium sulphate, corticosteroid compliance rates, deferred cord clamping and less invasive ventilation strategy
- Provision of a seamless, responsive and multidisciplinary service built around the needs of new-born babies and the involvement of families in their care
- Further developing the expert neonatal workforce required and expanded roles for some allied health professionals to support clinical care such as SALT

- Collaborative working with Maternity and across the network to provide high quality neonatal care and to improve outcomes for all families, provide safe expert care as close to their home as possible, and keep mother and baby together while they need care
- Forge strategic relationships with Herts and West Essex local maternity and neonatal system (LMNS) to allow us influence policy and care pathways for women within our patch and wider LMNS
- Sustained reductions to term admissions to neonatal unit below 5%
- To acquire accreditation under the BLISS baby charter scheme and the UNICEF Baby Friendly Initiative to improve family experience and breastfeeding rates in accordance with national standards.

5.4.3 Maternity and Obstetrics

Our maternity and obstetrics services deliver maternity care for local women across the full maternity pathway. The national strategy for maternity – *Better Births* – sets out clear goals to improve the personalisation and continuity of care and to reduce still births, neonatal and maternity deaths. We are committed to delivering the strategy, working in partnership with the local maternity and neonatal system.

Our immediate priority is to reconfigure our midwifery teams to provide continuity of care across the antenatal, perinatal and postnatal pathway with an emphasis on BAME and vulnerable groups who currently have poorer outcomes. We are also appointing consultants with expertise in diabetes, perinatal mental health and maternal and fetal medicine to improve the care we can offer for more complex pregnancies. We will improve the links to wider medical specialties such as cardiology and neurology so that we can appropriately personalise the care for women who need additional input. This is in response to the recent Ockenden report and MBBRACE.

Implementing a revised perinatal quality surveillance model (December 2020) is a key priority and involves maternity and neonatal quality as they are inextricably interdependent. There are five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. They integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system. Revisions to the local, regional and national quality oversight model for the NHS are currently underway as part of the development of ICS and the future system oversight framework.

Telemedicine will be utilised to enable the remote monitoring of women during pregnancy, reducing the need for some antenatal visits and allowing more effective monitoring of high risk pregnancies. We will also implement more ambulatory pathways and explore the opportunity for a day assessment model.

We have implemented a CPG pathway for induction of labour, which has already allowed us to use data comparison to identify an opportunity to reduce the length of time between induction and birth. We will continue to use the CPG approach to continuously improve the care we offer.

Our priorities for the next five years include the delivery of the targets in the national strategy:

- Improving continuity of care in line with the national 'Better Births' strategy
- Progress against trajectory to deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and 50% by 2025 and to reduce preterm births from 8% to 6%.
- Deliver full implementation of the Saving Babies' Lives Care Bundle (v2) by 31st March 2021.
- Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2021, more than 35% of women are booked on to a continuity of carer pathway. All reasonable endeavours must be undertaken to ensure that continuity of carer is provided to groups that experience the poorest outcomes, such as women from ethnic minorities and the most deprived socio-economic groups. Continuity of carer should be delivered alongside ensuring high quality care maternity for all women.
- Progress against trajectory to deliver improvements in choice and personalisation through Local Maternity & Neonatal Systems so that by March 2021 all women have a personalised care plan and more women can give birth in midwifery settings.
- In addition to the national strategy we will implement CPG pathways to support consistent delivery of best practice care.

5.4.4 Gynaecology

Gynaecology services include the early pregnancy unit (EPU) and the gynaecology assessment unit (GAU) as well as traditional outpatient and inpatient services.

Care has shifted over time towards less invasive procedures, either laparoscopic day cases or outpatient procedures, and there is further scope to shift services in these ways, including more nurse led clinics.

Gynaecology oncology surgery is currently provided by the trust but is not of optimum scale, particularly for ovarian cancer. There are different views as to whether this service should be expanded or stopped and consolidated across the local cancer network. We will review the volumes undertaken and the outcomes achieved and agree a clear direction of travel with the cancer network within the next year.

Our priorities for the next five years include:

- Reviewing pathways into the GAU to maximise the ambulatory care pathway, again shifting care into a less acute setting
- Focus on the provision of one stop and outpatients procedures and reduce the need for multiple attendances and in-patient beds.
- We see high volumes of endometriosis surgery and our ambition is to be accredited as an endometriosis centre within the next 2 years
- Work with the cancer network to review our gynae-oncology service and agree clear direction of travel for the future of the service
- Work to become an accredited urogynaecology centre with the focus on local and regional networks. We aim to achieve this within a year.

5.5 Clinical support services

Clinical support services include pathology, radiology, pharmacy and therapies. Their services underpin the care delivered by all other specialties, and the range and scale of diagnostics, particularly radiology, is growing rapidly. Mirroring the activity of the hospital, clinical support services must be rapidly available to support ED and inpatient needs (acute services) and on a planned elective basis (elective services).

A new national strategy for diagnostics was published in early October 2020 which sets out significant ambitions to rapidly expand the scale, availability and responsiveness of diagnostics services. The key actions defined in the strategy are:

- Acute and elective diagnostics should be separated wherever possible to increase efficiency
- Acute diagnostic services (for A&E and inpatient care) should be improved so that patients who require CT scanning or ultrasound from A&E can be imaged without delay. Inpatients needing CT or MRI should be able to be scanned on the day of request
- Community diagnostic hubs should be established away from acute (emergency) hospital sites and kept as clear of Covid-19 as possible
- Diagnostic services should be organised so that as far as possible patients only have to attend once and, where appropriate, they should be tested for Covid-19 before diagnostic tests are undertaken
- Community phlebotomy services should be improved, so that all patients can have blood samples taken close to their homes, at least six days a week, without needing to come to acute hospitals.

During 2021 we will develop a diagnostics strategy to reflect the national strategy, and which will build on and give more detail to the headline ambitions set out below.

5.5.1 Pathology

Currently there is a comprehensive laboratory service across the sites providing standard hospital services for both acute and elective services. The HWE ICS strategy for pathology is to consolidate and outsource all elective pathology services across the ICS (including GP initiated) through an on-going procurement process being undertaken jointly with E&NHT and Princess Alexandra Hospital. The ambition is for an ICS wide provider and an overarching integrated network. There is an acknowledged risk that succession planning and recruitment could be problematic with the outsourcing of elective work unless there is a strong network with the ICS wide service, which we will drive and champion.

Acute 'hot lab' services will remain on site but delivered through the ICS network pathology provider. COVID19 has had a significant impact, requiring microbiology services on site as a 24/7 service rather than a 5 day service. The longer term consequences of this will need to be considered.

There are a number of ways in which technology will improve services. Point of care testing is expected to increase, and one stop diagnostic pathways will be enabled by technology. Pre diagnostic MDTs will improve patient experience by enabling all tests to be undertaken on the same day. Digital ordering and an electronic system that is integrated with the electronic patient record will allow both hospital staff and GPs to see what tests have been undertaken and when, reducing the duplication of tests and improving patient safety.

Phlebotomy services are currently provided on the hospital sites, but in line with the national strategy the ambition is to move the majority of the service within the community, reducing waiting times and providing care closer to home.

Pathology holds the contract for coroner post mortems across Hertfordshire.

Priorities for the next five years include:

- Implementation of the HWE ICS wide pathology network provider model
- Increased point of care testing
- Work with primary care to increase local access to phlebotomy services.

5.5.2 Radiology

Radiology services are provided across all three sites to meet urgent and elective needs. Imaging modalities provided are plain X-Ray, MRI, CT, Nuclear Medicine, Mammography and Fluoroscopy. Dexa is provided by Rheumatology at St Albans City Hospital and PET CT and SPECT CT are fully outsourced to other providers. Out of hours emergency radiology reporting is also outsourced.

In line with national trends, activity is growing rapidly year on year and the complexity of scans is also increasing, but this has not been matched by equivalent increases in staffing or equipment, putting growing pressure onto services. Workforce constraints across all staffing groups are the key challenge facing the service, although ageing equipment is also a risk and a clear replacement programme will be a priority for the diagnostics strategy, particularly for MRI.

A new CT scanner has recently been implemented adjacent to the ED at WGH to improve urgent care services. To support recovery from Covid, an additional MRI and CT scanner have been sourced for the SACH site, enabling a Covid-safe service to be operated. These

machines have allowed activity to be maintained at pre Covid levels rather than enabled an increase in capacity at this time.

There is widespread agreement across the trust about the fundamental importance of diagnostics including imaging, particularly as clinical indications for technology such as CT become broader. This is reflected in the emerging clinical adjacencies for the WGH redevelopment, which have imaging at the centre of the hospital. The ambitions for imaging are reflect this and are consistent with the national report:

- Increase capacity to meet demand across all modalities, including doubling CT and MRI capacity
- Increase workforce to meet demand, including securing additional radiology training posts
- Bring back in house all outsourced activity where modalities are already provided, and consider the business case for providing other modalities on site
- Join an IT-enabled radiology network with other providers to allow the sharing of data and digital imaging between providers, reducing duplication, and to improve out of hours support
- Create a rapid diagnostics centre on the SACH site to enable a one stop approach and to create a clear elective pathway away from the acute WGH site.

There is also a need to ensure that people only receive scans that are appropriate to them and which will impact on their clinical management, both to improve the patient experience and to reduce demand for imaging. This will be enabled by the new EPR and the CPG approach, which will use best practice pathways to ensure that people get the most appropriate diagnostic for their condition.

Interventional radiology is a medical specialty in which its trained clinicians perform minimally invasive procedures to diagnose and treat various diseases. These procedures have grown in popularity with both providers and patients; as an alternative to open surgery, interventional radiology procedures may reduce risk, pain and recovery time for patients.

There is a planned joint appointment for an interventional radiologist post with the Royal Free Hospital to increase our existing capacity, and the strategy is to create a new interventional radiology suite at WGH. Interventional radiology network arrangements are being considered with neighbouring Trusts, ideally consistent with the wider radiology network.

Priorities for the next five years include:

- Develop a detailed diagnostics and imaging strategy (2021)
- Develop a diagnostics / imaging IT strategy
- Work with medical and surgical specialities to review diagnostic components of outpatient pathways to streamline care and improve patient experience
- Recover activity backlog due to COVID and maximise the benefits from new CT and MRI facilities at SACH
- Upgrade our interventional radiology suite at WGH and continue to develop our interventional radiology service offer and workforce, including working with partners to strengthen out of hours interventional radiology provision.

5.5.3 Pharmacy

The pharmacy service primarily supports inpatient services, but also provides prescriptions for outpatients. In common with other providers the key challenges for the service are the transfer of medicines at the interface between settings as people move between hospital and GP services. A lack of a common IT system leads to poor communications and wastage, and changes in medication are not always understood meaning that people don't take the optimal drugs for their condition. Delays in TTAs often also impact on the speed of discharges.

Our priorities for the next five years include:

- The implementation of electronic prescribing, interoperable with both the new EPR and with primary care IT systems
- Integration of the acute and primary care pharmacy teams to better join up prescribing between different settings of care
- A new pharmacy robot to speed up dispensing within the hospital
- As part of the WGH redevelopment, we will also explore the possibility of an on-site fully owned pharmacy to replace FP10s and reduce the VAT burden.

5.5.4 Therapies

The therapies service provides physiotherapy and occupational therapy services to inpatients and outpatients. During Covid, 85% of outpatient services were delivered virtually and we expect to continue to provide a significant proportion of the service virtually over the longer term.

Covid also changed the way that inpatient services were delivered, with less intervention at discharge and more therapy provided during the inpatient stay to support Covid patients.

As part of the trust's ambition to maintain discharge to assess arrangements, there will be an increased need for the trust's team to integrate with OTs and physiotherapists from other ICP partners to deliver a single joined up service on a trusted assessor model to remove duplication of assessments. This will increase the capacity to expand roles internally such as supporting ITU in turning patients.

In addition to integration, the other priority for the service will be to maximise the opportunities to expand the AHP role, developing both advanced practitioners and potentially consultant AHP roles that can take on more responsibilities in specialties such as orthopaedics.

5.6 Cancer

The Trust works in partnership with other Hospitals in Herts and West Essex and in London to provide a wide range of cancer diagnosis and treatment.

A key partner is the Mount Vernon Cancer Centre (MVCC) who is the main provider of oncology treatment (including radiotherapy) for our cancer patients. Most cancer diagnostics are undertaken within the Trust, however some specialist cancer diagnostics are also provided by MVCC / the Paul Strickland Cancer Diagnostics Centre as well as at other neighbouring Trusts who provide more specialist diagnosis and treatment for some cancer pathways.

Our role in the key cancer pathways is summarised below. Clinical leadership and care delivery is led at speciality level. The Trust's Cancer team provide a leadership and co-ordination role, ensuring patients are tracked through their pathways, delivering clinical nurse specialist input into pathways and providing a specialist palliative care service. The cancer team also work with specialities to review pathways and support continuous improvement in care delivery in line with best practice and provide a central co-ordination point for work with partners on improving cancer services across the health and care system.

Pathway / Tumour type	WHHT diagnostics	Specialist diagnostics pathway	Oncology pathway	Surgery pathway
Breast Cancer	A comprehensive local Breast Cancer service is provided at SACH with one stop diagnostics.		Chemotherapy and radiotherapy at MVCC	Surgery at WHHT. (SACH or WGH) Reconstruction surgery at Royal Free Hospital.
Lower Gastro-Intestinal Cancers	Colonoscopy, MRI and CT undertaken at WGH and HHGH	PET CT scans at Paul Strickland Scanning Centre.	Chemotherapy and radiotherapy at MVCC	Surgery undertaken at WHHT. (WGH & SACH)
Upper Gastro-Intestinal Cancers (Oesophagic-Gastric)	Staging laparoscopies and endoscopic ultrasound (EUS) at WGH (WHHT also provide to ENHT & L&D)	PET CT scans at Paul Strickland Scanning Centre.	Chemotherapy and radiotherapy at MVCC	Surgery undertaken at Imperial (Hammersmith Hospital)

Pathway / Tumour type	WHHT diagnostics	Specialist diagnostics pathway	Oncology pathway	Surgery pathway
Upper Gastro-Intestinal Cancers (Hepabilliary)	Diagnostics at WHHT – endoscopic ultrasound (EUS) and ERCP (WHHT also provide to ENHT & L&D)	PET CT scans at Paul Strickland Scanning Centre. Gallian PET CT at Royal Free Hospital.	Chemotherapy and radiotherapy at MVCC.	Surgery at Royal Free Hospital.
Urological cancers (prostate, renal, testicular, penile and bladder)	Ultrasound and flexi cystoscopy at HHGH, MRI and template biopsies at WGH & SACH Some MRI capacity outsourced to Spire Bushey.	PET CT scans at Paul Strickland Scanning Centre.	Brachytherapy at MVCC.	Surgery at WGH & SACH for less complex cancers, specialist surgery at the Lister Hospital. (ENHT is the specialist centre for Luton, South Bedfordshire and Hertfordshire)
Gynaecological cancer	Rapid Access Clinics at WGH and SACH Colposcopy at WGH and SACH, hysteroscopy at SACH	MRI at Paul Strickland Scanning Centre	Chemotherapy and radiotherapy at MVCC. Complex chemotherapy at UCLH.	Surgery at WGH (WHHT is the specialist centre for Luton, South Bedfordshire and Hertfordshire)
Haematological Cancers	Lymph node biopsies and bone marrow undertaken at WGH.	MRI and PET CT at Paul Strickland Scanning Centre.	Chemotherapy at WGH. Complex Chemotherapy at UCLH.	
Head and Neck (including ENT, thyroid and oral cancers)	Ultrasound FNA within WHHT	CT and MRI at L&D or Northwick Park Hospital	Chemotherapy and radiotherapy at MVCC.	Some surgery can be done at WGH, but all specialist cancer surgery is done either at L&D or Northwick Park Hospital

Pathway / Tumour type	WHHT diagnostics	Specialist diagnostics pathway	Oncology pathway	Surgery pathway
Skin cancer	Skin lesion biopsies at WGH & HHGH	Some more complex diagnostics at Royal Free Hospital or Lister	Chemotherapy at MVCC.	Surgery at Lister or Royal Free.
Lung Cancer	CT, EBUS and bronchoscopies undertaken at WGH.	PET CT at Paul Strickland Scanning Centre. CT guided biopsies at Royal Free Hospital (Barnet). VATs biopsies and rigid bronchoscopies at Harefield.	Chemotherapy and radiotherapy at MVCC.	Surgery at Harefield.
Paediatric cancer	Initial diagnostics at WGH dependent on clinical situation.	Great Ormond St for diagnostics under 16s. UCLH for diagnostics for teenagers and young adults).	GOSH and UCLH are the primary treatment centres. WHHT provide a level two Paediatric Oncology Shared Care Unit at WGH to deliver some care, including less complex chemotherapy locally.	Surgery at GOSH and UCLH.

The Trust has a good track record against the national cancer waiting time standards. However, Covid-19 has had a negative impact on both cancer waits and on the number of people being screened or referred for treatment on a suspected cancer pathway, which is likely to have a long term impact on the health of the local population. Over the next 12 months, meeting the cancer performance targets will continue to be challenging given the on-going challenges of managing Covid, such as reduced capacity within radiology and for some procedures, the difficulties in supporting patients to attend hospital and the difficulties associated with self-isolation which delays pathways. Increasing capacity and recovering performance to pre Covid levels and meeting the new 28 diagnosis standard will

be an immediate priority along with continued improvements to pathways and a focus on integrated, personalised and consistent care.

We are committed to working with local partners through the Hertfordshire and West Essex Integrated Care System and the East of England Cancer alliance to implement the National Cancer Strategy and NHS Long Term Plan Cancer priorities as set out below:

- From 2019 start to roll out new Rapid Diagnostic Centres across the country
- From 2019, begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis and access to more personalised treatments
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days
- By 2020 HPV primary screening for cervical cancer will be in place across England
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
- By 2022 the lung health check model will be extended
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2
- From 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

A key strategic priority is to develop a rapid diagnostics centre for Cancer at SACH in line with the development of SACH as the planned surgical and cancer site for the trust. While this will be fully enabled by the redevelopment of the site, the introduction of CT and MRI services on the site this year will facilitate earlier implementation for some pathways. The ambition for the rapid diagnostics centre is to enable people to attend once for tests and diagnosis wherever clinically possible, to reduce the time to diagnosis, improve patient experience, and enable quicker access to cancer nursing support and cancer information services.

Another longer term priority is responding to the findings of the Mount Vernon Cancer Review. We will be working with the MVCC review team to explore the potential to re-provide some of the specialist cancer services currently provided at Mount Vernon on the Watford General Hospital site as well as opportunities to repatriate some activity from UCLH

to provide a more local service. Our clinicians see this as a really exciting opportunity to improve cancer services for local residents.

Our other priorities include:

- Work with partners to understand the drivers of inequalities in cancer outcomes between different population groups, and developing targeted actions to reduce those inequalities
- Working with primary care colleagues to improve identification and referral of patients and ensure we have good systems in place to monitor and continuously improve the early detection of cancer
- Strengthening our acute oncology service to support more patients with cancer admitted for emergency care
- Improve pre-dying recognition and care, enabling people to die in the place of their choice and reducing deaths in hospital. (More detail on priorities and plans to improve end of life care are set out in our **End of Life Care Strategy 2021 -2024**)
- Implementing personalised care risk stratified follow up care for key cancer pathways (First phase priority pathways are breast, colorectal and prostate, other pathways to follow in line with national guidance when confirmed)
- Improving the lymph node biopsy pathway (haematological cancers)
- Increasing local provision of inpatient chemotherapy for haematological cancers
- Increased oncology provision for lung cancer and bladder cancer pathways
- Review diagnostics pathways for thyroid cancers to identify opportunities to deliver more diagnostics locally

6. Implementation and milestones for the next 5 years

This strategy sets out a wide range of commitments for the next five years which are summarised in the table overleaf. During the engagement phase of the development of this strategy (February to June 2021) we will identify the priorities for the clinical strategy by year, including any financial and workforce implications. We will set explicit success measures and the key actions we will undertake to deliver on our commitments. This will enable the development of a clear milestone plan by year which will feed into the annual corporate objectives for the trust and divisional business plans.

To deliver the strategy we will align corporate transformation resources with divisional operational resources to provide trust-wide leadership on whole trust change programmes and support for divisional teams where additional capacity is required. This support will be networked with embedded resources supporting the digital strategy and the development of the clinical and estates briefs for the new hospital so that we deliver change in an integrated way, ensuring that our services are fit for purpose to move into our new hospital in 2025.

Ambition	Commitment	Trust Strategic Priorities			
		BC	BV	GT	GP
We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population	Implement the national '111 First' approach	■			
	Work with HVCCG to define the future model of urgent care for the St Albans and Harpenden population	■	■		
	Ensure people are seen quickly within our emergency department (ED), with rapid access to specialty opinion when needed so that decisions about their future care can be made promptly (SMART).	■	■	■	
	Further expand our emergency assessment unit capacity to bring together an integrated model to maximise same day emergency care across all specialties and provide a permanent base for our frailty service	■	■	■	■
	Develop and expand our virtual hospital model as our best practice standard	■	■	■	
	Review emergency surgical pathways and ensure we have enough ring-fenced emergency theatre capacity so that patients can receive timely care	■	■		■
	Adopt a 'getting it right first time' approach, to get the right patient to the right place for the care they need first time, reducing the number of times that a patient has to move within the hospital	■	■	■	
	Continue to work with system partners to improve discharge pathways out of the hospital.	■	■	■	
	Develop a more proactive understanding of needs, demand and capacity so that we can better respond to changes in demand and keep waiting times short	■			
	Increase planned surgery at SACH by improving utilisation of our theatres, increasing on-site diagnostic provision (MRI and CT) and providing an enhanced level of post-operative care so that patients with more complex needs can be treated there	■	■	■	■
	Modernise our patient communication and booking processes, innovating to improve and constantly talking to and learning from our service users and their carers to make the patient experience as good as possible	■	■	■	
	Make full use of emerging digital technology, with a culture that seeks and supports innovation	■	■		
	Review the activity volumes undertaken in our smaller specialties, with the intention of improving outcomes for our population by either developing a network approach with another provider to strengthen and support our service or to stop delivering the service altogether	■		■	
	Review those specialties where care is delivered by third party consultants to ensure they best meet the needs of our patients, and change the delivery model where required	■		■	
	Review all of our existing clinical pathways to other providers to rationalise them where this is in the best interests of patients	■			
	Explore where we can further develop strategic partnerships to improve outcomes or address workforce challenges.	■		■	
	Review the potential to work with partners to co-locate elements of cancer provision currently provided at Mount Vernon Cancer Centre onto the Watford General Hospital site as part of our redevelopment plans.	■		■	■

Ambition	Commitment	Trust Strategic Priorities			
		BC	BV	GT	GP
	Review where there are opportunities to repatriate activity that currently is undertaken by London (or other out of area) hospitals but which could be effectively and safely delivered on one of our trust sites.				
	Expand and develop our care of the elderly service to better meet the needs of our patients, working closely with partners in the community to deliver care as close to home as possible				
We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate	Always seek to innovate and to use new technologies to continuously improve the care that we can provide in the lowest intensity clinical setting available				
	Provide people with a diagnosis on the day wherever clinically possible to reduce the period of uncertainty and anxiety				
	Increase the capacity of diagnostics available across our sites, including development of a rapid diagnostics centre at SACH				
	Remove same day multi-site pathways as quickly as it is clinically safe to do so.				
We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population	Implement continuity of care from antenatal to postnatal care, reflecting the recommendations of the national strategy *Better Births*.				
	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 and reflecting best practice				
	Integrate our new electronic patient record with primary, community, mental health and ambulance records so that information relating to the person's health is available to clinicians in all settings to support their decision making				
	Ensure all patients who require specialist input can access it quickly, enabling a clear care plan to be developed for their time in hospital and to allow early planning for their discharge should they be admitted				
	Integrate social care, community and mental health support into the emergency department model				
	Where applicable, ensure that patients are assessed for future care needs in their home or future environment not within the hospital				
	Improve our communication with the patient and their GP on discharge, to ensure that any additional support required in the community is put into place, followed up with a compassionate conversation within 24 hours				
	Working with partners fully implement the ICS-agreed model of care for frailty				
	As part of our work with the West Herts ICP, use data and risk stratification to identify people in their last phase of life, and use an integrated care planning approach to discuss and agree their goals with them				
We will be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy	Understand and reduce the health inequalities within our local population, working in co-production with communities to understand their needs and appropriately adapt our services to personalise care				
	Through our ICP work with communities to address some of the causes of inequalities, and empower people to improve their own health and wellbeing				
We will personalise the care we deliver through shared decision	Improve the information that we provide to patients to help them to understand their treatment options and support informed consent				

Ambition	Commitment	Trust Strategic Priorities			
		BC	BV	GT	GP
making, taking account of the goals of the individual 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	Increase the understanding of patients about their condition and to build in reflection time before patients consent to procedures to enable them to consider and raise any questions or concerns that they may have				
	Give consideration to how inequalities impact on individual patients, and tailor our approach appropriately				
	Integrate our pathways for long term conditions with primary care, community and mental health to ensure that patients only have one care plan across all their providers and that it is jointly developed and shared				
	Implement patient initiated follow ups in all areas where it is clinically appropriate				
	Use our existing strategic partnerships to ensure that our population can access and benefit from advances in precision medicine				
We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation	Use the CPG approach to develop a series of approximately 80 pathways managing the most burdensome health issues that are continuously evidenced as being the most efficient and effective way of managing that condition				
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	Make timely advice and guidance services available to GPs across all our specialties				
	Maximise the clinically effective use of virtual consultation models				
	Redesign elective pathways to ensure that diagnostic tests are undertaken at the right point in the pathway to facilitate diagnosis without unnecessary tests being undertaken				
	Make our tertiary pathways seamless, and involve patients in multidisciplinary discussions about their care where they wish to be involved.				
	Consistently implement one stop clinics that enable test and diagnosis on the same day				
	Expand our range of multidisciplinary clinics, starting with the most common overlapping conditions, so that care is more joined up				
We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer.	Use and embed new technologies as an integral part of our building and new ways of working				

Trust Board Meeting
4 February 2021

Title of the paper	**Clinical Engagement Plan (Service redevelopment engagement plan)**
Agenda Item	**16/87**
Presenter	Helen Brown, Deputy Chief Executive Louise Halfpenny, Director of Communications
Author(s)	Carol Deans, Communications Consultant
Purpose	*For approval*: **x**; *For discussion*: ; *For information*:
Executive Summary	The Trust and Herts Valleys CCG Boards collectively agreed in October 2020 to progress infrastructure plans based on the current three site configuration, albeit with substantial redevelopment and redesign. This will provide a new hospital for west Hertfordshire on the Watford General Hospital site and make considerable improvements, including extensive redevelopment and refurbishment, at Hemel Hempstead General Hospital and St Albans City Hospital. The Trust is committed to delivering the right care in the right place, both within each site and across the three sites. In line with one of the key recommendations of the NHS Long Term Plan, urgent and emergency care (unplanned care) will be separated from planned care. Each hospital will have a clear and valuable purpose: • Watford General Hospital – emergency, specialist and complex care • St Albans City Hospital – planned surgical care and cancer services • Hemel Hempstead Hospital – urgent and planned medical care, long term conditions Two documents have been drafted, in addition to the Trust's digital strategy, as part of planning for the future of healthcare in west Hertfordshire: • **Clinical Strategy –** sets out the Trust's ambitions for the next five years and its top priorities – integration of care, personalisation of care, and consistency – and outlines the clinical services that will be delivered and how it will be done • **Clinical Brief –** looks in detail at the current and future location of clinical services on the three hospital sites, and the patient journeys of today and tomorrow A plan to formally engage with stakeholders and the community on the draft Clinical Strategy (including digital transformation), draft Clinical Brief, and proposed three-site clinical model has been developed. Feedback gained

	through the formal engagement will enable the Board to ensure the views and ideas of stakeholders, staff, patients and the local community can be considered as part of the Outline Business Case process. The formal engagement will be in two stages (initial engagement followed by a second phase of engagement after the initial feedback has been reviewed and considered). Time has been identified within the plan to ensure feedback can be reviewed, summarised and an explanation of how the feedback will inform plans to be shared with stakeholders prior to formal decision making on both documents in the summer. Initial engagement is expected to start week commencing 15 February 2021. The plan sets out engagement principles and objectives, identifies key stakeholders and outlines the communication, engagement and feedback methods that will be used. It is intended that the feedback received will be independently analysed.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care — *Objectives 1-4*: **x** **Aim 2** Great team — *Objectives 5-8*: **Aim 3** Best value — *Objective 9*: **Aim 4** Great place — *Objective 10-12*: **x**
Links to well-led key lines of enquiry	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐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: Great Place Programme Board — Date: 21 January 2021
Action required	The Board is asked to: • approve the engagement plan • note that Board members will have the opportunity to provide comments on the draft engagement documents as they are developed and finalised • note that the statutory consultation for the outline planning application for the Watford site will also take place during the initial phase of engagement • agree that engagement documents can be approved by the Deputy Chief Executive

Agenda Item: 14/87c

Trust Board meeting – 4 February 2021

Clinical Engagement Plan (Service redevelopment engagement plan)

Presented by: Helen Brown, Deputy Chief Executive and Louise Halfpenny, Director of Communications

1. Purpose

1.1 This paper provides detail about, and seeks approval from the Board for, a formal engagement exercise that will inform the new clinical strategy and clinical brief and consequently the redevelopment of acute services.

1.2 Feedback gained through formal engagement will enable the Board to ensure the views and ideas of stakeholders, staff, patients and the local community can be considered as part of the Outline Business Case process.

2. Background

2.1 The course is set for a transformational redevelopment of health and hospital services in west Hertfordshire. The Trust has a once in a generation opportunity to transform its hospital buildings and use the best design and latest technology to deliver great care.

2.2 The Trust and Herts Valleys CCG Boards collectively agreed in October 2020 to progress infrastructure plans based on the current three site configuration, albeit with substantial redevelopment and redesign. This will provide a new hospital for west Hertfordshire on the Watford General Hospital site and make considerable improvements, including extensive redevelopment and refurbishment, at Hemel Hempstead General Hospital and St Albans City Hospital.

2.3 The Trust is committed to delivering the right care in the right place, both within each site and across the three sites. In line with one of the key recommendations of the NHS Long Term Plan, urgent and emergency care (unplanned care) will be separated from planned care. Each hospital will have a clear and valuable purpose:

- Watford General Hospital – emergency, specialist and complex care
- St Albans City Hospital – planned surgical care and cancer services
- Hemel Hempstead Hospital – urgent and planned medical care, long term conditions

2.4 Hemel Hempstead and St Albans City hospitals are really important to the future service model; they are considered to be more than local hospitals and an integral part of the Trust's family of services.

2.5 Two documents have been drafted, in addition to the Trust's digital strategy, as part of planning for the future of healthcare in west Hertfordshire:

- **Clinical Strategy –** sets out the Trust's ambitions for the next five years and its top priorities – integration of care, personalisation of care, and consistency – and outlines the clinical services that will be delivered and how it will be done
- **Clinical Brief –** looks in detail at the current and future location of clinical services on the three hospital sites, and the patient journeys of today and tomorrow.

3. Stakeholder and community engagement

3.1 Engagement plan

3.1.1 It is important that feedback from stakeholders and the community is considered as part of decision-making. An engagement plan has therefore been produced to guide the Trust through a formal engagement exercise with stakeholders and the community. The plan sets out engagement principles and objectives, identifies key stakeholders and outlines the communication, engagement and feedback methods that will be used.

3.1.2 The engagement plan is included at Appendix A.

3.1.3 By delivering an effective engagement programme the Trust will ensure messages reach all intended audiences and their views are fed back into finalising our clinical strategy and into the redevelopment programme.

3.1.4 Opportunities for both broad community and stakeholder engagement as well as more niche and targeted engagement (for example with those whose views have been heard less often, such as younger people and those with protected characteristics) will be identified and promoted whilst also ensuring that staff hear about any changes first.

3.1.5 The draft engagement plan is being shared with a range of stakeholders (including Healthwatch and St Albans Health and Wellbeing Partnership) to get feedback on the plans, ensure the engagement is as inclusive as possible and identify what support they can offer to promote and encourage feedback. It will also be considered by Hertfordshire Health Scrutiny Committee, as part of its Topic Group session in February 2021.

3.2. **Engagement timeline**

January 2021	Pre-engagement: Update / inform key stakeholders and partners and seek feedback about, and support for, the engagement plan
4 February 2021	Trust Board approval of engagement plan
February 2021	Hertfordshire Health Scrutiny Committee topic group meeting
w/c 15 February 2021	Engagement: launch and inform
15 February – 24 March 2021	Engagement: community, staff and stakeholder engagement
1 – 24 March 2021	Engagement plus: targeted engagement to encourage involvement from seldom heard communities and those with protected characteristics
25 March – 10 May 2021	Review feedback and draft response to feedback
10 May – 4 June 2021	Engagement: feedback and testing of Trust response to feedback
June 2021	Review feedback
July 2021	Decision: feedback considered by Trust and CCG Boards and clinical brief finalised for Outline Business Case

3.2.1 Time has been identified within the plan to enable initial feedback to be independently analysed and reviewed by the Trust. This will enable the Trust to provide stakeholders and the community with a summary of the feedback received and an explanation of how it will inform its plans. An additional phase of engagement will then be undertaken to test the Trust's response to the initial engagement and get further feedback from the community and stakeholders.

3.3. **Engagement materials**

3.3.1 An engagement document is being drafted to summarise the key elements of the clinical strategy and clinical brief, outline the thinking behind the proposals, and provide information about the impact of the proposed changes on local people, particularly associated with outpatient services.

3.3.2 The engagement document sets out:

- the current situation
- why we need to change
- clinical priorities
- digital improvement opportunities
- proposals for a three site service model covering emergency and specialist care, planned surgery and cancer, outpatient care and diagnostics
- how care services will change, site by site
- travel and access

3.3.3 The draft engagement document will be shared with Trust Board colleagues ahead of the Board meeting and feedback will be welcome ahead of the proposed start of the engagement in the week commencing 15 Feburary 2021.

3.3.4 A summary of the engagement document will also be produced to help make the engagement as accessible and inclusive as possible.

3.3.5 Indicative travel impact analysis is being undertaken by external experts. The outcome of this analysis will be available for the Board to consider alongside the engagement feedback.

4. BDP Outline Planning Application

4.1 BDP will be undertaking community involvement ahead of submission of the outline planning application of the Watford site whilst the Trust's engagement exercise is proposed to take place. Opportunities have therefore been identified to ensure that involvement activities are able to complement each other. This will include joint events and ensuring information about the clinical strategy and clinical brief is included within BDP engagement materials.

5. Risks

5.1 Risks will be minimised by following best practice and ensuring the engagement is as inclusive and accessible as possible.

5.2 The Trust will follow NHS best practice for its engagement to minimise any risk of engagement. This will include following the Gunning Principles, namely:

- *proposals* are *still at a formative stage*
- *sufficient information* about the proposals will be made *available to permit 'intelligent consideration'*
- adequate *time* has been planned *for consideration and response* at two separate stages
- responses will be *conscientiously taken into account*

6. Recommendation

6.1 The Board is recommended to:

- approve the engagement plan
- note that Board members will have the opportunity to provide comments on the draft engagement documents as they are developed and finalised
- note that the statutory consultation for the outline planning application for the Watford site, led by BDP, will also take place during the initial phase of engagement
- agree that engagement documents can be approved by the Deputy Chief Executive.

Helen Brown
Deputy Chief Executive

26/01/21

Appendix A: Service redevelopment engagement plan

Draft service redevelopment engagement plan

Introduction

West Hertfordshire Hospitals NHS Trust (WHHT) and Herts Valleys Clinical Commissioning Group (HVCCG) are firmly committed to ensuring feedback is considered as part of decision-making and will continue to engage proactively with local stakeholders as the acute redevelopment plans are progressed.

This engagement plan builds on previous engagement activities, in particular learning around the impact of restrictions on physical meetings and events due to Covid-19 and feedback from the Stakeholder Reference Group.

By delivering an effective consultation and engagement programme we will ensure messages reach all intended audiences and their views are fed back into the redevelopment.

Opportunities for both broad community and stakeholder engagement as well as more niche and targeted engagement (for example with those whose views have been heard less often, such as younger people and those with protected characteristics) will be identified and promoted whilst also ensuring that staff hear about any changes first.

Existing trusted and established channels and forums will continue to be used to engage with various audiences and this will be complemented by creative use of online engagement, including through social media.

Opportunities for ongoing meaningful engagement and involvement will be identified and promoted throughout the redevelopment of the three sites.

Engagement principles and objectives

We will be open, honest and responsive in our communications and engagement activities to support the key test of strong patient and public involvement.

The objectives of this communication and engagement plan are to:

- plan and manage the engagement process
- communicate and raise awareness of the three site model and the clinical model that will enable services to be co-ordinated and co-located across all three sites
- keep stakeholders informed and involved throughout the process
- provide a range of opportunities to listen to and engage with staff, patients, interest groups and the general public in shaping the reconfiguration of clinical services across all through sites, enabling them to give their views, ask questions, raise concerns and make comments
- ensure all feedback gathered is fed into the overall service development and outcomes used to guide decisions around the future reconfiguration of services across the three sites
- recognise the different needs and current levels of understanding amongst different audiences and develop communications that are consistent, clear and tailored to their needs

- deliver clear, co-ordinated, consistent and timely communications to all audiences relating to engagement and consultation around potential changes
- manage media interest throughout the engagement period and beyond, in order to maintain the reputation of all organisations involved and ensure the correct messages are being relayed to the public

We will:

- Identify the different audiences and prepare communication and engagement tools to meet their needs
- Plan and deliver the core messages and intended outcomes through identified communication channels
- Promote equal access to the engagement opportunities, taking due account of the Equality and Diversity Act 2010
- Ensure that all communication and engagement is meaningful
- Ensure that our approach to consultation and engagement is consistent
- Provide feedback on what we have heard and how this will inform our plans

Engagement timeline

January 2021	Pre-engagement: Update / inform key stakeholders and partners and seek feedback about, and support for, the engagement plan
4 February 2021	Trust Board approval of engagement plan
February 2021	Hertfordshire Health Scrutiny Committee topic group meeting
w/c 15 February 2021	Engagement: launch and inform
15 February – 24 March 2021	Engagement: community, staff and stakeholder engagement
1 – 24 March 2021	Engagement plus: targeted engagement to encourage involvement from seldom heard communities and those with protected characteristics
25 March – 10 May 2021	Review feedback and draft response to feedback
10 May – 4 June 2021	Engagement: feedback and testing (you said - we think / will do - is that right / any further considerations?)
June 2021	Review feedback
July 2021	Decision: feedback considered by Trust and CCG Boards and clinical brief finalised for OBC

Stakeholders - overview

- Staff
  - directly affected (medical, other clinical, non-clinical)
  - indirectly affected (medical, other clinical, non-clinical)
  - staff networks / champion groups
  - all
- Current and recent patients (and carers)
- Local residents
  - interested / involved
  - not engaged (yet)
- Local stakeholders
  - interested / involved
  - not engaged (yet)
- Local voluntary and third sector organisations
- Faith groups
- Community groups
- Regulators (CQC, NHS England and Improvement)
- Hertfordshire County Council, including Health Scrutiny Committee
- Parish, District & Borough Councils
- Emergency services (Police, Fire & Ambulance Services)
- Press/media
- Elected representatives (MPs, Councillors)
- Local Healthwatch

Key communication and engagement methods

Engagement

- Virtual exhibition / display (tbc with BDP)
- Online events (including on social media platforms)
- Social media – general and targeted (through Trust, partners, groups, advertising, takeovers – refer to Charmed Communications' social media research report)
- Surveys
- Via other organisations (including attendance at their meetings and articles in their newsletters/bulletins)
- Through meetings with, and events for, reference groups, staff networks and teams

Promotion and information (one-way)

- Posters / flyers
- Adverts
- Text messages and/or newsletters to current/recent patients
- Information sent with patient appointments / correspondence
- Links before and/or after virtual appointments
- Video
- Website / intranet content
- Media coverage

Feedback methods

Feedback will be captured through a range of formats to ensure involvement opportunities are as inclusive as possible. This could include:

- Surveys (online and paper copies)
- Comments on social media
- Verbal feedback at meetings and events
- Written feedback within meetings / events (chat function)
- Written feedback (posted or emailed)
- Video and audio feedback (posted or emailed)

Further details will be agreed once the provider of the feedback analysis and reporting has been agreed.

Engagement activity and feedback evidence log

A log of engagement activity and sources of feedback received will be maintained by the redevelopment communications officer.

Feedback will be reviewed, analysed and summarised on behalf of the Trust and CCG by specialist, independent analysts.

Engagement activities plan

An operational plan of engagement activities and practical actions and the engagement materials required has been produced and will be regularly updated and reviewed by the communications and engagement workstream.

Key audiences and engagement

Stakeholder	Objective	Method(s)	Lead	Time frame	Comments/update
Staff • directly affected (medical, other clinical, non-clinical)	Ensure those delivering the services are involved in creating the plans so	Clinical workstream led meetings / events Team meetings (with feedback to clinical workstream) As part of general staff briefings and engagement	Clinical workstream project team	Ongoing	Meetings delayed due to Covid Need to ensure feedback from community and stakeholders are fed into the discussions
• indirectly affected (medical, other clinical, non-clinical)	Ensure support services / staff are aware of the potential impact and can have their views and ideas considered	Professional Reference Group (PRG) Team meetings (with feedback to clinical workstream) Meetings / events with departmental and professional leads As part of general staff briefings and engagement	Clinical workstream project team	Throughout formal engagement period	Need to encourage wider participation in PRG
• Staff networks / champion groups	Get their support with promotion of engagement opportunities from a wider range of staff and the communities they are part of	Attendance at their meetings Provide them with template articles and adverts to use with their own communications	Communications	Ongoing	Initial contact made with all groups
• all	Ensure all staff are aware of the potential changes and have the opportunity to share their ideas	As part of general staff briefings and engagement Posters in public and staff areas of all three hospitals	Trust communications team	Throughout formal engagement period	Incorporate updates and engagement opportunities within BAU activities

Stakeholder	Objective	Method(s)	Lead	Time frame	Comments/update
Current and recent patients (and carers)	To hear from people with recent or current experience of the services	Text / email / post via PAS Information with appointment correspondence / contacts Information and links before and/or after Attend Anywhere and Medopad Posters in public / patient areas of all three hospitals	Patient experience team?	Throughout formal engagement period Followed by Ongoing (timing tba by Trust)	Will enable more insight into the potential opportunities and impacts of various options Access to data via PAS tbc with IG
Local residents: • interested / involved	Hear from a wider number of people	Trust's social media Website Online public events Blueprint Involvement in reference groups	Communications	Throughout formal engagement period	
• not engaged (yet)	Hear from a more diverse group of people	Targeted advertising on social media Through non-Trust social media accounts / groups Promotion by other organisations and groups Engaging with admins for various social media groups / communities Posters in public places that will be open (eg supermarkets, council offices, vaccination hubs, GP surgeries, pharmacies)	Communications	Throughout formal engagement period	Once engaged, may be able to increase involvement through online events and involvement in reference groups Engagement with other social media communities could become business as usual

Stakeholder	Objective	Method(s)	Lead	Time frame	Comments/update
Local stakeholders: • interested / involved	Ongoing relationships Maintain their interest Get their support with promotion of engagement opportunities from a wider community	Reference and steering groups Presentations / updates at their meetings /events Template articles and adverts for them to include in their communications Tag in / engagement through social media Blueprint	Communications	Ongoing	
Local stakeholders: • not engaged (yet)	Get their support with promotion of engagement opportunities from a wider community Get insight from a wide range of perspectives (eg health conditions, age, interest) Hear from a more diverse group of people	Correspondence to give updates and request help with sharing information and promoting engagement opportunities Template articles and adverts for them to include in their communications Offer to attend their meetings / events Tag in / engagement through social media	Communications	Formal engagement period Followed by ongoing	
Local voluntary and third sector organisations					
Faith groups					
Community groups					
Regulators (CQC, NHS England and Improvement)	Ensure they are kept up-to-date with any proposals and given the opportunity to formally give feedback about any implications for their services Get their support with promotion of engagement opportunities within their organisations	Correspondence Through BAU relationships	Existing BAU relationship leads		Existing BAU relationship leads to be briefed by communications
Emergency services (Police, Fire & Ambulance Services)					

Stakeholder	Objective	Method(s)	Lead	Time frame	Comments/update
Press/media	Increase understanding and promotion of engagement opportunities with their audiences Encourage more balanced reporting	Press releases Offer interview opportunities Briefing / relationship-building meetings with editors	Trust Director of Communications	Start before formal engagement and then ongoing	
Hertfordshire County Council	Ensure Health Scrutiny Committee is regularly briefed and satisfied with engagement plans	Topic Group Regular updates to HSC Attendance at HSC	Directors of Communications Deputy Chief Executive	Ongoing	Topic Group brief agreed and will include opportunity to review and contribute to engagement plans Topic Group date tbc
Parish, District & Borough Councils	Ensure they are kept up-to-date with any proposals and given the opportunity to share their feedback Get their support with promotion of engagement opportunities from a wider community	Regular updates to and/or attendance at health-related meetings / event Correspondence to give updates and request help with sharing information and promoting engagement opportunities Template articles and adverts for them to include in their communications	Directors of Communications Deputy Chief Executive	Ongoing	
Elected representatives	Increase their understanding Get their support with promotion of engagement opportunities within their wards / constituencies	Correspondence Through BAU relationships	? Communications Existing BAU relationship lead(s)	Formal engagement and then ongoing	

Stakeholder	Objective	Method(s)	Lead	Time frame	Comments/update
Local Healthwatch	Ensure they are kept up-to-date with any proposals and given the opportunity to formally give feedback about any implications Get their feedback and ideas for the engagement plan Get their support with promotion of engagement opportunities from a wider community	Through BAU relationships	Existing BAU relationship lead(s)	Start before formal engagement and then ongoing	

Hertfordshire Mental Health and Learning Disability Integrated Care Partnership eNewsletter

September/October 2020

Welcome to our first e-newsletter, with updates on the progress of the Mental Health and Learning Disability Integrated Care Partnership for Hertfordshire (MHLD ICP) as it evolves.

A warm welcome from Beverley and Tom, Co-Chairs of the MHLD ICP

The development of the MHLD ICP is progressing at pace and recently we have focused on building the foundations of co-production, understanding our strengths and areas for improvement when tackling inequalities and further defining the scope of the ICP and the population we will be responsible for. We are continuing to establish ourselves as an ICP in the context of restoring and transforming our services, planning ahead for future challenges including COVID, as well as meeting other local and national requirements.

Tom Cahill

Responding to COVID has helped us to work much more closely and achieve even greater resilience as system partners. It has driven us forward with innovations and advanced our use of technology, allowing us to adapt to various new ways of working. Whilst this continues to be a very challenging time for the people in Hertfordshire, we remain committed to building on the significant progress we have made to achieve our vision:

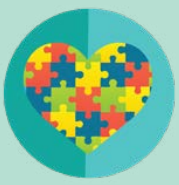
"Supporting people living with a mental illness and/or a learning disability in Hertfordshire to live longer, happier and healthier lives."

Beverley Flowers

Our Priority Transformation Areas:

Children and Young People's Mental Health and Emotional Wellbeing

Learning Disability



Autism and Neurodiversity

Crisis Services for people with severe mental illness

Dementia

Substance Misuse

Enhanced Primary Mental Health Care

Guiding Principles for the **Hertfordshire Mental Health and Learning Disabilities Partnership**

A strong mental health and learning disabilities voice across and for the system

- We will work in partnership with service users and carers to develop services
- Our services will be underpinned by clinical excellence and evidence based practice
- We will contribute to and align ourselves with the Long Term Plan and future development of mental health and learning disabilities services
- We will look after our people and help them live well and be rewarded for their work

A focus on preventing people from becoming unwell and the promotion of positive health and wellbeing

- We will welcome and work alongside individuals and organisations who share our mission to help people live well in the communities we serve and will actively engage with partners in communities, health, social care, housing and volunteers.
- We will focus on early intervention and care delivered as close to home as possible where people live, learn, work and play
- We will nurture and cherish what matters to people and their families and communities
- We will make sure that our money and assets are utilised to the fullest extent to deliver value for the people we serve

Safe, high quality mental health and learning disabilities support and services across Hertfordshire

- We will work to try to keep people safe from harm
- We will encourage positive risk taking
- We will recognise and support the whole person not just their illness or injury
- We will ensure that those vulnerable individuals with severe mental illness and/ or learning disabilities receive care support for both their physical and mental health needs
- We will provide services that we would recommend

Integration of mental and physical health support and services

- We will work with statutory NHS and Social Care organisations, independent and voluntary organisations providing a better experience for people and their families
- We will deliver care with and around Primary Care Networks, with schools and other key organisations to support people of all ages to receive joined up care
- We will lobby for the role of mental health and learning disabilities alongside physical health - ‘No health without Mental Health’ - ensuring those living with a long term condition or other comorbidities are supported with their mental health

Our Progress (September – October 2020)

We would like to update you on the work we have been doing, as partners across the MHLD ICP and how this is supporting people in Hertfordshire to live better lives and have a better experience of our services and support:

Co-production

From the outset, the MHLD ICP has been committed to working in co-production and placing this at the heart of what we do. We will work in partnership with people with lived experience, individuals, organisations and communities, to nurture and cherish what matters to people. This is reflected in our Principles and the statement of commitment to co-production made by the Board:

"The Board is committed to working in partnership with people who have lived experience of mental illness, dementia, a learning disability or autism and their carers alongside other system partners and stakeholders, to reach a consensus on the future direction and development of services and support in Hertfordshire."

To ensure we deliver on this commitment, we have established a Co-production Development Group, with the purpose of strengthening the culture of co-production across the Partnerships.

Our Priority Transformation Areas:

Children's and Young People's Mental Health and Emotional Wellbeing

The CAMHS Transformation programme will deliver a clear single route into all emotional and mental wellbeing services, integrated pathways irrespective of providers and greater early support to prevent the needs of children and young people escalating. The key focus for September and October is developing the 'blueprint' for the new system. Designing these Access and Pathway Plans will inform the way forward and bring greater clarity on the future model.

Dementia

The Dementia Strategy 2020-21 has now been approved by Hertfordshire County Council (HCC)and both East and North Herts and Herts Valleys Clinical Commissioning Groups (ENHCCG and HVCCG). It has been through relevant Governing Bodies and is due to go to cabinet panel in HCC in November.

HCC's Director of Adult Care has set up a project group to drive forward the work around support for carers. Additionally GP leads have met with HPFT colleagues in two workshops to plan the roll out of diagnosis in primary care, and to agree criteria for referrals from primary care into our Early Memory Diagnosis and Support Service (EMDASS).

Learning Disability

The Hertfordshire Learning Disability Mortality Review Programme (LeDeR) Annual Report 2019/20 was recently published. The report evidences that there are still considerable barriers to people with learning disabilities accessing good healthcare support. The key findings are:

- People with a learning disability continue to die approximately 20 years younger than the general population.
- The causes of death have changed this year and in Hertfordshire these also differ from the national picture.
- A majority of notifications of deaths are people of white British ethnicity, with low reporting for people from BAME backgrounds which indicates potential under reporting.

Recommendations from the report will be taken forward by LeDer Group to ensure that people with Learning Disabilities have equal opportunities to live happier, healthier and longer lives.

Substance Misuse

Change Grow Live (CGL), is a national health and social care charity providing Drug and Alcohol Services across Hertfordshire. It has developed the following services which are anticipated to significantly improve outcomes through early intervention and maximising community support:

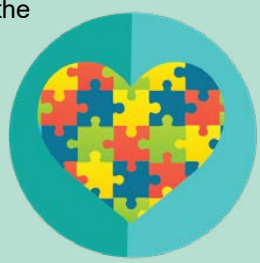
- The Alcohol Telecoms Service will go live on 26 October. This service is for *non-dependent drinkers, drinking at risky levels*, who may not be able or willing to come into a regular treatment service.
- The Alcohol Community Detox service will provide a seamless pathway to medical alcohol detoxification for patients who attend Watford General Hospital, reducing the need for acute inpatient admission for the duration of a medical detox.

Enhanced Primary Care Mental Health (EPMH)

The Community Mental Health Framework, published in September 2019, supports the ambition for the Long Term Plan to transform Community Mental Health. Pilots being delivered in Hertfordshire, will contribute to the design of the overall model, which seeks to bridge the gap between primary and secondary care services and wraps care around the individual:

- GP Plus/Enhanced Primary Care Mental Health places a mental health clinician into primary care, to liaise directly with GPs and to receive referrals direct from the surgery.
- The Enhanced Primary Care Mental Health Service, funded through NHSE Transformation monies, went live in Lower Lea Valley and Watford in July. The new service increases the availability of psychologically minded and recovery based outcomes, delivering structured support to people experiencing mild to moderate mental health issues, to enable them to stay connected in their communities.

Autism and Neurodiversity



The second phase of the Adult Autism review has been completed and is in the process of being considered by partners. The service proposed will provide a combination of one to one support for people with autism, alongside a range of training and development opportunities and workshops on understanding autism and prevalent co-morbidities.

Crisis for People with Severe Mental Illness

The Crisis Care Concordat, which paused earlier this year, has previously been instrumental in improving the coordination and delivery of services to those in crisis and crisis prevention, driving forward change and drawing financial resources into the system.

There is a clear view that the system would benefit from the Crisis Care Concordat Group being reinstated under the umbrella of the MHLD ICP. A new and reinvigorated Group will be established this autumn, where the purpose, scope and priorities for the Group will be reset.

Next Steps…

The foundations of our MHLD ICP are now firmly established and we are moving into the next stage of our development. Our focus for the next period is:

- Identifying where the Partnership can have most impact within each of the priority transformation areas and where to focus our input first.
- Agreeing how the Integrated Care system (ICS), geographical Integrated Care Partnerships (ICPs) and the MHLD ICP will work together and deciding what we need to focus on together and separately.
- Developing an approach for engaging with a wider group of stakeholders, who can contribute to the development of the MHLD ICP.

If you would like to find out more about the MHLD ICP, please contact Kate Linhart, Head of MHLD ICP Development at: kathryn.linhart@nhs.net

Trust Board Meeting
February 2021

Title of the paper	Corporate Risk Register Report
Agenda Item	18/87
Presenter	Mike Van der Watt, Chief Medical Officer
Author	Chux Ihekwereme, Risk Lead Barbara Anthony, Corporate Governance
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	The purpose of this report is to provide an update on the status of the Corporate Risk Register (CRR) to the Trust Board. This report captures the decisions made by the Risk Review Group (RRG) on 14 January 2021. Data for this report was extracted from Datix on 06 January 2021 following updates made at the RRG meeting; a total of 23 open risks were registered on the CRR at that time. The report contains 9 open risks on the CRR arising from the Covid-19 pandemic. All Covid-19 related risks on Datix (on the CRR and Divisional Risk Registers) are reviewed by the RRG on a bi-monthly basis. Due to the volatility of the pandemic, Risk Leads are required to provide updates on these risks on Datix at least once a month. The report was reviewed by Quality Committee in January where the Committee received additional assurance on the strength of the Trust's risk management process.
Trust strategic aims	**Aim 1** Best care – *Objectives 1-4* ✓ **Aim 2** Great team – *Objectives 5-8* ✓ **Aim 3** Best value – *Objective 9* ✓ **Aim 4** Great place – *Objective 10-12* ✓
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on?

	☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	• Risk Review Group in January 2021 • Quality Committee in January 2021
Action required	The Trust Board is asked to review the corporate risk register and endorse the changes to the CRR.

Agenda Item: 18/87

Trust Board Meeting – February 2021

Corporate Risk Register Report

Presented by: Mike Van der Watt, Chief Medical Officer

1. Purpose

1.1 The purpose of this report is to provide the Trust Board with an update on the status of the corporate risk register (CRR) including current risk scores, new, escalated, de-escalated, merged and closed risks.

2. Background

2.1 The CRR forms part of the Trust's overall board assurance and integrated risk management arrangements.

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

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

2.4 The CRR contains all risks rated 15 or above from each of the operational/divisional risk registers. The risk register is a 'live' repository of risks recorded on Datix and Risk Owners regularly review and update entries to reflect the current position of the risk.

2.5 Divisions regularly review all their risks rated 12 and under on the risk register and those risks which have been on the register for over two years.

2.6 Risks are closed as appropriate and any open risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to the relevant subcommittee of the Board to agree future action.

3. Corporate Risk Register

3.1 This report captures the decisions made by the Risk Review Group (RRG) on 14 January 2021. Data for this report was extracted on 06 January 2021 with a few updates made following the RRG; a total of 23 open risks were registered on the CRR at that time.

3.2 A full summary of all corporate risks as presented to the Risk Review Group on 14 January 2021 is provided in Appendix 1.

3.3 The table below presents the movement of risks on the CRR by division, against each month since September 2019.

3.4 **Risk activity**
The following provides an overview of risk activity as discussed at the Risk Review Group on 14 January 2021:

3.4.1 New risks (1)

One risk was presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR) and was **accepted**:

ID	Division	Current Risk Rating	Risk title	Rationale	Exec Lead
4356	Corporate Services	15	The ability to treat by surgical intervention patients with a diagnosis of cancer within national guidance and in safety during	The demand on ITU / HDU beds to treat severely compromised patients testing positive to COVID 19 has created a situation whereby patients with a diagnosis of cancer requiring surgical intervention in line with national guidance will be compromised to receive post-operative support due to available beds. The situation has an immediate impact on treatment plans for those patients with cancer requiring urgent surgical intervention.	MvdW

3.4.2 Escalated risks (1)
During this reporting period, 1 risk was escalated to the RRG for approval:

ID	Division	Current Risk Rating	Risk title	Rationale	Exec Lead
4334	Surgery and Cancer	20	Limited capacity for bedding infectious patients within the ICU	Limited capacity within the unit for bedding non-Covid patients and Covid patients. Limited capacity of side rooms to manage infectious patients. Cause: Limited capacity of ICU nursing staff Delayed discharge from the unit and delayed admissions Effect: Unable to effectively manage the capacity and demand for beds within ICU, patients cared for in inappropriate environment. Impact: Possible infectious patients bedded in an open bay. Staff wellbeing - Additional pressure of managing Covid patients on the unit and all it entails. Possible physiological impact on very sick patients regarding being treated by staff wearing protective uniform and equipment	[Non-Stated]

3.4.3 De-escalated risks (0)

There was no de-escalated risk presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR).

3.4.4 Closed Risk (0)

No risk on the CRR was tabled for closure at the RRG meeting:

3.4.5 Reduced risk score (0)

No risk was considered for reduction in current risk rating at the RRG meeting.

3.4.6 Increased risk score (0)

No risk was considered for increase in current risk rating at the RRG meeting.

3.4.7 Merged Risk (0)

During this reporting period, there were no merged risks to consider.

4. Risks arising from the Covid-19 Pandemic

4.1 There are currently 9 open risks on the corporate risk register arising from the Covid-19 pandemic. Due to the volatility of the pandemic, Risk Leads are required to provide updates on these risks on Datix at least once a month.

4.2 **Emerging Risks**

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

5. Risks

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

6. Recommendation

6.1 The Board is asked to review the CRR and agree the changes made to the CRR during this reporting period.

Mike van der Watt
Chief Medical Officer

January 2021

Appendix 1

Corporate Risk Register – Data extracted from Datix on 06 January 2021 (by Division)

COVID-19 RELATED	ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	FURTHER ACTIONS TAKEN? /CONTINGENCY PLAN(S)?	RATING (CURRENT)	EXECUTIVE LEAD
Clinical Support Services (1)							
No	2755	28/07/2011	Risk of failure of the MRI scanner at HHGH and deterioration in image quality	16	Radiologists are reporting that image quality is deteriorating, more repeats at WGH causing capacity issues for in-patients. Clinicians requesting their patients are not scanned at HHGH. Image quality deteriorating daily complaints. Centrally awarded MRI scanner replacement 2020/21. Current scanner now "end of life" and parts not guaranteed available. Contingency worked up if scanner fails before being replaced.	16	Sally Tucker
Clinical Informatics (5)							
No	4116	23/11/2018	Delivery of the Trust's Digital transformation programme	16	• Other stakeholder groups to be engaged • Membership and agenda of Informatics Transformation Group needs further work and the group has not met for some time	16	Sean Gilchrist
No	3894	12/06/2017	ICT Applications reduced availability, poor reliability & performance	20	Capital funding "carry over" bid made against 2018/19 Capital Programme •The Interim Tactical Server Business Case was approved to provide a new SQL environment for the trust held applications This project has just started and will be completed by Nov 2019.	16	Sean Gilchrist

					•As part of the discussions with the new ITO the trust will be developing an applications strategy to manage the current and future clinical applications as effectively as possible. The infrastructure risk will remain high until full stabilised with the new ITO.		
No	3899	12/06/2017	ICT Trust Bleep System	20	Project in-flight to replace bleep system	20	Sean Gilchrist
No	4197	16/08/2019	Missing Patches - ICT Server Estate	16	Reviewing legacy server estate and applications to understand if these can be upgraded or decommissioned. The Electronic Patient Record Programme has started and will look to consolidate applications.	16	Sean Gilchrist
No	4283	20/05/2020	Vulnerabilities causing a cyber security incident (Penetration Test)	15	TBA	15	
Corporate Services (11)							
No	4304	28/07/2020	End of Life IT [Medical] Devices/Systems	15	the Trust is working towards migrating off the legacy estate	15	

Yes	4319	09/09/2020	Inability to deliver the Trusts recovery plan, during COVID 19 and in the event of a second wave and influenza.	25	For discussion	20	Dr Michael van der Watt
No	4207	12/09/2019	Inadequate post in-patient discharge appointment booking processes	20	1. To review a two way process in that a referral needs to be generated and then a receipt is sent back from the booking team or Specialty to discuss options with Manager of Infoflex 2. To ensure responsibility of the referral is sitting with Junior doctors 3. To provide a system whereby requests for outpatietn appointments will be made mandatory on the infloflex(Inpatient Discharge Summary). 4. To review roles of all ward clerks, cover provided and hours worked. This would require corporate oversight An escalated outstanding action from the Emergency Medicine Division has now been completed. A meeting is to be arranged to progress the wider ward clerk work.	16	Sally Tucker
Yes	4279	28/04/2020	Increased Absence Levels	16		20	
No	3120	09/07/2014	Lack of Storage facility for Patient Medical Notes leading to missing, poor condition and delayed location	20	14/05: business case for the re- volumisation of Health Records to sent by June.	20	Sean Gilchrist

Yes	4292	05/06/2020	Nationally NHS staff from a BAME background are disproportionately impacted in risks and outcomes from COVID-19	15	Future work in this area will be aligned to WRES	15	Paul Da Gama
Yes	3828	09/11/2016	Patients may come to harm and have a poor experience due to long waits for elective care	15	- WGH Theatre reconfiguration project - Surgery transformation group (workstreams: theatre efficiency; scheduling; POA pathways & processes (reducing cancellations); outsourcing) - Surgical check ins with oversight of workstream outputs - Enhanced care programme at SACH - Weekly Surgical division long waits check in with Director of Performance	20	Sally Tucker
Yes	4300	23/07/2020	Potential for nosocomial infection or outbreaks as a result of cross infection within the ward or environment from COVID-19	20	1. Continued monitoring of national guidance for IPC to manage changes in pathways the Clinical Decision Panel and IPC Panel 2. Continued monitoring of measures to support full compliance with IPC within divisional performance reviews, trust level metrics and through the IPC BAF 3. Continue monitoring of national guidance for implementing and updating PPE & IPC, staff and patient surveillance, testing measures through other groups e.g. social distancing group and Incident management group 4. Review existing outbreak/ nosocomial incident management systems and processors to align with national requirements and external reporting arrangements. 5. Implementation of bed space separation in form of plastic curtains in higher risk areas. 6. Review of screening programme to cover longer stay patients- screening for all inpatients at day 10-12 of inpatient stay	20	Tracey Carter

No	4191	10/07/2019	Risk of a financial liability to Trust following outcome of legal case 'Flowers'	20	Financial impact being calculated. Also communicating with staff who raised queries pertaining to this issue. Expected that NHS Employers will also issue guidance on this matter as affects all Trusts	15	Paul Da Gama
Yes	4356	06/01/2021	The ability to treat by surgical intervention patients with a diagnosis of cancer within national guidance and in safety during	20	Implementation of the Ethical Review Panel process Evaluation of the Ethical Review Panel and CAG discussion Monitoring via the Surgical division patient outcomes	15	Dr Michael van der Watt
Yes	4280	28/04/2020	Workforce Well-Being	16	Well-Being strategy being developed to capture current activities to support staff. Pastoral support and formalised counselling services locally and across the region. Risk Assessments protocols developed. Home working and other flexible working measures enhanced. Opening of the sanctuary at Watford Fc.	20	
Emergency Medicine (1)							
No	3995	06/03/2018	Challenges in Recruitment of Emergency Medicine Medical Workforce	20	Posts to be advertised by 15/10/2020 interview date 16/11/2020	16	
Environment (2)							
No	2795	15/12/2011	Management and control of - Asbestos Containing Materials (ACMs)	20	Permit to work system and contractor induction review - Monitor and review in line with Site Control Officer role. - December 2020 MICAD project Lead in post - asbestos is a priority - Review December 2020 Asbestos policy being reviewed December 2020	16	Patrick Hennessy

					Training identified to be scheduled - Using register, working with non-licensed materials Statutory Compliance meetings commenced June 2020 - Asbestos is part of the Specialist Groups . Will be monitored via this forum, Div Governance and Health and Safety - Review December 2020		
No	4332	12/10/2020	Water Safety Incident affecting PMoK, Cherry Tree House and Restaurant buildings	20	- A complete overview has begun by an appointed engineering consultant. This is to review overall system performance in the PMoK building which is required due to its complexity.	15	Patrick Hennessy
Surgery & Cancer (2)							
No	2951	05/12/2013	Insufficient anaesthetic staffing levels impacting on patient care	16	Actively advertising for 2 post: 2 x substantive advert - recruited 1 Dec and 1 Jan Offers out to 8 Spec doctors - 7 of which are overseas - awaiting start dates. Only 3 remain in process - start date to be confirmed - Possible 2 to recruit Ongoing recruitement for this grade - currently at short listing stage Once staff in post risk score to be reduced Score to remain the same as we now have 2 retirements (feb and April) This risk is suspended during the current changes to activity and service during Covid 19 pandemic. It will be monitored and suspension removed as appropriate.	16	Paul Da Gama
Yes	4334	30/10/2020	Limited capacity for bedding infectious patients within the ICU	20	Increase in number of side room by 4 required. Planned for next financial year. Nursing establishement to be increased to 31 beds from 16. (1:2 to include support staff)	20	

					Regular review of risk as noted that scoring for this risk will flutuate dependant on climate		
Women's and Children (1)							
Yes	4339	20/11/2020	Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels	20	1. Responsibility to: Employ the agency midwives as above September 2020 2. Responsibility to: Change the preceptor banding to 6 to be scoped with Finance and HR. September 2020 3. Responsibility to: R&R strategy October 2020 4. Responsibility to: Review non-clinical WTE to see if more clinical and less management and specialist redeployed at risk September 2020	16	Tracey Carter

Trust Board Meeting
04 February 2021

Title of the paper	**Board engagement report**
Agenda Item	**19/87**
Presenter	**Tracey Carter, Chief Nurse and Director of Infection Prevention and Control**
Author(s)	**Jean Hickman, Trust Secretary**
Purpose	*For approval*: *For discussion*: *For information*: ✓
Executive Summary	One of the key lines of enquiry under NHS Improvement's well-led domain is for the Board to actively engage with the people who use the services, the public, staff and external partners. The Board uses a wide range of forums to engage with staff, volunteers, patients and their families and carers in order to see first-hand the realities of providing services and to triangulate the information received at Board and committee meetings. Just as the response to the COVID-19 pandemic has changed the way some services are delivered, it has had a similar effect on the format of Board engagement over the past year. Despite the limitations for face-to-face engagement, the Board has continued to undertake a wide range of engagement which has included structured and ad hoc Board visits, as well as regular walkarounds, night walks, presentations to the Board and patient's stories. It is important to note that, where appropriate, all engagement discussed in this report has been undertaken in a controlled manner, following the COVID-19 national and local guidance.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care — *Objectives 1-4* — ✓ **Aim 2** Great team — *Objectives 5-8* — ✓ **Aim 3** Best value — *Objective 9* — ✓ **Aim 4** Great place — *Objective 10-12* — ✓
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on?

	☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	N/A
Action required	The Board is asked to receive this report as assurance on the processes in place for the Board to engage with staff and patients.

Agenda Item: 19/87

Trust Board meeting – 04 February 2021

Board engagement report

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

1. Purpose

1.1 The aim of this paper is to update on the active engagement with staff, volunteers, patients and their families and carers which has been undertaken by the Board over the past year.

2. Background

2.1 A key focus of the Board is on the services provided to patients, ensuring that they remain safe, shaping a positive culture for the organisation and being an excellent employer. Within the well-led framework, one of the key lines of enquiry (KLOE) relates to engagement with the people who use the services, the public, staff and external partners.

2.2 The well-led framework, published by NHS Improvement in 2017, underpins the Care Quality Commission's (CQC) regulatory assessments of the well-led question. In the last CQC inspection report published on 17 June 2020, the Trust's rating for the well-led domain had moved from 'requires improvement' to 'good' and the Trust is now aspiring to improve this further to 'outstanding' at future inspections.

2.3 Despite the onset of the COVID-19 pandemic in March 2020 which dramatically changed the way the Trust operated, engagement with staff, volunteers, patients and their relatives and carers continued to be a clear focus for the Board.

2.4 Where appropriate, all engagement discussed in this report has been undertaken in a controlled manner, following national and local COVID-19 guidelines.

3. Board engagement

3.1 The Board meets 10 times a year and this has continued throughout the pandemic. Since March 2020, to protect the safety of Board members, staff and members of the public, the chairman and key executive directors have attended the meeting in person with the remainder of the Board joining virtually. The meetings in March to June 2020 were held entirely in private and from July 2020 the public have been invited to attend virtually.

3.2 At Board meetings, members have continued to hear from services on the care they provide and this has included listening to patients and their families on what it is like to be a patient at the Trust. Due to the pandemic these reports were received virtually. In 2020, the Board received reports from the services list below.

January 2020	Paediatric integrated community service
February 2020	Maternity safeguarding
March 2020	Spiritual and pastoral care service
July 2020	Keeping communication open to patients and relatives during the COVID-19
September 2020	Caring for patients with learning disabilities
October 2020	The volunteer service
November 2020	The work of the palliative care team
December 2020	Developing our approach to engaging and involving local people and partners

4. Scheduled Board visit programme

4.1 Each Board member takes part in a monthly structured programme of Board visits, which is managed by the chief nurse is in place. The visits include both clinical or non-clinical areas and Board members form small groups to visit a pre-arranged area for half an hour prior to a Board meeting. In March 2020, the programme was modified to focus on key COVID-19 related areas to provide an opportunity for the Board to say thank you to staff in these areas for the incredible work they are doing and for the Board to understand first-hand the unprecedented challenges that they are facing. As the non-executive directors have not been attending the Board meeting in person during the pandemic, they have been undertaking virtual visits.

4.2 Verbal feedback from the visits is received in the private session of the Board meeting. The visits have proved to be extremely worthwhile for Board members and comments from staff have been really positive.

4.3 The 2020 schedule of visits to date is attached in appendix 1.

5. Chair and non-executive directors engagement

5.1 Throughout the year, the chairman has continued to be on site twice a week, visiting sites and services across the three hospitals to provide leadership, offer assurance and raise morale through some of the most challenging times that the Trust has ever experienced. As well as taking part in the Board visit programme, the chairman has attended a number of guided night walks to all areas of the Trust.

5.2 In addition, the chairman led two events to commemorate the staff that died during the pandemic; a staff memorial service at Watford Football Stadium and the opening of a staff memorial garden at Watford, which was attended by bereaved families. An event attended by around 700 people was also held to thank volunteers for their hard work and support. This was led by the chairman, as was the Trust's long service staff awards ceremony. Monthly staff awards were presented to staff by the chairman and he also turned on the Christmas tree lights at Watford in December 2020.

5.3 As well as attending the Board meetings virtually, non-executive directors took part in virtual Board visits. A summary of the areas visited can be seen in appendix 1.

5.4 Over the past year, non-executive directors have picked up additional leadership roles over and above their regular work. This has included the areas of staff health and wellbeing, freedom to speak up and maternity with one non-executive becoming the maternity safety champion and one supporting the vaccination programme.

5.5 The chairman and non-executive directors have taken part in a number of videos to provide encouragement and support to staff and the executive team.

6. Chief executive and executive engagement

6.1 Despite communication challenges posed by the COVID-19 pandemic, the executive team has worked hard to proactively engage with staff. The chief executive has continued to undertake weekly quality walkabouts with the deputy director of nursing, visiting a wide range of services across the three hospitals. This has included donning full PPE in order to visit COVID-19 wards and ITU. The chief executive also supported the chairman to present the long service staff awards ceremony and two memorial events for staff that died during the pandemic.

6.2 Individual executive directors undertook a wide range of ad hoc visits across all areas of the Trust to speak to staff, learn more about their achievements and the challenges they face. A summary of these visits is captured on a whiteboard in the Trust Offices.

6.3 All on-call directors made an effort to be on the hospital sites during their on-call weekends to support staff and address concerns relating to the pandemic and regular weekly calls with the divisional senior management teams were established in the early days of the pandemic and have continued throughout 2020. Regular meetings also continued virtually with the medical staff committee and the joint consultative committee.

6.4 A new Live4Five staff communications forum was launched which provided an opportunity for staff to receive an operational update on the Trust's respond to the COVID-19 pandemic from the chief executive and other executives. Staff are able to post questions anonymously and receive a live response. This communications platform has proved to be very popular with up to 150 staff attending each session.

6.5 As part of a 'We Value You' week in November 2020, the executive team handed out thank you bags to staff across all three hospitals. These contained a mug, chocolates, vouchers for refreshments and information on health and wellbeing. Particular effort was made by the executive team to reach out to members of staff in back office functions that do not always get as much recognition as other front facing staffing groups. Similarly, in December 2020, chocolate treats were given to staff to wish them a merry Christmas and say thank you for their efforts during the year.

6.6 The executive team made use of video technology to remind staff on the availability of the Trust's health and wellbeing programme, including access to counselling and pastoral care.

6.7 The chief nurse met regularly with the senior nursing team throughout the pandemic and held a shared professional decision making event with national speakers. Furthermore, the chief nurse and deputy chief nurse each undertook a shift in the intensive therapy unit to understand the challenges faced by staff when caring for patients with COVID-19.

6.8 There have been a number of night walks arranged over the past year led by the chief nurse and deputy chief nurse and involving executives, non-executives and heads of nursing. In 2020, the visits focused on the health and wellbeing of staff, the clinical supervision model, the development of the electronic patient record and other key issues.

6.9 As evidence showed that those from a BAME (black, Asian and minority ethnic) background were disproportionately impacted by COVID-19, the Trust's Connect BAME Staff Network was revitalised and targeted engagement around the importance of the having the COVID-19 vaccination was undertaken. Safe space meetings were held in partnership with Connect and the chief nurse led on a piece a work with the Trust's chaplaincy to work with local cultural and religious leaders to bust myths around COVID-19 and encourage staff from multicultural backgrounds to have the vaccination.

7. Patient engagement

7.1 Due to the importance of maintaining strict infection, prevention and control measures, the opportunities for face to face engagement with patients was very limited in 2020. Patient visiting was suspended due to the pandemic and as staff working on wards were extremely busy, new ways were established to answer enquiries from relatives. These included a visitor's phone line, a family liaison hub, a new volunteer response role and virtual visiting using iPads, In addition a "message to a loved one" service was launched which involved inviting relatives to send in messages by email and this was transferred to a letter template and passed to the volunteer hub to be delivered to the patient.

8. Wider engagement

8.1 The Trust's first ever virtual annual general meeting was held on 03 September 2020 which was attended by 60 people, a significant increase compared with previous years.

8.2 The Trust and Herts Valleys Clinical Commissioning Group have continued to engage with external stakeholders and staff in 2020 on the development of the outline business case (OBC) for the acute redevelopment, in particular the process to identify a shortlist of options for detailed appraisal. A variety of communications channels have been used to reach as many people as possible, including using established channels and forums to engage with various audiences and this has been complemented by working more closely with local authorities in distributing information, such as an invitation to join a stakeholder reference group. The Trust's inclusion and diversity manager has supported the engagement work to attract more young people, as well as BAME communities to promote equal access to appropriate and quality services and to ensure that feedback is representative of the communities served.

8.3 The chief executive and chairman continued to have regular meetings with local MPs and Hertfordshire Healthwatch throughout the year to keep them abreast of activity and developments in the Trust.

8.4 Other external engagement has continued throughout the past year, including regular meetings with colleagues in primary care and with the Royal Free London to ensure clinical pathway group work moved forward.

8.5 Through the Trust's charity, Raise, working with volunteers, there has been an enormous amount of staff support in the form of gifts from external local businesses. This was aimed at showing public appreciation for the incredible hard work and dedication by staff during the pandemic which has been invaluable in helping to keep up morale.

9. Recommendation

9.1 The Board is asked to receive this report as assurance on the processes in place for the Board to engage with staff and patients.

Tracey Carter
Chief Nurse

February 2020

Appendix 1

Board Visits Schedule 2020

January	Patients Lounge
	Katherine Ward
	Occupational Health
	Starfish Ward
	Palliative Care Team
February	Radiology (St Albans)
	Delamare Ward
	Theatres
	Day Surgery
	Minor injuries Unit
	Estates
March	Pharmacy
	Ridge Ward
	Helen Donald Unit
	Human Resources
	Radiology (Watford)
April	Switchboard
	Mortuary
	Estates
	Patient Affairs and Patient Advice and Liaison Service
May	Staff Sanctuary, Watford Football Club
	Volunteer Hub
	Microbiology
July	Emergency Department
	Emergency Planning
	Patient Advice Liaison Service
September	Diabetes Centre
	Medical Equipment
	Radiology
	Paediatric Outpatients
October	Endoscopy
	Special Care Baby Unit
	Antenatal Department
November	Delamare Ward
	Intensive Care Unit
	Princess Michael of Kent Unit (level 5)
	Princess Michael of Kent Unit (level 4)
December	Family Liaison Centre
	Acute Admissions Unit (level 3)
	Urgent Treatment Centre

Agenda Item: 20/87

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**04 February 2020**
Recommendation:	**For assurance**
Chairperson:	**Christine Allen, Chief Executive**
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Trust Management Committee at its meeting on 11 November 2020, 25 November 2020, 9 December 2020 and 23 December 2020.

Background

The Committee meets monthly and its areas of responsibility are: -

- Delivery of the clinical strategy
- Revenue investment up to £1m
- Operational performance
- Operational risk
- Safety and business continuity
- Information technology
- Internal and external communication strategy
- Clinical quality
- Business planning
- Environment

Business undertaken.

Topics covered at the meetings of 11 November, 25 November 2020, 9 December 2020 and 23 December 2020.

- The Deputy CEO presented the Clinical Strategy paper and Strategy updates.
- The Deputy COO presented the Surge plan, Covid-19 updates and EAU business case.
    - The Surge plan was approved. (11 Nov 2020).
    - The EAU business case was approved. (9 Dec 2020).
- The Deputy Chief Nurse gave an overview of the Family Liaison Line service.
    - The business case was agreed. (23 Nov 2020)
- The CPO presented the Talent Management Strategy and Implementation plan.
    - The strategy was approved. (23 Nov 2020)
- The CIO presented the Windows 10 Business Case.
    - The business case was approved. (23 Nov 2020).
- The Director of Performance provided Access & Performance and IPR updates.
- The CFO presented the Finance updates and Brexit-end of transition

checklist.

- The COO presented the Terms of Reference for the Operational Recovery Group.
    - The Terms of Reference were approved. (9 Dec 2020).
- The CMO provided feedback from CAG.
- The CN provided feedback from PAC and presented the Inpatient Ward Establishment review.
- The DoC presented the Private Patients refreshed prices business case.
    - The business case was approved. (23 Dec 2020)
- The DMCS presented the Covid testing case.
    - The Covid testing addendum was approved. (23 Dec 2020)
- The DoE presented papers connected with the Hospital Redevelopment plan.

Risks to refer to the risk register	None
Items to escalate to the Board.	None

Report to:	Trust Board – Part 1
Title of Report:	Assurance report from Finance and Performance Committee
Date of meeting:	28 January 2021
Recommendation:	For information and assurance
Chairperson:	Paul Cartwright, Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 28 January 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.

Workplan

FPC and CFO agreed that work plan both for the rest of this year and for next year should be considered before the next meeting in the light of our experience of COVID-19; Do we have all the work steps that we should? Are there things that could be removed?

Risks

FPC was assured that the risk registers appropriately reflected the risks faced; there were no changes since the last review and the new way of presenting the risk register was considered appropriate. The risk of HIP1 moneys being smaller than expected was discussed; this is considered a very real uncertainty and is being addressed by The Great Place to Work Committee to make sure that WHHT is taking the most appropriate stance to this uncertainty.

BAF

The BAF schedule was discussed briefly and felt to be broadly appropriate; FPC and CFO agreed that the identified breakthrough measures in the BAF would be double checked to ensure that they were indeed the most appropriate in the light of COVID-19 experience.

Access & Performance

Access standards were discussed and seemed as would be expected in the light of the current wave of COVID-19. Model Hospital data is not yet available to compare with others to help FPC assure understanding of WHHT performance.

IPR

With the high level of COVID-19 activity, the substantial drop in elective work is to be expected. It was noted that there is still an emphasis on keeping Cancer and other important care going as far as possible during this COVID-19 wave. It was noted that COVID-19 19 statistics were showing a slight decline in activity with 268 COVID-19 patients on 28/1 compared to over 300+ a week ago. 20 patients were in ITU with 5 non COVID-19 ITU patients. It was noted that ITU surge capacity is 34 patients. Judge Business School modelling suggests that COVID-19 numbers will not begin to materially decline for a further two weeks. FPC assured that WHHT making as much use as possible of outsourcing and external diagnostics etc to contain decline in Cancer performance and address 52 week waits.

Vaccination

Vaccination is proceeding well, and appropriate measure of progress will be incorporated into the IPR in future.

Finances

With the Block income and national approach to COVID-19, FPC is reasonably assured that the financial outlook for the rest of 20/21 is contained within reasonably narrow bounds with the expected outcome still being of meeting the previously agreed forecast deficit of £4.2m. The clear need now is to understand and plan the financial exit from COVID-19 with a vaccinated workforce on the back of operational priorities; FPC will continue to focus and return to this theme and supports the finance function as it continues to peer through the COVID-19 fog to understand and calibrate what is going on and what is a reasonable financial performance to expect.

Commercial arrangements

FPC noted with interest the current work and thinking on both Private Patient and Insurance and looks forward to seeing the results of this work at FPC soon.

Capital Projects

FPC noted that WHHT is - in common with most preceding years – in the position of having to spend £35.4m (over 2/3 of the total capital plan) in

the final three months of the year. The CFO is confident that WHHT will be able to do so efficiently in the remaining time available. Examining progress on capital projects in the final months of this financial year will be a key part of next month's meeting. It was noted that a new regular monthly FPC schedule was being designed by the CFO that would set out the probable timetable of progress of business cases and Board approvals required to execute the capital plan, and this would be introduced before the end of this financial year.

Central NHS plans for planning for next year are not yet finalised and so little time was spent in the meeting on the planning process for 21/22; the FPC chair and CFO will discuss WHHT approach to planning further outside of this meeting.

Car Park

It was noted that (as feared at the last FPC) that there has been delay in the progress of the MSCP discussions and that as a result, WHHT has a choice of whether to suspend work on the MSCP for a month or so (with all the disruption that would entail) or to extend the Pre-Contract Services Agreement for a further month with the additional risks that would entail. Further information will be available following JIC this afternoon and a recommendation would be made to next week's Board meeting accordingly. FPC was comfortable with the approach being adopted by the team and appreciated the crisp and effective summary of the issues given.

EAU

Discussion of this Business Case was postponed until February.

Risks to refer to risk register	None
Issues to escalate	The Committee reports the following to the Board **For information and discussion:** • Approach to MSCP (once determined following JIC meeting) • Operational Performance and Financial Assurance

ITEM 23/87

Report to:	Trust Board
Title of Report:	Assurance report from Quality Committee
Date of Board meeting:	4 February 2021
Recommendation:	For information and assurance
Chairperson:	Jonathan Rennison, Non-Executive Director
Purpose	The report summarises the assurances received and approvals of recommendations made by the Quality Committee at its meeting on 17 December 2020.
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 in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.
Assurances received and areas of challenge	**Corporate risk register and board assurance framework** The Committee received an update on the status of the Corporate Risk Register (CRR) as discussed by the Risk Review Group (RRG) at its meeting held on 15 December 2020. A total of twenty one open risks were registered on the CRR at that time. One new risk which had emerged in the Women's and Children's division was presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR) and was accepted: Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels. It was recognised that WHHT does not pay the additional inner/ outer London weighting pay and this was contributing to the challenges the Trust was facing in recruiting Midwives at Band 6 level. Work was in progress to match WHHT's pay for Midwifery staff with the outer London pay offered by neighbouring Trusts. The Committee noted the Board Assurance Framework (BAF). **COVID-19 risk report** There were currently seven open risks on the corporate risk register arising from the Covid-19 pandemic. Risk Leads provide updates on the COVID-19 related risks on Datix once a month. **Infection Prevention and Control Board Assurance Framework (IPC BAF)** The Committee received an update on the IPC BAF which is structured against 10 specific criteria each with a range of key lines of enquiry (KLOE) that reflect the legislative framework for Health and Safety Act

1974 and Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. The IPC BAF programme continues to be updated as part of mainstream practice against the 10 key standards and associated key lines of enquiry (KLOE).

Further guidance with a checklist for assessment of compliance when following the patient pathway for suspected/known COVID-19 cases from triage to assessment to admission and/or discharge to help prevent the spread of infection had been released by the NHS on the 9 December 2020. This checklist and monitoring tool had been implemented at WHHT as of week commencing 14 December 2020 and will be fully adopted into the audit programme for IPC going forward.

Nosocomial outbreaks

Summary of Tudor/Castle Nosocomial Outbreak

The Trust reported five nosocomial outbreaks in November/December. Forty five patient cases had been identified with positive screens for COVID-19 and eighteen patients had died from COVID. A number of these outbreaks had been declared as serious incidents (SIs). Twenty one staff had also screened positive.

The Trust had taken the following immediate actions;

- Ward restricted to admissions.
- Positive patients moved to COVID-19 positive cohort area.
- Screening of contacts undertaken every 72 hours.
- Staff PCR screening commenced in all outbreaks.
- Epidemiology investigations (timelines) and genome sequencing supported by PHE.
- Duty of candour to affected patients.
- Reporting to PHE, CCG and NHSE and regular outbreak meetings undertaken.
- SI outbreak investigation commenced including a detailed case review of all eighteen patient deaths.
- Increased screening on admission, day 3, 5, 10, weekly thereafter for any remaining patients.
- Commencing point prevalence testing of staff.
- Hepa filters in non-covid ward bay areas due to limited ventilation i.e. no mechanical ventilation in Tudor/Castle, 1-3 air changes in PMOK bays.
- A review against the 10 key actions published in November has been undertaken and implemented to support nosocomial outbreaks.

An external review in relation to Tudor Ward will be commissioned once terms of reference are agreed.

The Trust has had a number of large outbreaks and the CCG and regional IPC team have visited to review IPC, and advise on further action. National learning has also been taken into consideration and mitigation put in place i.e. open bays – screens purchased and being put

in place, bed spacing – plastic curtains to separate and segregate the bed spaces and reduce nosocomial transmission.

A round table review is planned to be undertaken as part of a peer review in the next few weeks prior to Christmas.

Maternity deep dive and Morecambe Bay Review 2015
The Quality Committee received the presentation on quality and safety in Maternity and Obstetrics which focused on the Maternity Strategy for 2020-2023 (Best Care, Great Team, Best value and Great place), Work-streams for Herts and West Essex LMNS Transformation programme, WHHT's strategic direction 2020-2025 and challenges, WHHT demographic data – areas of high index of multiple deprivation, birth outcomes, Maternity and Neonatal Safety Collaborative Work streams and National Neonatal Audit Programme (NNAP).

The key focus;

- Review pathways for antenatal admissions and IOL's, business case for Victoria Ward
- Safeguarding – revision of pathways and restructuring
- Better Births and CoC – working with the LMS/New model of midwifery care
- Strengthening patient experience and co-production
- Shared learning with risk and governance
- Multidisciplinary evaluation of a number of external reports, all RCA's and SI's
- Preparing for UNICEF Stage 3 Baby Friendly Assessment
- Robust recruitment and retention
- ANNBS QA
- Saving Babies Lives V2 meeting the standards
- QI project/recovery plan for Gap & Grow implementation
- Recovery plan for midwifery and obstetric training
- New build
- Electronic patient records (EPR)
- CNST – achieving the 10 safety standards
- Pregnant women Flu vaccinations

An external company had been commissioned to facilitate mediation to resolve cultural issues within the Consultant Obstetrician and senior Midwives groups and this work had been completed in October 2020. A nominated Execute will monitor the embedding of the new ways of working. The development of a behavioural charter based on the two mediation agreements (doctors and midwives) is in progress and this will be shared with all staff groups and it will also form the accepted cultural norms of the Trust.

WHHT maternity services were rated as "Good", overall, in the CQC announced inspection in 2018 with, "Required Improvement" (RI) for the Safe domain. The actions from this inspection had been completed with

regular monitoring except for the ongoing Corporate IT work stream.

Regulation 28: Prevention of Future Deaths**-** Additional actions were undertaken as outlined in the Maternity Improvement plan for 2020/21 and these formed the basis of the Trusts response to the Prevention Future Deaths report. The Director of Midwifery & Gynaecology Nursing advised that a report would be presented at the QC meeting in January 2021.

The Trust had utilised external support for incident investigations with a number of internal investigations conducted via root cause analysis and the serious incident framework, from the LMNS and an independent consultant obstetrician and clinical risk lead to allow transparency and independent clinical expertise.

Critical care Mortality Outcome review

A review had been undertaken at Watford General Hospital in September 2020 on behalf of the East of England Adult Critical Care Network to better understand the possible reasons for the variation in mortality, to ensure that learning had occurred and to try to minimise the outcome variation during any further increase in COVID-19 admissions. Recommendations from the key lines of enquiry have been translated into an action plan to monitor service improvement and to provide assurance against progress.

The unit continues to review ICNARC data received and will communicate the findings and learning across the service.

The Trust experienced depletion in oxygen in April which affected critical care resulting in quick transfers of a number of patients throughout the region. The issue with the oxygen supply had now been resolved.

Bushey Spire Surgical Pathway

The Committee received assurance that going forward BSH would share and report on a range of patient safety and quality improvement metrics such as incidents, risk management, complaints, patient experience, trend and theme analysis and share the learning with the WHHT through the surgical division's governance arrangements and as per the corporate arrangements.

Escalation/Winter plan deep dive

The Emergency Department had conducted a deep dive on the emergency care pathway and escalation for the winter plan in line with FIRST, a CQC resource that helps to monitor safety and to identify the additional work that may be needed to maintain it. The Divisional Manager for Emergency Medicine and the Lead Nurse Emergency Medicine provided the following assurance;

The Emergency Department has;

- The leadership capacity and capability to deliver high-quality,

sustainable care.
- A culture of high-quality, sustainable care.
- Clear responsibilities, roles and systems of accountability to support good governance and management.
- Clear and effective processes for managing risks, issues and performance
- Service users are involved to support high-quality sustainable services
- There are robust systems and processes for learning, continuous improvement and innovation

The Committee noted assurance reports the following meetings;
- Patient Experience Group
- Quality and safety Group
- Risk review Group

Risks to refer to risk register	See above
Items for the Board to note	Corporate risk register (CRR) and Board Assurance Framework (BAF) Infection prevention and control Bushey Spire Surgical Pathway
Recommendations to the Board	To note the assurance report

Attendance record

Members	
Ginny Edwards	Non-Executive Director (Chair)
Phil Townsend	Trust Chair
Christine Allen	Chief Executive
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control
Paul Cartwright	Non-Executive Director
Jonathan Rennison	Non-Executive Director
Sally Tucker	Chief Operating Officer
Michelle Hope	Associate Chief Nurse, Quality Governance
Anna Wood	Director of Governance

In attendance	
Jill Jaratina	Assistant Trust Secretary (minutes)
Paddy Hennessy	Director of Environment

Attendees for specific items	
Stephanie Johnson	Divisional Manager Emergency Medicine
David Thorpe	Deputy Chief Nurse
Simon West	Divisional Director Surgery, Anaesthetics and Cancer
Colette Mannion	Director of Midwifery & Gynaecology Nursing
Jaspal Bhula	Consultant ITU
Victoria Houghton	Matron ITU
William Forson	Divisional Director for Women's and Children
Pamela Mellor	Quality & Governance Lead Midwife

Apologies	
Mike van der Watt	Chief Medical Officer

Agenda item:

Report to:	Trust Board
Title of Report:	Assurance report from Great Place Committee
Date of meeting:	21 January 2021
Recommendation:	For information and assurance
Chairperson:	Helen Davis, Associate Non-Executive Director
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Great Place Committee at its meeting on 21 January 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.

EPR update

The Committee noted that the EPR approvals process has completed following a presentation at the DHSC joint investment committee and subsequent signing of the contract with Cerner.

The pre data migration trial load 1 activities have commenced and extracts from current PAS system has been taken in preparation for merging. The key immediate priorities for the programme are to continue to execute the data migration trial load activities, progress with technology dependencies, reporting development and start organisation readiness and transformation work.

The Committee observed that reporting is listed as a high risk in the EPR programme as it involves a manual process. This risk is being mitigated by engaging a 3rd party who can bring in automated processes if manual processing fails. The Committee was mindful that it should keep the risk that Covid-19 poses under review as clinical staff time will be needed to input and review the EPR system.

The Committee noted that there only remains 10 months until the go-live date. The project is on track and on budget but there remains a lot to do. The committee discussed alignment with the current contract with ATOS

for IT provision and a range of options that will need to be considered for either extending or re-procuring this contract. The CIO and CFO will make a recommendation to the committee on this issue in due course, The Trust needs to undertake an organisational development review to ensure it is ready for the transformation programmes and what additional support is required.

Further development of the risk profile will take place on the relationship between the BAF, CRR and programme risks and will be brought back to the Committee in March 21. The acute redevelopment and EPR programmes will align their approaches, however it was noted that as EPR is in implementation phase vs acute redevelopment OBC stage the nature of the risks is different and this will be reflected in the approach to risk management.

Overall, the Committee was assured that the project was very well managed and materially on track in terms of budget and time. There was significant work to be done over the next 10 months during a time when there was significant pressure on staff. The Trust will consider the organisation development implication of this and the redevelopment programme. The Trust will undertake a piece or work to address and report back to the Committee on its strategy for managing this going forward. Further work will also be undertaken with respect to the ATOS contract.

Acute redevelopment programme overview

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

The Committee acknowledged the high level of activity that was taking place and discussed the assurance process going forward. It noted that it would receive substantial assurance around the detail of the redevelopment at the February workshop in terms of costs, bed numbers, capacity/demand issues and associated risks. It noted that the Programme Board is responsible for making decisions and recommendations to Trust Board. The Committee's function is to assure itself and the Board that GPB's decisions/recommendations are appropriately developed. The CCG is informed and assured via its members attending the GPPB and the Committee.
The timeline for confirming the preferred option has been reset to April 2021 to enable further work on the detail of the schedule of accommodation, detail within the different options and finalising capital costs; this also reflects some delays due to COVID 19.

The programme budget remains on track for this year and within £7m. The budget for the OBC requires further discussion with the regulator with OBC costs tied to overall capital cost of preferred option. .

Overall, the Committee received assurance that the programme was still on track to deliver OBC approval in October 21. Any slippage in the timeline would be managed within the contingency allowance.

The February workshop would be a key meeting as the Committee will receive detailed assurance about the work currently underway prior to formal decision making on the preferred option in March. Work will continue on 1:200 engagement with staff but the Trust will be using a different strategy because of Covid-19.

Process to complete economic appraisal

The Committee received information regarding the process for completing the economic appraisal for the programme. The Economic Case is informed by the Comprehensive Investment Appraisal Model (CIA-M). This model brings together costs, benefits and risks across shortlisted options. To help shape the overall economic case the requirements for the economic and financial modelling were determined at the outset of the project and distributed throughout the relevant work streams for input and collaboration. Overall progress on data collection, CIA model completeness, and benefits definition and quantification is reviewed on a weekly basis at the finance and activity work stream meeting, to ensure accurate and up to date reporting.

The Committee noted that the economic appraisal would be considered by the Trust Board at its April meeting.

Overall, the Committee was informed that there was a significant amount of work needed for the preparation of the economic case with the economic model as a key part. The Committee was assured that there was a detailed work plan in place for delivering the model with the first cut in January 2021. Work will continue over the coming months on an iterative basis and the Committee will receive a further update at its February workshop.

Deep dive into the Acute Redevelopment Programme risks

The Committee noted the risk register for the redevelopment programme and the additional work taking place to align the programme risks with the Board Assurance Framework, already mentioned earlier in the Agenda.

The Committee noted that most of risks reflected in the report would need refreshing on completion of the OBC. The Committee assessed that the most significant risk would be agreeing the capital cost of the project and the timeframe for getting OBC approval. . Stakeholder engagement also remained as an area of important focus.

Overall, the Committee was assured by the detailed risk register and noted the common themes of capital costs, stakeholder environment and the timeframe for project completion, recognising that adhering as closely to the 2025 timeline as possible remains a priority.. It noted that the risk register would be refreshed when the project reached the preferred option stage.

Board Assurance Framework

The Committee noted that the report provided it with assurance that the risks to achieving the strategic aims and objectives were being appropriately mitigated through the board assurance framework (BAF). The latest updates were marked in red. Prior to the next committee meeting, a meeting will discuss how best to report a broader range of programme risks relating to both redevelopment and digital transformation going forward.

Service Redevelopment Engagement Plan.

The Committee noted that an engagement plan had been developed to support a formal stakeholder and community engagement exercise to ensure feedback on the draft clinical strategy and the clinical brief / three-site model is considered as part of the decision making for the acute redevelopment plan.

It noted that formal engagement would be in two stages (initial engagement followed by feedback and testing). Time had been identified within the plan to ensure feedback could be reviewed and summarised. An explanation of how the feedback will inform plans would be shared with stakeholders.

Initial engagement is expected to start week commencing 15 February. The plan sets out engagement principles and objectives, identifies key stakeholders and outlines the communication, engagement and feedback methods that will be used. It is intended that the feedback received will be independently analysed.

The Committee noted that an update on the programme and proposed approach to engagement would be presented to a Topic Group of Health, Overview and Scrutiny Committee on 8 February 2021. . The

	Committee noted that clinical engagement across the system was very important. The Committee noted the publishing of the Naxton Report by the hospital campaign group. The committee was advised that the report had been reviewed by the Programme Director and RFL Property Services and assurance had been provided that nothing within the report is considered to change the findings of the site feasibility study and therefore the decision not to shortlist any new site options. There is significant stakeholder and press interest in the report; as such a formal statement would be issued jointly by the Trust and HVCCG. A formal report will be provided to the next committee for assurance. Overall, the Committee was assured that there would be a period of formal engagement in mid to late March on the Clinical Strategy and Clinical Brief. It noted the key meeting by the Health and Overview Scrutiny Committee and the intention of the Committee to receive a further update about the Naxton Report at its next meeting.
Risks to refer to risk register	None
Issues to escalate	The Committee recommends the following update for information to Part 1 of the February 21 Board:

Agenda Item:25/87

Report to:	Trust Board
Title of Report:	Charity Committee Assurance Report to Board
Date of meeting:	10 December 2020
Recommendation:	For Information and Assurance
Chairperson:	Jonathan Rennison, Non-Executive Director
Purpose	The report provides an update to the Corporate Trustee on actions since the last Charity Committee in September 2020.
Background	The Committee meets quarterly and provides assurance to the Board: • that robust processes are in place to manage charitable funds and to ensure they are implemented; • that donated funds are utilised in a way that takes into account any stipulations set out by donors and ensure best value is obtained from the funds donated; • that further donations are being encouraged; • that systems comply with regulation and governance of NHS Charities.

Charitable Funds Committee,

December 2020

Items to Report to the Board

1. We received an update on the charity's progress for this quarter. Key points from the update included:

- Work is proceeding with the rationalisation of funds. We will be obtaining feedback from affected fundholders and reporting this information back to the next committee.
- The process for outsourcing the charity finance function is continuing. The dedicated finance consultant is in post and will assist the transition to the external finance provider.
- Work is progressing on the charity's database and website and a review will take place to ensure that it is accessible.
- Future progress reporting will set out the charity's targets and will report progress against these, pending the implementation of the KPI dashboard.

2. The charity's finances are proceeding well. Our position and projections are as follows:

a. We are projecting that our fund balances will be £1,125k at the end of March 2021.
b. In the 7-month period ending 31st October 2020 the Charity had a surplus of £203k and projected a deficit of £116k for the period November to March 2021, giving an overall surplus of £87k for the year.
c. Received COVID income of £314k and only spent £17k. It has been forecast that in the 5 months ending 31 March 2021 the Charity will spend a further £154k of COVID funds.
d. Is holding £57k of cash and it is estimated that the cash balance will be £408k at 31st March 2021.
e. The charity's investment portfolio has increased by 5.9% since 31 March 2020 and currently stands as £655k. We were pleased to see that many of the losses incurred in March 2020 have now been recovered.

We noted that the charity's cash flow is forecast to reduce, and we will need to consider realising some of the charity's investments in the absence of increased fund-raising activity. It is also unusual for the charity to hold such a large sum of cash and we noted the investment advisor's comments regarding market volatility. Looking ahead, it will be important for the charity's budget to allow cash to be changed to investments. We will closely monitor the general fund and focus on raising un-restricted funds.

We will receive an updated budget setting report ahead of the next committee which will mirror the cash flow report and include forecasts for both this financial year and next.

3. The Committee was provided with a review and update on current risks on the charity risk register. The report was discussed in the detail and future reports will include information around assurances and mitigation. We will seek input from the Trust's Risk Lead for advice on the format of the report.

4. The Committee approved the annual report and accounts which had previously been approved by Corporate Trustee due to timing issue. We have since been made aware that the Independent Examiner's signature was included in the accounts due to an administrative error. We have apologised for this and will ensure this does not happen again.

5. We will be reviewing the policies due for review this year and which concern the charity as well as the committee's terms of reference.

6. Requests for funds – the Committee received three requests for funds:

a. We Value You Week' Application
    i. Retrospective funding was sought for two previous approvals which had then been merged due to the impact of Covid-19.
    ii. Whilst we understood the underlying reasons, we noted that there needed to be a compliant approval process if urgent changes were required and will be incorporating this point into our existing processes.

b. Endoscopy Simulator
    i. This application had previously received approval for funding with the Trust agreeing to contribute £33k funded from revenue from the training program. The Trust is now unable to provide that funding due to the training programme being paused because of Covid-19.
    ii. We discussed which funds would be the most appropriate to use and noted the options available were dormant funds, Covid-19 funds, Hemel Hempstead funds or Surgical, Educational & Training funds.
    iii. We were mindful that we did not want the need for discussion to cause unnecessary delay and further agreed that we were happy to approve the application subject to the fund holder(s) agreeing to the legitimate use of funds.
    iv. We agreed the additional £33k could be funded from the following three options listed in order of preference:
        1. £9,352 "Endoscopy Unit" charitable fund + £12,607 "Surgical Education & Training charitable fund + £11,041 Covid charitable fund.
        2. £9,352 "Endoscopy Unit" charitable fund + £23,648 Covid charitable fund.
        3. £9,352 "Endoscopy Unit + £23,648 General charitable fund.
    v. Our preference was for the Surgical, Education and Training fund to fund the purchase. If Covid funds were used, confirmation would be needed as to why the application aligned with that fund's purpose. We also asked for confirmation on whether any dormant funds could be used which would then need to be kept separate from rationalisation.

c. Staff wellbeing facilities application for funds
    i. The committee confirmed approval for £65k for development of the staff kitchen at WGH. We noted the submission date for Stage 3 funding of the Charities Together grant and that we were on track to submit the application in time, albeit with risk.

d. **Recommendation to CT:**
    i. Approval of retrospective funding for the We Value You Week.
    ii. Approval of £33,000 for the Endoscopy Simulator purchase.
    iii. Approval of £65,000 for the development of the staff kitchen at WGH.