TRUST BOARD MEETING IN PUBLIC
AGENDA

4 March 2021 at 09.30 – 12.00
Via Zoom

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

Time	Item ref	Title	Purpose	Accountable officer	Paper or verbal
Standing items					
09.30	1/88	**Opening and welcome**	Information	Chair	Verbal
	2/88	**Patient story – presentation on the End-of-Life Care strategy**	Information	Chief Nurse	Verbal
09.50	3/88	**Apologies for absence**	Information	Chair	Verbal
	4/88	**Declarations of interest**	Information	Chair	Paper
	5/88	**Minutes of previous meeting on 4 February 2021**	Approval	Chair	Paper
	6/88	**Board decision log**	Information	Chair	Paper
	7/88	**Board action log**	Approval	Chair	Paper
	8/88	**Chair's and Chief Executive's report**	Information	Chair / Chief Executive	Paper
Performance					
10.00	09/88	**Board Assurance Framework**	Approval	Chief Executive	Paper
10.10	10/88	**Activity Recovery Update & Access Standards Performance**	Information and assurance	Chief Operating Officer	Paper
	11/88	**Integrated performance report** Key messages from: • Chief Operating Officer • Chief Nurse • Chief Medical Officer • Chief People Officer • Chief Financial Officer • Chief Information Officer	Information and assurance	Chief Operating Officer	Paper
Aim 1: Best Care					
10.35	12/88	**Mortality and learning from deaths Q3 report**	Information and assurance	Director of Governance	Paper
Aim 3: Great Team					

10.45	13/88	**Gender Pay Gap Annual Report.**	Information and assurance	Chief People Officer	Paper
10.55	14/88	**Sharing Good Practice to improve our People Practices (Disciplinary)**	Information and assurance	Chief People Officer	Paper
Aim 4: Great Place					
11.05	15/88	**Strategic Priorities Update**	Information and assurance	Deputy Chief Executive	Paper
Risk and Governance					
11.15	16/88	**Corporate Risk Register report**	Approval	Chief Medical Officer	Paper
Committee Reports					
11.20	17/88	**Trust Management Committee**	Information and assurance	Chief Executive	Paper
	18/88	**People, Education and Research Committee**	Information and assurance	Chair of Committee/Chief People Officer	Paper
	19/88	**Finance and Performance Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
	20/88	**Quality Committee**	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	21/88	**Audit Committee**	Information and assurance	Chair of Committee/Chief Financial Officer	Paper
	22/88	**Great Place Committee**	Information and assurance	Chair of Committee/Deputy Chief Executive	Paper
Closing Items					
11.45	23/88	**Any other business previously notified to the chair**	N/A	Chair	Verbal
11.50	24/88	**Questions from Hertfordshire Healthwatch**	N/A	Chair	Verbal
	25/88	**Questions from our patients and members of the public**	N/A	Chair	Verbal
12.00	26/88	**Date of the next board meeting: 1 April 2021** Executive Meeting Room, Watford General Hospital and via Zoom	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

Declarations of board members and attendees interests
4 March 2021

NHS
West Hertfordshire Hospitals
NHS Trust

Agenda item: 04/88

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
Helen Davis	Associate Non-Executive Director	• Director and shareholder at Brierley Advisory LLP • Associate Consultant at Archus • 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

Last updated: February 2021

Name	Role	Description of interest
		• Husband is CEO of The Nuffield Trust • Husband is Director of Edwards Consulting Ltd • Husband is a non-remunerated member of the Strategy Committee of Guy's and St Thomas's Charitable Trust • Trustee Infection Prevention Society
Natalie Edwards	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	Chief People Officer	None
Barbara Anthony	Trust Secretary	None

Last updated: February 2021

TRUST BOARD MEETING IN PUBLIC
4 February 2021
via Zoom

Chair	Title	Attendance
Phil Townsend	Chairman	Yes (virtual)
Voting members		
Christine Allen	Chief Executive	Yes (virtual)
Helen Brown	Deputy Chief Executive	Yes (virtual)
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes (virtual)
Don Richards	Chief Financial Officer	Yes (virtual)
Dr Mike Van der Watt	Chief Medical Officer	Yes (virtual)
Ginny Edwards	Non-Executive Director (Vice-Chair)	Yes (virtual)
Jonathan Rennison	Non-Executive Director (Senior Independent Director)	Yes (virtual)
Edwin Josephs	Non-Executive Director	Yes (virtual)
Paul Cartwright	Non-Executive Director	Yes (virtual)
Natalie Edwards	Non-Executive Director	Yes (virtual)
Non-voting members		
Paul Bannister	Chief Information Officer	Yes (virtual)
Sally Tucker	Chief Operating Officer	Yes (virtual)
Paul Da Gama	Chief People Officer	Yes (virtual)
Helen Davis	Associate Non-Executive Director	Yes (virtual)
Dr Andy Barlow	Divisional Director for Medicine	Yes (virtual)
Dr Anna Wood	Director of Governance	Yes (virtual)
Dr Simon West	Divisional Director for Surgery, Anaesthetics and Cancer	Yes (virtual)
Mr William Forson	Divisional Director for Women's and Children	Yes (virtual)
In attendance		
Dr Rachel Hoey	Divisional Director for Emergency Medicine	Yes (virtual)
Fran Gertler	Director of Integrated Care	Yes (virtual)
Tejal Vaghela	CPG Programme Manager	Yes (virtual)
Collette Mannion	Director of Midwifery	Yes (virtual)
Clare Parker	Director of Strategy and Integration	Yes (virtual)
Andrew McMemeny	Deputy Director of HR, Business Partnering, OD and Learning	Yes (virtual)
Dr Shruti Ganatra	Consultant Paediatrician	Yes (virtual)
Barbara Anthony	Interim Trust Secretary	Yes (virtual)
Jill Jaratina	Assistant Trust Secretary	Yes (virtual)

3 members of the public were in virtual attendance

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
1/87	**Opening and welcome**		
1.1	The Chair welcomed the Board and noted that one year had passed since the Board had met in person. He thanked staff for their hard work and hoped that Board meetings would soon return to normal.		
2/87	**Patient story**		
2.1	Fran Gertler, Director of Integrated Care and Tejal Vaghela, CPG Programme Manager introduced their presentation on the resulting patient benefits from the Clinical Practice Group programme and highlighted that: • Clinical Practice Groups aimed to optimise patient care, safety and outcomes whilst reducing unwarranted clinical variations by using standardised pathways and developing a continuous improvement culture. • The Trust continued to work with the Royal Free Hospital to further develop and implement pathways across specialities. • Future plans were to develop 40 pathways in the next 3 years and ensure their integration with the EPR system.		
2.2	The Chair asked how many pathways required completion. The Director of Integrated Care explained that they had focused on the digitalised pathways that were shared with the Royal Free's programme in order to benefit from their learning. It was a rolling programme and work was on-going with the Clinical Leads to identify and tailor pathways to the needs of the Trust. The Chair noted that integration with EPR was essential.		
2.3	Ginny Edwards asked how the team was incorporating the patient experience strategy and shared decision work. The CPG Programme Manager explained that work involving patient experience was reviewed by the coproduction board. Shared decision work would be developed under the Trust's co-design work.		
2.4	Jonathan Rennison asked if there were opportunities to fast track those accelerated pathways which met multiple strategic objectives. The Director of Integrated Care explained that the programme analysed prospective pathways against objectives and what was on the horizon. The Chief Medical Officer added that the progamme was modelled on the Intermountain Hospitals programme in Utah, which the team visited a while ago. The main selection criteria targeted processes with a large volume of cases where there was suspected major clinical variation. Clinical audit outcomes also acted as a guide.		
OPENING			
3/87	**Apologies for absence**		
3.1	No apologies were recorded.		
4/87	**Declarations of interests,**		
4.1	No changes were reported to the declarations of interest.		
5/87	**Minutes of previous meeting**		
5.1	9.0.3 – should read that Chief Operating Officer responded that the continued upward trend in Covid-19 presentations was going to make delivery of the access standards challenging.		
5.2	Edwin Josephs' attendance should be added to the minutes.		

Agenda item	Discussion	Lead	Dead-line
5.3	**Resolution**: The Board approved the minutes of the meeting of the Board in public on 3 December 2020 as a true and accurate record, subject to the amendments listed above.		
6/87	**Decision log**		
6.1	Paul Cartwright requested the log to be in European date format and noted that it should include the delegated decisions the MSCP business case and EPR contract with Cerner.		
7/87	**Action log**		
	No amendments were recorded.		
8/87	**Chair's and Chief Executive's report**		
8.1	The Chairman noted: • Natalie Forrest's appointment as Lead of the Hospital Redevelopment and Capital Improvement Programme and it was our intention to invite Ms Forrest to visit the Trust. • The National Clinical Excellence awards had been processed and letters sent out. • The appointment of Natalie Edwards as a substantive NED. • The Electronic Patient Records contract entered into with Cerner.		
8.2	The Chief Executive noted: • The amazing dedication of staff during the rise in Covid-19 numbers since the Board last met in December 2020. • The new testing hub that opened on 7 Jan 2021 and the two Covid-19 secure rooms for children which ensured a better environment for sick children. • The opening of the vaccination hub at Watford Football Club who were thanked for their continued help and support. • The Pastoral Care Team's memorial service in December 2020 to remember friends and family who had passed away. • Chief Nurse Tracey Carter had opened the acute respiratory unit. • The appointment of Chris Badger as Director of Adult Care Services for Hertfordshire.		
9/87	**Board Assurance Framework (BAF)**		
9.1	The Chief Executive introduced the report which was used by the Board and its sub-committees to measure the risks of achieving the Trust's strategic objectives. She noted that changes were highlighted in red and that the BAF was cross referenced against the Trust's operational risks. The BAF included a risk appetite statement. Some items required a further review and the Trust would undertake an annual refresh over the next 6-8 weeks where the BAF would be cross referenced against the risk appetite statement to ensure it reflected the current position in light of Covid-19. This review would come to Board at Spring.		
9.2	Paul Cartwright noted that FPC had discussed its respective risks and were considering, as an on-going action, whether the breakthrough measures were current.		
9.3	**ACTION**: Dates to be reviewed and updated. **RESOLUTION**: The Board approved the Board Assurance Framework.	BA	March 21

Agenda item	Discussion	Lead	Dead-line
PERFORMANCE			
10/87	**Activity Recovery Update & Access Standards Performance**		
10.1	The Chief Operating Officer presented the report and asked the Board to note the context of the data for the December period. The Trust started to see a further upward trend in Covid-19 infection rates towards the end of December and the beginning of January 2021. • There were 353 Covid-19 positive patients resulting in 105 beds closed due to Covid-19 contacts, of which 30 were empty. • Referrals had decreased but cancer referrals remained stable indicating that patients were able to be referred for care. However, there was increase in DNAs and work was being done with the CCG to encourage patients to attend. • Independent sector capacity was being utilized for Endoscopy and also for MRI services pending the arrival of the MRI scanner in St Albans in March 21. • Elective activity at St Albans was stood down in order to free up staff to care for acutely ill patients at Watford because of high staff absence levels. Non-face to face out patient targets were achieved by using technological support. • A&E performance deteriorated to 68.4% from averages of 80-85% and demonstrated the pressure placed on Watford. An increase in urgent attendances, particularly at evening times added to this. Regrettably, challenges with maintaining patient flow resulted in 12-hour breaches. Other organisations were similarly affected NHSEI changing its reporting process. • Opal 4 status, (the highest level of capacity constraint) was declared between 29 December -8 January 2021. ICS partners also faced similar pressures resulting in Gold calls during that period. • Ambulance handover delays increased with the Trust being the most affected. A system of mutual aid was developed between the ambulance service and the Trust where site-based paramedics worked with Trust staff to ensure patient safety whilst patients waited for assessment. • 52-week waits had increased but the rate had slowed compared to previous months. • Harm reviews were being undertaken for patients on waiting lists to ensure oversight from divisional governance structures and MDT meetings.		
10.2	Paul Cartwright noted Model Hospital data was not available from the Centre and queried what other methods could be used to evaluate performance. The COO explained that she (virtually) met with ICS partners x3/week and continued to discuss mutual aid for cancer care to ensure equal access for patients across the system. The independent sector's capacity was being used and conversations would shortly start regarding recovery.		
10.3	Jonathan Rennison asked how the Trust was addressing the backlog in reviews. Mr West, Divisional Director for Surgery, Anaesthetics and Cancer explained the division had directed all		

Agenda item	Discussion	Lead	Dead-line
	surgeons to allocate sessions for harm reviews. This depended on their availability and noted that colorectal surgeons were engaged in performing cancer surgery. Dr Barlow, Divisional Director for Medicine confirmed the division had adopted a similar approach, most departments continued to risk assess patients. The work was on-going, and staff were aware of the necessity.		
11/87	**Integrated performance review**		
11.1	The Chief Operating Officer reported there were currently: • 213 Covid-19 positive patients, down 353 from the height of phase 2. 25 patients were in ITU of which 19 were Covid-19 patients. Surge plans were being used to support patients and segregate pathways. • The Trust was currently under a great deal of pressure with 59 beds closed; 14 of which were empty due to Covid. • 391 staff were currently absent from the organization, 280 due to Covid.		
11.2	The Chief Operating Officer provided her Chief's update: • Zoning continued within the departments with the surge plan still in use. • The Trust faced exceptional pressures particularly with ambulance handovers. • Work continued within the Cardiac Cath labs. • Work continued with the Phase 2 EAU expansion which would increase EAU's capacity from 10 patients to 30.		
11. 3	The Chief Nurse gave the following update: • Workforce was affected by the increased Covid infection rate. The focus was on providing the safest care during the pandemic. • In January 2021, weekly harm reviews and monthly tabletop reviews of workforce templates were commenced to triangulate resources on giving the best care possible. • Nosocomial infections were a key focus. In December 2020, a round table review was undertaken by NHSE, PHE, HVCCG as well as genomic sequencing testing for outbreaks on wards in preceding months. • The Pastoral Care Team demonstrated innovative ways of supporting staff as well as using the renovated spiritual care centre for counselling and reaching out to staff during their down time. • End of life care co-ordinators were in post as well as the Lead Nurse for Patient Experience.		
11.4	The Chief Medical Officer gave the following update: • The Ethical Panel recommenced to support ITU staff making decisions for seriously ill or terminally ill patients as well as offering pastoral support. • The virtual hospital showed continued growth. Dr Andy Barlow, Divisional Director for Medicine had been appointed as regional lead and would focus on virtual services for patients with heart failure and COPD. • Improvements were made to patient flow with a daily rota of senior staff reviewing discharges resulting in a significant difference to numbers.		
11.5	The Chief People Officer gave the following update: • Vaccinations rates increased significantly. Jane Taylor was		

Agenda item	Discussion	Lead	Dead-line
	thanked for her efforts with the vaccination programme. • Disciplinary policies had been reviewed in light of national recommendations to focus on informal resolution. Additional assurance would be provided from a review by the Trust's FTSU Guardian. • A greater number of staff were working remotely due to the new variant. • Overseas recruitment continued with 30 new starters in November 2020 and 21 in December 2020.		
11.6	The Chief Financial Officer gave the following update: • The Trust was forecasted to spend no more than £4.2m above the funding available for the remainder of the financial year. Month 9 was the first month where more was spent than allocated to the Trust. However, the forecasted £800k deficit was in line with the trajectory endorsed by NHSEI. • Covid-19 expenditure was higher than expected but elective care costs and outsourcing activity was lower. Therefore, the trajectory remained in line with the plan. • Capital expenditure was at its highest for the past 10 years.		
11.7	The Chief Information Officer presented the following update: • There was a continued challenge around pathology which was expected to resolve by the summer. • The EPR programme continued at pace and the continued support from clinical and operational staff throughout the pandemic was commended. • The Windows 10 programme also continued at pace with approximately 200 devices upgraded each week. • Work on the Digital Strategy continued with the Finance and Strategy teams. The requirement for HIP developments to be as efficient as possible was noted.		
11.8	The Chairman asked how overseas nurses were welcomed during the pandemic. The CPO explained that new starters were supported with shopping during isolation and online induction. It was acknowledged that isolation was difficult for overseas new starters.		
11.9	Ginny Edward asked when capital investment would provide assurance on the PAMS assurance model. The CFO explained compliance was on-going and would be helped by the proactive maintenance management system which would manage backlog maintenance. To date, £4m was spent on backlog maintenance but next year would be more challenging unless national funds were received. Fire safety improvements continued to be prioritised.		
11.10	Helen Davis asked if restrictions on travel would impact overseas recruitment. The CPO explained current staff would find it more difficult to return home for visits, but it did not appear to be deterring overseas staff from joining the hospital. It was hoped that vaccination efforts would result in it being a temporary issue. Conversations would take place at an individual level but the Trust would need to comply with government legislation.		
11.11	Natalie Edwards asked how training programmes were managed and how the occupational health team were coping during the pandemic. The CPO explained the online training programme had received positive feedback. The Covid-19 staff hub had been affected by staff absence during the pandemic. The Trust was better prepared for Phase 2 in that HR and Occupational Health were contactable. The Chief Nurse agreed that staff were able to access		

Agenda item	Discussion	Lead	Dead-line
	services and considered that Occupational Health had worked with the IPC to improve their networks. Dr Barlow, Divisional Director for Medicine added that the staff hub had also linked in with the virtual hospital to support staff at home.		
11.12	Paul Cartwright asked what proportion of workforce were declining vaccination and why. The CPO explained that data on refusals was not available. However, a lower take-up had been noted within BAME staff groups and work was underway to address this.		
11.13	Jonathan Rennison asked for assurance that the Trust was on track with safe care for mothers and whether investment was available to maintain that continuity of care. The Chief Nurse confirmed the launch of the Orchid Team which focused on expectant mothers from the BAME community and those with complex pregnancies. The Trust needed to reach 35% by April 2021 but there was national recognition that the pandemic was a significant obstacle. Recruitment remained the biggest issue with initiatives in place to support this. Work continued around Birth Rate plus to meet the increased midwife staffing ratio.		
11.14	Mr Rennison queried how compliance with maternity training could improve, particularly in light of the Ockenden report and on-going CNST requirements. The Chief Nurse explained Covid-19 had caused problems and was being addressed by the Division through an analysis of training needs to increase compliance. Progress could be reported on "drills and skills" training as well as foetal monitoring. The current training would be reviewed at Quality Committee in the next few months.		
11.15	Mr Rennison queried assurance regarding work with BAME staff and when this would feature regularly on the Board agenda. The Chief People Officer explained that a diversity dashboard would be available at March Board and regularly thereafter. The Chief Nurse, CEO and CPO also met regularly with the Connect Network. Natalie Edwards confirmed that the BAME staff community remained a regular focus for the PERC committee.		
11.16	Ginny Edwards asked if the Trust felt it understood the inequalities that staff faced such as poverty, housing and the resources available to lower paid staff. The CPO confirmed it was something the Trust needed to consider more. The CEO added that the Trust was using the Connect Group to work on this issue and this group included Mitie staff.		
12/87	**Best care Covid-19 Briefing**		
12.1	The Chief Nurse explained that the report's purpose was to provide information and assurance to the Board in relation to work on phase 2 of the pandemic and highlighted: • The Ethical review panel. • The reconfiguration of the zones due Covid-19 • The overview of Covid-19 risks which would be discussed at Quality Committee in February 2021. • The use of harm review panels to deliver the safest care. The Chair noted that the report had been fully discussed at Quality Committee in January 2021.		
13/87	**Ockenden review**		
13.1	The Chief Nurse introduced the report on the Ockenden review and noted the full discussion of the report at Quality Committee. She highlighted:		

Agenda item	Discussion	Lead	Dead-line
	• Its aim of improving scrutiny and safety of maternity services as well as working in partnership with local maternity networks and organisations. • The national requirement to report on 12 immediate actions; the Board was asked to approve the responses to those actions as set out in the paper. • That Quality Committee would continue to monitor maternity safety and the Board would receive updates for discussion and assurance.		
13.2	The Director of Midwifery highlighted the requirement for: • The Trust to agree to the birth rate plus target and confirmed submission of the Trust's business case to the Trust Management Committee for additional funds to enable the target to be met. • The requirement for assurance from the Board that the annual maternity CNST rebate would be invested back into maternity safety.		
13.3	Ginny Edwards, Co-Chair of Quality Committee recommended approval of the report as well as additional measure for a review to be done by the FTSU Guardian to ensure staff could report concerns. The Chief Nurse supported this recommendation and added the Ockenden Review had set out a new role to support the voices of women and staff that would link into the FTSU Guardian.		
13.4	**Approval:** The Board approved the assessment tool within the report.		
14/87	**Great Place Strategic Priorities update**		
14.1	The Deputy CEO provided the following update: • The Programme Team for Redevelopment was liaising with UCLH and Mount Vernon about potentially co-locating the Mount Vernon Cancer service to the Watford site. • EAU expansion was nearing completion. Handover was expected for the middle of February 21, with the service starting in early March 2021. The technical aspects of the lease and capital programme would be presented to FPC in February 21 and to Board in March 21. • The Estates and Capital Projects teams were commended for their work on the capital programme and work required due to Covid-19. During February, the focus would be on pushing schemes forward and maximizing expenditure. • Formal confirmation of approval for the MSCP business case was awaited from JIC. Meetings would be arranged with LABV to discuss technical points. • DHSC and Treasury had approved the Trust to continue with its pathology service procurement process.		
14.2	Paul Cartwright highlighted the need for a capital control schedule that would monitor the capital spend of business cases by triangulating information on the progress and amount of capital spend for each project. The Deputy CEO agreed that a control schedule could be developed by Q2 when the requisite information would be available. The CEO recommended that FPC should monitor the control schedule and escalate issues to the Board. **ACTION**: A capital control schedule will be developed for use at FPC.	DR	March 21

Agenda item	Discussion	Lead	Dead-line
14.3	Helen Davis noted the number and complexity of the projects and asked for assurance that the Trust had the resources to deliver all of the projects at the same time. The Deputy CEO confirmed that this issue would be considered over the next 2-3 months to ensure sufficient resources were available for the strategic change programme.		
15/87	**Clinical Strategy**		
15.1	The Director of Strategy and Integration presented the strategy and highlighted the key points: • The organisation, delivery and development of services over the next 5 years to meet the needs of the local population in terms of improving health and reducing health inequalities. • Utilization of technology to deliver health services efficiently. • The best use of the hospital redevelopment and development of the ambition to provide Best Care. • The development, in partnership, of new care models around integrated, consistent and personalized care, underpinned by new divisional strategies. • Clinical engagement work undertaken to develop the plan. • The Trust's 1, 3 & 5 year commitments for delivery of the plan and how it connected with the Digital Strategy and Hospital Redevelopment Plan.		
15.2	Helen Davis queried if the strategy should be peer reviewed to determine if it went far enough. The Director of Strategy and Integration considered it was ambitious and should be considered in the context of how far the strategy was going over the time period. There was a need to link the strategy with the ICP as it involved a lot of new, partnership working. The Deputy CEO added that she would explore with colleagues at the Royal Free Hospital whether they would peer review the strategy.		
15.3	Paul Cartwright queried how the financial structure could be designed such that NHS partners were incentivised to the do the right thing. The Director of Strategy and Integration explained that she expected the future ICP regime to move towards a local budget where financial arrangements could be aligned to make the right decisions. The CFO agreed and added that FPC would be able to monitor the development of the ICP financial regime.		
15.4	Ginny Edwards asked if all of the Trust's underpinning strategies were aligned to deliver at the same pace as the clinical strategy. The Deputy CEO confirmed the issue was on her radar and would be monitored over the next five years. The Chair added that it was important to start with the Clinical Strategy to be confident of achieving a clinically led service. The Chief Nurse was pleased that the strategy focused on maternity care, the opportunities around a number of independent reviews and working as system.		
15.5	Jonathan Rennison asked how the Charity's strategy would be included in the 5-year plan as there were clear opportunities for several fundraising appeals. The Deputy CEO reassured him that the charity's strategy would be included.		

Agenda item	Discussion	Lead	Dead-line
	Resolution: The Board approved the Clinical Strategy.		
16/87	**Clinical Engagement Plan**		
16.1	The Deputy CEO set out that the Clinical Engagement Plan was a high-level summary of the clinical models and the vision of how services would be delivered in the remodelled hospital. It would set out the services that the Trust expected to deliver across its 3 sites as well as any changes to services. Engagement would be carried out in 2 stages due to local elections. The Trust was also working closely with the CCG and Health and Overview Scrutiny Committee which would soon hold a topic group meeting on the redevelopment. The Board was asked to confirm that the plans looked appropriate. A formal set of recommendations for the 3 sites would be presented to the Board in July.		
16.2	Ginny Edwards asked how the Trust was going to assure itself that it was using best practice and learning to make sure the hospital design was not based on one person's view. The Deputy CEO explained that a range of views would be obtained. Engagement would be in 2 steps to provide a middle period to take stock, reflect and report on the findings, followed by a further period of engagement. The key to ensuring best practice was flexibility. The design team had significant experience in designing hospitals and the HIP programme had significant expertise.		
16.3	Paul Cartwright asked if care homes had been included as a stakeholder as he was aware that large care homes were interested to know the strategy around discharge. The Deputy CEO thanked him for the information and would make sure that they were included. **Resolution**: The Board approved Appendix A (Clinical Engagement plan).		
17/87	**Hertfordshire and West Essex ICS update**		
17.1	The CEO reported that she would be attending the ICS Partnership Board soon and would ask for their regular newsletter to be restarted as it was important for all ICPs to know what was happening in their system. The newsletter update on the MHLP was noted.		
18/87	**Corporate Risk Register**		
18.1 18.2	The Chief Medical Officer noted that the risk register had been fully discussed at Quality Committee. • There were currently 23 open risks, none of which were related to Covid. • There was one new risk related to the timeliness of surgery for patients with cancer due to the lack of non-covid ITU and HDU beds. • 1 risk had been escalated related to the capacity for infected patients to be managed in ITU for covid/non-covid due to capacity issues. • No risks had been de-escalated and none had been closed. A detailed covid risk assessment would be brought to the next Board meeting.		
	RESOLUTION: The Board approved the Corporate Risk Register		

Agenda item	Discussion	Lead	Dead-line
19/87	**Board Engagement Report**		
19.1	The Chief Nurse presented the report and noted that whilst engagement had been predominantly virtual it had been effective. Board members had conducted numerous virtual meetings with a broad range of staff groups via board visits, virtual meetings and even clinical work within the vaccination hub. The Board was asked to accept the report for information and assurance on the different engagement work that had taken place over the last 6 months.		
20/87	**Assurance Report from the Trust Management Committee**		
20.1	The Chief Executive noted the BAU work that had taken place despite the pandemic such as the EAU expansion, Windows 10 upgrade and family liaison service. The terms of reference for the operational recovery group were reviewed as was work around private patients prices. Work continued in dealing with the pandemic but she wished to provide assurance that a significant amount of non-pandemic work was also continuing.		
21/87	**Assurance Report from the People, Education and Research Committee**		
21.1	Natalie Edwards reported that the committee had received items on: • Workforce performance which touched on items around recruitment and sickness absence. • Gender and race pay gap and the diversity dashboard. • Education and development work undertaken despite the disruption due to covid. • The Health & Wellbeing Guardian role. • An update on the teaching hospital role. The Chair noted that it would be good to receive a board update on the teaching hospital in future months.		
22/87	**Assurance Report from the Finance and Performance Committee**		
22.1	Paul Cartwright highlighted items not covered in the preceding conversations: • The management of capital spend during Q4; approximately 75% of capital remained to be used. • The Trust's exit plan covid – how the Trust does the right things first within an uncertain financial structure. The Chief Financial Officer set out that this year's spend had improved but it would take time for plans to come together. The approval of the MSCP would result in a number of payments falling due that would consume the budget. He remained the budget would be spent.		
23/87	**Assurance Report from the Quality Committee**		
23.1 23.2	Jonathan Rennison highlighted the following points: • The committee had received a high degree of assurance regarding the nosocomial outbreak in terms of actions and opportunities to make the space safe. • The maternity deep dive resulted in a high degree of assurance around quality improvement within maternity, how cultural issues would be addressed and recognition of the issues around workforce and recruitment. Ginny Edwards reported the January committed had received assurance on the following points:		

Agenda item	Discussion	Lead	Dead-line
	• IPC BAF and nosocomial update following the December review. • Covid briefing and the BAF/risk register. It recommended the covid risks to be separately reported to Board. • The Ockenden Report and assurance on the assessment tool. • The maternity safety strategy and noted the actions in place for assurance on progress. • An update on GIRFT for hospital dentistry and radiology and noted the actions needed to make progress following the pandemic.		
23.3	The Chief Nurse added discussions also took place on maternity serious incidents and the review of harm levels. The Trust's IPR was reviewed around maternity SIs.		
24/87	**Assurance Report from the Great Place Committee**		
24.1	Helen Davis set out the report could be taken as read.		
25/87	**Assurance Report from the Charity Committee**		
25.1	Jonathan Rennison highlighted the items that had been approved for funding. • Retrospective approval of funding for We Value You week as changes to the proposal had triggered the £25k threshold. The committee asked for processes to be improved so that applications that retrospectively triggered the threshold could be actioned. It also approved the retrospective funding. • Funding of £33k for the endoscopy simulator. The committee approved the funding as it met with the charity's objects and would benefit patients. • Approval of £65k for the staff kitchen. Approval had previously been granted for work up to £150k, but the committee had asked for a final confirmation of the spend which it was happy to approve.		
25.2	The Board noted that it was approving the applications as Corporate Trustee of the charity and acting in the best interests of the charity rather than the Trust. **RESOLUTION:** The Corporate Trust approved the 3 applications for funding.		
26/87	**AOB**		
26.1	**None**		
27/87	**Questions from Hertfordshire Healthwatch**		
27.1	There was no attendance from Healthwatch.		
28/87	**Questions from the patients and members of the public**		
28.1	There were no questions from members of the public.		
29/87	**Date of the next Board meeting**		
29.1	The next Board meeting would be held on 4 March 2021.		

BOARD AND CORPORATE TRUSTEE DECISION LOG			
Board meeting/decision date	**Decision reference (from minutes)**	**Item presented to Board for action**	**Comments/outcome**
Thursday, March 05, 2020	13.03/80	2019 annual gender gap report	The Board approved the 2019 annual gender gap report.
Thursday, March 05, 2020	14.03/80	2019 annual equality report	The Board approved the 2019 annual equality report for publication.
Thursday, March 05, 2020	15.02/80	2018/19 medical appraisal annual audit report	The Board approved the 2018/19 medical appraisal annual audit report for submission
Thursday, March 05, 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
Thursday, April 02, 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.
Thursday, April 02, 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.
Thursday, April 02, 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.
Thursday, April 02, 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
Thursday, May 07, 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.
Thursday, May 07, 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
Thursday, May 07, 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
Thursday, May 07, 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
Thursday, May 07, 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.
Thursday, June 04, 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.
Thursday, June 04, 2020	16.03/83	Capital expenditure programme	The Board approved the capital expenditure programme for 2020/21
Thursday, June 04, 2020	19.07/83	Board self assessment of effectiveness	The Board approved the assessment of effectiveness subject to a small number of ammendments
Thursday, July 02, 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*
Thursday, July 02, 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*
Thursday, July 02, 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*
Thursday, July 02, 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
Thursday, July 02, 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
##########	04.09/85 (Extraordinary Board meeting)	Electronic Patient Record (EPR)	The Board approved the following: • The timetable set out for FBC and coming back to board for approval in October. • The spend through to December of £5.4m, subject to written confirmation of funding. • The risk related to procurement challenge, subject to confirmation that there was no risk to individual Board members. • The formal launch of the programme
##########	16.03/82	Great Place Committee Terms of Reference	The Board approved the Terms of Reverence for the Great Place Committee
##########	10.04/86 (Part 2)	Phase 3 Recovery Letter	The Board approved the recommendation to delegate to the Executive team final sign off of the forecast submission to the ICS
##########	06.04/83	Redevelopment options shortlist	Taking into consideration all of the information and analysis provided by the option appraisal report, emergency care high level risk assessment, the communications and stakeholder engagement report and the independent site feasibility report the WHHT Board: 1. Approved the proposed shortlist and preferred options for emergency and planned care 2. Noted the activities undertaken over the past four months to ensure that local people are informed of and engaged in planning for the redevelopment of WHHT hospital facilities. 3. Approved the recommended actions to address and mitigate the key concerns identified via the engagement activities summarised within the stakeholder engagement report.*
##########	15.05/84	Office relocation of HR and finance staff	The Board approved the proposals for office relocation as set out in the business case
##########	21.02/84	The current charity investment strategy	The Corporate Trustee supported the current investment strategy be continued
##########	21.02/84	Outsourced charity finance function	The Corporate Trustee supported the move to an outsourced finance function
##########	21.03/84	£10k contribution to an endoscopy simulator	The Corporate Trustee approved a £10k contribution to an endoscopy simulator
##########	21.03/84	Conribution to staff wellbeing facilities	The Corporate Trustee approved up to £150k for staff wellbeing facilities at Watford, St Albans and Hemel Hempstead
##########	09.06/87 (Part 2)	Full Business Case for Electronic Patient Record	The Board approved the Full Business Case for EPR
##########	09.07/87 (Part 2)	Electronic Patient Record	The Board delegated authority to the Chairman, The Chief Executive and two NEDS to approve the contract for the interim solution
##########	15.02/85	Revised Standing Financial Instructions, Standing Orders and Scheme of Delegation	The Board approved the revised Standing Financial Instructions, Standing Orders and Scheme of Delegation
##########	13.03/86	Digital Strategy	The Board approved the Digital Strategy*
##########	23.03/86	Charity Annual Report	The Corporate Trustee approved the Annual Report*
##########	13.04/87	Ockenden review	The Board approved the assessment tool within the report.
##########	15.05/87	Clinical Strategy	The Board approved the Clinical Strategy.
##########	16.03/87	Clinical Engagement Plan	The Board approved Appendix A (Clinical Engagement plan).
##########	25.02/87	Assurance Report from the Charity Committee	The Corporate Trust approved the 3 applications for funding.

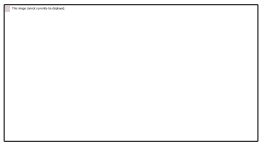
Agenda item: 07/88

Action log Part 1 – 04 March 2021

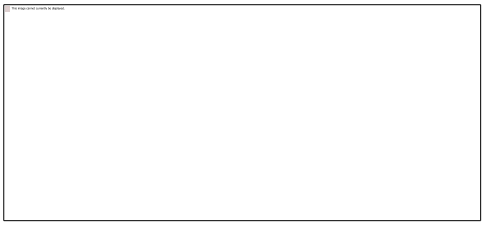
Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	08.01/86	Chief Officers to ensure that commentary included in the BAF to explain any changes in dates.	Chief Officers	February 2021	Complete
2	09.03/87	**Board Assurance Framework**: Dates to be reviewed and updated.	Trust Secretary	March 2021	Complete
3	14.02/87	**Great Place Strategic Priorities update**: A capital control schedule will be developed for use at FPC	CFO	March 2021	In progress

Trust Board Meeting
04 March 2021

Title of the paper	**Chairman and Chief Executive report**
Agenda Item	**08/88**
Presenter	**Phil Townsend, Chairman and Christine Allen, Chief Executive**
Author(s)	**Barbara Anthony, Trust Secretary**
Purpose	**For approval**: **For discussion**: **For information**: ✓
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance.
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: 08/88



Trust Board Meeting – 04 March 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

NHS Leaders regional call with the Duke of Cambridge

2.1 Christine Allen joined the Duke of Cambridge and fellow NHS Leaders in the East of England to discuss the recent progress made around the Covid-19 vaccine rollout, and the dedication of NHS staff working tirelessly to ensure that the most vulnerable people in society are protected from coronavirus. The group also discussed the impact of the pandemic on their and their workforce's mental health, and the role that NHS leaders can play to ensure that stigma does not prevent frontline workers from seeking help and support when needed. The Duke of Cambridge paid tribute to all of the hard work carried out by the region's NHS staff.

LGBT+ staff network launched.

2.2 A new staff network for lesbian, gay, bisexual and transgender (LGBT+) colleagues and allies has been formed. The network aims to work with West Herts' senior leaders to ensure that #TeamWestHerts has a culture in place that values LGBT+ staff and volunteers and in doing that, provides the best care for all patients. The network meets regularly and is open to anyone wishing to be part of a positive movement for inclusivity, equality and cultural change.

Electronic patient record (EPR) is on its way

2.3 Our new electronic patient record (EPR) will deliver an exciting, improved way of working from this autumn. A week-long series of demonstrations was held during the week of Monday 22 February with the EPR programme team giving an overview of the patient's journey. Throughout March, Mike van der Watt, Chief Medical Officer, and Tracey Carter, Chief Nurse, will host a series of 30-minute virtual roadshows to explain what EPR will really mean to us. The roadshows are open to all and there will be an opportunity to ask any questions you may have on the new system. Please visit the new EPR page on the Trust's website for further information.

"Your care, your views" launched.

2.4 Our hospital redevelopment engagement programme **'Your care, your views'** was launched on 18 February 2021 to understand views on the redesign of our services. Our proposals for new ways to provide care are being developed alongside exciting plans for our three hospitals. We are applying for funding to transform Watford General Hospital (with up to 90% new buildings) and to redevelop and refurbish our hospitals in Hemel Hempstead and St Albans. There will be various ways in which staff can take part so that we can understand the full range of views about how we can improve our services and build the best possible facilities for the future. Further information can be found on a dedicated page on the Trust's website and a series of staff meetings has also been set up.

Government sets out its proposals for NHS reforms in the Health and Care Bill

2.5 The government recently announced its proposals for reforming the NHS after the pandemic in its white paper on the Health and Care Bill. The proposals include a legislative framework for the Integrated Care Systems and Integrated Care Partnerships with the focus on providing integrated care services and reduction is competitive tenders. There will be a new duty to collaborate for NHS organisations and local authorities to work in the best interests of the local population and to address the wider determinants of health. We will monitor the progress of the Bill and keep you updated as and when changes to how we work are required.

New Trust Secretary appointment

2.6 The Trust is delighted to announce its recent appointment of Barbara Anthony as Trust Secretary. Barbara is a solicitor and has worked within the NHS in mental health and acute trusts since 2011 and has been working at West Herts as the Interim Trust Secretary since December 2020.

Medical Education Centre appointments

2.7 We are delighted to announce the appointment of two new faculty members in the Medical Education Centre. Dr Latha Thanagraj will take on the role of Royal College of Physicians tutor and will support internal medicine training, specialist trainees and educational supervisors in the general medicine specialties. Dr Mamatha Kumar has been appointed as foundation programme director for the F1 year. Dr Kumar will support our 54 trainees through their training year and will be responsible for their annual reviews at the end of the academic year. Both consultants have taken up their post and are available to support trainees now.

3 COMMUNITY NEWS

3.1 Healthwatch Hertfordshire have launched a consultation on the Mount Vernon Cancer Centre Services and resolve concerns about the ageing estate, support facilities and patient pathways. They are conducting a series of online focus groups and updating webinars for stakeholders to attend. More information can be found on the Mount Vernon Cancer Services Review website**.**

4 BOARD NEWS

Changes to the Board

Appointment of Chief People Officer

We are delighted to announce that Andrew McMemeny, Acting Chief People Officer, has been appointed as Chief People Officer at the Trust. Andrew brings a wealth of experience to the role as well as significant understanding of the challenges and opportunities facing the Trust. Congratulations Andrew!

Board visit programme

4.1 As part of the monthly board visit programme, in February 2021 the Board visited the Granger Unit, Estates Department, Stroke Unit in Watford and ED via MS Teams. Verbal feedback from the session will be given to the private session of the Board.

Chair's meetings

- Consultant interviews.
- ICS Partnership Board
- Conducted MP updates with CEO.
- Attended subcommittees.
- Vaccination hub visits.
- Led Board development.
- East of England regional Chair's event.
- Trust secretary interviews.
- Spoke with the incoming Chair of the Royal Free.
- Visited St Albans & Watford testing centres with Martin Keeble.
- Chief People Officer interview.
- Attended Healthwatch meeting.

5 RECOMMENDATION

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

Phil Townsend
Chairman

Christine Allen
Chief Executive

March 2021

Trust Board Meeting
4 March 2021

Title of the paper	**Board assurance framework report**
Agenda Item	**09/88**
Presenter	**Christine Allen, Chief Executive**
Author	Barbara Anthony, Trust Secretary
Purpose	*For approval* ✓ | *For discussion* | *For information*
Executive Summary	This report is to provide the Board with assurance that risks to achieving the Trust's strategic objectives are being appropriately mitigated, to consider those elements that report direct to Board and any recommendations of changes from assurance committees. Elements of the BAF were reviewed on 18 February 2021 by the People, Education and Research Committee and on 25 February 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 – 18 February 2021 • Finance and Performance Committee – 25 February 2021 • Quality Committee – 25 February 2021
Action required	The Board is asked to consider and approve the latest version of the BAF.

Agenda Item: 09/88

Trust Board meeting – 04 March 2021

Board Assurance Framework report

Presented by: Christine Allen, Chief Executive

1. Purpose

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

2. Background

2.1 All NHS Trusts are required to use a Board Assurance Framework (BAF), not least because it has been proven good practice for many years in both healthcare and a whole range of complicated high-risk organisations. The BAF is a "live" document that changes over time, and it picks up all the controls that the Trust has in place to manage, minimise and/or remove the identified risks and points towards concise and comprehensive evidence that the controls are working.

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

- The Trust's four aims and 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 February 2021.

3.2 Elements of the BAF were reviewed on 18 February 2021 by the People, Education and Research Committee and on the 25 February 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

March 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	Apr-21	Review undertaken and position remains the same. Next review April 2021.
			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 Themes reported back via divsional governance meetings and IPC ward based sessions (board round) This action is on going formal IPC BAF updated Feb 21 by NHSE	AF/GB	Mar-21	Actions completed and in place. IPC BAF reporting part of QC workplan and repository in place on PM3 now on formal spreadsheet system with evidence uploaded. RCA's completed for Covid cases over 7 days = Thematic reviews undertaken. 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	April 21	Quality Impact Assessment completed and also a review of COVID templates. Bi annual establishment review completed. Night sister role embeded and to continue this financial year with a business case being produced. Education and Training courses recommenced. Preceptorship paused until end of February. Focus on International recruitment with OSCE training recommenced. CSW focus on recrutiment and retention. Organisational RAG rating system introduced for day and predected night shifts. Any Red areas datix submitted and reviewed. Weekly harm free reviews implemented triangulating data including workdforce.
			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	Apr-21	Review undertaken and position remains the same. Next review April 2021.
	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. Work with CCG to manage those patinets discharged with urinary catheters to facilitate removal at earliest opportunity.	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, monitoring of removal.	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 (spot check audit developed) PPE campaign Risk assessing correct PPE usage PPE spot checks and formal auditing 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. Identification in themes of non-compliance around eye protect alternative products assessed and implemented.
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	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	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	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	April 21	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. Friends and Family Test recommenced and feeding back to all wards. Family Liaison line supporting information sharing and patient and family experience.
			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	Apr-21	Continue to monitor visitation. Family liaison line business case completed, approved and being implemented. FLL staff engaged with all wards and working well in communicating to families/carers of our patients . ITU visitation was reevaluated and returned to previous process due to wave 2 pressures. New codesign projects accepted and progressing but aware of operational pressures during 2nd wave. Compassionate conversation supports patients and families in this post discharge conversation to clarify issues or signpost on for additonal support. Review again in April 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, sufficiencly 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)** **Reduce vacancy rates in hard to recruit "hotspots"**	**Equality, diversity and inclusion domain of the staff survey - improvement to above national median** **Trust wide vacancy rate less than 10%** **Reduced vacancy rate in hotspots vs. baseline**	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	
			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	
			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	
			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 March 2021

Title of the paper	**Activity Recovery Update & Access Standards Performance (January 2021 data reporting period)**
Agenda Item	**10/88**
Presenter	**Sally Tucker** **Chief Operating Officer**
Author(s)	**Jane Shentall** **Director of Performance**
Purpose	*For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary	**Activity Recovery** Activity recovery has unsurprisingly been adversely affected by the second COVID wave. All indicators are below target, with the exception of non-face to face activity. **Performance** Performance data is provisional at the time of writing (25/2/2021). Ongoing COVID-19 demand has affected all care pathways with increased acute activity or suspension of some elements of elective service. In addition elective capacity is prioritised for the most urgent patients, either P1 or P2 and this applies to outsourcing as well as in house activity.

Indicator	Target	Actual	Change
A&E 4 hour standard	95%	65.3%	↓
Diagnostic waits	99%	69.3%	↓
RTT incomplete pathways < 18 weeks	92%	76.1%	↑
52 week waits	0	1463	↓
2 week wait referrals	93%	85.2%	↓
2 week wait breast symptomatic referrals	93%	64.1%	↓
28 day Faster Diagnosis standard	70%	76.7%	↓
31 day first definitive treatment	96%	98.4%	↑
31 day subsequent - surgery	94%	83.3%	↓
31 day subsequent - drug	98%	100.0%	↔
31 day subsequent - palliative	94%	100.0%	↔
62 day referral to first treatment	85%	84.7%	↑
62 day screening referral to first treatment	90%	85.7%	↓

↑ 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 further to 65.3% in comparison to the previous month (68.4%). Services have remained under enormous pressure with no improvement in 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 69,3% (previously 71.5%). RTT performance is lower at 76.1% (from 78.8% last month) with an increase in 52 week breaches (1463 vs 1131 in December). A number of the cancer waiting standards were not achieved in the month: • Two week wait 85.2% (target 93%) • Breast Symptomatic 64.1% (target 93%) • 31 day subsequent surgery 83.3% (target 94%) • 62 referral to first treatment 84.7% (target 85%) • 62 day screening 85.7% (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 — 24 February 2021 Finance & Performance Committee — 25 February 2021
Action required	The Committee is asked to receive this report for information.

Agenda Item: 10/88

Trust Board Meeting – 4 March 2021

Activity Recovery & Access Standards Performance
(January 2021 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 (January 2021)

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 Referrals overall were at 65% of the January 2020 level, and lower than the previous month. Cancer referrals were also lower, at 83%. 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 All diagnostic measures were lower than the previous year and below target. Endoscopy is particularly affected by the surge of Critical Care into the Unit. Some activity has been maintained through the provision of evening and weekend lists however.

2.4 Outpatient activity was 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) at SACH was suspended in mid-December and WGH admissions restricted to the most urgent cases. Some independent sector activity has continued, although this is limited to only P1 and P2 cases only.

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%	65,3%	↓
Diagnostic waits	99%	69.3%	↓
RTT incomplete pathways < 18 weeks	92%	76,1%	↓
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2 week wait breast symptomatic referrals	93%	64.1%	↑
31 day subsequent - surgery	94%	83.3%	↓
62 day referral to first treatment	85%	84.7%	↓
62 day screening referral to first treatment	90%	85.7%	↑

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

3.2 January 2021 saw a reduction in attendances, down 17.4% overall, although type 1 was only 6% lower. The ratio of ambulance arrivals to attendances in January was 1:2.5 (vs December 1:2.9) but despite this increase, offloads delays improved across the board. Flow through the department remained challenging, with access to beds constrained by availability of the right bed, ie COVID positive, suspect/holding etc.

3.3 As reported last month, due to the issues described above with flow out of A&E, further 12 hour breaches were incurred, more than half in non-COVID pathways.

3.4 Inpatient admissions continue to be affected enormously, with only the most urgent (P1 and P2) patients treated, with limited inhouse capacity and some outsourcing activity.

4 A&E 95% target

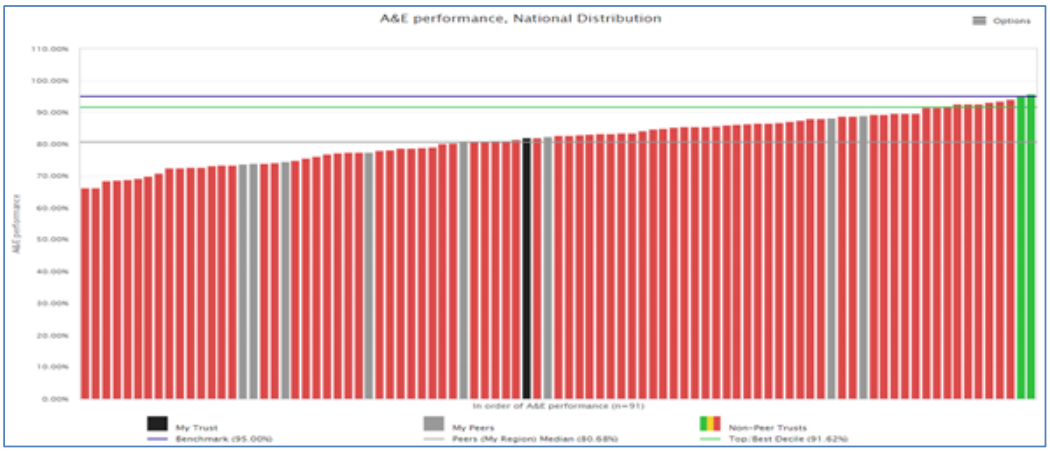
4.1 Overall performance against the 95% 4 hour standard was lower than the previous month at 65.3% (previously 68.4%).

- Type 1 performance (WGH excluding UTC) was 44.1% (previously 42.5%).
- CED performance improved and was compliant with the target at 95.9%.
- Flow of Majors patients remains challenging with only 32.6% (previously 32.9%) compliance with the target.
- Non-admitted performance was 63.4% (previously 58.8%) for the month.
- The Urgent Treatment Centres at Hemel Hempstead and Watford were both compliant with the 4 hour standard.
- The Minor Injuries Unit at SACH remains closed.

4.2 50.7% of type 1 attendances were patients arriving in an EEAST ambulance (December 49%).

4.3 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 3.3 very significant bottlenecks have arisen in ED, throughout the entire pathway, particularly affecting ambulance offloads and onward admission. In January 75 patients waited longer than 12 hours from the time of decision to admit to departure from ED. 46 of these patients were confirmed COVID negative at the time of decision to admit

6 Ambulance Handover Delays

6.1 Handover delays between 30-60 minutes increased to 508 (previously 488). Delays over 60 minutes have improved at 259 (514 last month). 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.

6.2 EEAST data shows that journeys to A&E have increased by 6% on the previous year. No other trust in the region is experiencing the same increase in demand. 98.6% of EEAST conveyances were to ED, the highest in the region.

6.3 There have been system wide discussions on this issue. EEAST undertook a senior clinical review of cases conveyed to WGH, starting just before and over the Christmas period. This revealed very few patients suitable for community management.

6.4 An ambulance conveyance project is underway, with a view to establishing amongst other things, whether there are any gaps in community services, differences between West Herts and East & North Herts and West Essex.

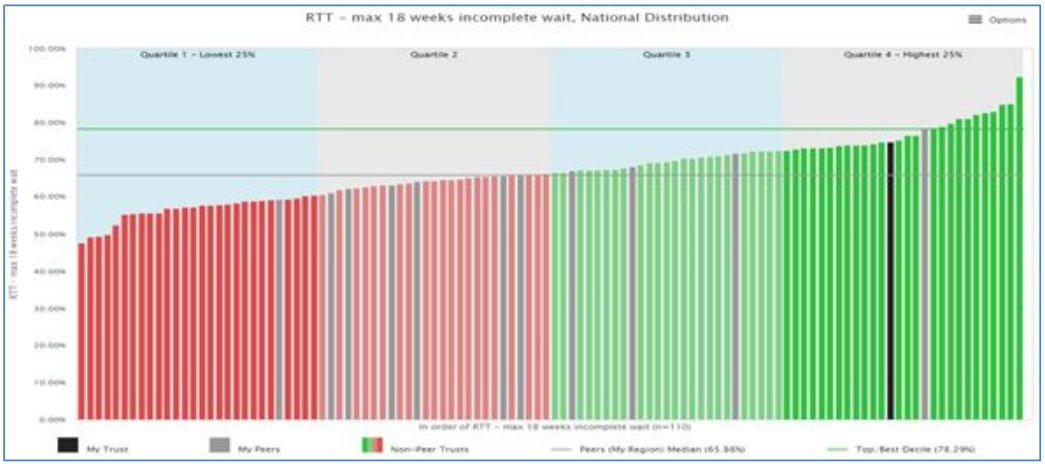
7 RTT Incomplete pathways

7.1 There has been some deterioration in RTT open pathway performance at 76.1% (previously 78.8%). A specialty level breakdown is shown in appendix 3, along with an indicator showing the change from the previous month.

7.2 The PTL has increased slightly (21525 vs 20409) but remains lower than in previous years. The backlog has grown to 5147 from 4220 the previous month.

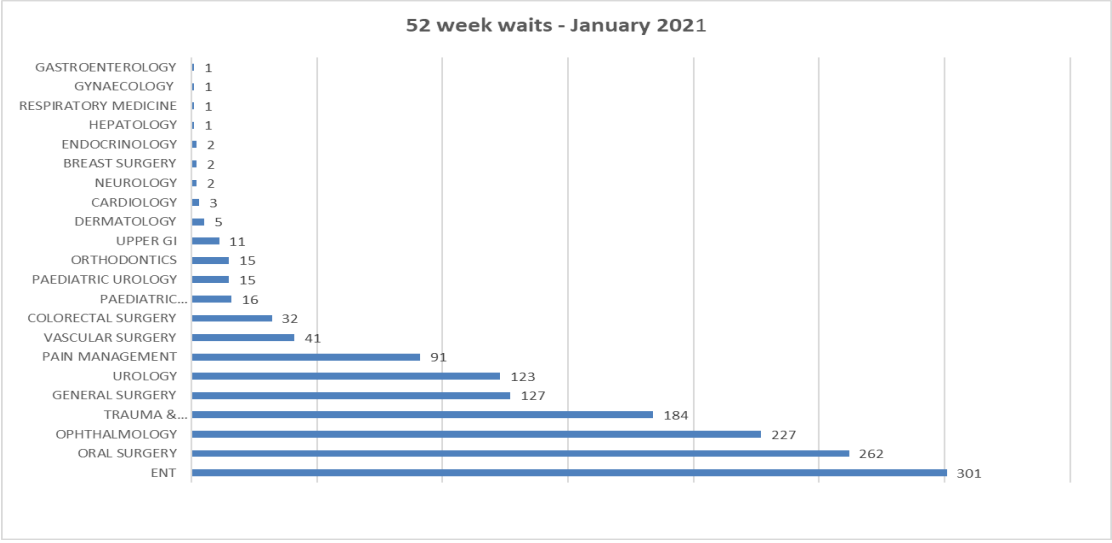
7.3 Model Hospital benchmarking (October 2020 performance at 74.8%) shows the Trust (the black bar) in the top quartile (16th from top). It should be noted that no organisation achieved the standard, the highest performance being 87.4%. The regional median 65.8% and national median 66.5% are better than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

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



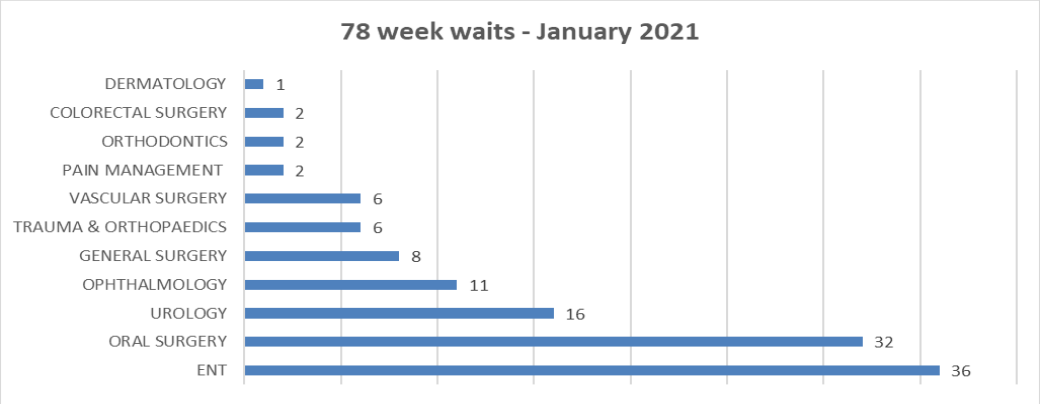
8 Long (52+) waits

8.1 The number of patients waiting more than 52 weeks has risen to 1463 compared to the previous month when there were 1131.



8.2 143 pathways over 52 weeks were closed, 101 non-admitted and 42 admitted.

8.3 At the end of the month there were 122 patients waiting over 78 weeks, of which just under 20% have deferred surgery due to concerns regarding COVID with a much smaller number declining treatment for other reasons.



9 Cancer Waiting Times Performance

9.1 2 week wait (85.2%) and 2 week wait breast symptomatic (64.1%) performance were both below the standard (93%) were not achieved this month although the latter has improved on the previous month.

9.2 There are currently 4 breaches of the 31 day subsequent surgery standard which have affected performance which was below the target (94%) at 83.3% at the time of writing.

9.4 Performance against the 62 day referral to first treatment standard is currently non-compliant with the 85% target at 84.7% although the reporting period is still open and additional activity will be recorded which could affect performance either way. There are currently 14 breaches (LGI, UGI, Urology, Haematology, Head & Neck, Gynaecology) with 84 pathways in total.

9.5 Performance against the 62 day screening referral standard is currently not compliant at 85.7% (target 90%). There was 1 breach (Breast) with 6 pathways in total.

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

9.7 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.

9.8 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. The number of patients are tracked on a weekly basis to ensure robust oversight. The most recent information available shows the following totals.

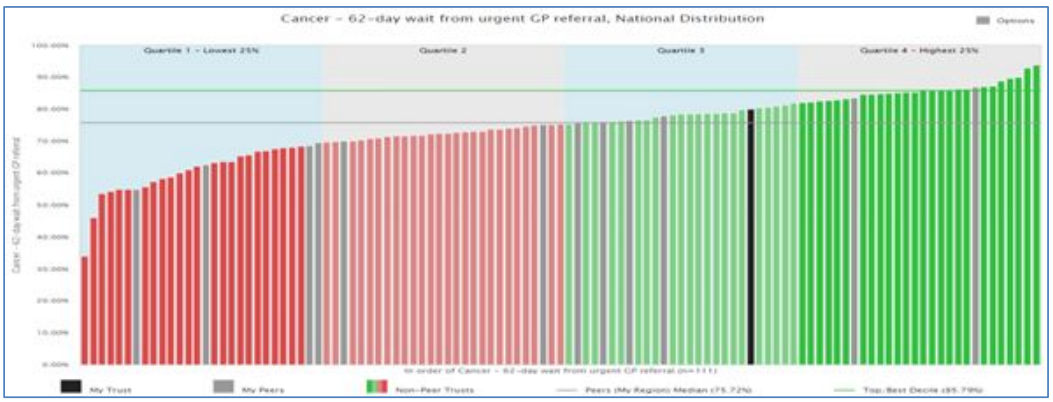
November	>62 total	99
	>62 day with a diagnosis	21
	>104 total	28
	>104 with a diagnosis	8

December	>62 total	81
	>62 day with a diagnosis	22
	>104 total	17
	>104 with a diagnosis	4

January	>62 total	104
	>62 day with a diagnosis	23
	>104 total	21
	>104 with a diagnosis	3

9.9 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.



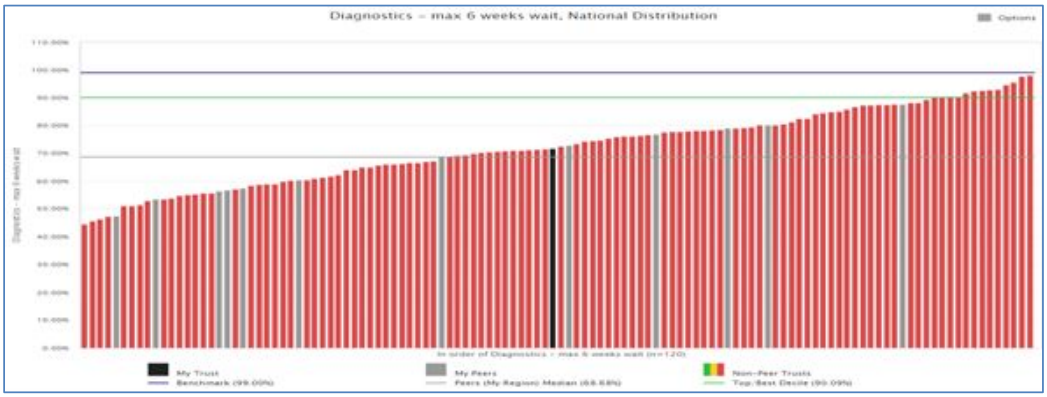
10 Diagnostic waiting times performance

10.1 The standard for diagnostic waiting times was not achieved, and performance fell to 69% (from 72.5%). Most modalities' performance remains below the standard.

Diagnostic Waiting Times Performance	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
W01: Imaging - Magnetic Resonance Imaging	52.8	55.2	75.6	72.9	75.8	82.4	82.4	75.5	76.7	64.2
W02: Imaging - Computed Tomography	53.3	90	83.3	91.3	83.5	78.3	83.8	87.7	92.2	83.6
W03: Imaging - Non-obstetric ultrasound	23.6	39.8	88.5	92	82.7	66.9	58.5	65.5	58.3	61.2
W04: Imaging - Barium Enema	80	100	100	100	100	100	75	75	100	100
W05: Imaging - DEXA Scan	7.5	39.3	73.6	84	35.1	38.8	32	37.7	41.1	49.8
W06: Physiological Measurement - Audiology - Audiology Assessments			100	57.2	54.8	55.8	68.1	59.8	64.8	66.3
W07: Physiological Measurement - Cardiology - echocardiography	2.2	5.7	40	36.8	70.3	86.1	97.8	98.4	97.6	90.1
W08: Physiological Measurement - Cardiology - electrophysiology										
W09: Physiological Measurement - Neurophysiology - peripheral neurophysiology	50		100	85.5	100	100	100	100	95.3	98.8
W10: Physiological Measurement - Respiratory physiology - sleep studies										
W11g: Physiological Measurement - Urodynamics - pressures & flows (Gynae)	100	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	94.7
W12: Endoscopy - Colonoscopy	46.9	28	50.7	69.7	69.8	79.5	75.8	82.3	76.5	79.8
W13: Endoscopy - Flexi sigmoidoscopy	40.1	32.8	40.6	50.5	62.9	81.3	91.7	86.8	84.3	80.2
W14: Endoscopy - Cystoscopy	35.1	38.6	47.7	55.6	60.3	69.2	71.1	57.6	49.7	49.1
W15: Endoscopy - Gastroscopy	22	19.9	41.8	61.8	54	53.1	69.5	75.9	68.5	65.9
Total	26.5	39.6	64.8	73.4	68.5	69.4	72	74.3	72.5	69

10.2 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.



11 Harm Reviews

11.1 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 15/2/2021 is shown below.

Surgery (Trigger: 48 weeks)	Total > 48 weeks	Harm Reviews	
		Completed	In progress or outstanding
GENERAL SURGERY	166	48.8%	51.2%
UROLOGY	170	68.8%	31.2%
TRAUMA & ORTHOPAEDICS	310	38.7%	61.3%
ENT	344	91.0%	9.0%
OPHTHALMOLOGY	307	69.4%	30.6%
ORAL SURGERY	284	69.4%	30.6%
COLORECTAL SURGERY	46	58.7%	41.3%
BREAST SERVICE	2	0.0%	100.0%
UPPER GI SURGERY	12	58.3%	41.7%
VASCULAR SURGERY	50	62.0%	38.0%
ORTHODONTICS	13	76.9%	23.1%
PAIN MANAGEMENT	165	26.7%	73.3%
PAEDIATRIC UROLOGY	18	88.9%	11.1%
PAEDIATRIC OPHTHALMOLOGY	29	34.5%	65.5%
Total	**1916**	**61.9%**	**38.1%**

Medicine (Trigger: 40 weeks)	Total > 40 weeks	Harm Reviews	
		Completed	In progress or outstanding
GASTROENTEROLOGY	1	0.0%	100.0%
CARDIOLOGY	19	15.8%	84.2%
DERMATOLOGY	6	0.0%	100.0%
RESPIRATORY MEDICINE	22	0.0%	100.0%
NEUROLOGY	5	40.0%	60.0%
RHEUMATOLOGY	3	0.0%	100.0%
GERIATRIC MEDICINE	1	0.0%	100.0%
ENDOCRINOLOGY	2	50.0%	50.0%
CLINICAL HAEMATOLOGY	2	0.0%	100.0%
HEPATOLOGY	1	0.0%	100.0%
Total	**62**	**9.7%**	**90.3%**

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	8	25.0%	75.0%
PAEDIATRICS	2	0.0%	100.0%
Total	**10**	**20.0%**	**80.0%**

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.

11.2 A review of the current harm review process is underway in the Surgical division and options to improve the position are being considered. A preferred option will be presented to CDP in due course.

11.3 The most recent cancer harm review position is shown below.

Period covered: Mar-Dec20	Tracking		Reviews completed
Tumour Site	Total reviews required	Total reviews in progress	
Urology	68	8	60
Colorectal	54	4	50
Head & Neck	24	12	12
Upper GI	17	3	14
Breast	14	2	12
Gynaecology	17	6	11
Lung	32	16	16
Haematology	24	5	19
Dermatology	3	0	3
Sarcoma	1	1	0

12 Risks

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

12.2 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

13 Recommendation

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

Jane Shentall
Director of Performance
25 February 2021

Appendix 1 - Elective Recovery – Actual vs Plan vs Target

Activity type+B3:M51			Sep	Oct	Nov	Dec	Jan	Update / Comment
Diagnostics	CT	Trust plan	103%	102%	102%	102%	102%	**Diagnostics** COVID pressures have impacted significantly on capacity for elective diagnostics. In addition temporary equipment failure resulted in some loss of capacity through the month. **Endoscopy** Critical care surge has reduced capacity for endoscopy activity considerably although some mitigations (evening and weekend working) are in place. **Outpatients** Cancellation of routine activity to release staff to support wards has had a major impact on activity, although non-face to face consultations have continued. **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** Diagnostic activity has been commissioned locally to an independent sector provider who is not on the national framework. This organisation have also undertaken some Orthopaedic LA lists. Spire Bushey capacity (2 theatres) has been available from the 2nd week of the month but list fill has been challenging due to restricting admissions to only P1& P2 (the higher priorities) patients, and the limited casemix that can be accommodated there.
		Target	90%	100%	100%	100%	100%	
		Actual	90%	91%	100%	109%	90%	
		Gap to plan	-13%	-11%	-2%	7%	-12%	
		Actual vs target	0%	-9%	0%	9%	-10%	
	MRI	Trust plan	113%	102%	104%	104%	102%	
		Target	90%	100%	100%	100%	100%	
		Actual	75%	75%	89%	85%	64%	
		Gap to plan	-38%	-27%	-15%	-19%	-38%	
		Actual vs target	-15%	-25%	-11%	-15%	-36%	
	Endoscopy	Trust plan	55%	81%	100%	100%	100%	
		Target	90%	100%	100%	100%	100%	
		Actual	60%	79%	73%	71%	57%	
		Gap to plan	5%	-2%	-27%	-29%	-43%	
		Actual vs target	-30%	-21%	-27%	-29%	-43%	
Outpatients	All Outpatients	Trust plan	75%	90%	90%	90%	90%	
		Target	100%	100%	100%	100%	100%	
		Actual	77%	82%	80%	81%	71%	
		Gap to plan	2%	-8%	-10%	-9%	-19%	
		Actual vs target	-23%	-18%	-20%	-19%	-29%	
	All non face to face	Actual	39%	38%	43%	45%	44%	
		Target	25%	25%	25%	25%	25%	
		Gap	14%	13%	38%	20%	19%	
	F/Up non face to face %of all non face to face	Actual	63%	65%	67%	69%	71%	
		Target	60%	60%	60%	60%	60%	
		Gap	3%	5%	7%	9%	11%	
Electives	Day Case	Trust plan	98%	94%	94%	95%	95%	
		Target	80%	90%	90%	90%	90%	
		Actual	51%	74%	70%	69%	48%	
		Gap to plan	-47%	-20%	-24%	-26%	-47%	
		Actual vs target	-29%	-16%	-20%	-21%	-42%	
	Inpatient	Trust plan	79%	89%	89%	89%	89%	
		Target	80%	90%	90%	90%	90%	
		Actual	87%	76%	95%	76%	36%	
		Gap to plan	8%	-13%	6%	-13%	-53%	
		Actual vs target	7%	-14%	5%	-14%	-54%	

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 – January 2021

Service	Tota	<18 weeks	18 Weeks Plus	% Under 18 Weeks	Change since last month
PAEDIATRIC EPILEPSY	23	23	0	100.00%	↑
PAEDIATRIC GASTROENTEROLOGY	36	36	0	100.00%	↔
PAEDIATRIC CLINICAL HAEMATOLOGY	25	25	0	100.00%	↔
PAEDIATRIC RHEUMATOLOGY	1	1	0	100.00%	
PAEDIATRIC DIABETIC MEDICINE	2	2	0	100.00%	↑
PAEDIATRIC CYSTIC FIBROSIS	1	1	0	100.00%	
STROKE MEDICINE	5	5	0	100.00%	
TRANSIENT ISCHAEMIC ATTACK	1	1	0	100.00%	
GYNAECOLOGICAL ONCOLOGY	27	27	0	100.00%	↔
PAEDIATRICS	361	357	4	98.89%	↑
PAEDIATRIC ENDOCRINOLOGY	38	37	1	97.37%	↓
DIABETIC MEDICINE	122	118	4	96.72%	↑
BREAST SURGERY	290	280	10	96.55%	↓
CLINICAL HAEMATOLOGY	191	181	10	94.76%	↑
PAEDIATRIC DERMATOLOGY	70	66	4	94.29%	↑
MEDICAL ONCOLOGY	32	30	2	93.75%	↓
CLINICAL ONCOLOGY	41	38	3	92.68%	↓
GASTROENTEROLOGY	1316	1216	100	92.40%	↓
RESPIRATORY MEDICINE	792	727	65	91.79%	↓
GENERAL MEDICINE	11	10	1	90.91%	↓
DERMATOLOGY	2039	1835	204	90.00%	↓
ENDOCRINOLOGY	329	296	33	89.97%	↓
GERIATRIC MEDICINE	48	43	5	89.58%	↑
CARDIOLOGY	1804	1607	197	89.08%	↓
NEUROLOGY	839	747	92	89.03%	↓
GYNAECOLOGY	956	843	113	88.18%	↓
PAEDIATRIC CARDIOLOGY	70	61	9	87.14%	↓
HEPATOLOGY	54	47	7	87.04%	↑
RHEUMATOLOGY	577	491	86	85.10%	↓
ORTHOTICS	74	61	13	82.43%	↓
COLORECTAL SURGERY	484	365	119	75.41%	↓
OTHER	4	3	1	75.00%	
UROLOGY	1636	1207	429	73.78%	↓
UPPER GASTROINTESTINAL SURGERY	359	263	96	73.26%	↓
NEPHROLOGY		18	8	69.23%	↓
PAEDIATRIC UROLOGY	229	155	74	67.69%	↓
OPHTHALMOLOGY	1518	1023	495	67.39%	↑
PAEDIATRIC OPHTHALMOLOGY	160	103	57	64.38%	↓
TRAUMA & ORTHOPAEDICS	2333	1475	858	63.22%	↓
GENERAL SURGERY	1404	831	573	59.19%	↓
VASCULAR SURGERY	215	126	89	58.60%	↓
ENT	1284	734	550	57.17%	↓
ORAL SURGERY	863	459	404	53.19%	↓
PAIN MANAGEMENT	816	404	412	49.51%	↓
ORTHODONTICS	19	0	19	0.00%	↔
Total	**21525**	**16378**	**5147**	**76.09%**	↓

Appendix 4
Cancer waiting times performance – update (at 25/2/21)

Standard	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 YTD (latest)
2ww	93.0%	97.0%	97.6%	98.0%	95.1%	99.0%	97.7%	98.6%	96.4%	97.1%	96.9%	95.6%	85.4%	85.2%	94.6%
2ww 28 day FDS	75.0%	75.8%	84.7%	77.0%	68.8%	85.6%	82.1%	80.3%	81.7%	78.1%	83.6%	79.2%	82.0%	76.6%	80.5%
2ww breast	93.0%	94.2%	98.6%	98.5%	100.0%	87.9%	87.9%	98.1%	96.2%	97.1%	98.7%	88.1%	50.0%	64.1%	85.2%
31 day 1st	96.0%	96.3%	97.2%	97.1%	98.5%	92.1%	97.2%	96.5%	96.6%	96.4%	94.3%	97.2%	100.0%	98.4%	97.1%
31 day surgery	94.0%	100.0%	100.0%	100.0%	93.3%	87.5%	100.0%	89.5%	70.0%	83.3%	100.0%	94.7%	87.0%	83.3%	89.5%
31 day drug	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%
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%	84.8%	80.1%	83.1%	70.3%	76.9%	86.4%	76.9%	86.6%	85.5%	82.0%	85.9%	82.6%	84.7%	82.6%
62 day screening	90%	72.0%	80.0%	92.0%	85.7%	64.3%	100.0%	0.0%	66.7%	66.7%	66.7%	92.3%	85.7%	85.7%	75.4%

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

Trust Board
4 March 2021

Title of the paper	**Integrated Performance Report** ***(February 2021 reporting period – January 2021 data)***
Agenda Item	**11/88**
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** • COVID-19 positive inpatients has fallen with 138 (from 312), and ITU positive patients has reduced to 14 (from 21) (slide 3, 28-30) • Staff absence indicators have also improved with COVID-19 sickness at 168 (from 457) with 54 absent due to a household contact and 24 due to track and trace (slide 3) • No hospital definite or hospital probable nosocomial infections were reported • 91% of staff have received a first vaccination (slide 3) • 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 are stable and within the as expected range: SHMI at 99.2 (97.9 last period), HSMR 91.5 (previously 88.8) (slides 4, 25) • There were 4 hospital apportioned clostridium difficile cases (previous month 0) with a year to date total of 22 (slides 4, 26) • The overall C-section rate was 35.6% (previously 36.6%), above (worse than) target (28%); the elective rate was 15.9% (was 17.2%) and is just above the local target (11%), and the emergency rate (target 15%) was 19.7% (was 19.4%). The year to date rate for all C-sections is 34.1% (slides 4, 32). • There were 7 serious incidents and patient safety incidents that are harmful has increased to 23.8% (previous month 19%) and year to date 12% (slides 4, 34) • VTE risk assessment compliance is better (higher) than target (95%) at 96.7% and year to date the rate is 96.4% (slides 4, 37) • Stroke indicators: Admission to the unit within 4 hours is below target (90%) at 13.2% (previously 14%); 60.9% (was 76.3%) of patients spent 90% of their admission on the unit (target 80% (slides 4, 38) **Caring & Responsive Services** • Complaints response times were above (better than) target (80%) at 87.1% with 2 reactivated complaints received in the month (slides 5, 44) • Ambulance turnaround delays increased with 508 (was 388) between 30 and 60 minutes but with an improvement in delays over 60 minutes at 259 (was 514) (slides 5, 39) • ED 4 hour performance was lower than the previous month (83.4%) at 65.3% with a year to date position of 80.6% (slides 5, 39) • There were 75 x 12 hour breaches in the month (slides 5, 39) • RTT (incomplete) performance was lower (previously 78.8%) to 76.1% (ytd 68.1%). There were 1463 x 52 week breaches (previously 1131) (slides 5, 46) • Diagnostic waiting times performance remains below the standard (99%) at 69% (was 72.5%) (slides 5, 46) • 2 week wait performance (85.2%) is below (lower than) target (93%) (slides 5, 47) • 2 week wait breast symptomatic is non-compliant with the standard (93%) at 64.1% (slides 5, 47) • 31 day subsequent surgery performance is below the standard (94%) at 83.3%

- Performance against the 62 day urgent referral to first treatment is currently non-compliant (85%) at 84.7% (slide 5, 49)
- 62 day screening performance is non-compliant at 85.7% (target 90%) (slides 5, 49)
- Outpatient DNA rates are worse than target at 8.6% (year to date 7.7%) (slides 5, 50)

Urgent Care Pathway

- New section derived from indicators reported elsewhere in the IPR supplemented with additional indicators, some as a snapshot and others at month end, as follows:
- Bed (Adult general & acute plus critical care) occupancy 91.6%
- COVID positive occupancy (including critical care) 50.3%
- 64 patients in hospital but medically fit for discharge (MFFD)
- 84 patients with a length of stay (LOS) of 21+ days
- 1717 surge capacity bed days used
- Type 1 A&E attendances increased at 44.2% with an associated decrease in performance at 21.2% for this type only
- 608 patients with an ED wait of 12 hours or longer from arrival to departure

Workforce & Finance

- 12 month turnover rate is stable at 12.8% and is just below (better than) target (13%); the vacancy rate is improved further, now at 8% (was 9.1%) and is better than target (10%) (slides 5, 51)
- Sickness absence rates have remained above (worse than) the target (3.5%) and increased (from 5.2%) to 6.4% (slides 6, 51)
- All staff appraisals are at 83.9%, were worse than target (90%) (slides 5, 52)
- Mandatory training is compliant at 90.7% (slides 5, 52)
- Bank pay is above the 12% monthly target at 14.4% (ytd 11.4%).
- Agency pay is better (lower) than the monthly 4.8% target at 3.8% (slides 6,17)
- For this month (10) the trust reported a position that was in line with our updated forecast. Expenditure of £38.0m was £1.15m higher than the £36.85m of income received. The YTD position now shows a deficit of £2.0m. 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 £0.35m worth of efficiencies in month. This was met and £1.2m has been delivered year to date. The revised full year target for efficiencies is £2m.
- The sensitivity of the forecast ranges from a £4.9m deficit in the worst case, a £4.2m deficit in the likely case and a £2.6m 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 (25/2/2021)

Trust strategic aims

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

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

Links to well-led key lines of

☒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

<table>
<tr><td>enquiry</td><td>to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Management Committee</td><td>24 February 2021</td></tr><tr><td>Finance & Performance Committee</td><td>25 February 2021</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for information, assurance and discussion.</td></tr>
</table>

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

February 2021

Reporting Period: January 2021

Trust Board: 4th March 2021

Performance data updated on: 25th February 2021

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

How Are we Doing?

Safe Care & Improving Outcomes

Safety Thermometer New Harm Free Care

Suspended

Target 95%

Clostrioides Difficile cases

4

Target 3

VTE assessment

96.7%

Target 95%

Inpatient Friends & Family positive scores

92.8%

Target 95%

Caring & Responsive Services

Complaints response times

87.1%

Target 80%

ED 4 hour standard

65.3%

Target 95%

RTT 52 week waits

1463

Target 0

CWT - 62 day referral to first treatment

84.7%

Target 85%

Workforce & Finance

Mandatory Training

90.7%

Appraisal Rates

83.9%

Target 90%

Agency pay

3.8%

Target 4.8%

Vacancy rate

8.0%

Target 10%

I&E forecast

(Full year)

£2,003

I&E actual

(YTD actual & BAU plan)

£2,003

Target -£ 2,249

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

COVID-19 SNAPSHOT – 15th February 2021

BEST CARE

GREAT TEAM

INPATIENTS

C-19 positive **138**	C-19 suspected **11**	ITU C-19 positive **14**
C-19 result awaited **23**	C-19 negative **302**	ITU C-19 negative **8**

STAFF VACCINATION & TESTING

1st Vaccination % to date **91.0%**	
C-19 positive **0**	C-19 negative **84**

PATIENT TESTING

Non-elective C-19 positive **2**	Non-elective C-19 negative **57**
Elective C-19 positive **0**	Elective C-19 negative **2**

STAFF ABSENCE

C-19 sickness absence **168**	C-19 household contact **54**
C-19 symptomatic **90**	C-19 test and trace **24**

NOSOCOMIAL INFECTIONS

Hospital definite **0**	Hospital Probable **0**
Hospital indeterminate **2**	Community **0**

PPE ESTIMATED STOCK DURATION (DAYS)

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

The very best care for every patient, every day

Essential Measures – Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Care & Improving Outcomes		Caring & Responsive Services		Workforce & Finance	
Mortality Higher than previous month but within the "as expected" range	SHMI 99.2 HSMR 91.5	**Complaints response times** Above target (80%) and better (higher) than previous month	87.1% YTD 77.9%	**All staff appraisal** Worse (lower than) previous month Below target (90%)	83.9% YTD 86.1%
Infection Control – clostrioides Difficile (hospital & healthcare) 4 Cat1 and 0 Cat2 cases this month	4 (Cat1: 4 Cat 2:0) YTD 34	**Inpatient Friends & Family Test** Inpatient positive scores below target (95%)	Resp 5.8% + ve 92.8%	**Mandatory training** Consistently achieved (target 90%) and stable	90.7% YTD 92.0%
Serious incidents & Never Events (NE) Variable – 7 SIs in reporting period	SI 7 YTD 42 NE 0 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	12.8% YTD 13.5%
Patient safety incidents which are harmful Higher than previous month	23.8% YTD 12.0%	**Outpatient DNA rates** Higher (worse than) target (8%) and the same as previous month	8.6% YTD 7.7%	**Income & Expenditure** Position is in line with the revised plan	£1.15m YTD £2.00m
Combined Caesarean Section Standard (28%) not achieved but better (lower) than previous month	35.6% YTD 34.1%	**ED waiting times** Worse than previous month Target (95%)	65.3% YTD 80.6%	**Capital Spend** £3.6m Capital spend in January	(£3.65)m YTD (£17.36)m
VTE assessments Better (above) than target (95%) Similar to previous month	96.7% YTD 96.4%	**RTT waiting times** Lower than the target (92%) Increase in 52 week waits	76.1% YTD 68.1% 1463	**CIP Efficiency** YTD achievement of £0.9m 1.9m if expected to be delivered	YTD £0.00m 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 13.2% YTD 25.0% Adm 60.9% YTD 74.2%	**Cancer waiting times** 2ww below target 62 day above target (85%) Better than previous month	2ww 85.2% YTD 94.5% 62 day 84.7% YTD 82.7%	**Other Finance Indicators** Financial risk rating Activity vs plan Elective activity Non-elective activity	FRR 0 Elec 1806 vs 3771.25 Non-Elec 3268 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**	

The very best care for every patient, every day

West Hertfordshire Hospitals NHS Trust

COVID19 – SNAPSHOT - Indicator Summary

Domain	Theme	Trend Month on Month	Dec-20	Jan-21	Feb-21
COVID 19 Snapshot	**Inpatients**				
	C-19 positive	Improving	119	312	138
	C-19 suspected	Worsening	15	9	11
	C-19 result awaited	Improving	86	47	23
	C-19 negative	Improving	405	215	302
	ITU C-19 positive	Improving	5	21	14
	ITU C-19 negative	Improving	9	7	8
	Staff Testing				
	1st Vaccination % to date	Improving	N/A	79.2%	91.0%
	C-19 positive	Worsening	13	15	0
	C-19 negative		107	29	84
	Patient Testing				
	Non-elective C-19 positive	Improving	13	18	2
	Non-elective C-19 negative	Improving	73	28	57
	Elective C-19 positive	Stable	0	0	0
	Elective C-19 negative	Improving	3	1	2
	Staff Absence				
	C-19 sickness absence	Improving	208	457	168
	C-19 household contact	Improving	93	159	54
	C-19 symptomatic	Improving	71	181	90
	C-19 test and trace	Improving	44	117	24
	Nosocomial Infections				
	Hospital definite	Improving	2	4	0
	Hospital probable	Improving	2	6	0
	Hospital indeterminate	Worsening	2	1	2
	Community	Improving	3	3	0
	Estimated duration of PPE stock (days)				
	Fluid resistant face masks	Stable	19	19	15
	FFP3 face masks	Stable	15	15	19
	Gloves	Stable	16	16	16
	Gowns	Stable	20	20	20

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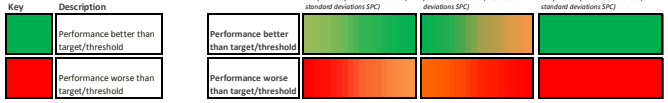
Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Nov-20	Dec-20	Jan-21	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 stable and better than target	99.4	97.9	99.2			Aug-20	National	100	Aug-20
		HSMR - Total (Rolling three months)	27	100	Performance deteriorated but better than target	82.4	88.8	91.5			Oct-20	National	100	Oct-20
		Quality of Care: Infection Control												
		Clostridioides Difficile - Hospital associated (Cat 1)	29	n/a		3	0	4	22		Jan-21	National	n/a	
		Clostridioides Difficile - Healthcare associated (Cat 2)	29	n/a		1	2	0	12		Jan-21	National	n/a	
		Clostridioides Difficile - Hospital and Healthcare associated Total	29	3	Performance stable but worse than target	4	2	4	34	28	Jan-21	National	n/a	
		Hand Hygiene Compliance	30	95%	Performance stable and better than target	97.1%	96.5%	96.9%	97.2%	95%	Jan-21	Local	n/a	
		Quality of Care: Emergency Readmissions												
		30 Day Emergency Readmissions - Elective *	34	4.5%	Performance stable and better than target	5.2%	4.3%	4.2%	4.4%	4.5%	Jul-20	National	4.5%	Jul-20
		30 Day Emergency Readmissions - Emerg *	34	15.1%	Performance stable and better than target	12.2%	12.4%	13.5%	12.6%	15.1%	Jul-20	National	15.1%	Jul-20
		Quality of Care: Caesarean Section rates												
		Caesarean Section rate - Combined*	35	28.0%	Performance stable but worse than target	32.5%	36.6%	35.6%	34.1%	28.0%	Jan-21	Local	28.0%	2017/18
		Caesarean Section rate - Emergency*	35	15.0%	Performance stable but worse than target	18.2%	19.4%	19.7%	17.6%	15.0%	Jan-21	Local	16.0%	2017/18
		Caesarean Section rate - Elective*	35	11.0%	Performance stable but worse than target	14.2%	17.2%	15.9%	16.5%	11.0%	Jan-21	Local	12.0%	2017/18
		Patient Safety												
		% nursing hours (shift fill rate)	37	95.0%	Performance stable and better than target	99.8%	97.3%	96.9%	99.6%	95.0%	Jan-21	National	n/a	
		Serious incidents - number*	38	0	Performance stable but worse than target	5	15	7	42	0	Jan-21	National	n/a	
		Serious incidents - % that are harmful*	38	0.0%	Performance stable but worse than target	100.0%	93.3%	100.0%	84.6%	0%	Jan-21	National	n/a	
		% of patients safety incidents which are harmful*	38	0.0%	Performance deteriorated and worse than target	11.9%	19.0%	23.8%	12.0%	0%	Jan-21	National	n/a	
		Never events	38	0	Performance stable and better than target	0	2	0	3	0	Jan-21	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%	Jan-21	National	93.7%	Mar-20
		Safety Thermometer % New Harm Free Care (acquired within Trust)	-	95.0%	Performance improved but worse than target					95.0%	Jan-21	National	97.8%	Mar-20
		Category 4 pressure ulcers - New (Hospital acquired)	40	0	Performance stable and better than target	0	1	0	1	0	Jan-21	Local	n/a	
		Category 3 pressure ulcers - New (Hospital acquired)	40	0	Performance stable and better than target	1	0	0	2	0	Jan-21	Local	n/a	
		VTE risk assessment*	42	95.0%	Performance stable and better than target	97.2%	97.1%	96.7%	96.4%	95.0%	Jan-21	National	95.3%	Q3 19/20
		Patients admitted to stroke unit within 4 hours of hospital arrival	43	90.0%	Performance deteriorated and worse than target	26.1%	14.0%	13.2%	25.0%	90.0%	Jan-21	National	59.3%	Sep-20
		Stroke patients spending 90% of their time on stroke unit	43	80.0%	Performance stable but worse than target	86.2%	76.3%	60.9%	74.2%	80.0%	Jan-21	National	84.3%	Sep-20



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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Nov-20	Dec-20	Jan-21	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	347	488	508	3431	0	Jan-21	National	n/a	
		Ambulance turnaround time > 60 mins		0	Performance stable but worse than target	148	514	259	1453	0	Jan-21	National	n/a	
		% Patients admitted through A&E - 0 day LOS		n/a		30.6%	25.0%	15.7%	26.5%		Jan-21	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	suspended				33.0%	Jan-21	National	n/a	
		Mixed sex accommodation breaches	45	0	Performance improved and better than target					0	Jan-21	National	59 Trusts breaching	Feb-20
		LOS > 21 days	46	65	Performance stable but worse than target	62	82	84	84	65	Jan-21	National	n/a	
		Delayed Tranfers of Care (DToC) beddays used in month	46	n/a		Suspended				n/a	Jan-21	National	n/a	
		Delayed Tranfers of Care (DToC) beds used in month	46	n/a		0	0	0	30	n/a	Jan-21	National	n/a	
	Caring	**Patient Experience: Friends & Family Test**												
		A&E FFT % positive	47	95%	Performance deteriora and worse than targe	Suspended	97.2%	90.9%	94.8%	95%	Jan-21	National	85.0%	Feb-20
		Inpatient Scores FFT % positive	47	95%	Performance deteriora and worse than targe		93.9%	92.8%	93.4%	95%	Jan-21	National	95.9%	Feb-20
		Daycase FFT % positive	48	95%	Performance stable b worse than target		0.0%	0.0%	0.0%	95%	Jan-21	National	n/a	
		Maternity FFT % positive	48	95%	Performance stable b worse than target		100.0%	0.0%	100.0%	95%	Jan-21	National	96.9%	Feb-20
		Patient Experience: Complaints												
		Complaints responded to within target/agreed timescale	49	80%	Performance stable and better than target	85.4%	66.7%	87.1%	77.9%	80%	Jan-21	National	n/a	
		Reactivated complaints	49	0	Performance stable but worse than target	0	6	2	17	0	Jan-21	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	82.1%	68.4%	65.3%	80.6%	95.0%	Jan-21	National	78.5%	Jan-21
		A&E 12hr trolley waits		0	Performance deteriorated and worse than target	0	21	75	96	0	Jan-21	National		
		Referral to Treatment - Incomplete*	51	92.0%	Performance stable but worse than target	78.4%	78.8%	76.1%	68.1%	92.0%	Jan-21	National	67.8%	Dec-20
		Referral to Treatment - 52 week waits - Incompletes	51	0	Performance deteriorated and worse than target	1112	1131	1463	7279	0	Jan-21	National	1453675 (all Trusts)	Dec-20
		Diagnostic (DM01) <6 weeks		99.0%	Performance stable but worse than target	74.3%	72.5%	69.0%	65.7%	99.0%	Jan-21	National	70.8%	Dec-20
		Cancer												
		Cancer - Two week wait *	52	93.0%	Performance deteriorated and worse than target	95.6%	85.4%	85.2%	94.5%	93.0%	Jan-21	National	87.5%	Q3 20/21
		Cancer - Breast Symptomatic two week wait *	52	93.0%	Performance improved but worse than target	88.1%	50.0%	64.3%	84.4%	93.0%	Jan-21	National	70.4%	Q3 20/21
		Cancer - 28 day waits (faster diagnosis standard)-shadow reporting	52	75.0%	Performance stable and better than target	80.4%	82.7%	77.6%	81.3%	74.0%	Jan-21	National	n/a	
		Cancer - 31 day *	53	96.0%	Performance stable and better than target	98.3%	100.0%	98.5%	97.1%	96.0%	Jan-21	National	95.7%	Q3 20/21
		Cancer - 31 day subsequent drug *	53	98.0%	Performance stable and better than target	100.0%	100.0%	100.0%	99.2%	98.0%	Jan-21	National	99.4%	Q3 20/21
		Cancer - 31 day subsequent surgery *	53	94.0%	Performance stable but worse than target	95.0%	87.0%	83.3%	89.2%	94.0%	Jan-21	National	88.9%	Q3 20/21
		Cancer - 62 day *	54	85.0%	Performance stable but worse than target	86.4%	82.6%	84.7%	82.7%	85.0%	Jan-21	National	75.1%	Q3 20/21
		Cancer - 62 day screening *	54	90.0%	Performance stable but worse than target	92.0%	85.7%	84.6%	74.6%	90.0%	Jan-21	National	85.5%	Q3 20/21
		Access to Services: Outpatients												
		Outpatient cancellation rate within 6 weeks^	55	5.0%	Performance stable but worse than target	7.4%	6.6%	9.4%	14.8%	5.0%	Jan-21	Local	n/a	
		DNA rate	55	8.0%	Performance stable but worse than target	7.9%	8.6%	8.6%	7.7%	8.0%	Jan-21	National	n/a	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Nov-20	Dec-20	Jan-21	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	99.8%	97.3%	96.9%	99.6%	95%	National	N/A	
		Patient Safety Incidents which are harmful	38	0%	Performance deteriorated and worse than target	11.9%	19.0%	23.8%	12.0%	0%	National	N/A	
	EFFECTIVE	Occupancy - Adult G&A (including critical care) (on 15th)	N/A	92%	Performance stable and better than target	89.4%	92.3%	91.6%	91.6%	92%	National	N/A	
		Occupancy - C19+ve (including critical care) (on 15th)	N/A	N/A		10.2%	19.5%	50.3%	N/A	N/A	National	N/A	
		Patients medically fit for discharge (on 15th)	N/A	N/A		49	54	64	N/A	N/A	National	N/A	
		C-19+ve patients medically fit for discharge (on 15th)	N/A	N/A		4	14	27	N/A	N/A	National	N/A	
		C-19+ve bed days used (including critical care)	N/A	N/A		2041	4486	7624	24290	N/A	National	N/A	
		Long LOS > 21 days	46	65	Performance stable but worse than target	62	82	84	84	65	National	N/A	
		Surge capacity bed days used	N/A	N/A		674	1341	1717	6823	N/A	National	N/A	
	RESPONSIVE	A&E type 1 attendances	N/A	95%	Performance deteriorated and worse than target	65.7%	42.5%	44.2%	66.4%	95%	National	TBC	
		Ambulance turnaround - delays over 60 minutes	N/A	0	Performance stable but worse than target	148	514	259	1453	0	National	N/A	
		A&E Type 1 admitted pathway performance	N/A	95%	Performance stable but worse than target	53.6%	25.4%	21.2%	50.4%	95%	National	TBC	
		A&E 12 hour waits (arrival to departure)	N/A	0	Performance stable but worse than target	160	716	608	2132	0	National	N/A	
		A&E 12 hour breaches (decision to admit to departure)	N/A	0	Performance stable but worse than target	0	21	75	96	0	National	N/A	

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Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Theme	Page	Target	Trend	Nov-20	Dec-20	Jan-21	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)	56	13.0%	Performance improved and better than target	13.0%	12.9%	12.8%	13.5%	13.0%	Jan-21	National	15.0% (Beds and Herts orgs)	Q1 19/20
		% staff leaving within first year (excluding medics and fixed term contracts)	56	n/a		15.5%	15.5%	13.9%	16.0%	n/a	Jan-21	National	n/a	
		Vacancy rate	56	10.0%	Performance improved and better than target	9.6%	9.1%	8.0%	9.5%	10.0%	Jan-21	National	11.1% (local survey)	Q1 19/20
		Sickness rate	56	3.5%	Performance stable but worse than target	4.2%	5.2%	6.4%	5.3%	3.5%	Jan-21	National	3.7% (EoE orgs)	Q1 19/20
		Developing Staff												
		Appraisal rate (Total)	57	90.0%	Performance deteriorated and worse than target	82.2%	85.8%	83.9%	83.9%	90.0%	Jan-21	National	n/a	
		Mandatory Training	57	90.0%	Performance improved and better than target	90.7%	90.7%	90.7%	90.7%	90.0%	Jan-21	Local	91.0% (local survey)	Q1 19/20
		Essential Training	57	90.0%	Performance improved but worse than target	0.0%	0.0%	0.0%	90.8%	90.0%	Jan-21	Local	n/a	
		Finance overview												
		Financial Risk Rating	15-25	0	Performance improved and better than target	0.00	0.00	0.00			Jan-21	Local	n/a	
		Income & Expenditure Actual	15-25	-£326	Performance improved and better than target	£23	£814	£1,153	£2,003	-£2,249	Jan-21	Local	n/a	
		Income & Expenditure forecast	15-25	£2,003	Performance deteriorated but better than target	£36	£850	£2,003	£2,003	£2,003	Jan-21	Local	n/a	
		Cash balance at the end of the month	15-25	£2,141	Performance stable and better than target	£42,896	£50,025	£50,641	£50,641	£2,141	Jan-21	Local	n/a	
		Capital expenditure	15-25	-£2,008	Performance stable and better than target	-£3,740	-£2,489	-£3,650	-£17,360	-£20,075	Jan-21	Local	n/a	
		CIP delivery against plan	15-25	£0	Performance stable and better than target	suspended	£0	£0	£0	£8,068	Jan-21	Local	n/a	
		% Bank Pay**	15-25	12.0%	Performance deteriorated and worse than target	12.7%	11.8%	14.4%	11.4%	12.0%	Jan-21	Local	n/a	
		% Agency Pay**	15-25	4.8%	Performance stable and better than target	4.7%	4.7%	3.8%	4.1%	4.8%	Jan-21	Local	7.3% (local survey)	Q1 19/20
		Activity (chargeable)												
		GP referrals		8,027	Performance stable and better than target	5,924	6,044	5,077	48,756	80,270	Jan-21	National	n/a	
		A&E attendances		15,594	Performance stable and better than target	10,674	10,722	8,860	102,646	146,889	Jan-21	National	n/a	
		Elective spells (overnight)		448	Performance stable but worse than target	476	384	176	2,922	4,700	Jan-21	National	n/a	
		Elective daycase		3,324	Performance stable but worse than target	2,655	2,404	1,630	15,946	34,898	Jan-21	National	n/a	
		Total elective spells		3,771	Performance stable but worse than target	3,131	2,788	1,806	18,126	39,598	Jan-21	National	n/a	
		Non-elective spells		5,090	Performance stable and better than target	3,798	3,527	3,268	34,940	50,079	Jan-21	National	n/a	
		Births		333	Performance deteriorated but better than target	340	257	266	3,426	3,276	Jan-21	National	n/a	
		Outpatient attendances		19,528	Performance stable but worse than target	11,648	10,108	8,923	97,817	205,049	Jan-21	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

We are seeing a progressive reduction in the number of admissions of patients infected with Covid-19, and we appear to be on course to be able to cohort all Covid-19 patients in the Granger suite by the end of February, other than those in ITU. This would then enable the zoning arrangements with PMOK to be stood down, and allow wards to return to "normal" activities. The number of Covid-19 patients requiring ITU has not yet reduced significantly, and thus ITU remains on surge, restricting the trust in the number of elective operations that can be done in patients with a high anaesthetic risk. This restriction means we are only doing category P1 and 2 patients, both in the trust and at Spire Bushey. This is reviewed weekly. Our mortality rates in patients infected with Covid-19 appears to be reducing quite significantly, but we await formal assessment from Dr Foster.

Our experience and innovation with the Virtual Hospital continues to expand, and we are currently designing the pathways for a COPD virtual hospital, and a Heart Failure virtual hospital, in partnership with the CCG and CLCH. Dr Andrew Barlow has asked to lead on the implementation of Covid virtual hospital/home oxygen therapy by NHSE for the East of England region.

The present arrangement of consultant review of every inpatient 7 days a week has considerably improved patient flow, and the Divisions have been tasked to plan a sustainable model to continue a form of this in the long term.

Chief Nurse

Although the number of Covid patients is now decreasing and with the overall sickness rate decreasing in the workforce, the impact of staff availability is still a challenge due to Covid restrictions i.e. pregnancy, CEV staff and the recent extension of this category. We continue to work on Covid templates and have developed an overall site RAG rating and further updated the staffing escalation guidance. The months of March and April will see us review as to how we transition back to the planned staffing templates dependant on the impact of unavailability of staff, national guidance and recovery of elective services.

The submission of our response to the Ockendon review for maternity which was approved at the February Board, was further reviewed and agreed as a collective by the 'local maternity and neonatal system' and submitted on the 15th February. We have undertaken a combination of virtual visits so our NED safety champion can join us in February. Quarterly reviews of investigations, outcomes have been implemented post December 20 review of the previous 12 months of investigations as Executive maternity safety champion. This will provide further oversight of the findings from investigations, and review themes and trends with actions for improvements.

Infection prevention control remains a key focus as we continue to review new guidance and ensure compliance with the infection prevention control board assurance framework (IPC BAF). With the reporting of serious incidents an increase will be seen as we report individual cases not necessarily an overarching outbreak.

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Key messages for the Board

Caring & Responsive Services

Chief Nurse

Carers:

A proposal for Raising Carers Awareness for Staff at WHHT is underway and we are developing a carers' strategy by establishing a carers' group to coproduce this new strategy.

Working with the engagement manager at Carers in Hertfordshire, 3 Carers Listening events were held. 2 in January 2021 and 1 in February 2021. Approximately 40 Carers joined the virtual events, all of which had been a service user or as a carer of the person they cared for being a service user.

Each Carer had an opportunity to highlight 1)Things that needed to Stop/Change 2) What worked well and should continue 3)Ideas for moving forward. A further virtual meeting will be held at the beginning of March with the Carers, to look at the common themes highlighted so a coproduced strategy over the next 6-8 weeks can be developed for the trust.

Spiritual & Pastoral care:

During the pandemic the pastoral care team have been working on the "Keep Me Connected" project. The idea of the project is for the pastoral care team to help keep patients, families and the patient's local community or faith group connected. Pastoral care team members have been contacted by hundreds of faith group members and relatives who have asked the team to visit patients to keep them connected to their loved ones and their community. This project has relieved the stress, anxiety and worry for patients and families and has strengthened relationships with local faith groups.

Chief Operating Officer

The upward trend in COVID+ demand continued into mid January culminating in the Trusts highest level of COVID+ cases on 12th January 2021 of 324. ITU surge continued to be utilised involving the use of the Endoscopy Unit and Theatres recovery.

Beyond this date the Trust began to experience a steady and sustained decline in cases, as of 15th February the Trust was supporting a total of 142 cases, inclusive of 14 cases in ITU.

During this 2nd wave the Trust was supported with 34 ITU transfers to other facilities and approaches are now being made to support the repatriation of those patients viable for transfer back to us as their local Trust.

Based upon an improving position the Trust has been able to reduce the number of areas being utilised for surge capacity and gradually alter the function of some ward areas from COVID to non-COVID use.

Providing the workforce staffing position also continues to improve the Trust is planning a gradual re-start of some elective services at St. Albans Hospital from the beginning of March 2021.

Phase 2 of EAU's expansion continues with an anticipated completion date being the end of February 2021. Divisional preparation of the area for use will then be undertaken with the expectation of service go live by no later than mid March 2021.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief People Officer

Recruitment – We are pleased with the continued progress for the recruitment of nursing and HCA staff. In January 2021 a further 24 nursing staff were recruited with a further 100 nurses in the pipeline. In addition, 38 HCA staff commenced at the Trust with a further 22 planned to commence in February.

Supporting our staff – We are continuing to offer psychological and wellbeing support for our staff. In particular we are arranging supportive events for the existing a new staff designated as shielding. 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. This facility is expected to continue to be available to staff until 22 March 2021.

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 and continuing decrease in absence levels which now stand at around 6.4%. This continues to reduce weekly with further support allocated from the absence hub. The well-being team are actively supporting and encouraging staff to take breaks with an emphasis on the long hours staff are spending at their PC. This includes advice on posture and review of equipment alongside the offer of free eye tests.

Staff Retention - The Trust continues to perform well in relation to staff turnover with a continued reduction demonstrated in January 2021. It is recognised that staff retention may become more challenging following the return to business as usual and therefore retention strategies and plans are in place to support our staff.

Mandatory Training – The Trust continues to demonstrate continued good compliance for mandatory training. There are particular subjects and staff groups where compliance could be improved and therefore more detailed work is being undertaken to address this and support improvement.

Appraisals – The staff appraisal rate is currently at 84% and therefore continues to demonstrate effective engagement during this challenging time for our workforce. Although the target is 90% the emphasis is on supporting managers take the time to support their staff by giving them the opportunity for an appraisal meeting as part of the wider support offering.

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Key messages for the Board

West Hertfordshire Hospitals NHS Trust

Workforce & Finance

Chief Finance Officer

For this month (10) the trust reported a position that was in line with our updated forecast. Expenditure of £38.0m was £1.15m higher than the £36.85m of income received. The YTD position now shows a deficit of £2.0m. 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. This trend has been consistent for a few months. When compared to the business as usual (BAU) financial plan (set before the start of the pandemic) our £359.8m of YTD costs were £10.5m higher than the £349.3m BAU plan. It's important to note that £21.8m 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 months of December and January. Unsurprisingly, this was linked 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 36% of the original plan in month, 48% year to date.
- Outpatient attendances were 72% of the original plan in month, 68% of plan for the year to date.
- A&E attendances 70% of plan for the month, compared to a 74% year to date.

The Trust spent £3.7m on buildings and equipment assets in December. The year to date capital spend stands at £17.3m. 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 January headline metrics continue to show a stable position and an improvement in the customer satisfaction score, whilst recognising it is still below target.

Metric	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Priority 1 incidents	4	7	2	3	3	1	1	2
Priority 2 incidents	17	20	21	10	12	8	8	6
Incident backlog	350	415	416	417	458	469	400	469
First time fix rate	87%	91%	92%	91%	91%	84%	86%	90%
Customer satisfaction score	7.2	6.6	6.8	6.9	6.5	7.0	4.9	6.1
Network availability	100%	100%	100%	100%	100%	100%	100%	100%

The technology team at WHHT continue to try and improve performance and functionality across the hospitals. Current programmes of work include:

- Supporting the expansion of the Virtual Hospital for New Airways and Cardiology
- Pursuing the possibility of application upgrades that support the EPR programme, our Windows 10 environment and enhanced clinical functionality
- Completion of the Medical Records Full Business Case
- Benefits realisation analysis for our Digital strategy
- Leadership of the ICS Shared Care Record programme
- Windows 10 mass deployment – we have now deployed nearly 2,000 devices since Christmas with (despite a few glitches) some very encouraging feedback
- Business Case for Pathology hardware and software upgrades
- Preparation for our printer transformation
- Planning for our future ITO arrangements
- Management of our EPR programme

The EPR programme continues to move at great pace. Key achievements and activities since the board last met include the completion of the build of the test environment, feedback on the data quality results for trial load 1, the launch of the EPR microsite and news letter and the start of the Future State Validation process.

The Future State Validation is a key activity where hundreds of WHHT staff get to see how their specific workflows will look and operate once we go-live. It is a key part of our engagement activities, with initial feedback from most clinical teams very positive.

The current go-live date for EPR is 27th Nov, less than ten months away.

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West Hertfordshire Hospitals NHS Trust

Workforce & Finance: Income and Expenditure January 2021

			In Month (£000's)				YTD			
Trust Definition	**Expense Type**	**Annual Budget**	**Budget**	**Actual**	**Variance**		**Budget**	**Actual**	**Variance**	
Income	Divisional Income	81,568	6,495	9,253	2,758	Bii	67,918	84,671	16,753	Fii
	NHS Revenue	336,416	27,810	27,616	(194)	Bi	280,748	273,110	(7,638)	Fi
	Income Unallocated CIPs	0	0	0	0		0	0	0	
Income Total		**417,984**	**34,305**	**36,868**	**2,564**	**B**	**348,666**	**357,780**	**9,115**	**F**
Pay	Medical Pay	(81,974)	(6,794)	(7,245)	(451)		(68,399)	(69,756)	(1,357)	
	Non-Clinical Pay	(60,714)	(5,098)	(4,281)	817		(49,906)	(42,311)	7,595	
	Nursing Pay	(80,758)	(6,751)	(7,107)	(356)		(67,293)	(66,651)	642	
	Other Clinical Pay	(30,851)	(2,581)	(2,768)	(188)		(25,693)	(26,599)	(906)	
	Scientific, Technical & Profes	(27,350)	(2,282)	(2,368)	(86)		(22,790)	(23,279)	(490)	
	Pay Unallocated CIPs	9,386	1,203	0	(1,203)		6,618	0	(6,618)	
Pay Total		**(272,261)**	**(22,303)**	**(23,770)**	**(1,466)**	**C**	**(227,463)**	**(228,597)**	**(1,134)**	**G**
Non Pay	Clin Supp Serv	(31,291)	(2,474)	(2,038)	435		(25,972)	(23,086)	2,886	
	Drugs	(21,424)	(1,694)	(2,167)	(473)		(17,782)	(16,690)	1,092	
	OTHER (NON CLIN)	(82,118)	(6,879)	(8,659)	(1,780)		(68,198)	(77,718)	(9,520)	
	Non Pay Unallocated CIPS	5,654	749		(749)		3,916		(3,916)	
Non Pay Total		**(129,179)**	**(10,298)**	**(12,864)**	**(2,566)**	**D**	**(108,037)**	**(117,494)**	**(9,457)**	**H**
Recharges	Recharges	0	0	0	0		0	0	0	
Recharges Total								**0**	**0**	
Financing Charges	Depreciation	(10,948)	(913)	(913)			(9,121)	(9,109)	12	
	Trust Debt Redemption	(5,570)	(462)	(477)	(15)		(4,646)	(4,600)	46	
	Unwinding Discount	(27)	(2)	2	4		(22)	16	38	
Financing Charges Total		**(16,545)**	**(1,378)**	**(1,388)**	**(11)**	**E**	**(13,790)**	**(13,693)**	**97**	**I**
Total		**0**	**326**	**(1,153)**	**(1,480)**	**A**	**(624)**	**(2,003)**	**(1,380)**	**J**

The performance to plan was worse than plan by £1,480k. An actual deficit of £1,153k 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 £2,564k.
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 £27,616k 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 January . The underperformance was £194k in month. It should also be noted that retrospective funding for the UTC was recognised 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 £23,770k which was £1,466k overspent. Within the pay position, an additional £1,305k 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 £2,566k. This includes an additional £816k 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 dividend charges.

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Workforce & Finance: Finance overview dashboard

Financial Overview 31st January 2021

Month 10 Income & Expenditure

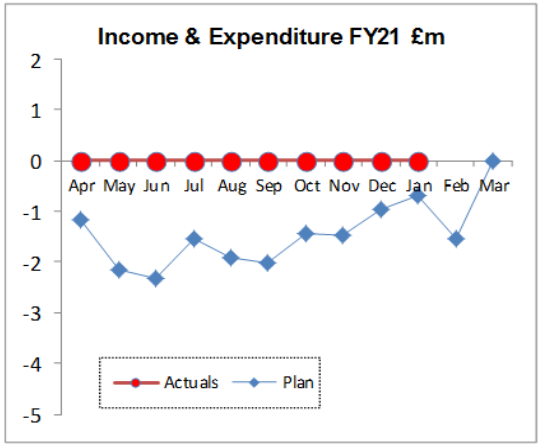
£m	Plan	Actual	Var
Surplus / (Deficit)	0.3	(1.2)	(1.5)

£m	YTD 20/21		
Surplus / (Deficit)	(0.6)	(2.0)	(1.4)

Statutory / Regulatory Duties

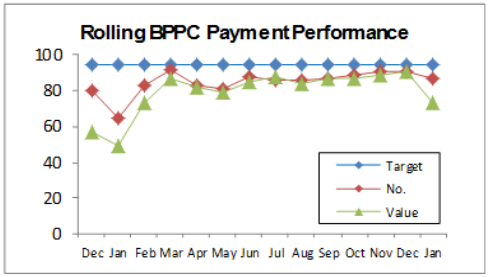
Breakeven	The trust achieved break even year to date and has a break even plan for FY21.	G
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 31/1/21 equated to £50.6m.	G
BPPC	Month10 performance -87% on number, 73.5% on value (95% target)	A

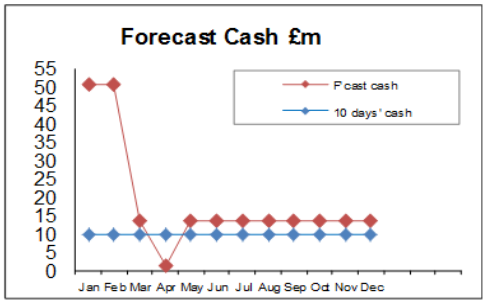
Financial Risk Rating	FY21	2

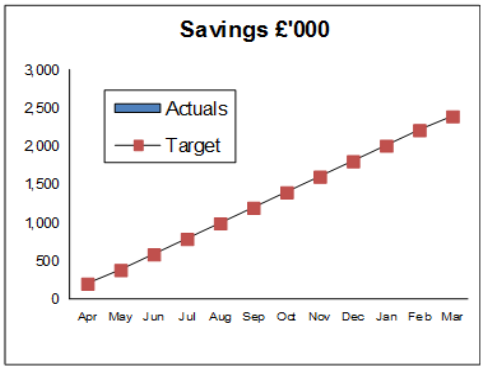


YTD Variance by Division £m

Medicine	14.3
Unscheduled Care	9.5
Surgery	23.6
Women's	6.6
Clinical Support	5.2
Estates & Facilities	2.1
Corporate	2.6
Other	(54.6)
Total	**9.3**







Commentary

See earlier pages for I&E detail.

The Better Practice Payment statistics for January show 87% by value and 73.5% by number.

The cash balance at the end of December was £50.6m.

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

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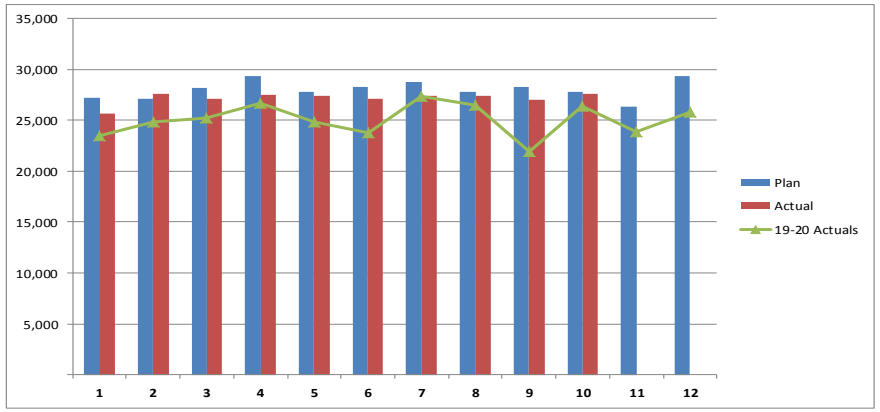
Workforce & Finance: Trust Income – January 2021

NHS Revenue: Performance by Month (£s)



NHS revenue continues to be set at a block amount of £27.6m for the month of January. This resulted in an underperformance against the business as usual plan of £27.8m. However, within other SLA income, retrospective funding for the UTC was recognised in month.

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 £0.67m
In January, Critical care over performed in month by £0.72m. 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 £2.7m. This is predominately within the Surgery division.
For Non Elective the in month position showed under performance of £1.15m.
Despite an increase in virtual interactions, the overall fall in Outpatient attendances meant performance was £1.77m away from plan.

The adverse variances above were offset by other SLA income being favorable to plan by £5.37m. This reflects the block reimbursement arrangements.
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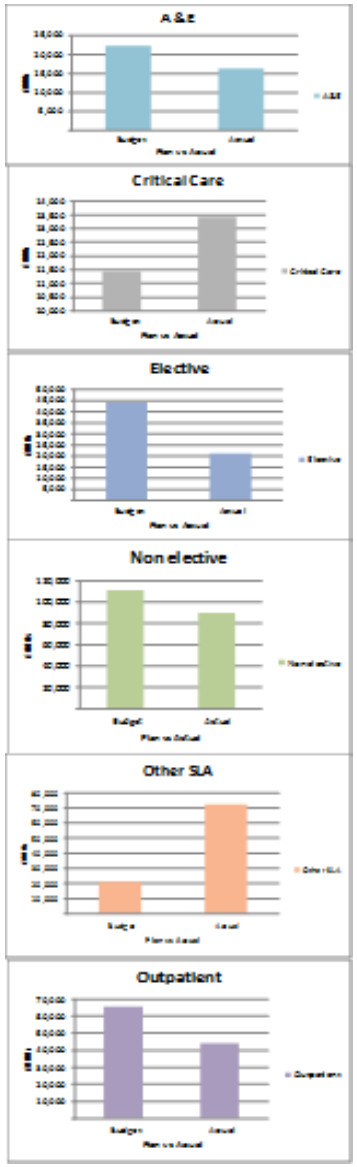

In Month Performance (£s)

			In Month (£000's)		
Expense Type	POD	Annual Budget	Budget	Actual	Variance
NHS Revenue	A&E	26,486	2,244	1,572	(673)
	Critical Care	13,664	1,153	1,871	718
	Elective	53,207	4,206	1,506	(2,700)
	Non elective	132,024	11,213	10,066	(1,147)
	Other SLA	32,315	2,677	8,049	5,373
	Outpatient	78,721	6,318	4,552	(1,766)
	NHS Rev Unallocated CIPs				
NHS Revenue Total	Total	336,416	27,810	27,616	(194)

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	3,771	2,825	-1,135
	Non elective	64,358	5,466	3,816	-1,650
	Other SLA	3,774,708	298,396	266,934	-46,382
	Outpatient	479,834	38,037	30,973	-8,890
NHS Revenue Total	Total	4,568,020	362,777	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 £1.8m worth of income for expected 'in-envelope' covid costs.

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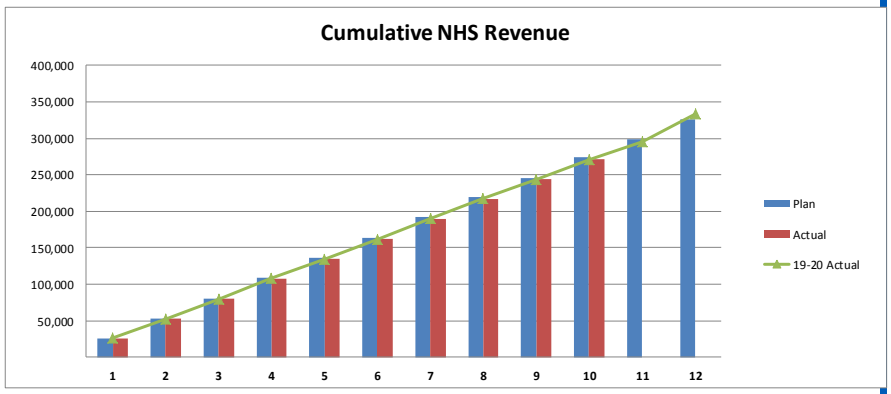
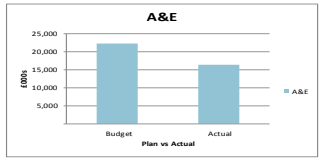
Workforce & Finance : Year To Date (YTD) – Trust Income

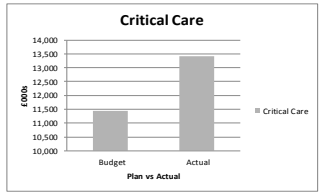
NHS Revenue: Performance by Month (£s)

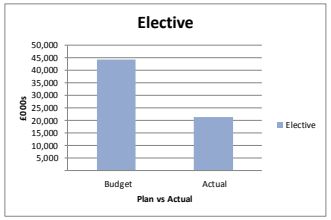


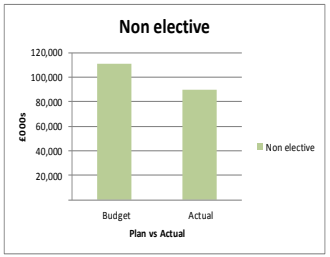
Month 10 YTD shows Income under performance of £7.6m. £273.1m has been generated against plan of £280.7m.

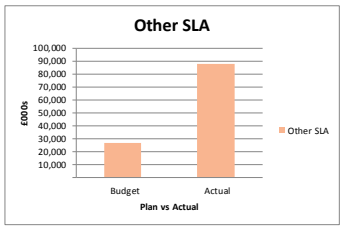
A&E has a YTD under performance of £5.9m which is linked to a price and volume variance.
Critical care is £1.9m better than plan and has seen an average occupancy rate of 81%. The increase is linked to the Covid-19 pandemic.
Elective performance is £22.8m away from the YTD plan. This is mostly driven 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 £20.78m. This is predominately centred around the Emergency division and is linked to a reduction in emergencies throughout the pandemic.
YTD Outpatient performance shows £21.2m worth of under performance.
Other SLA income is £61.1m 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	22,188	16,311	(5,877)
Critical Care	11,431	13,424	1,993
Elective	44,164	21,335	(22,829)
Non elective	110,683	89,903	(20,780)
Other SLA	26,819	87,870	61,051
Outpatient	65,464	44,268	(21,196)
NHS Rev Unalloc			
Total	**280,748**	**273,110**	**(7,638)**

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 £11.2m. This is driven by claims for Covid -19 revenue reimbursement from the centre.

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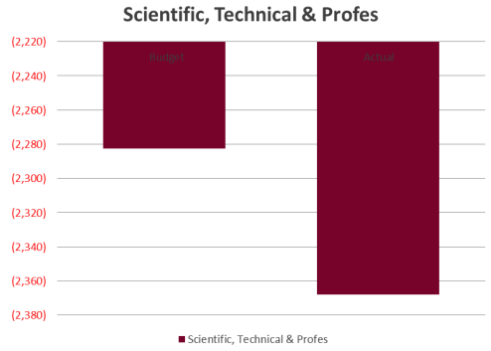
Workforce & Finance: Trust Pay January 2021

Trust Pay Performance

		In Month (£000's)			WTE		
Expense Type	**Annual Budget**	**Budget**	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Medical Pay	(81,974)	(6,794)	(7,245)	(451)	717.92	748.32	-30
Non-Clinical Pay	(60,714)	(5,098)	(4,281)	817	1,258.30	1,249.86	8
Nursing Pay	(80,758)	(6,751)	(7,107)	(356)	1,648.15	1,715.76	-68
Other Clinical Pay	(30,851)	(2,581)	(2,768)	(188)	1,046.99	1,092.63	-46
Scientific, Technical & Profes	(27,350)	(2,282)	(2,368)	(86)	513.11	533.90	-21
Pay Unidentified CIPs	9,386	1,203		(1,203)	0.00	0.00	0
Total	**(272,261)**	**(22,303)**	**(23,770)**	**(1,466)**	**5,184.47**	**5,340.47**	**-156**



The Trust reported an in month overspend of £1.47m. £1.3m worth of cost captured in relation to Covid-19.

Key areas to note include;

Medical pay was £0.45m 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 £0.54m. 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 £0.08m overspend in month.
Expected pay efficiencies in month were not achieved and this caused a £1.2m 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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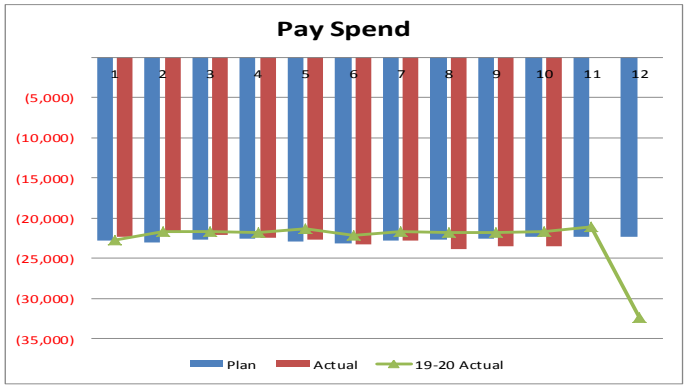
Workforce & Finance: Trust Pay January 2021



The year to date reported position shows an overspend of £1.1m.

Key year to date themes to note are:

Medical pay – is showing a £1.36m overspend. This reflects operational changes made during the covid-19 pandemic.

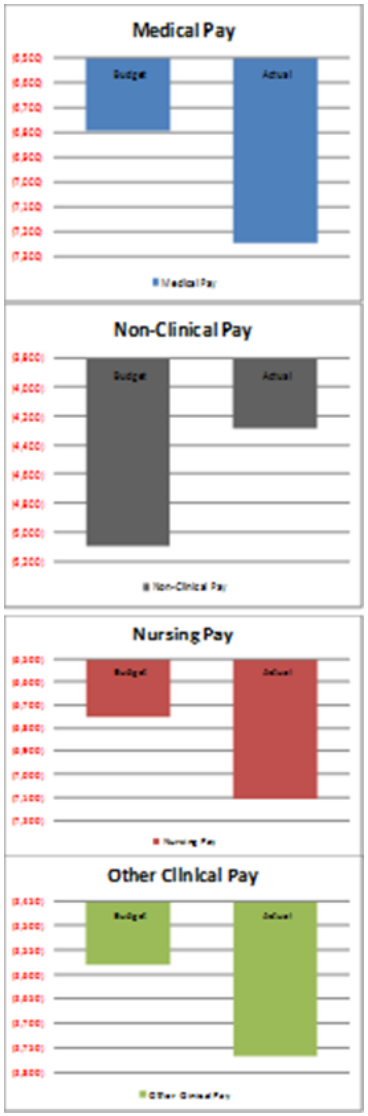
Nursing and other clinical pay has a combined overspend of £0.26m YTD. This is driven by an increase in bank fill rates seen over the winter months. The cost also includes operational changes made to deal with Covid-19 (zonal deployment).

Scientific & therapeutic agency premium to cover vacancies across clinical support, theatres and cardiology are causing £0.5m 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 £6.6m overspend.

Total Pay costs which have been spent in relation to the Covid-19 pandemic total £9.17m.



YTD Pay Performance

Expense Type	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Medical Pay	(81,974)	(68,399)	(69,756)	(1,357)
Non-Clinical Pay	(60,714)	(49,906)	(42,311)	7,595
Nursing Pay	(80,758)	(67,293)	(66,651)	642
Other Clinical Pay	(30,851)	(25,693)	(26,599)	(906)
Scientific, Technical & Profes	(27,350)	(22,790)	(23,279)	(490)
Pay Unallocated CIPs	9,386	6,618		(6,618)
	(272,261)	**(227,463)**	**(228,597)**	**(1,134)**

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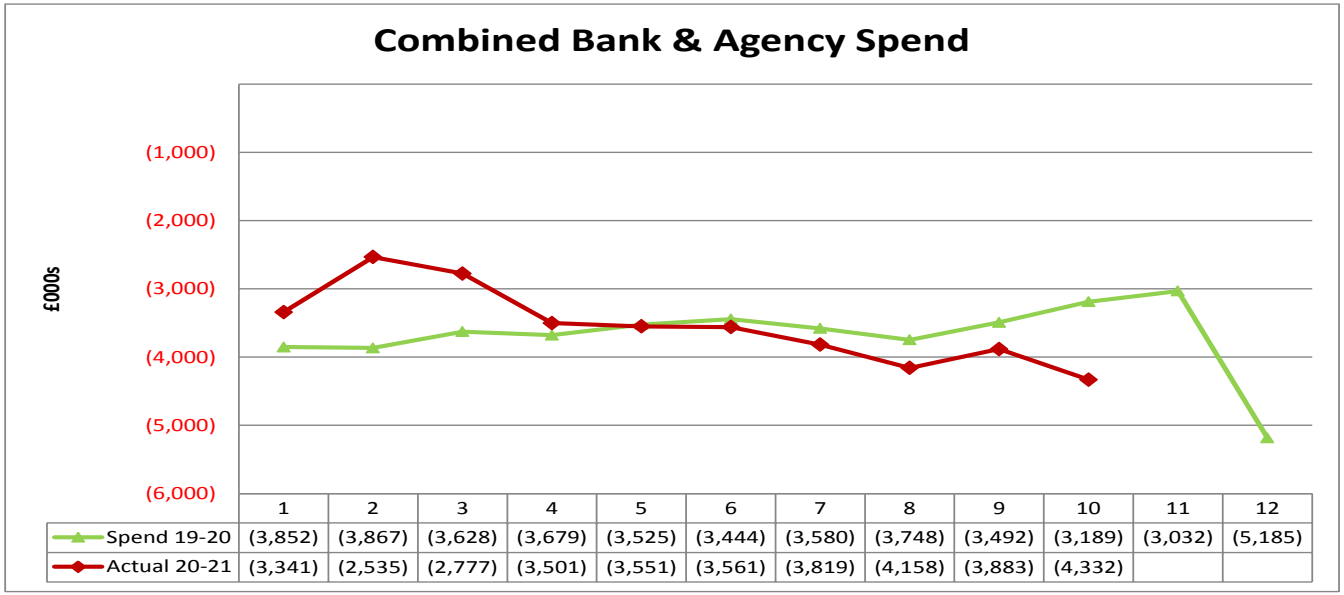
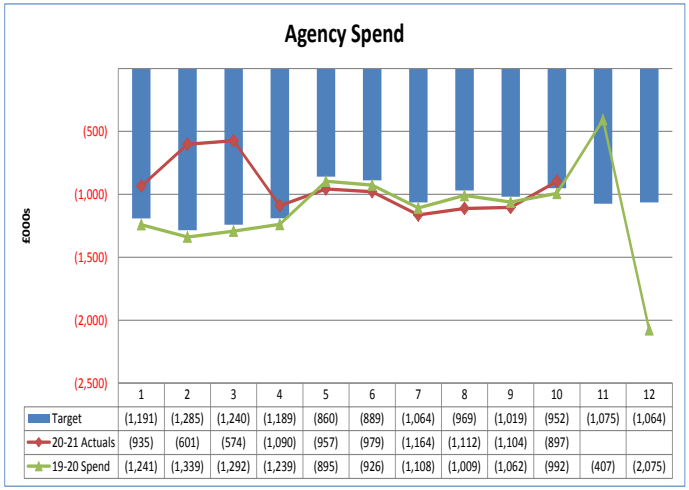
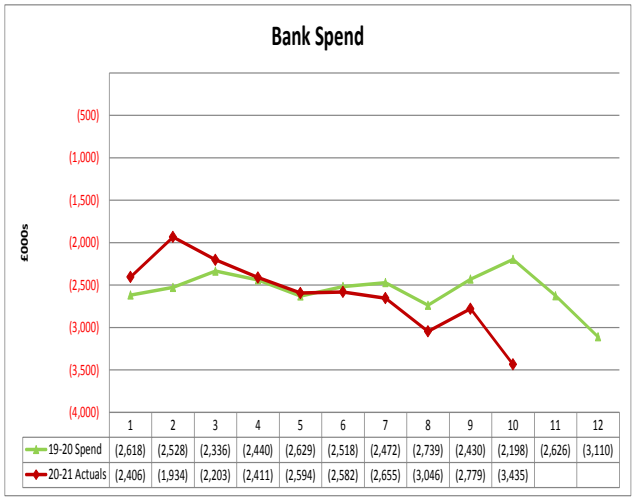
Workforce & Finance: Bank & Agency Spend January 2021



	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)	(4,332)		



	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)	(897)		
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)	(3,435)		

Agency

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

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

Agency expenditure in the month totaled £0.9m and represented a reduction against last month.

Of the £0.9m in-month spend, £0.19m was spent in relation to covid.

Year to date Agency spend stands at £9.7m. This is within the £10.7m YTD target. At year end, the Trust expects to meet the original agency target of £12.8m.

Bank

Bank spend for January was £3.4m. This represented an increase against previous months and was a key driver of the pay overspend.

Of the £3.4m spend, £0.9m was spent in relation to covid.

When comparing to the same month last year, the Trust has spent £1.1m more on temporary staffing.

21

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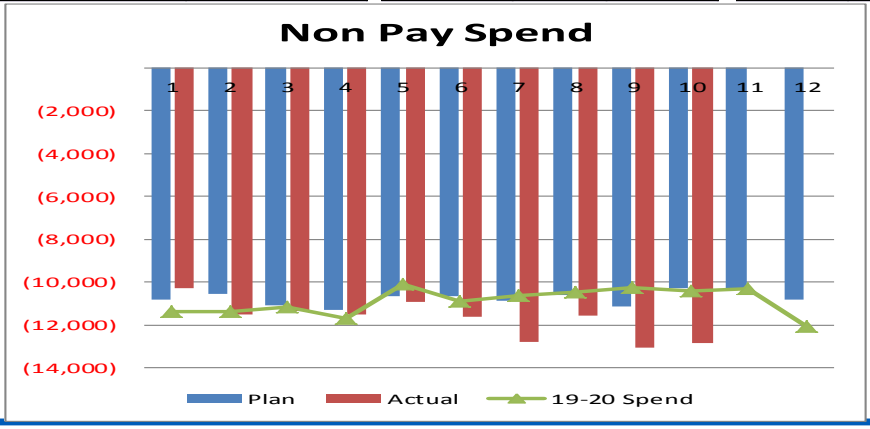
Workforce & Finance: Non Pay January 2021

Non Pay Performance

Expense Type	Annual Budget	In Month (£000's) Budget	In Month (£000's) Actual	In Month (£000's) Variance	YTD Budget	YTD Actual	YTD Variance
Clin Supp Serv	(31,291)	(2,474)	(2,038)	435	(25,972)	(23,086)	2,886
Drugs	(21,424)	(1,694)	(2,167)	(473)	(17,782)	(16,690)	1,092
OTHER (NON CLIN)	(82,118)	(6,879)	(8,659)	(1,780)	(68,198)	(77,718)	(9,520)
Non Pay Unallocated CIPS	5,654	749		(749)	3,916		(3,916)
Total	**(129,179)**	**(10,298)**	**(12,864)**	**(2,566)**	**(108,037)**	**(117,494)**	**(9,457)**



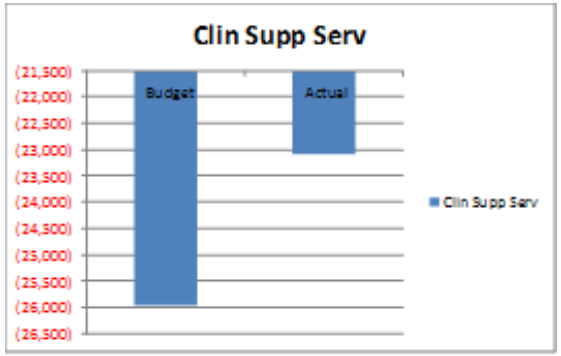
The in month non pay position (excl finance charges) reported an overspend of £2.6m. Actual Spend was £12.9m against a budget of £10.3m.

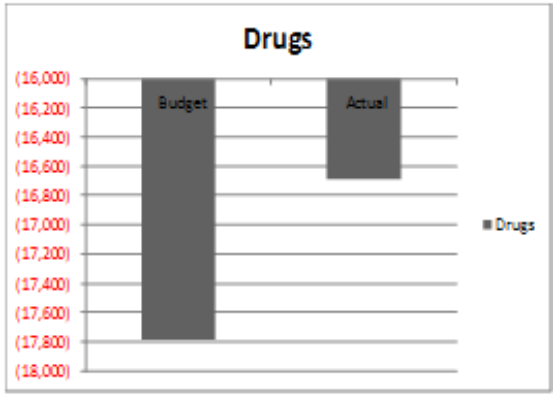
The main drivers of the position include:

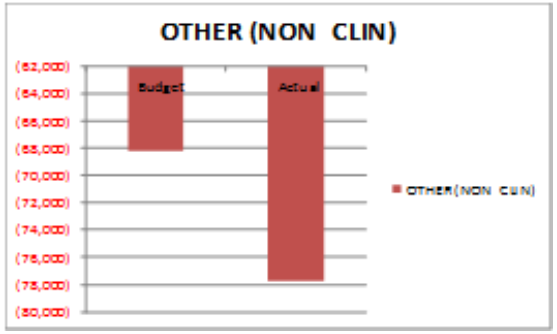
- **Clinical supplies were £0.43m underspent in month. This was linked to the number of elective procedures performed in month.**
- **Drugs were overspent by £0.47m. This is linked to pass through ARV drugs which is offset by the divisional income position.**
- **Other non clinical supplies were overspent by £1.8m. The majority of this relates to covid related infrastructure costs.**
- **The position includes a total spend of £0.82m in relation to covid-19 in month.**

YTD the position is £9.5m overspent. This includes total YTD covid non pay costs of £12.67m.

YTD Performance







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Workforce & Finance: Covid-19 Cost Capture January 2021

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 10

In Month 10 the following costs have been captured:

£1,305k pay
£816 k non-pay

This has been partially offset with £1,802k worth of central income for the month.

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	365	2767
	Non-Clinical Pay	181	1639
	Nursing Pay	421	2337
	Other Clinical Pay	166	1020
	Scientific, Technical & Profes	171	1406
Pay Total		**1,305**	**9,170**

		£000s	
Trust Definition	Expense Type	In Month Actual	YTD Actual
Non Pay	Bedding & Linen	1	2
	Cleaning supplies & materials	80	620
	Computer expenditure		65
	Consultancy	4	426
	Dressings		
	Drugs	30	232
	Estates expenditure	30	1322
	Fuel & power	-4	8
	Furniture & office equipment	2	14
	Hardware & crockery		
	Healthcare from other NHS Bod	20	61
	Laboratory expenses	179	2619
	Medical & Surgical Equipment	30	1173
	Other non-pay	224	4341
	Patient Clothing		
	Printing & stationery		58
	Provisions	1	-37
	Rates	-6	12
	Staff Uniforms	239	1741
	Telephones		5
	Travel & subsistence		3
	Depreciation	-14	
Non Pay Total		**816**	**12,665**
Grand Total		**2,121**	**21,835**

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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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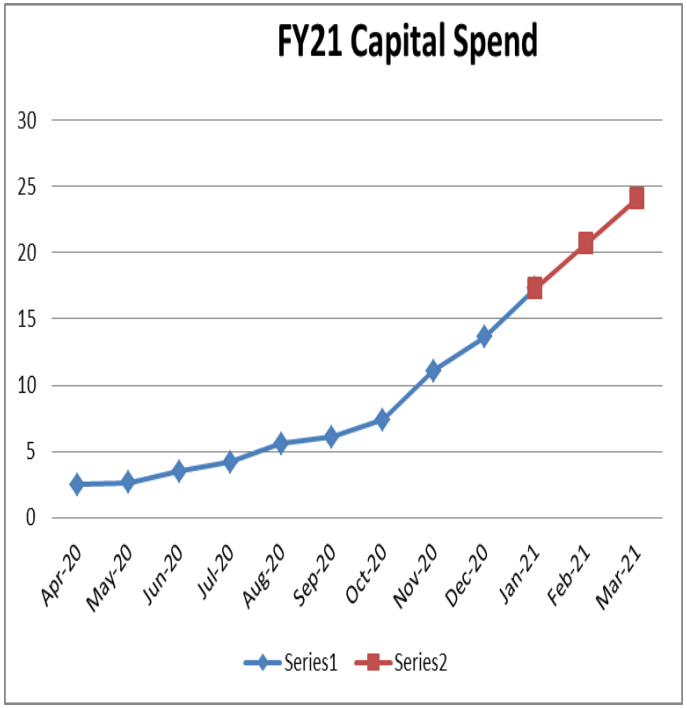
Workforce & Finance: Capital Expenditure January 2021



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

YTD Capital spend by Scheme

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**
10	Your Care Your Future	0.8
10	EAU2 Modular Expansion Shrodell	0.3
10	EPR	0.2
10	MSCP	0.8
10	Cardiac Catheter Lab	0.6
10	Covid-19 related projects	0.2
10	Other sundry	0.80
	Month 10 Total Spend	**3.70**
	YTD Spend	**17.30**

West Hertfordshire Hospitals NHS Trust

Detailed reports

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Safe Care & Improving Outcomes: Mortality Indicators

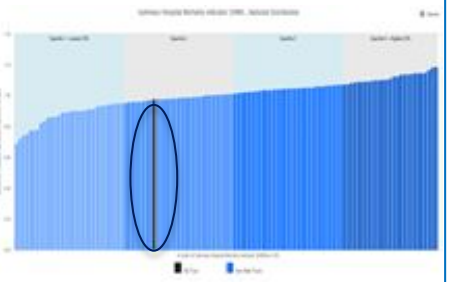
In this reporting period:
The latest available Summary Hospital Mortality Indicator (SHMI), November 2019 to October 2020, is 99.16 and within the 'as expected' range (band 2). The Trust's HSMR of 99.5 is also within the 'as expected' range. HSMR has seen a slight drop, but has been broadly stable over the last 3 data points. The Trust's SHMI has shown a slight rise, but is one of the lowest in the region.

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. Septicaemia except in labour is currently an outlying SMR group. This group has been subject to audit and findings will be presented at the next Mortality and Review Group meeting on 9th March.. Other alerting groups are viral infection (to which COVID is mapped) and other perinatal conditions.

Qualitative aspects of Mortality:
Monthly specialty/departmental mortality review meetings take place. The structured judgement review (SJR) process has just restarted following a period of suspension resulting from COVID demands. An SJR quality assurance exercise is currently being undertaken of patients with learning disabilities who died from COVID during the most recent pandemic in that 2 consultants are independently examining the care of each patient.

Performance stable
Better than target/threshold

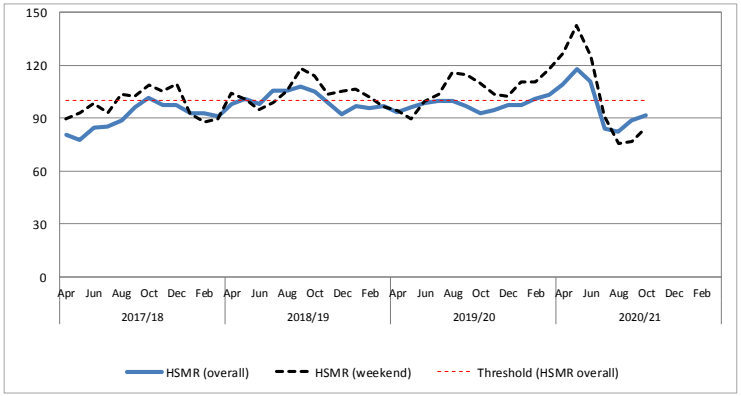
Benchmarking: MODEL HOSPITAL
Summary Hospital Mortality Indicator (SHMI)



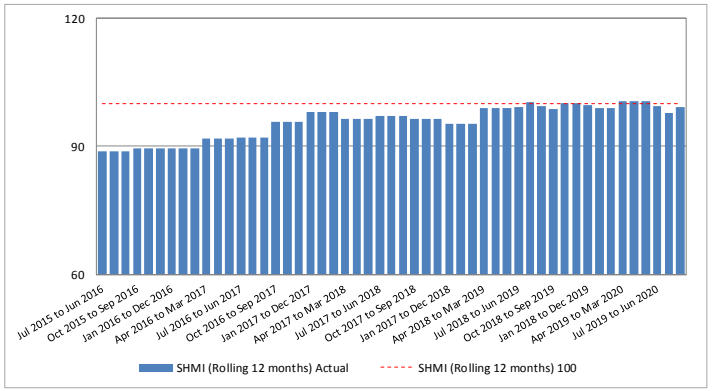
Period: Jan 2021

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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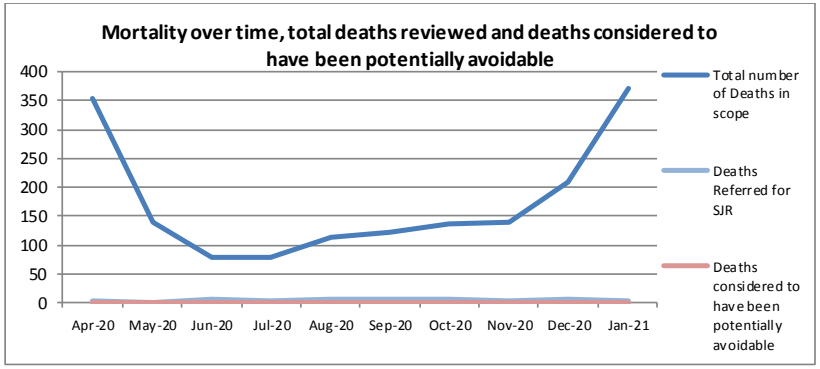
Safe Care & Improving Outcomes: Learning from deaths dashboard

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
372	210	5	8	0	3	0	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
372	487	5	18	0	13	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1752	1652	53	137	27	32	5	2



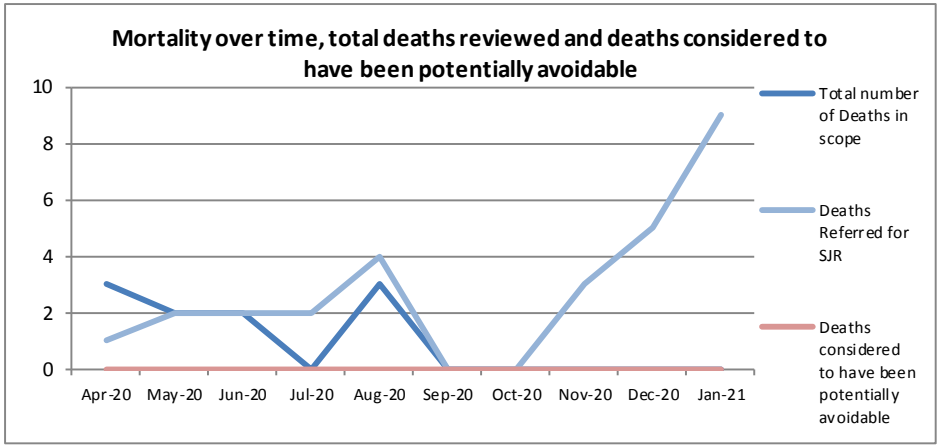
Total Deaths Reviewed by RCP Methodology Score

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	0	This Month	0	This Month	0	This Month	0
This Quarter (QTD)	0	This Quarter (QTD)	0	This Quarter (QTD)	0	This Quarter (QTD)	0	This Quarter (QTD)	0	This Quarter (QTD)	0
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	9	5	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	9	8	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	23	28	23	0	0



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

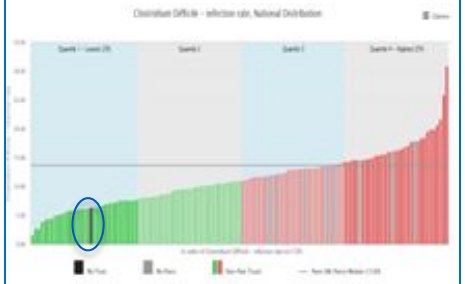
In this reporting period:
Clostrioides difficile Infection (CDI) objectives for 2020/21 are based on criteria commenced on 1 April 2019: Hospital onset healthcare associated – cases detected 2 days or more after admission (CAT1). Community onset healthcare associated – cases that occur in the community 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. Cases identified with no lapses in care are planned to be reviewed with CCG in March 2021, these cases are not removed from the official numbers but are not subject to financial penalties. In Jan 2021 4 cases of C diff infection were attributed to the Trust (x4 cat 1) . Total number of Trust apportioned cases April to Jan is 34. RCA's have been completed in all cases up to end of July, from Aug to Jan data obtained and further detailed reviews planned . No links have been identified with any of the cases during Jan 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. 1 case of MRSAb identified Jan, a pre 48 hour case . The PIR on previous identified post 48 hour case in Nov has been completed and discussed with the 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 January 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

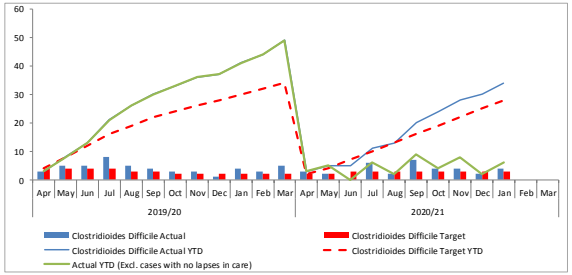


Period: to March 2019

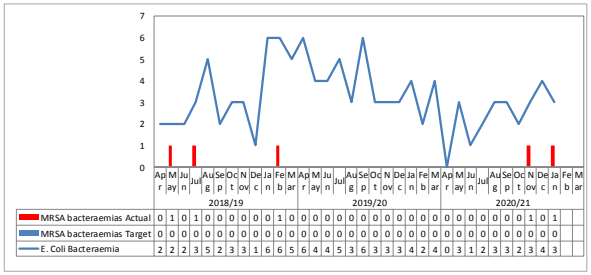
WHHT 6.42 Peer 13.68
National 11.11

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

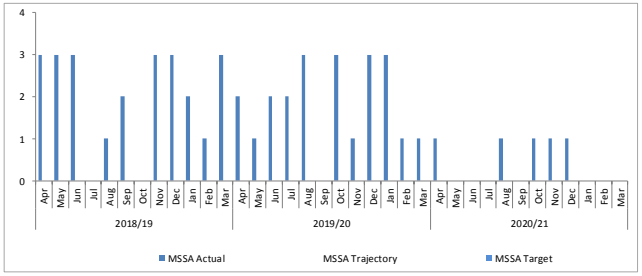
Clostrioides Difficile Infection (CDI)



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 3 post-48hr cases and 8 pre-48 hour cases (non-trust) reported in January 2021. 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):

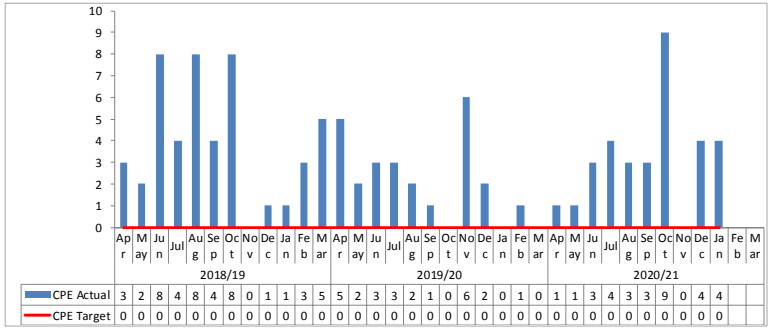
There were no post-48 hour cases and 2 pre-48 hour cases of MSSAb in January 2021. Each case is usually reviewed by a microbiologist using an RCA tool to identify and share learning .

Carbapenemase-producing Enterobacteriaceae (CPE):

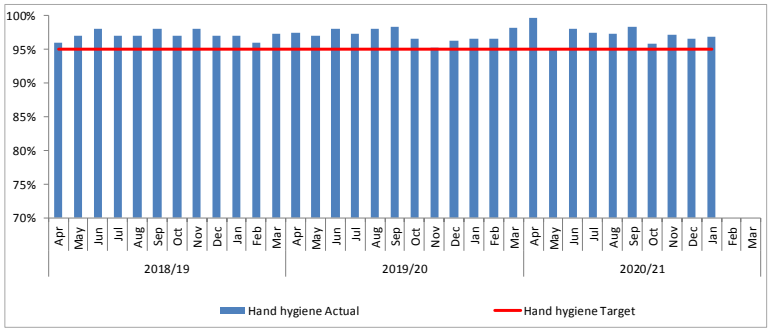
The trust's routine management and compliance process for CPE continues, including screening, enhanced cleaning and isolation. Clusters of cases have been identified across the division of medicine between October to December, further microbiological data suggests the same typing and evidence of some 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 any 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. Spot check audits and PPE audits have also been developed and are in place . Themes and gaps have been added to divisional IPC action plans. During January work to support clinical areas and operational teams in the safe management of the rising number of COVID -19 patients has been the priority. There is continued monitoring of water quality, ventilation, decontamination, antimicrobial stewardship and cleaning across the trust. 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 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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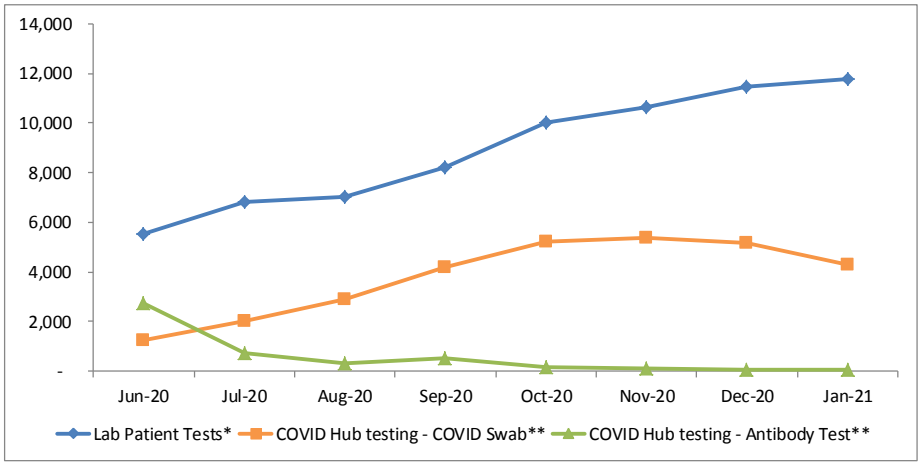
Safe care & Improving Outcomes: COVID-19 (Slide 1 of 3)

Laboratory and COVID Hub testing – Staff and patient volumes

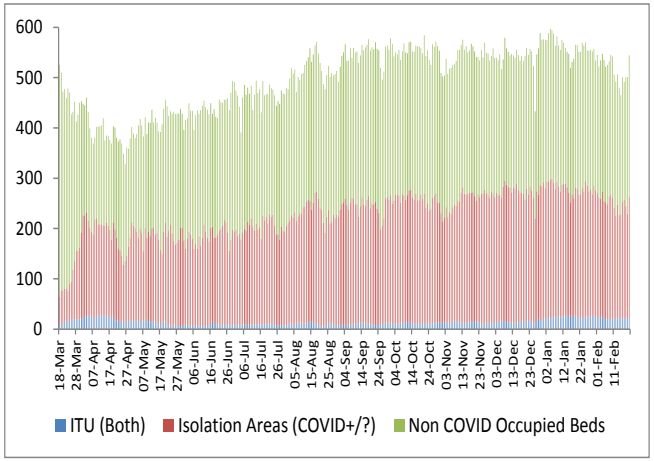
Tests/Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Lab Patient Tests*	5,516	6,816	7,022	8,195	10,030	10,664	11,473	11,764
COVID Hub testing - COVID Swab**	1,251	2,029	2,907	4,165	5,217	5,387	5,162	4,265
COVID Hub testing - Antibody Test**	2,735	742	281	537	154	119	58	61

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

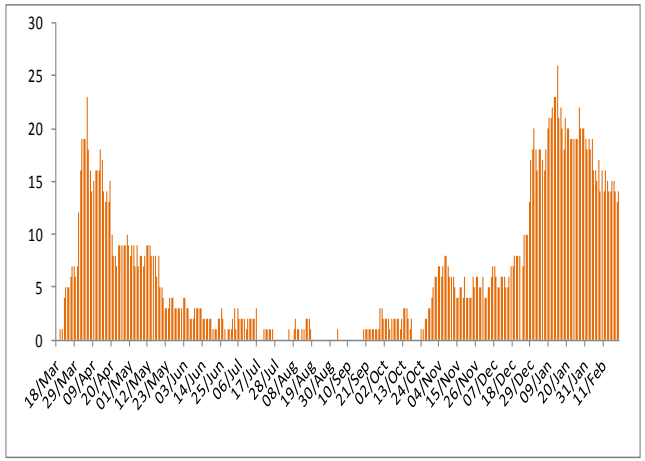
**(includes WHHT/bank/agency/mitie/household - based on appt date



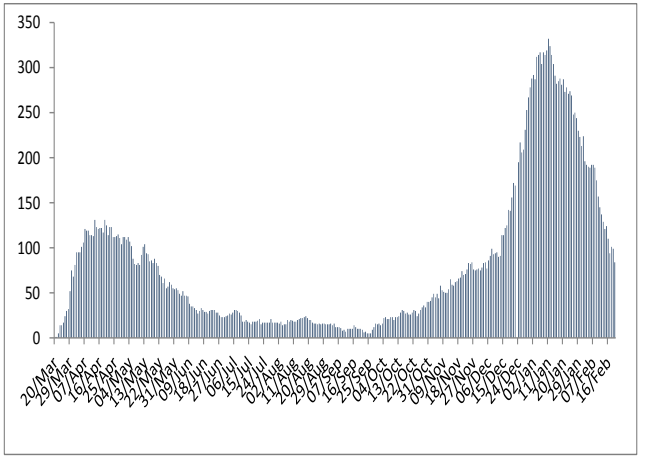
Occupied beds all areas at 0800



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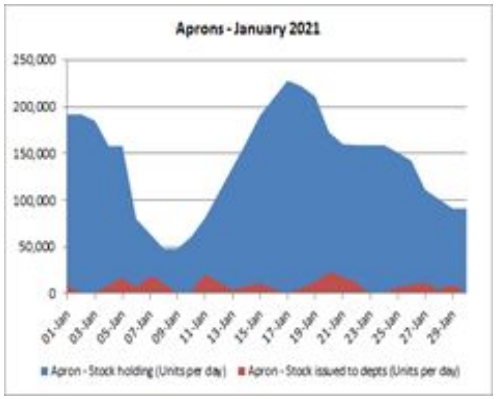
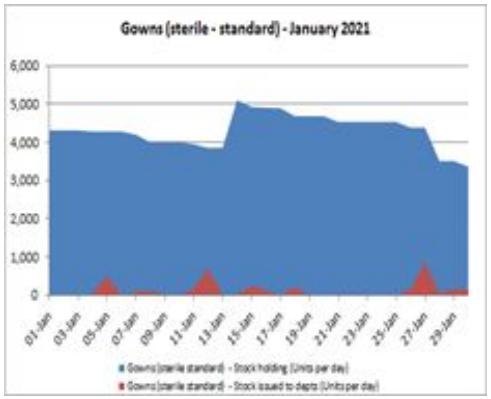
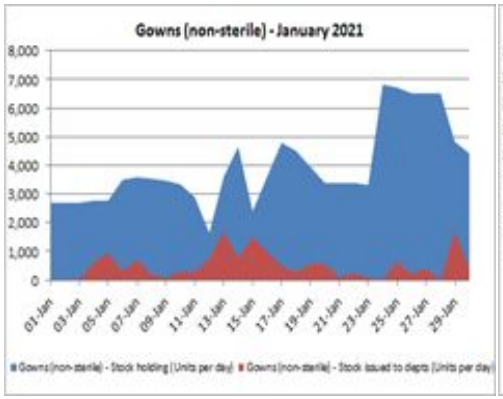
Safe care & Improving Outcomes: COVID-19 (Slide 2 of 3)

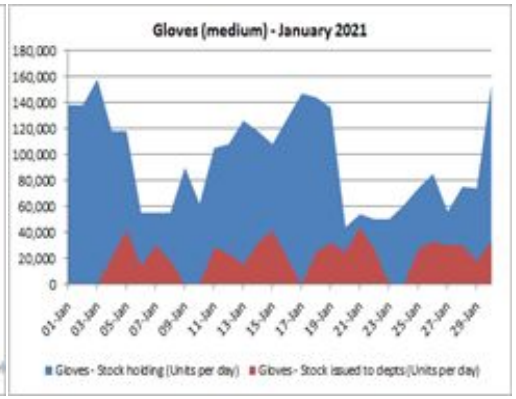
PPE

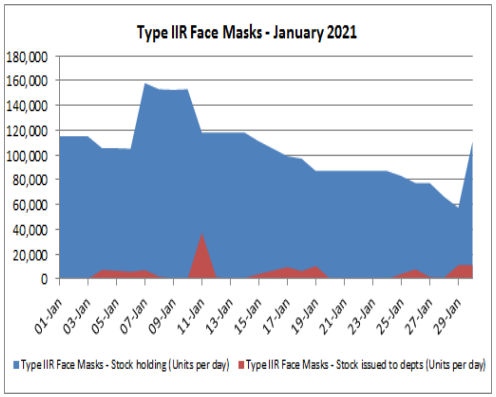
- Central DHSC control of supply and delivery of items from the National Pandemic stock continues.
- The graphs below show at a summary level usage (red block) has remained below stock level although during May stock levels for gowns were under pressure.
- The main current concern remains that National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

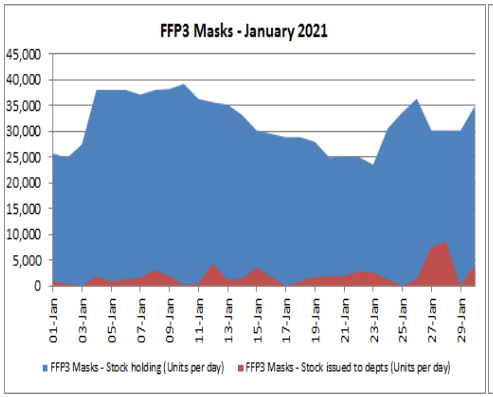


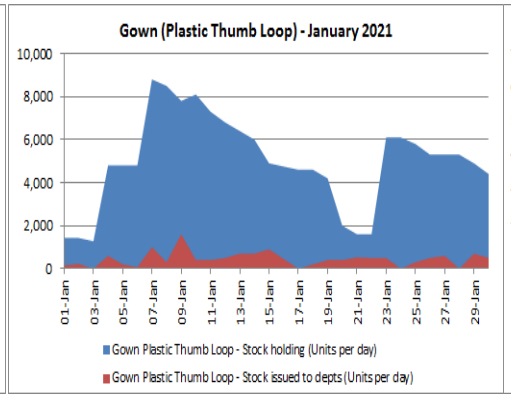


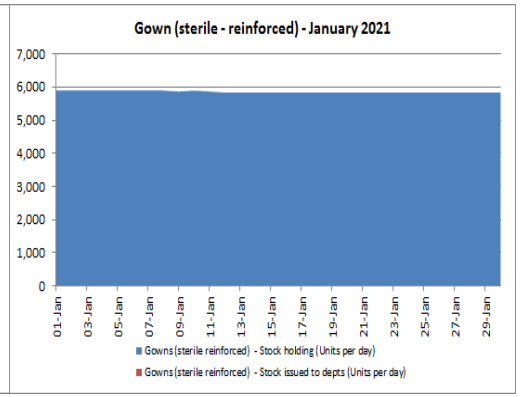












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Objective Ref
Safe Care & Improving Outcomes: Safe	Chief Financial Officer	Finance & Performance Committee	1b / 2a / 2b / 2c / 3a

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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 January there has been increasing numbers of patients admitted with Covid; the safe placement and management of these cases has been the key focus for the IPC team. Risk assessments for the management of those deemed to have had contact with positive cases has been undertaken to facilitate the operation and safe flow of patients through the organisation and prevent further nosocomial infection .

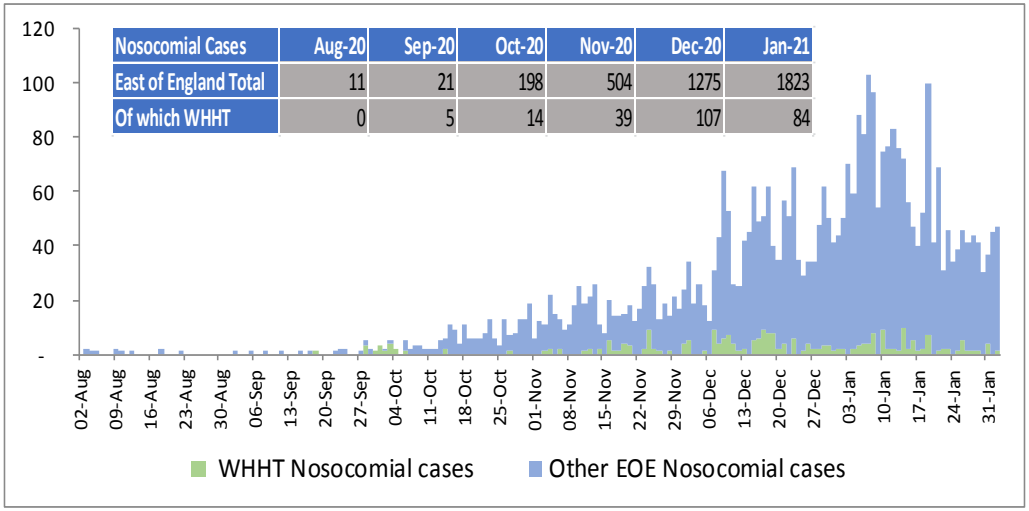
Following nosocomial outbreaks in Oct/Nov 2020 and the identification of a new variant strain of COVID-19, (with a high rate of transmission associated), the Trust has undertaken reviews including visits from NHSE/CCG IPC representatives. Feedback from the reviews was positive and suggestions for future management has been implemented.

In addition Microbiological genomic testing undertaken on random COVID-19 specimens including outbreak areas has illustrated that the new "Kent" variant was identified within the Trust in Nov 2020 and likely to have played a significant part in the transmission seen in many of the outbreak areas.

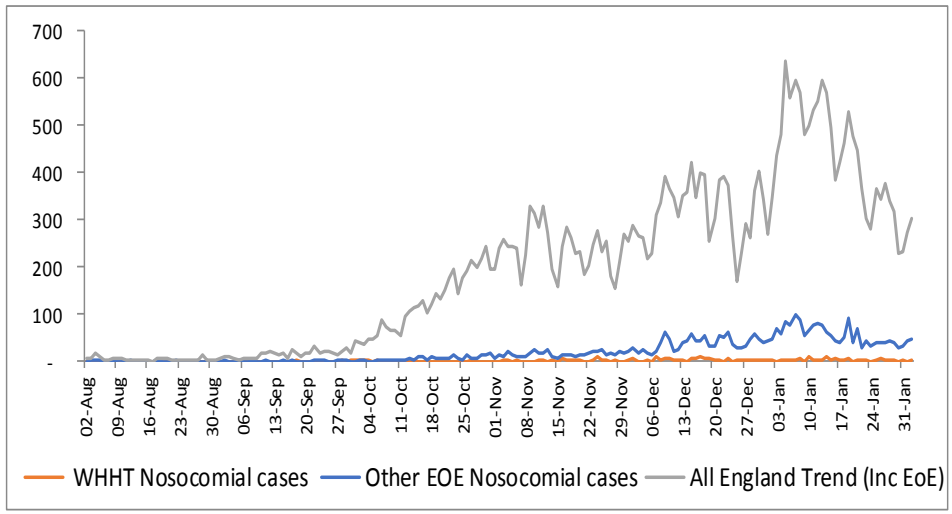
The IPC team supports the management of the COVID-19 Pandemic through support and advice in the safe management of patients with Covid including patient placement and PPE use. Spot check audits are undertaken to identify and areas of concern to target support.

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	Jan-21
East of England Total	11	21	198	504	1275	1823
Of which WHHT	0	5	14	39	107	84



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 (July 2020) was below the national average overall, and below for readmissions following an elective and emergency (original) admission.

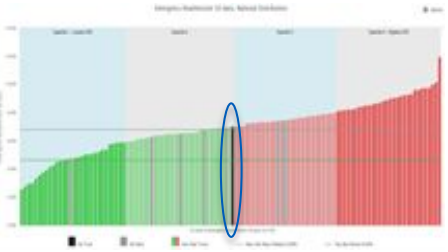
There has been an increase in the emergency readmissions rate to 13.5%, which is 1.6% lower than the national average of 15.1%.

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 July 2020

Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Emergency Readmission 30 days

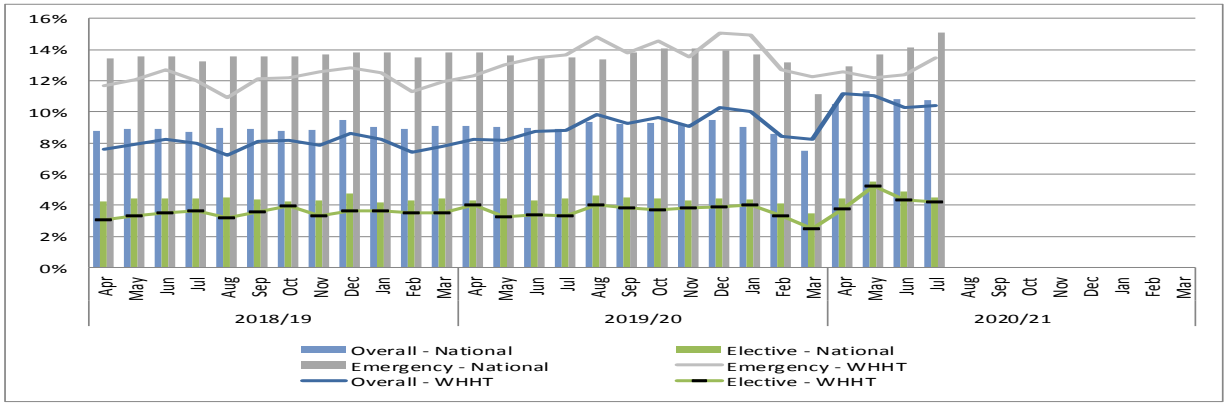


Period: Q3 2020/21

WHHT 7.01% Peer 6.8%
National 7.01%

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

Emergency Readmissions



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

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Safe care & Improving Outcomes: Caesarean Section rates

C-section rate
The elective and emergency combined rate is 35.6% (Emergency 19.7%, Elective15.9%).

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

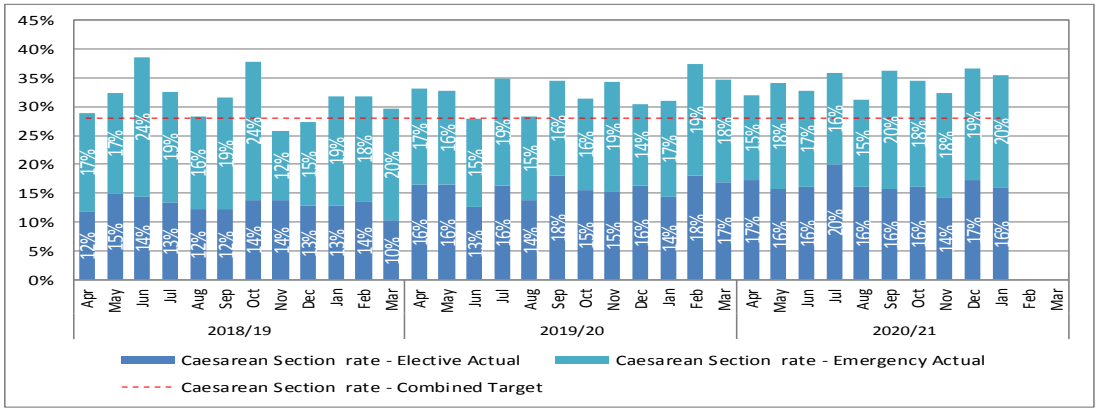
Benchmarking: MODEL HOSPITAL
Emergency Caesarean section rate

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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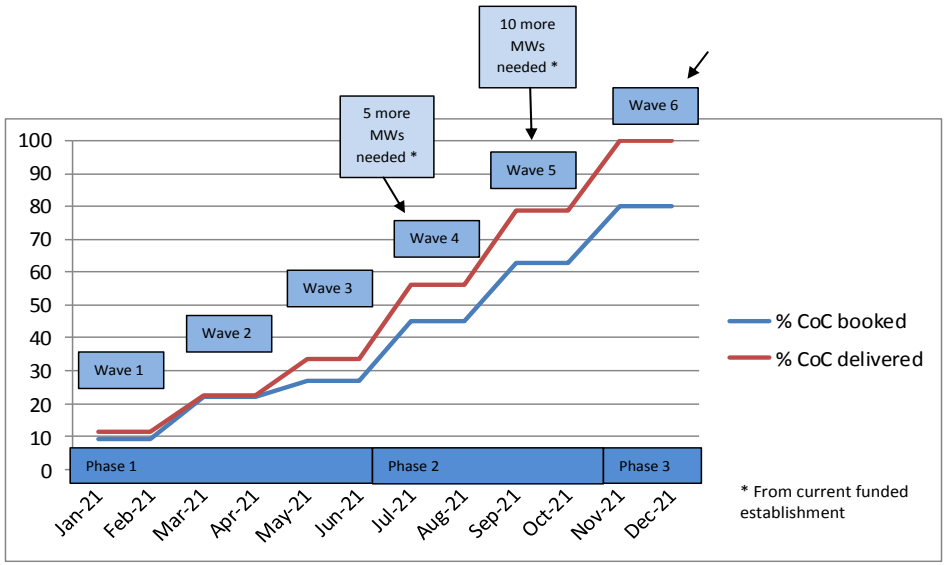
Safe care & Improving Outcomes: Maternity – Continuity of Carer

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 was 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. There is a specific requirement that the proportion of Black and Asian women and those from the most deprived neighborhoods are placed onto a continuity of carer pathway which 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 which confirmed that a waved approach to rollout is not currently feasible with the levels of midwifery vacancies and unavailability.
- The COVID-19 pandemic has had an impact on staffing availability.
- Orchid Team launched on 18/1/21 with 8WTE midwives and a caseload of 1:36. 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 March 2021.
- Better Births Project Midwife - LMNS funded post recruited to in December 2020
- 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 2021
- 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 16% 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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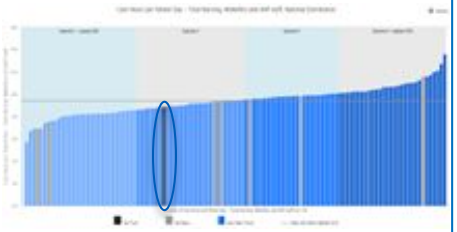
Safe care & Improving Outcomes: Workforce and CHPPD

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 January the overall fill rate was 96.9 % (89.2% registered / 104.1% unregistered). Due to the increase in covid demand a number of surge areas continued to be open throughout January. The Trust operated under Business Continuity 28 December through until 7 January. Throughout January there has been significant challenges around nursing and midwifery staffing resulting in a professional discussion and decision with senior leaders that adult ward areas would continue to operate under COVID Phase 2 templates. Workforce challenges in maternity are attributed to high vacancy and acuity and demand. Overall 53.3% shifts were RAG rated green, a decrease of 8.6% from last month. 41.5% were RAG rated amber, an increase 4.1% from last month and 5.2% were RAG rated red an increase of 4.5% from last month. Clinical areas log an incident via datix for any red shifts or red flags related to staffing. Ward leaders' supervisory time was 54.7%, of the 45.3% lost (10.82 % was due to annual leave, 34.48% due to redeployment to support safe staffing and the junior workforce). The preceptorship programme continued to be paused throughout January to support safe staffing and the vaccination programme. There continues to be an increased demand for temporary staff to meet service demand and substantive staffing challenges. A total of 98,763 hours were requested (5,991 more than last month). The overall fill rate is 67.2 % (63.3% registered and 72% unregistered), NHSP 56.8%, 10.4% agency. There were 32.8% unfilled. In addition, in order to support demand and acuity in ITU, Granger and ED and additional 89 shifts were covered by Thornbury agency. 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 8.29 a decrease of 0.54 from last month (Model Hospital data November 2020, peers 8.6 National 9.5). There was a significant demand for enhanced care/ mental health 1:1 in January and accounted for 1185 shifts an increase 889 shifts from last month (26 registered and 601 care staff by day and 37 registered and 521 care staff by night), this high volume has contribute to the Trust overall fill rates and CHPPD. Additional staffing to care for patients bedded in the surge areas will also impact on the fill rates and CHPPD. Throughout January clinical areas continued to be supported by the redeployed Frailty staff and SACH staff following the reduction in elective care. A collective nursing workforce response continued, with staff being redeployed across the organization to safe staffing to provide the safest care in a pandemic.

Performance stable
Better than target/threshold

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



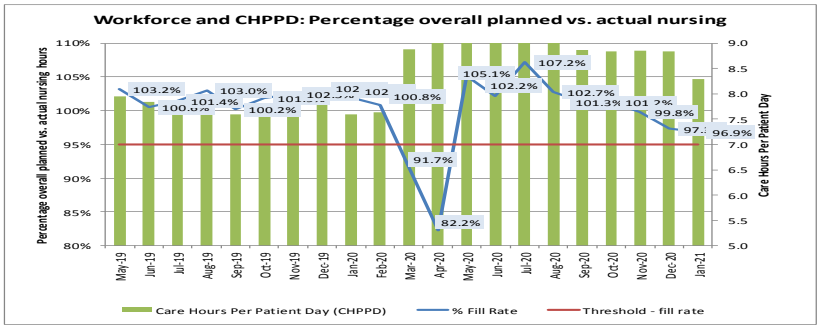
Period: November 2020

WHHT: 8.9 **Peer: 9.8**
National: 9.5

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

Factors/Themes

- Ongoing challenges with safe staffing due COVID positive patients, demand and acuity
- Continued to operate under Stages 1-3 (COVID Amber /Red Templates)
- RAG Rating escalation process put in place to indicate Division and overall Trust RAG for safe staffing
- Continue to be supported by NHSP and Agencies.
- Monthly Table Top Safe Staffing Review of Templates held with Chief Nurse
- Weekly Harm Free care meetings chaired by Chief Nurse
- COVID staffing is on the risk register (risk 4273) reviewed. Safe Staffing also division risk registers.
- ITU in super surge over 4 areas (main ITU area 1&2, Endoscopy and Recovery) Staffing as per National Guidance 1:2, reporting red on safe staffing daily. Fill rates ITU reflect staff that have been redeployed to support.
- 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 and remained off throughout January. They were both reviewed on 28 January, ETWD remains switched off, sickness rule switched back on, time trigger interval reduced from 14 days to 7 days.
- Areas closed, Frailty closed 2nd December to date; SACH elective care closed 29 December to date; PAU closed 29 December to 15 February; Patient Lounge 1 January to 8 February



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 – January 2021

Never events
No Never Events were reported in January 2021.

Serious Incidents
Seven (7) serious incidents (SIs) were declared in January 2021. Of these, Women and Children, Surgery, Anaesthetics and Cancer, and Medicine divisions reported two incidents each. Emergency Medicine division reported one incident. Of the seven SIs, two were classified as Covid-19 outbreaks. WACS- Maternity declared two SI's; one of which will be investigated externally by the national Maternity Healthcare safety investigation Branch (HSIB) the other led by the Trust.
Updated guidance received from NHSE/I requires that some patient cases should now be reported (retrospectively) as individual SIs, which will be reflected in the February report.

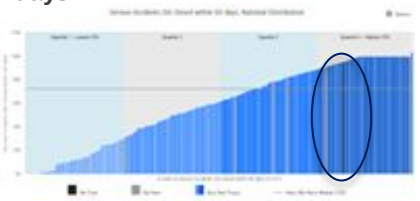
% of patient safety incidents which are harmful *
52.6% (141) of the incidents reported in January 2021 were recorded as causing "moderate or higher" level of harm to patients. This compares favorably with 62.5% (168) recorded in December 2020. This demonstrates a reduction in the percentage of incidents reported as harmful in January 2021 in comparison with the number of incidents reported in December 2020. Of the 141 incidents reported as causing moderate harm or higher, 132 incidents 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 lower in January 2021 (i.e. 7 incidents) compared with (9 incidents) reported in December 2020.

There were four incidents reported in January 2021 with a harm level rated as "death/Catastrophic".

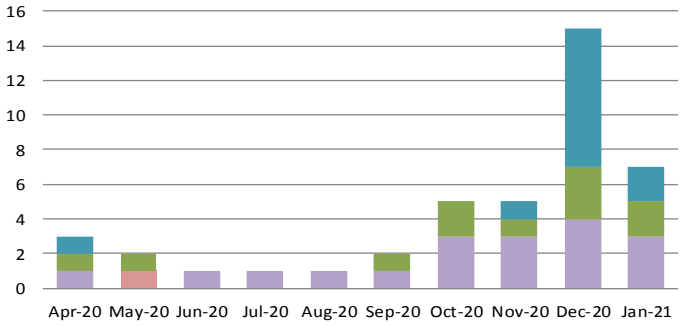
Performance deteriorated
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
Serious Incidents closed within 60 days



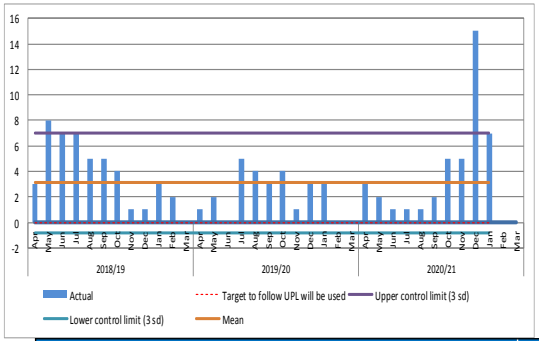
Period: 2018/19
WHHT 95% **Peer: 72%**
National: 61%

Serious Incidents by division

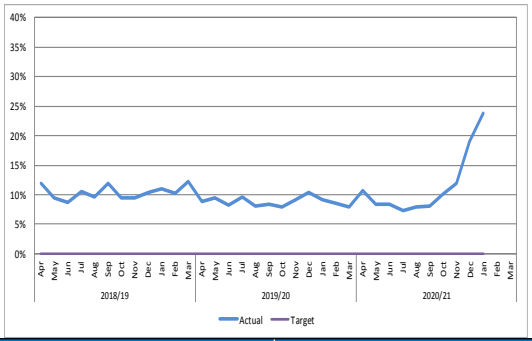


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Paeds	0	0	0	0	0	0	0	0	0	0
Maternity	1	0	0	0	0	0	0	1	8	2
Gynae	0	0	0	0	0	0	0	0	0	0
Surgery	1	1	0	0	0	1	2	1	3	2
Medicine	1	0	1	1	1	1	3	3	4	3
Emergency Medicine	0	1	0	0	0	0	0	0	0	0

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

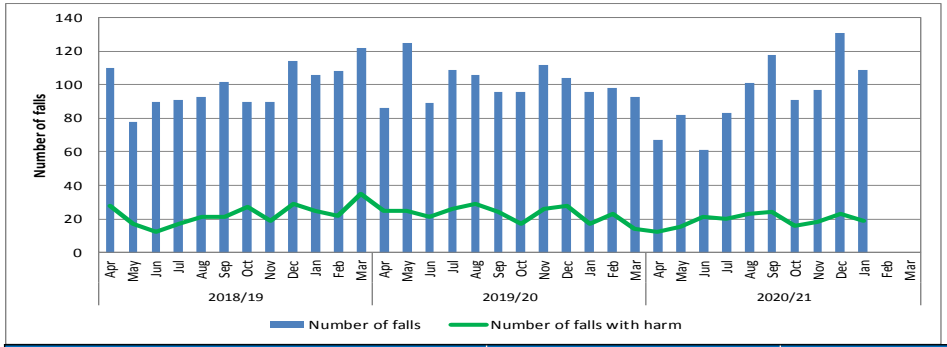
In this reporting period:

In January there were 106 inpatient falls: 15 falls with low harm; 1 with moderate harm and 1 with severe harm which resulted in poly-trauma.
The fall with severe harm was reviewed by both the falls and safeguarding teams immediately to support the ward staff through the post-falls procedures and begin the RCA process.
For falls with harm 8 (47%) were suspected (unwitnessed) and 9 (52.9%) were witnessed, 8 (47%) occurring during the night and 9 (52.9%) during the day. Of the falls with harm, 10 (58.8%) were linked to a cognitive impairment; 2 of which with a known Dementia.
Of the 106 falls reported in January, 80 (75.4%) occurred around the bed space, 72 of which were in a bay and 8 in a side-room. 21 (16.8%) of the falls reported were recurrent fallers.
Gade reported the highest number of falls: 8 falls (5 witnessed, 3 suspected; 6 within the patient's bed space in a bay and none in a side-room).
Ridge Ward reported 6 falls during January which was a 100% increase from the previous month; in discussion with the ward Physiotherapy team it appeared to be due to a high incidence of post-op delirium.
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.
The falls team has continued to collect data to observe the impact of COVID-19 on the use of the wristbands. It has not been appropriate to recommence the 'tag-in tag-out' system.
Weekly review of falls numbers has allowed for a more timely review of falls. There will be a reminder on the e-update for staff to refer appropriate patients to the falls practitioner.
The clinical engineering team are now informing the falls practitioner when Hi-low bed s are ordered to facilitate the support given to wards for high risk patients

Actions:

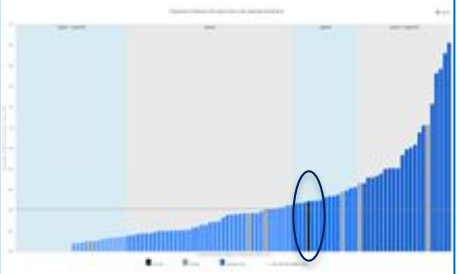
- Continue weekly review of falls numbers to gain a more detailed understanding of monthly trends to allow for a more tailored approach to falls prevention support
- Continue with ongoing support for Orthopaedic and Surgical Wards when incidence of post-op delirium is increased
- Review numbers of hi-low beds being ordered to explore this as a method of increasing support for wards with high risk patients
- 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

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Safe Care & Improving Outcomes: Pressure ulcers (HAPUs)

In January 2021 there were 26 reportable HAPU's, an increase from 19 in December (36.8%). There were no category 3 or category 4 pressure ulcers.

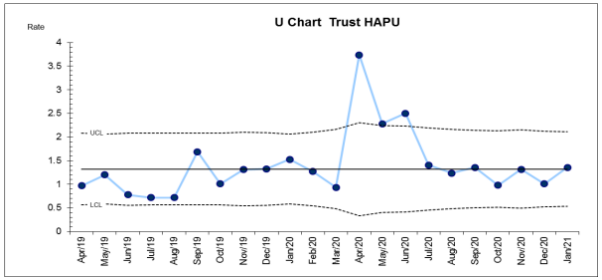
There were 11 MDRPU reported in January, compared with 5 in December. Out of 11 reportable MDRPU, 4 were associated with use of NIV. Despite an increase in the number of patients on NIV the Trust did not see an increase in pressure ulcers in relation to NIV. This reflects learning from wave 1 on the prevention of pressure ulcers and the positioning of the masks.

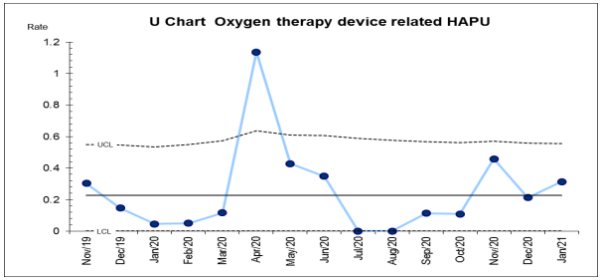
The HAPU data for January is within common case variation. Wave 1 saw special cause variation which has not been repeated in wave 2.

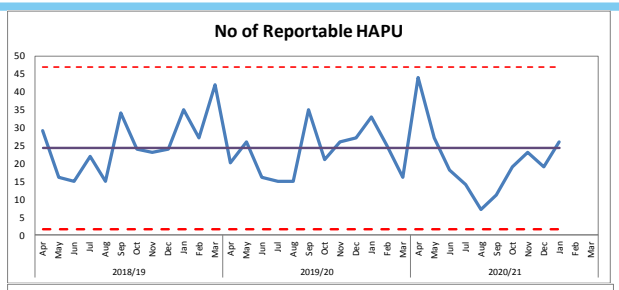
Actions/developments for Pressure Ulcer management:

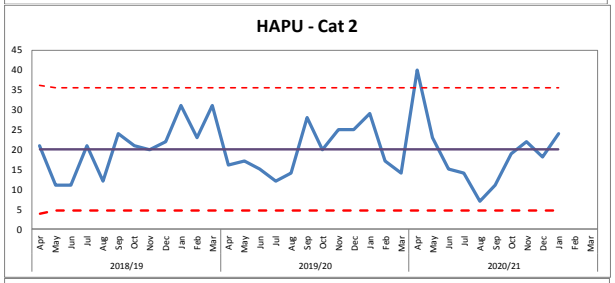
1. Continue to use of the wards safety huddles to raise awareness of:
 * the importance of timely effective repositioning, robust and timely reassessment of skin of patients at risk and documentation in accordance with the Trust guidelines.
 * Use Skin Champions to initiate projects on their wards to raise awareness around the need for precautionary and preventative approaches to MDRPU.
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 with 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 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. Supporting medical wards with regular reviews of skin carried about by the harmfree care team to support staff in meeting ongoing standards despite increased pressures and reduced staffing.

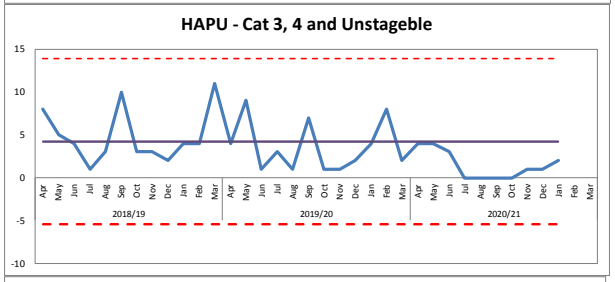
Reportable HAPU January 2020)			
Categories	HAPU	MDRPU	HAPU Total
Category 2	15	9	24
Category 3	0	0	0
Category 4	0	0	0
Unstageable (possibly category 3 or 4)	0	2	2
Total reportable	15	11	**26**
Non-Reportable HAPU			
Category 1	4	0	4
Suspected deep tissue injury (SDTI)	9	1	10
Total non- reportable	13	1	14

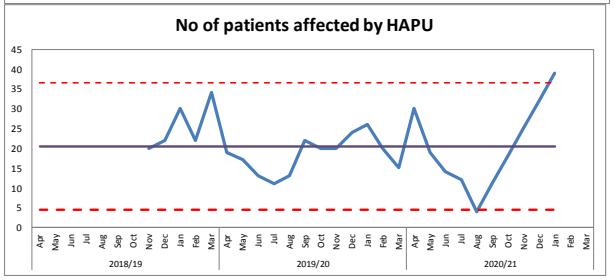












DOMAIN	EXECUTIVE LEAD	SUB-COMMITTEE	BAF Ref
Safe Care & Improving Outcomes: Safe	**Chief Nurse**	**Quality Committee**	**1b / 2a / 2c / 3a**

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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	**26**
AAU Y1	14
AAU G1	4
UCC	3
AAU B1	2
AAU P1	2
A&E	1
MIU	0
Medicine	**116**
Red	12
Croxley	12
Oxhey	11
CCU/ P/G 3	11
Aldenham	10
Bluebell	10
Winyard	7
Tudor	7
Cassio	7
AAU B/Y 3	7
Stroke	6
Sarratt	5
Winter	5
Heronsgate & Gade	5
Simpson	1
Frailty	0
Surgery	**50**
ICU	11
Ridge	9
Cleves	8
Flaunden	7
Elizabeth	6
Letchmore	6
Langley	2
DLM	1
Grand Total	**192**

Three Months

Emergency Medicine	**94**
AAU Y1	44
AAU G1	14
AAU P1	13
AAU B1	12
A&E	6
UCC	5
MIU	0
Medicine	**312**
Red	38
Bluebell	29
Oxhey	25
CCU/ P/G 3	24
Croxley	24
AAU B/Y 3	23
Winyard	23
Aldenham	22
Winter	20
Tudor	19
Cassio	18
Sarratt	18
Heronsgate & Gade	14
Stroke	13
Simpson	2
Frailty	0
Surgery	**105**
Cleves	23
ICU	19
Flaunden	16
Ridge	15
Elizabeth	13
Letchmore	9
Langley	9
DLM	1
Grand Total	**511**

Six Months

Emergency Medicine	**177**
AAU Y1	75
A&E	26
AAU P1	23
AAU B1	21
AAU G1	20
UCC	12
MIU	0
Medicine	**510**
Red	64
Winyard	45
Oxhey	38
Aldenham	38
Winter	38
Bluebell	37
AAU B/Y 3	35
Croxley	35
Heronsgate & Gade	35
CCU/ P/G 3	32
Cassio	30
Tudor	28
Sarratt	27
Stroke	25
Simpson	2
Frailty	1
Surgery	**195**
Flaunden	39
Cleves	35
ICU	31
Elizabeth	26
Letchmore	24
Ridge	22
Langley	15
DLM	3
Grand Total	**882**

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Safe care & Improving Outcomes: VTE risk assessment

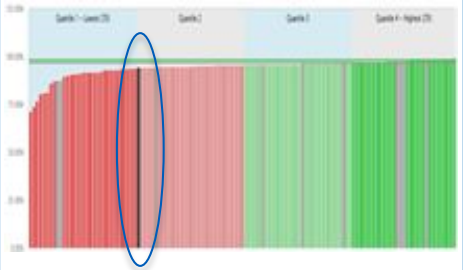
In this reporting period:
The target was achieved this month.

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

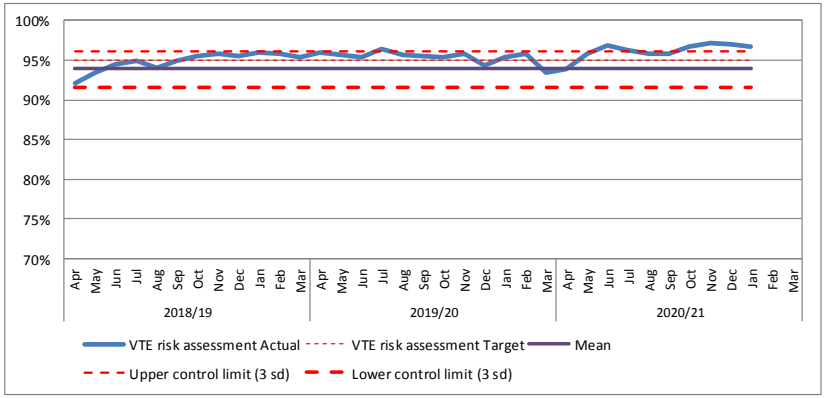


Period: Q3 2019/20

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 – 13.2%

Since the beginning of the Covid pandemic performance on this metric has deteriorated. All patients admitted to the Trust have Covid swabs prior to any planned ward transfers and wait in a holding ward until the swab results are available. Fast track swabs can take up to 6 hours resulting in the inability to standardise admission the Stroke Unit within 4 hours. While awaiting swab results and transfer to HASU, patients are reviewed by the stroke team and continue to receive stroke specialist care. Patients who receive thrombolysis are prioritised for transfer to a ring fenced side room on the Stroke Unit for monitoring and thrombolysis protocol care. Positive COVID stroke patients are not admitted to the stroke ward but still receive stroke specialist input.

90% stay on Stroke Unit 60.9 % (target 80%)

This target has not been achieved – there has been a knock on effect from the pandemic including an outbreak on the Stroke Unit resulting in patients requiring transfer to covid areas.

Thrombolysed within an hour 50 % (SSNAP target 55%)

The number of patients thrombolysed within a month will fluctuate month to month depending on factors such as symptoms, time of presentation and required imaging. Those patients who are thrombolysed out of hours (between 5pm and 8am) are reliant on the telemedicine out of hours service which introduces delays in consultation and uploading of images.

Performance stable
Better than target/threshold

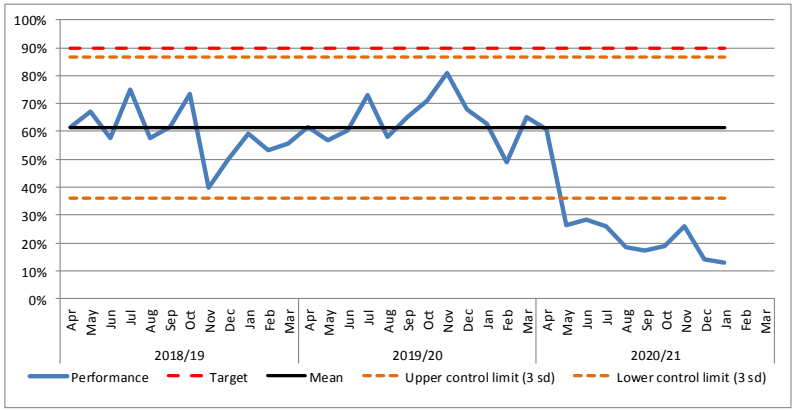
Benchmarking: SSNAP

Period: July to September 2020

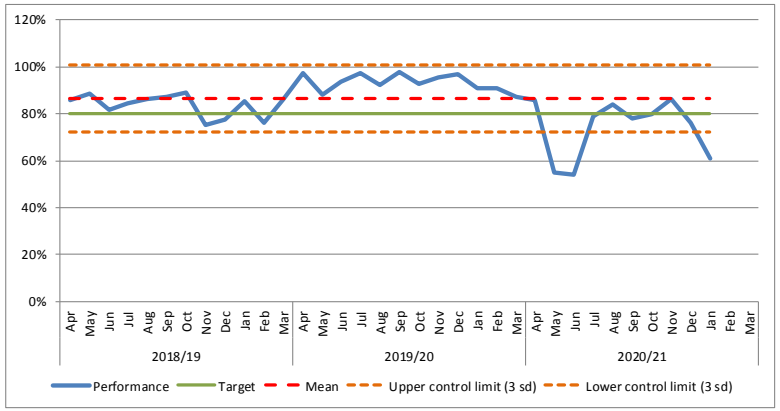
Admission within 4 hours: 59.3%

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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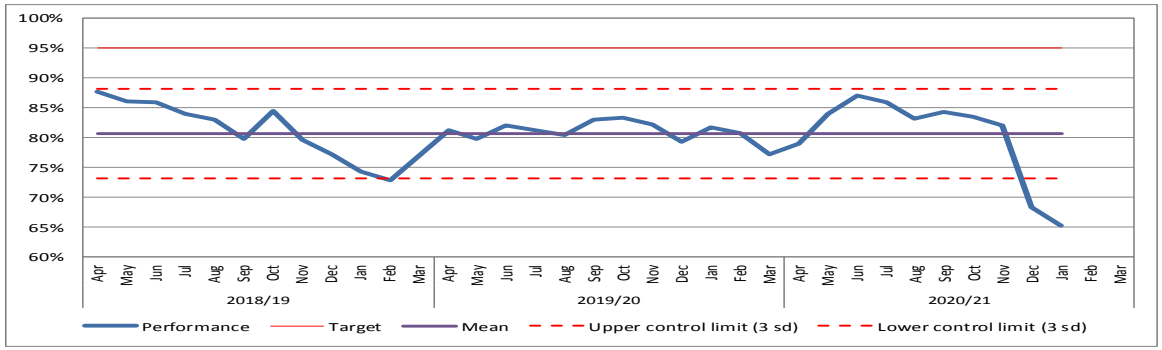
Caring & Responsive Services: Emergency Department

In this reporting period January 2021:
At 65.3%, overall Trust performance decreased on the previous month's position of 68.4% . This is as a result of the 2nd wave of covid with high number of Covid attendances. Compliance with the 95% standard was maintained at HH UTC at 100%. Performance at the WGH UTC was 99.6%. COVID hinders established assessment pathways, staffing is a considerable constraint and admitted pathways are disrupted. Hemel UTC attendances have continued to reduce, falling by 17% 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 dropped 19% in January compared to the previous month. 75 twelve hour breaches were incurred in January due to ED and bed capacity constraints. A harm review process has been established.

In January the average ambulance handover time at the start of the month was the same as December at 50 minutes improving to 32 minutes by month end. Conveyances continue to increase with a 6.2% rise from the previous year in comparison to a decreasing trend across the region. The number of over 60- minute offload delays decreased to 228 from 512 in December with patient cohorting enacted. In partnership with EEAST, crews were on site 24/7 to support which reduced offload delays. Patients were offloaded in clinical priority and assessment cubicles were ring fenced for initial assessment.

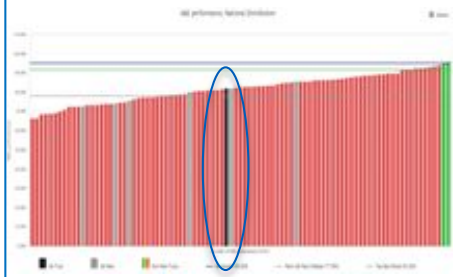
Next Steps:
- Continue to work with EEAST to support offload delays
- Ensure safest care in ED with corridor care SOP in place and active cohorting from EEAST.
- Harm reviews on patients who breach 12 hour DTA standard and those who are cohorted.
- We aim to improve flow with the addition of the Fracture 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 continue overseeing the ambulance work stream with a joint action plan between EEAST and the Trust.
- 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 increasing 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

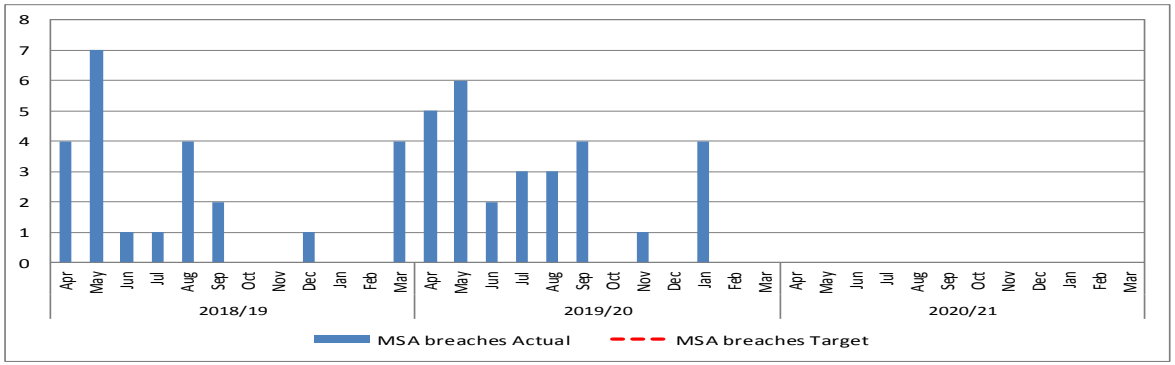
Benchmarking:

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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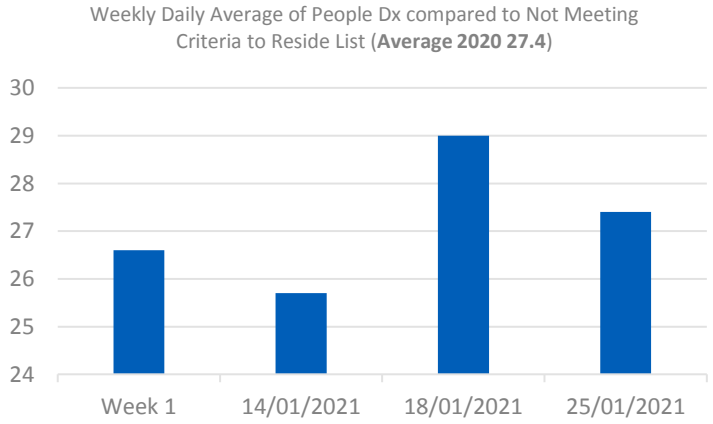
Caring & Responsive Services: Delayed Transfers of Care

In this reporting period:
Chart 1 indicates that over January 2021 we maintained performance at 2020 levels in terms of the same ratio of patient discharge via IDT compared to the total number of people who do not meet the criteria to reside. The performance is variable and may reflect a couple of issues – a high volume of referrals following the festive season and provider agencies being able to meet the post festive demand and the prevalence of COVID across home care and care home services. Performance improved as we moved through the month, which is in part due to the number of MO's reducing. Chart 2 details that the volume of people who do not transfer from hospital due to External reasons has decreased compared to December but the movement is negligible, with external issues being the key concern.



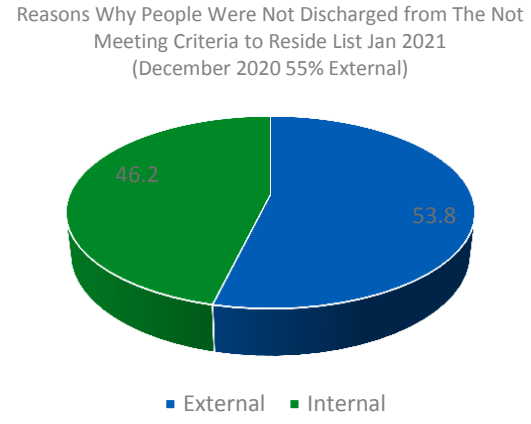


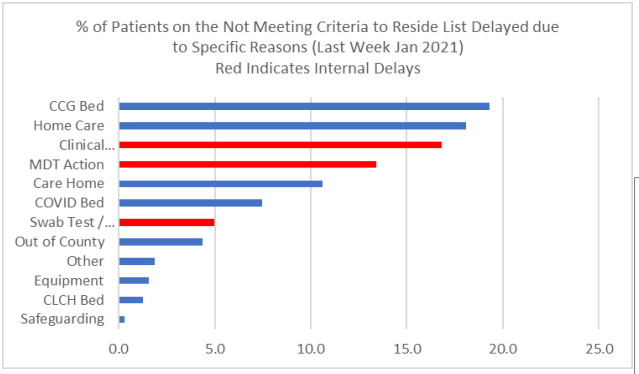
Chart 3 details specific nature of delays for people transferring who are fit to do so through the last week of the month to indicate common themes. Capacity remains the concern, although surprisingly the Complex Care Pathway is the most challenged, followed by home care. The key areas for focus for the trust is accurate decision making around medical status and delays due to MDT action.

Key areas of focus for IDT and the Trust need to be:

- Accuracy of Medical Decision Making, supporting effective discharge planning. Too many patients discharges are planned only for the ward to declare they are medical at the end of the day.
- Timeliness of Discharge Information Forms especially at weekends.
- Goal Setting on DIF's by therapists

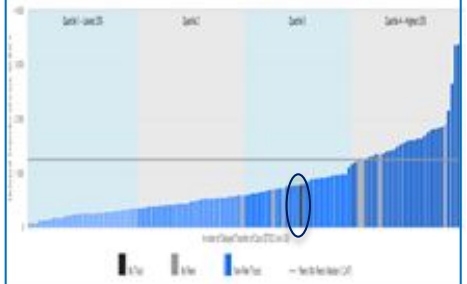
Externally IDT will be working with partners to:

IDT now have CCG presence in team to support complex pathway flow, there is scope for further joint funding and commissioning work
Development of Home Care Strategy
Planning for the ending of COVID funding and the substitute amendments to support flow



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

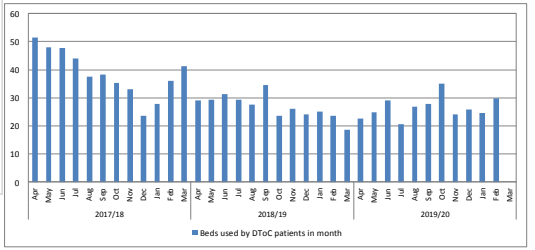


Period: December 2019

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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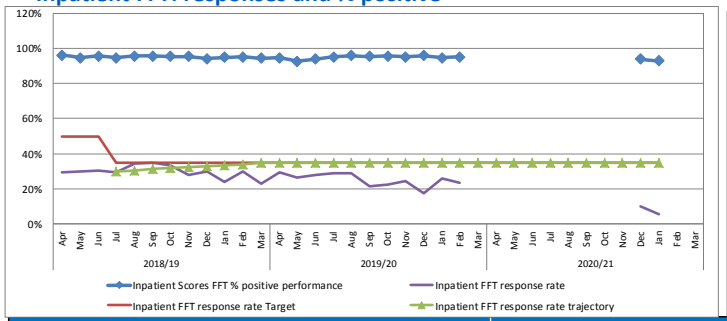
Caring & Responsive Services: Friends & Family Test (1 of 2)

In this reporting period:
Inpatients
There has been a considerable increase in the response rate for January of 25.4% from last months 18.2% , possibly due to last months error with IQVIA not processing forms on time before cut off (Delayed Christmas postal service) There is a marginal reduction in recommendation rate of 1.2% and increase of 0.8% of those not recommending,
Areas showing 80% plus on response rates include: Heronsgate, Tudor, SCBU.
Unfortunately response rates in Endoscopy, Ambulatory care Unit, Helen Donald, Safari Day Unit, ESAU all performed less then 10% in there Response rates.
There is an increase of 20 out of 24 inpatient wards achieving the internal response rate target of 30% (last month 17 wards) and 19 also achieved the CCG target of 35%. (Last month there were 12) (Again possibly due to last months error with IQVIA not processing forms on time before cut off.)
A total of 1624 comments were received from inpatients of which 1603 were positive and only 21 were negative. 94.7% positive response with 1189 indicating extremely likely to recommend the organisation , 414 likely and 54 neither likely or unlikely
Feedback for Cleves ward were "nurses and staff are fantastic at smiling All day and night not something the normal worker can achieve, top drawer service and thank you all god bless" and Tudor Ward had comments such as "Everyone is extremely professional caring and kind. Nothing is too much trouble. The ward is very clean. Bed is made every day. Treatment is always explain in full. Nurses work very hard"

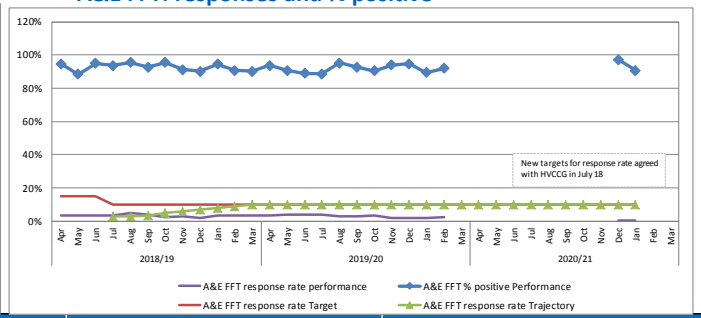
A&E
The response rate has shown an increase of 2.15%, however the data for recommending the service has shown a decrease this month from 94.8% down to 89.6%. Unfortunately the number of patients not recommending has shown an increase and a difference of 1.9% in comparison to last month.
There were 190 positive comments and 9 negatives
Positive comments for the department were that it was "Fast, everyone pleasant and helpful and effective," and "Very efficient. Lovely nurse and doctor, easy to talk to, made me feel reassured "
NHSEI have reiterated that the FFT is not designed to make comparisons between organisations. It should be used for continuous improvement, opportunity for feedback, anonymous, quick and easy for users, can be shared with staff in near real time, collectively can identify themes.

Next steps:
Following a presentation from NHSI/E on the FFT changes being implemented in April 2020, a paper will be presented to PAC & TMC

Inpatient FFT: responses and % positive



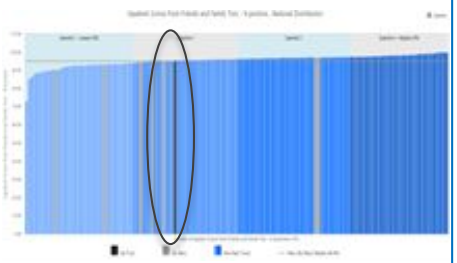
A&E FFT: responses and % positive



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

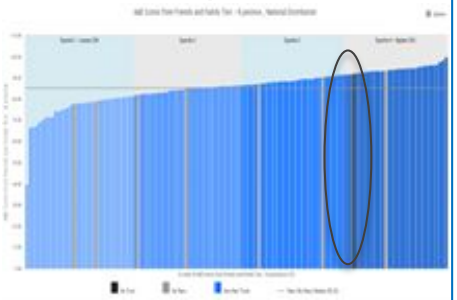
Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Inpatient FFT scores % positive



WHHT: 95.4% **Peer: 94.9%**
National: 96.2%

A&E scores - % positive



Period: February 2020

WHHT 92.1% **Region 85.2%**
National 86.6%

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

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Caring & Responsive Services: Friends & Family Test (2 of 2)

Day Case
The average response rate within day surgery has decreased from 23.6% to 19.9%; However both sites however had 0% negative comments St Albans response rate is 23.2% with a positive response rate of 99.2% and Watford response rate is 1.0% with a positive response rate of 100% and the recommendation rate did increased by 0.2% to 99.2%.
An example of positive feedback from St Albans was "I was made to feel at ease from start to finish everything was explained fully and was easy to understand" and at WGH it was commented that "the staff were all extremely nice"

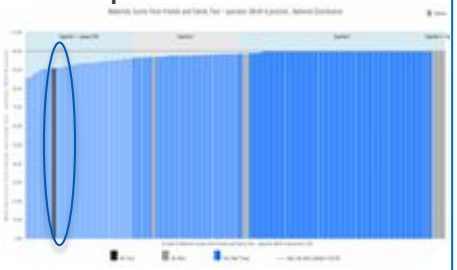
Outpatients
Responses have increased for the month of January as there were a total 4349 responses from last months 2269 responses, and the recommendation rate increased marginally and remains above 94% at 94.3% . There was a marginal increase of 0.1% for those not recommending from December.
A positive comment from Out patients at Hemel was "So far I've always been treated with respect on this visit and my previous visit with my husband as a patient. Explanation have always been given when questions asked with patience and kindness"
"Fantastic hospital" "Excellent care and treatment" "Doctor was very thorough and a good listener" were comments from St Albans Outpatients.

Themes continue to be regarding length of time waiting to be seen and some communication issues with cancelled appointments.

Maternity
The response rate has increased by 7.3% for the month of January to 37.0% and shown a positive increase in those recommending by 4.6% to 97.9%. A fall in not recommending showing a difference of 1.2% from last month to 0.7%
There was an increase of positive comments to 138 with only 1 negative.
Positive comments on Katherine ward were "There was so much support and help from everybody. Answered all my questions no matter how silly it was"
Next steps:
Following a presentation from NHSEI on the changes due in April 2021, a paper will be presented to PAC & TMC with recommendations for alternative feedback mechanisms for capturing patient experience.

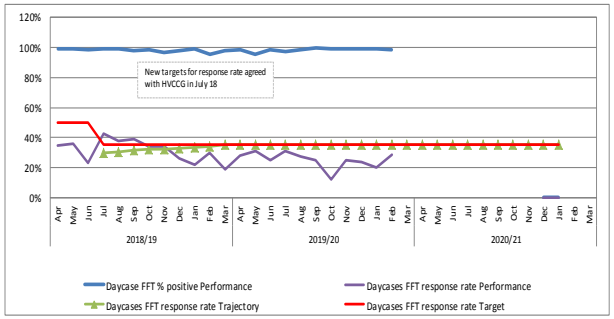
Performance stable
Better than target/threshold

Benchmarking: MODEL HOSPITAL
Maternity scores from FFT – Q2
Birth % positive

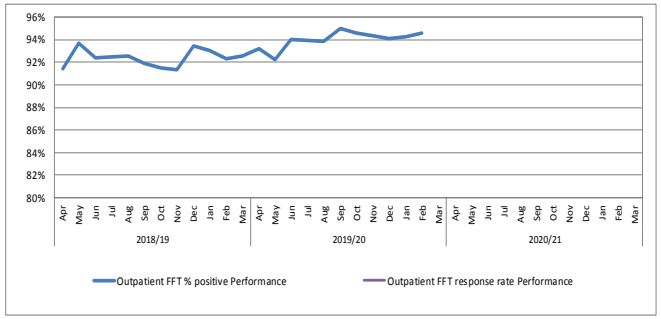


Period: February 2020
WHHT: 91.0% Peer: 100.0%
National: 98.7%
(Peers = Nightingale Group – acute multi-site trusts)

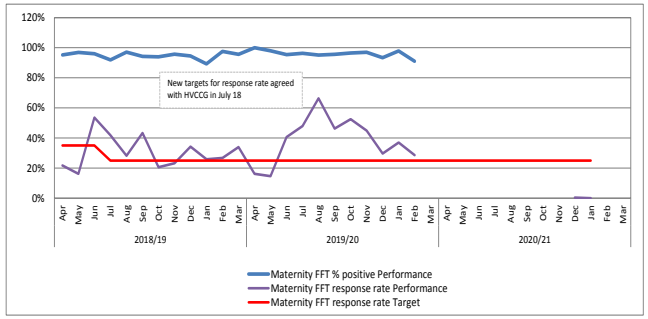
Daycase FFT: responses and % positive



Outpatient FFT: responses and % positive



Maternity FFT: responses and % positive



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

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Caring & Responsive Services: Complaints

In this reporting period:
87% of complaints were responded to within the required time in January (target 80%)
25 new complaints were received as follows:

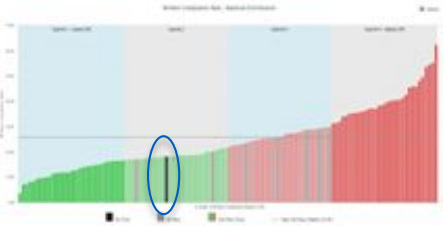
- 32% (8) relate to Surgery, Anaesthetics and Cancer (SAC)
- 24% (6) Medicine
- 16% (4) Women's & Children's (WACs)
- 16% (4) Emergency Medicine
- 4% (1) Corporate
- 4% (1) Environment
- 4% (1) Other

At month end there were a total of 35 live complaints (down by 12 compared to previous month).
38 complaints were closed in the month. Three (3) complaints were re-opened in January 2021 (2 corporate and 1 Medicine)

Factors/Themes:
Trust wide, common themes remain all aspects of clinical care (incl. clinical care and treatment) at 44% (11); Communication at 12% (3), Inappropriate/unsafe discharge 4% (1), Loss of Patient Property 12% (3), Cancellation of elective procedure 4% (1) Staff attitude 12% (3) and other 12% (3). No specific themes or trends have been identified although communication (written and verbal) remains a consistent factor throughout all complaints received.

Performance improved
Better than target/threshold

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

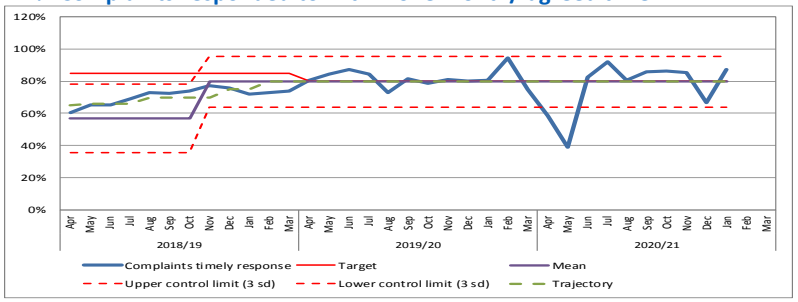


Period: December 2019

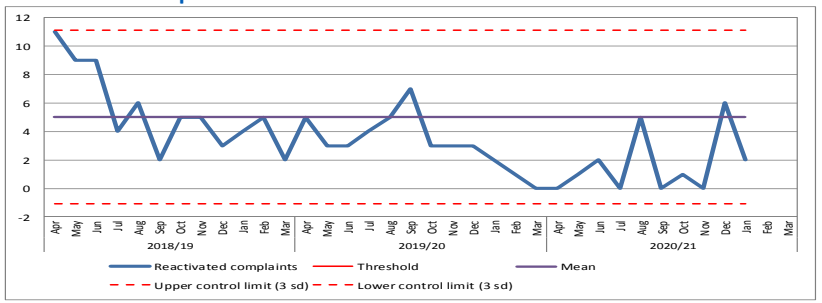
WHHT 18.36 Peer 25.90
National 21.95

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

% Complaints responded to within one month/ agreed time



Reactivated complaints



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

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Caring & Responsive Services: End of life care

In this reporting period:

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

Referrals to Specialist Palliative Care

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

In January 2021, **203** 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 **9** patients in January 2021 who died in a setting that was not their preferred place of death (PPD). For the 7 patients wishing to be at home all of them had physical symptoms that did not permit their transfer home . There was 1 patient that wished to die in a hospice but unfortunately there was no hospice bed available at that time.1 patient who wished to die in a nursing home, was 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 January , 6 patients were on the IPCD. There were 4 patients who **did not** have an IPCD and it was deemed that it **would** have been appropriate to use in 1 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.

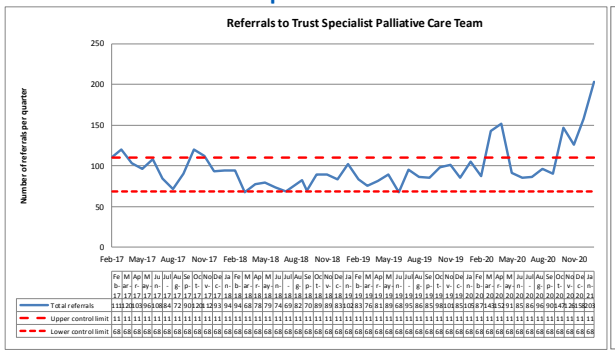
Of the 10 patients whose notes were reviewed, who died in January 2021, **all** patients had a TEP in place; however only 5 of those patients had had their TEP appropriately reviewed. There were no patients without a TEP in place. We continue to provide ongoing education on the importance of TEPs across the Trust.

Stable

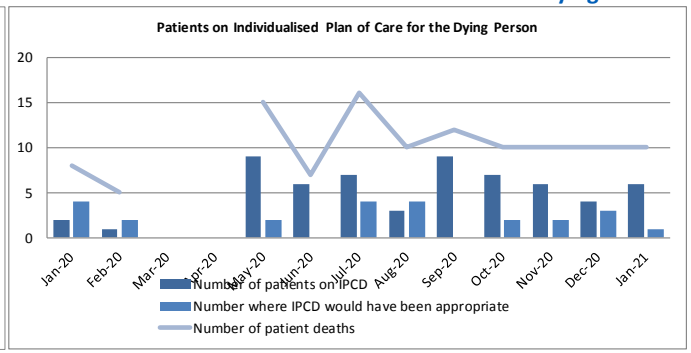
Benchmarking:

Not currently available

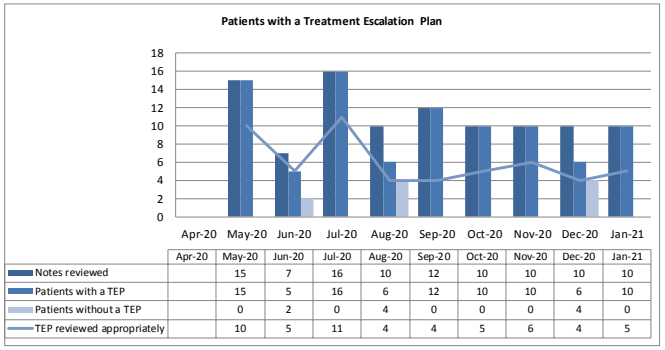
Referrals to Trust Specialist Palliative Care Team



Patients on Individualised Plan of Care for the Dying Person



Patients with a Treatment Escalation Plan



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Notes reviewed		15	7	16	10	12	10	10	10	10
Patients with a TEP		15	5	16	6	12	10	10	6	10
Patients without a TEP		0	2	0	4	0	0	0	4	0
TEP reviewed appropriately		10	5	11	4	4	5	6	4	5

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

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Caring & Responsive Services: RTT Open pathways

In this reporting period:
Improved open pathway performance fell slightly in December, from 78.8% to 76.1%. There was an increase in the over 18 week backlog, and the PTL has also increased.

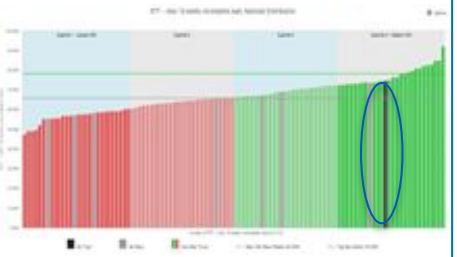
The median waiting time at WHHT (i.e. the weeks half the patients on an RTT pathway were waiting) was better than the national position (8.2 vs 11.2 weeks). The 92nd percentile wait time was also slightly below (47.3 vs 47.4 weeks).

The increase in 52 week waits continues, and at the end of the month there were 1463 patients whose waiting time exceeded 52 weeks wait, the majority occurring in Oral Surgery, ENT and Ophthalmology.

Diagnostics
Performance has decreased as a result of increasing pressures from urgent and emergency care demand with deterioration from 72.5% to 69%.

Performance improved
Worse than target/threshold

Benchmarking: MODEL HOSPITAL
RTT – 18 weeks incomplete wait

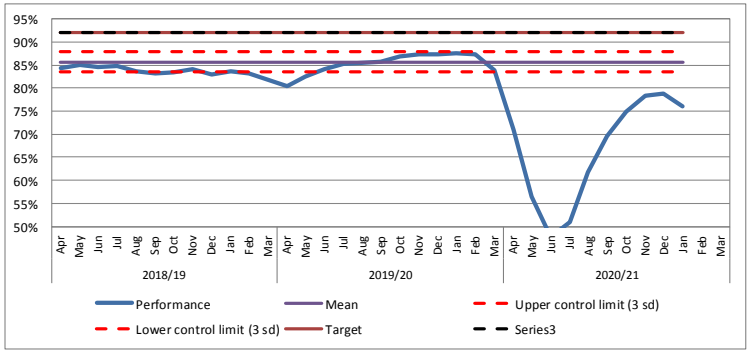


Period: October 2020

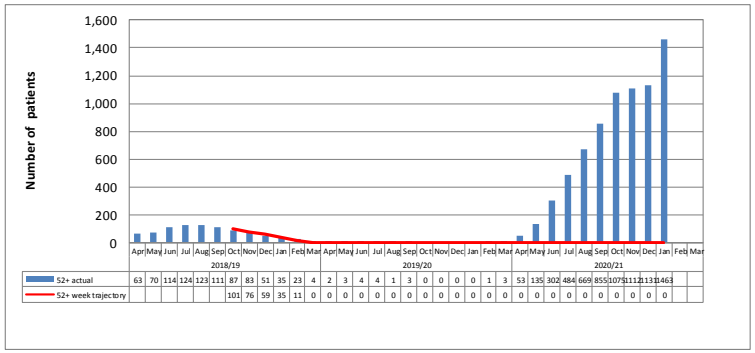
WHHT: 74.84% Peer: 65.90%
National: 66.52%

(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

51

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Caring & Responsive Services – Cancer: Two week wait

In this reporting period:

2 week waits:
The provisional position for January is non-compliant at 85.2 % with 1261 referrals - a reduction of 201 from December. Of these 187 were seen beyond 14 days. Of the 187, 144 x breast 3x gynae, 11 x H&N, 12 x LGI, 1 x lung, 2 x skin, 7 x UGI, 7 x urology and 1 x haematology. In January, the Trust received 83 % of 2ww referrals compared with February 2020.

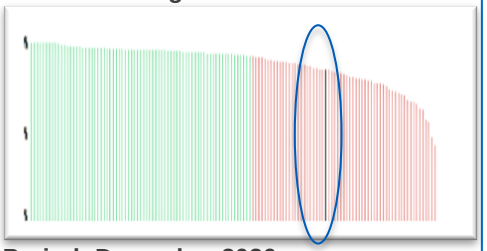
2 week wait breast symptomatic:
The provisional position for January is non-compliant at 64.3%. There were 154 referrals. Of these 55 patients were seen beyond 14 days. This was on account of a particularly high number of referrals in October and November which had an influence on clinic availability in December and January. During the second half of January, the service were able to book the first appointment at around day 12. A demand and capacity review is underway .

28 day Faster Diagnosis Standard achieved (target 75%): January's FDS activity is

- 2ww - 76.5%
- Breast Symptomatic – 86.8%
- Screening –71.4%- 2 patients with 2 Breaches (2X LGI)

Performance improved
Better than target/threshold

Benchmarking: NHSI ANALYTICS HUB
Cancer Waiting time dashboard

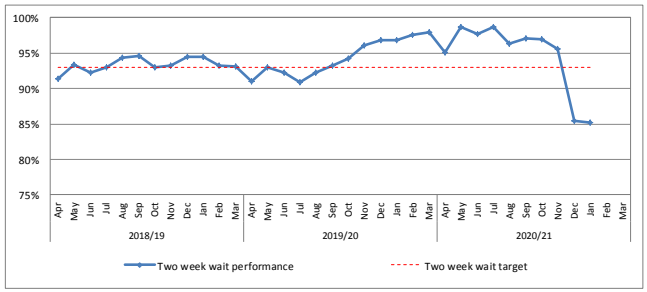


Period: December 2020

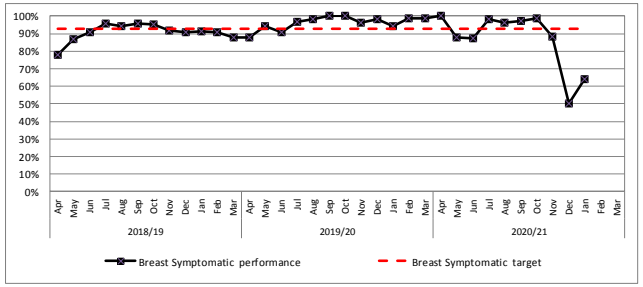
WHHT: 85.4% **Peer: 85.9%**
National: 87.5%

(Peers = East of England region)

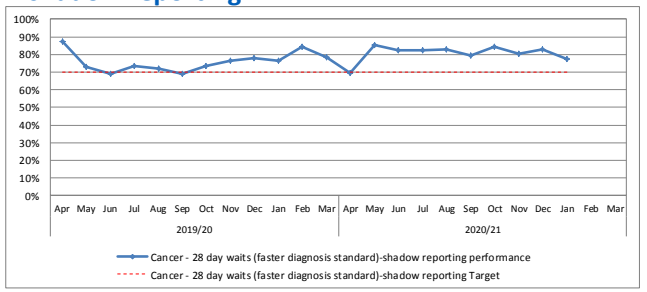
Two week waits: % within target time



Breast symptomatic patients: % within target time



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



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

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Caring & Responsive Services: Cancer 31 day

In this reporting period:

31 day referral to first definitive treatment
The position for January is provisionally compliant at 98.5 % with 131 pathways of these 2 were breaches (2 x gynae patients)

31 day subsequent surgery
The provisional position for January is non-compliant at 83.3%, there were 24 pathways with 4 breaches (2 x breast 1x urology and 1x gynae)

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

31 day subsequent palliative and other
The provisional position for January is compliant at 100 % with 10 pathways.

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

Performance improved
Better than target/threshold

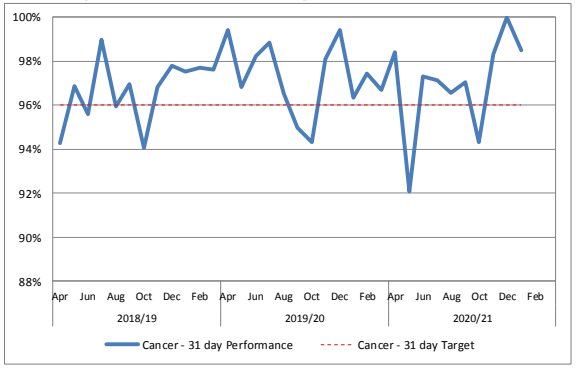
Benchmarking: NHSI Analytics Hub

Period: December 2020
31 day first:

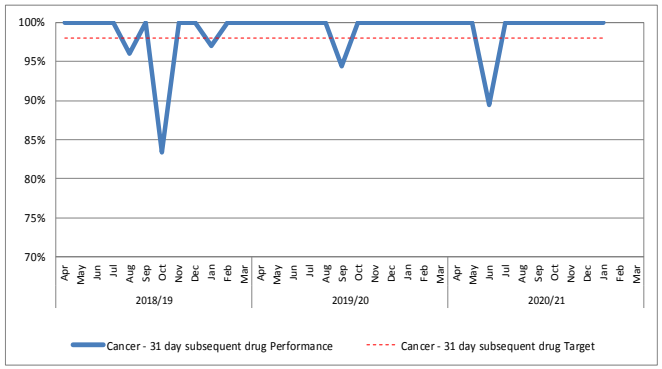
WHHT: 100.0% Region: 94.6%
National: 96.0%

31 day surgery:
WHHT: 87.0% Region: 86.0%
National: 89.1%

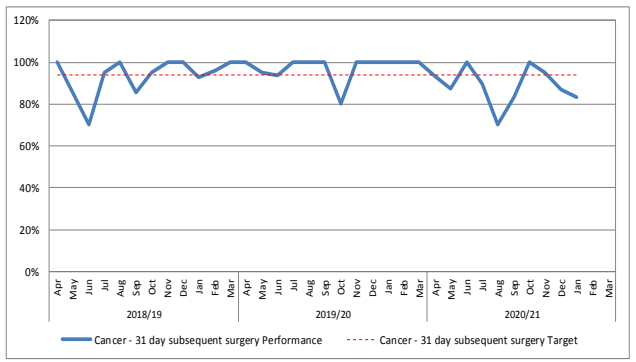
31 day first: % within target time



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

53

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Caring & Responsive Services: Cancer 62 day urgent GP referral

62 day referral to first definitive treatment –
The position for January is non-compliant at 84.7%. Provisionally there are 85 treatments (94 patients) with 13 breaches (16 patients). This includes 1x breast, 3x gynae, 2x haematology, 4 x LGI , 3x UGI 1 x head and neck , 2 x urology . The number of people that the Trust treated on a 62 day pathway has reduced this month. The average number of patients during the past 6 months has been 105/month . In January we treated 94 patients.

A review of the breaches, prior to full validation indicates lack of elective capacity due to either beds or theatre as a dominant theme. There were also delays within diagnostic pathways relating to requesting tests, waiting for results and booking OPA appointments. Staffing, patients' health and some complex pathways also featured.

62 day screening referral to first definitive treatment –Performance for January is provisionally non-compliant at 84.6% with 6.5 pathways (8 patients) with 1 breach

62 day consultant upgrade –The provisional January position is 100% with 4 pathways (5 Patients) all treated within target .

104 day breaches open pathways: Open On the 24th January there were 17 open pathways over 104 days, which consisted of 3x breast,5 x urology 2x LGI, 1x lung, 5x Head & Neck and 1x haematology. 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.

Closed – In January, the Trust closed 4 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

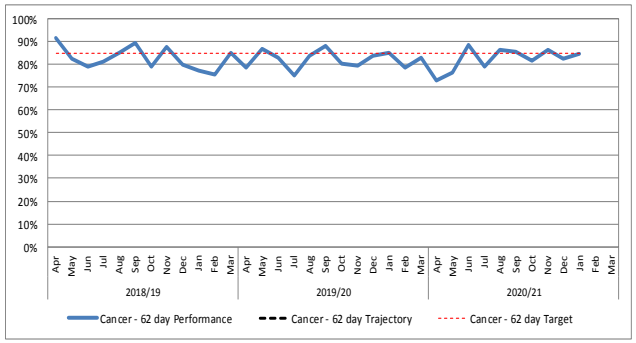
Period: October 2020
WHHT: 80.00% Peer: 75.77%
National: 75.39%

Peers = Nightingale Group – acute multi-site trusts

Benchmarking: NHS Analytics Hub
Period: December 2020
WHHT: 81.1% Peer: 73.5%
National: 75.2%

Peers = East of England Region

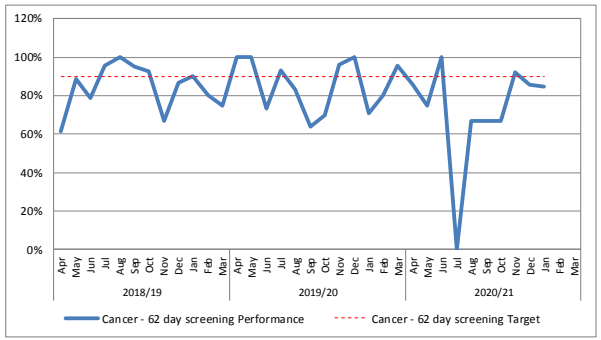
62 day GP: % within target time



62 day GP: Tumour Site

Tumour type	January
Breast	100
Gynaecological	83.3
Haematological	60
Head and Neck	50
Lower Gastrointestinal	33.3
Lung	100
Skin	100
Upper Gastrointestinal	28.6
Urological	94.4
Total	85.5

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

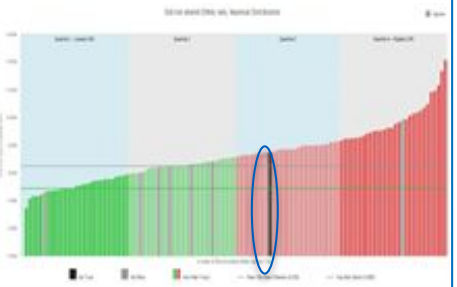
In this reporting period:

- Majority of re start work completed – focus is now Outpatient Transformation
- Reduced face to face activity on the WGH Site process in place for essential requests with rational for non virtual attendance
- Revised cancellation letter and COVID attendance instructions inserted in patient correspondence
- Structured Conversation ongoing with services
- Attain and WHHT Outpatient Transformation meeting plan in place for March 2021
- New Advice and guidance functionality conversions of referral, instructions have been communicated to all services
- Installation of Digital phones in OP completed.
- 426 Clinic Revision requests received and completed
- Clinic Build Cerner Training commenced
- Adoption and transgender SOP ratified and communicated to all services
- Medical Records FBC completed and circulated to Exec Team.
- Non printing of ERS Referrals and use of electronic clinic out come forms pilot date agreed
- Build out of Electronic clinic outcome forms for all services ongoing

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

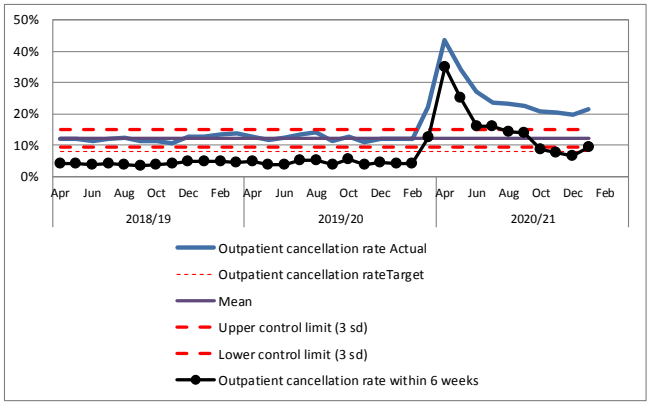


Period: Q3 2020/21

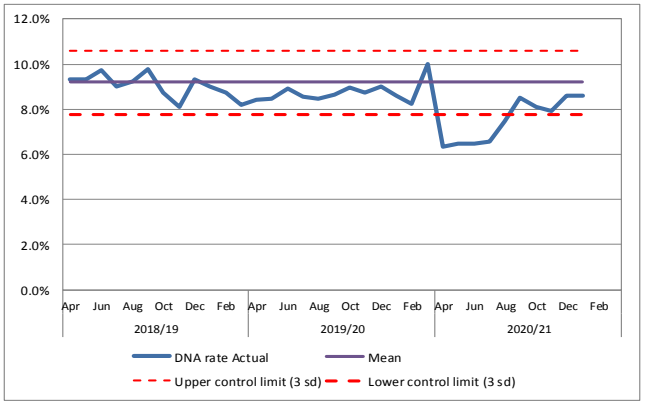
WHHT 7.52% Peer: 6.50%
National: 7.18%

(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 4,777 (4,717) wte last month (+57wte over the last month, +208wte over the last 12 months. The increase in staff is largely due to planned recruitment from abroad for nursing staff, admin & clerical staff for e.g. EPR, and HCA staff.

Vacancies (the difference between the ledger establishment and contracted wte on ESR) is 413 wte or 8% of the establishment (9.1% last month). The target rate is 10%. There has been little change in the funded establishment over Dec. NB – I have removed from the establishment a small number of medical rotational posts from Southend when the staff are employed outside the Trust and costs are re-charged.

Sickness – the Jan rate is 6.4% against a target of 3.5%. The 12 monthly sickness rate averages 5.1%. The monthly figure was 5.2% last month, and over 11% for April 2020, the highest rate recorded over the last 10 years. The sickness rate a year ago was 4.6%. The absence rate including sickness, and covid self isolating was 10%.

Labour Turnover –This is 12.8% (last month 12.9%). The target is 13%, so that the Trust has continued to achieve this target. 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 10.2% (10.0% last month). The rolling 3 monthly turnover rate is around 11%, which suggests that are relatively low short term pressures for staff leaving

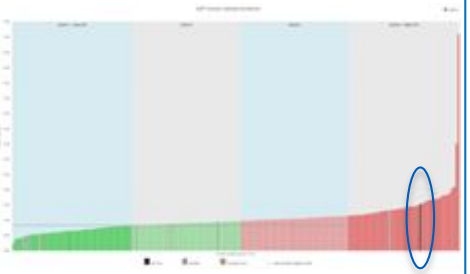
Next steps –

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. There is a NHSI / HEE target to reduce HCA vacancies to 0% by April 2021, and the Trust is on course to achieve this.

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

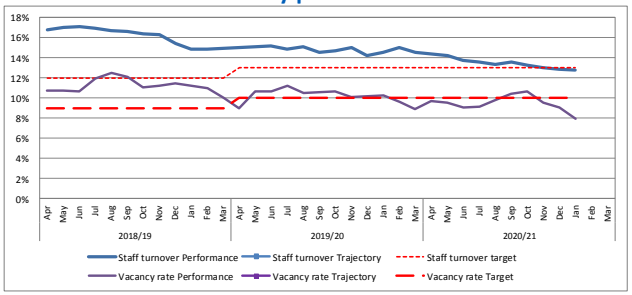


Period: October 2019

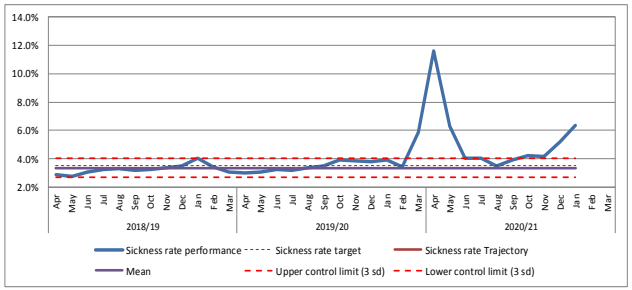
WHHT: 1.54% Peer: 0.83%
National: 0.98%

Peers = Nightingale Group – acute multi-site trusts)

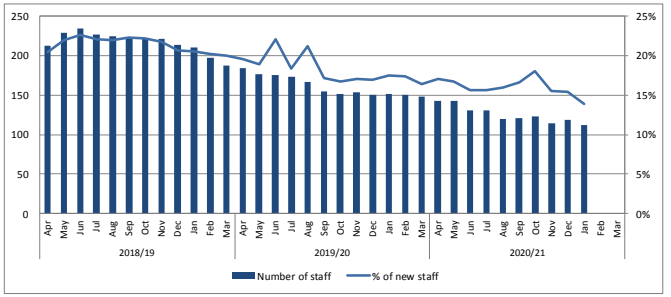
Staff turnover and vacancy performance



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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Workforce & Finance: Developing Staff

Appraisals
Appraisal rates are currently 84%, 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, although the recent increase in COVID sickness has prevented further improvements. 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 that 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. For local benchmarking for training compliance, within Herts Beds and Essex Trusts, the Trust ranks 4/16 local Trusts (Q3, 20/21).

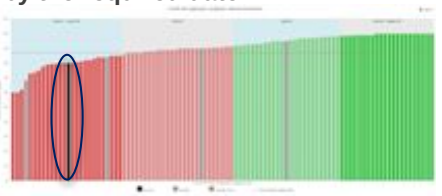
Mandatory / Essential training
The all Trust mandatory training rate remains above target at 90.7%. Compliance in the low 90's has now been consistently maintained since November of 2018. Compliance is now measured for one single set of mandatory training, rather than separating into mandatory and essential. 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 6/16 local Trusts (Q3, 20/21)

Performance improved
Better than target/threshold

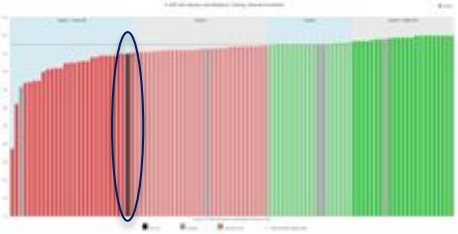
Benchmarking: Model Hospital
Trust staff with appraisal completed by the required date



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

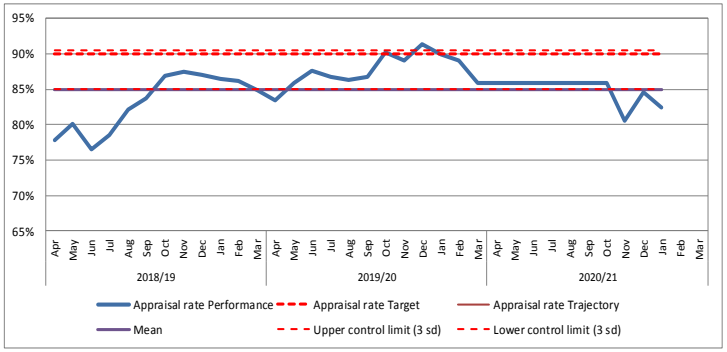
Performance stable
Better than target/threshold

Benchmarking: Model Hospital
Statutory & Mandatory training compliance rate

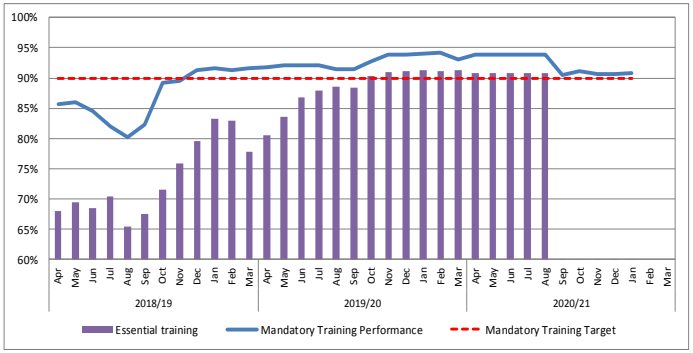


Period: 2018/19
WHHT 90% **Region 95%**
National 94%
Peers = Nightingale Group – acute multi-site trusts)

Appraisal performance



Essential training and mandatory training performance



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

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Workforce & Finance: Maternity Training Compliance Report

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	Jan-21
FETAL MONITORING TRAINING PROGRAMME (TARGET 90%)	MIDWIVES OVERALL K2 COMPLIANCE	92%	90%	90%	90%	86%	84%	85%	91%	82%	91%	98%	98%	96%	98%
	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%	100%
	MIDWIVES ON ABC K2 COMPLIANCE	100%	97%	100%	100%	98%	98%	98%	100%	88%	94%	100%	100%	97%	100%
	OVERALL COMPLIANCE K2 + STUDY DAYS											98%	98%	96%	98%
	DOCTORS OVERALL COMPLIANCE	93%	93%	93%	85%	79%	82%	84%	86%	88%	80%	100%	100%	97%	100%
	DOCTORS OVERALL COMPETENCY COMPLIANCE	97%	93%	93%	92%	83%	82%	87%	80%	86%	80%	100%	100%	97%	100%
MATERNITY EDUCATIONAL DAYS (TARGET 90%)	MED 1 MIDWIVES OVERALL % COMPLIANCE	92%	91%	87%	82%	82%	68%	74%	72%		72%	63%	65%	64%	68%
	MED 2 MIDWIVES OVERALL % COMPLIANCE	92%	91%	85%	80%	80%	68%	71%	69%		70%	62%	61%	62%	65%
	MED 3 MIDWIFE OVERALL % COMPLIANCE	93%	93%	92%	80%	79%	64%	66%	63%		58%	53%	56%	58%	53%
Obstetric Emergency Training (Skills & Drills, MST and PROMPT - NHS Resolution Target 90%)	MIDWIVES			92%		83%	92%	66%			58%		56%	58%	52%
	OBSTETRIANS			40%		100%	88%	23%			26%		55%	55%	40%
	ANAESTHETISTS			58%		87%	87%	16%			22%		33%	34%	39%
	THEATRE STAFF			59%		32%	68%	0%			0%		0%	0%	6%
	HCA			74%		21%	61%	15%			14%		11%	8%	3%
	TNA/ NN			68%		44%	84%	14%			14%		0%	0%	0%
	STAFF OVERAL % COMPLIANCE			65%		41%	83%	52%			34%		38%		39%

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Workforce & Finance: Workforce BAF scorecard

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

The BAF performance indicators reflect core areas of the workforce that we are monitoring. These include B5 nurse vacancies and turnover, reflecting the focus on recruitment and retention of these staff in conjunction with NHSI. These areas are identified as the Trust's highest workforce risk factors. B5 Nurse Turnover rates are 14.1% 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 1.2% for ward based nurses, much reduced from 11.5% three months ago. Over 100 B5 nurses have either started or are planned to start between now and the end of February 2021 - since mid-August we have increased our deployment of overseas nurses and approx. 24 have been arriving each month. The increase in recruitment and decrease in turnover has helped reduce B% vacancy levels to 1%. Vacancy rates for all ward based adult nurses are less than 2%.

Combined appraisals rates are currently 84% and progress towards 90% compliance has been limited due to the most recent wave of the COVID pandemic.. The HRBPs are continuing to work 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 monthly Trust sickness rate is 6.4% against a 3.5% target, and so is above target, again due to the most recent wave of COVID. The 12 month sickness figure is 5.1. It is anticipated that sickness will now reduce over Spring, although it is likely to remain above usual levels for this time of year..

The current agency pay bill percentage is 3.8%. The overall target rate for 2020/21 is 4.7%, reflecting the reduced agency cost target envelope.

The 12 month turnover rate is 12.8%, 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 6 / 16 nearby NHS organisations as at Q3 20/21, compared to 11 / 16 in the same quarter last year.
FFT scores have been suspended during COVID. The staff survey for 2020 is covered in slide 27.

Workforce Indictors - Progress Table

Progress against target - Jan 2021

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%	10.7%	8.0%	10.0%	-2.0%	↘	-20%
Band 5 Nurse Vacancy		3.2%	11.5%	1.2%	9.0%	-7.8%	↘	-87%
Headline Turnover	13.7%	14.6%	13.3%	12.8%	13.0%	-0.2%	↘	-2%
Band 5 Nurse Turnover	16.3%	17.0%	14.3%	14.1%	16.0%	-1.9%	↘	-12%
Total Sickness	3.6%	3.9%	4.2%	6.4%	3.5%	2.9%	↗	83%
Non-Medical Appraisal	54%	89.9%	85.9%	82.4%	90.0%	-7.6%	↘	8%
Medical Appraisal		97.0%	97.0%	97.0%	90.0%	7.0%	→	-8%
Core Skills Framework	89%	94.0%	91.1%	90.7%	90.0%	0.7%	↘	-1%
Agency as a % of Paybill	7.1%	4.6%	5.1%	3.8%	4.7%	-0.9%	↘	-19%
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		✓	✗	✗	✓

Item: 12/88

Trust Board Meeting
4 March 2021

Title of the paper	**Mortality and Learning from Deaths Quarter 3 2020/21**
Agenda Item	**12/88**
Presenter	**Dr Anna Wood**
Author(s)	**Deborah Wadsworth**
Purpose	*For approval*: *For discussion*: *For information*: ✓
Executive Summary	This report reviews mortality and learning from deaths during quarter 3 2020/21, with an update on current position. Findings from the fifth refresh of a separately commissioned Dr Foster report, looking specifically at COVID-19 mortality and demographic profiling within the Trust's patient cohort are shared. The January 2021 Dr Foster summary report shows HSMR as 100.6 and SHMI as 97.85. Both measures are within the expected range. Palliative care coding is higher than the national rate at 3.11% versus 2.31%. There is one new SMR outlier: • Other infections, including parasitic and one other condition continues to alert: • Septicaemia (except in labour) COVID-19 deaths are mapped to the viral infection group. This update also sets out structured judgement review activity during quarter 3.

<table>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><th>Aim 1
Best care
 
Objectives 1-4</th><th>Aim 2
Great team
 
Objectives 5-8</th><th>Aim 3
Best value
 
Objective 9</th><th>Aim 4
Great place
 
Objective 10-12</th></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>Quality Committee</td><td>25 February 2021</td></tr>
<tr><td></td><td></td></tr>
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<tr><td>Action required.</td><td>The Board is asked to receive this report for assurance on Trust mortality and learning from deaths scrutiny</td></tr>
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West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item: 12/88

Trust Board

Mortality and Learning from Deaths Quarter 3 2020/21

Presented by: Dr Anna Wood
Author: Deborah Wadsworth

1. Purpose

1.1 This paper aims to provide a review of trust mortality and related workstreams across quarter 3 2020/21 (1 October – 31 December 2020) and to provide an update on current position (January 2021).

1.2 The last Mortality Review Group meeting was held on 03 November 2020.

2. Background

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

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

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

3. Mortality metrics

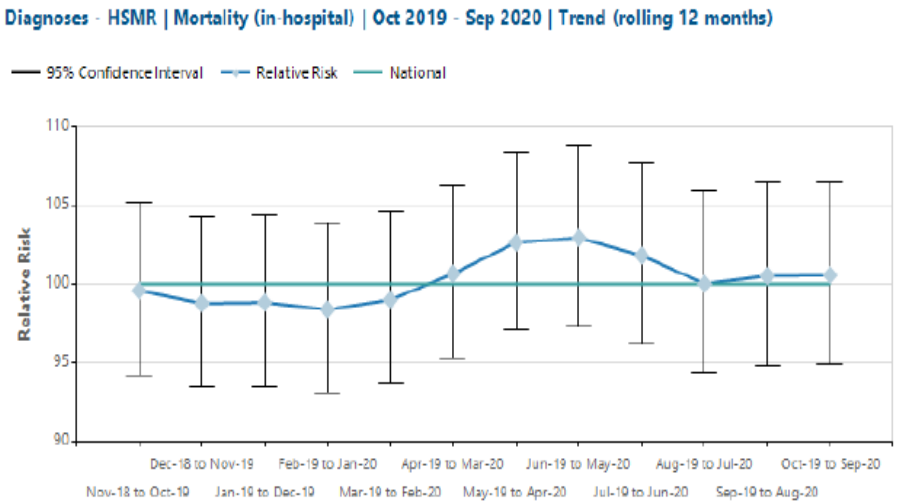
(From January 2020 Dr Foster update which encompasses data from October 2019 to September 2020)

- **HSMR** is 100.6
- **SHMI** is 97.85 both of which are within the expected range.
- Palliative care coding is slightly higher than the national rate at 2.87% versus 2.2 %.

3.1 Overall quantitative performance (the metrics)

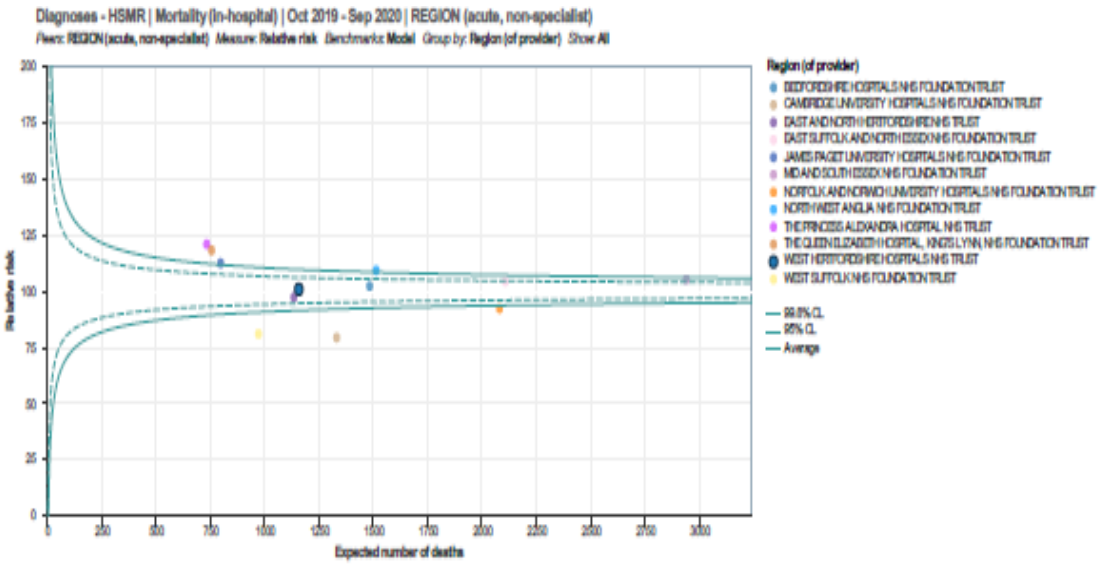
3.1.1 HSMR rolling 12 months (last point is September 2020)

a) Chart 1 Monthly Trend



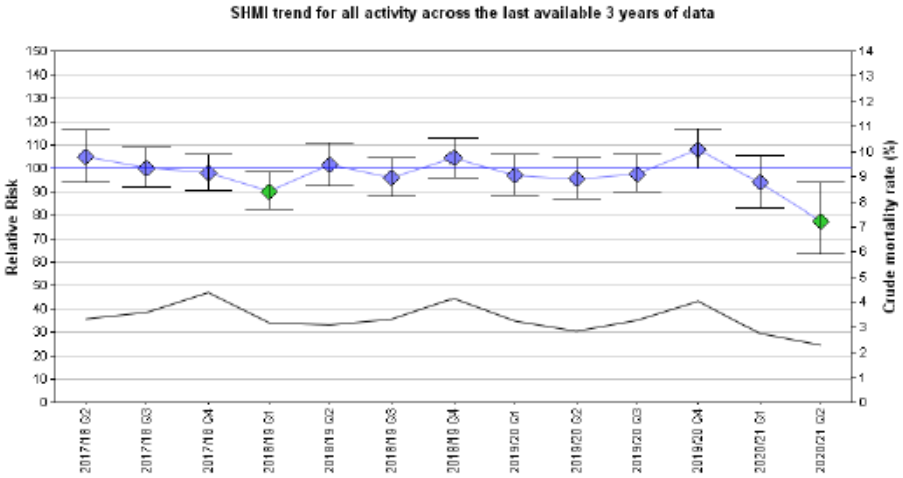
b) Chart 2 Peer comparison

The Trust is 1 of 4 Trusts within the East of England peer group of 15 with an HSMR within 'as expected' range.



3.1.2 **Chart 3 SHMI** **Last available 3 years** (last data point September 2020)

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



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

3.2 Outlying SMR and HSMR diagnoses

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

3.2.2 There is one new outlying SMR groups:

‘Other infections, including parasitic’ and the usual process of managing outliers will be followed (notes obtained and judgement of whether primary diagnostic coding correct and if so, then a judgement on clinical management)

The following groups continue to alert:

- Virus infection
- Septicaemia (except in labour)

The group ‘virus infection’ is where COVID-19 deaths are mapped to and an SJR exercise was carried out on a number from this cohort. Findings were shared in the quarter 1 report.

3.2.3 The Trust sepsis lead has analysed a cohort of primary diagnosis ‘septicaemia’ case notes and the conclusions of this audit by SJR methodology is that in over 50% cases, septicaemia was not the primary diagnosis and in only one case was the clinical care out with national sepsis clinical guidelines.

3.2.4 The sepsis review outcomes will be discussed at trust level at Trust Mortality Review Group.

4 Dr Foster bespoke COVID-19 report (appendix 1)

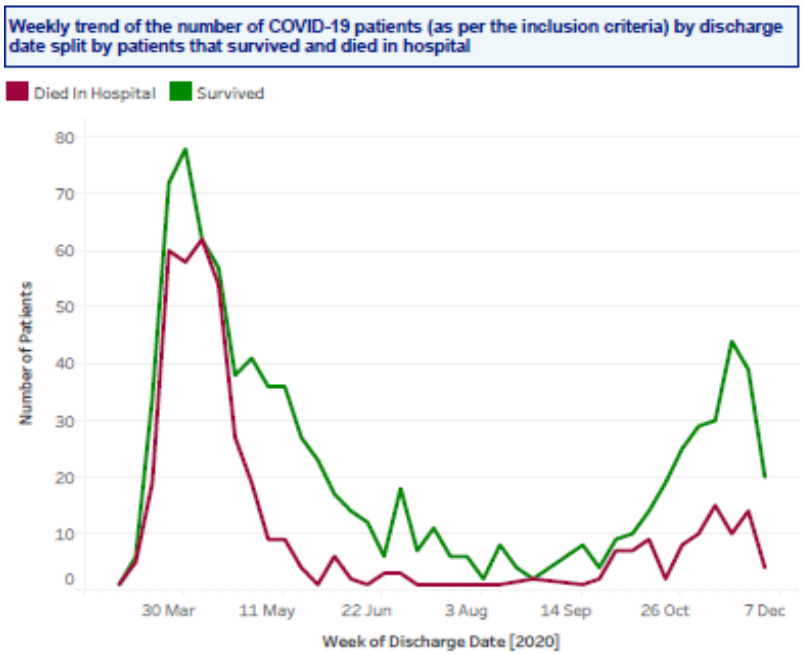
4.1 Dr Foster was commissioned in July 2020 to provide a bespoke report on COVID-19 mortality. It was agreed that this report would be produced monthly for 6 months. Each report is discussed at the Trust Mortality Review Meeting.

4.2 Findings from the fifth refresh report are as follows:

4.2.1 Overall Mortality Rate

· The mortality rate for all COVID-19 positive patients admitted to West Hertfordshire Hospitals NHS Trust is 33% compared to 29% for the peer comparison group. Generally, mortality rates at West Hertfordshire have decreased over time.

4.2.2 **Chart 4 Weekly trend of the number of COVID-19 patients by discharge date split by those that survived and dies in hospital**



4.2.3 Critical Care

· 8% of patients at West Hertfordshire were recorded as having spent time in critical care and the mortality rate among patients who spent time in critical care was 45% a reduction of 4% since quarter 2.

4.2.4 Primary Diagnosis

· 76% of patients had COVID-19 as the primary diagnosis in the last episode of the spell. Over time, the proportion of coding of COVID-19 in the primary diagnosis position has decreased.

4.2.5 Patient Demographics with Peer Comparison

- The largest proportion of COVID-19 positive patients, were in the 85+ age group and the mortality rate increased with each increasing age group.
- There was a higher mortality rate in males compared to females: 36% compared to 29% respectively.
- Most patients were in the white ethnicity group in which the mortality rate 35% was followed by Asian or Asian British at 30%.
- The population at West Hertfordshire was skewed towards the lesser deprived IMD Deciles, with 21% of all patients in the cohort, in the least deprived decile. The group with the highest crude mortality rate (40%) is IMD Decile 8.

West Hertfordshire had a slightly higher mortality rate in all 45+ age groups than the peer group.

4.2.6 Comorbidities, Palliative Care Cases and Ventilation with Peer Comparison

The largest diagnosis group was hypertension which accounted for 32%of patients with COVID-19. The next most prevalent conditions were chronic endocrine conditions (mostly consisting of patients with diabetes), chronic heart disease and chronic respiratory diseases: 22%, 19% and 18% of all COVID-19 positive cases respectively. These four diagnosis groups were also the most common amongst the peer group and they had very similar mortality rates with the exception of chronic heart disease where the mortality rate was 9% higher at West Hertfordshire.

The mortality rate was also higher at West Hertfordshire than in the peer group in the chronic kidney disease and palliative care groups. Other groups contained relatively small volumes.

The group with the highest mortality rate (94%), was palliative care and palliative care patients accounted for 30% of all deaths. After palliative care, the next highest mortality rates at West Hertfordshire from groups not consisting of small volumes were chronic kidney disease (55%) and chronic heart disease (52%).

14% of patients were recorded as having received ventilation (compared to 10% in the peer group) and of those that did, 61% died in hospital, which was slightly lower than the peer group (65%).

5 Structured judgement review (SJR)

5.1.1 Between 1 October 2020 and 31 December 2020, 19 referrals for structured judgement review were made. 17 completed reviews were received back from consultant reviewers, and of these, 5 were considered as having received suboptimal care.

5.1.3 **Potential avoidability of death for quarter 3 2020/21**

11 cases were referred to the tier 2 avoidability panel and reviewed and of these, 3 were considered by the panel to have been potentially avoidable. All 3 cases were different and no themes identified. All were referred for consideration (according to our policy) to the Serious Incident Panel.

5.14 **SJR themes and learning.**

SJR has been conducted on cases of ‘septicaemia’ as is an SMR outlier as mentioned earlier in the report.

In view of the national and regional concerns regarding a significantly increased proportion of patients dying from COVID-19 infection who had learning disabilities, the trust has commenced a case notes review by SJR methodology of this group of patients from the recent second wave of the pandemic. Each case will be reviewed by 2 senior consultants but scored independently and the report findings discussed at an appropriate forum.

Recent themes form SJR work have included misdiagnosis of abdominal pain after acute admission to hospital, poor documentation of initial clerking in patients presenting as acute surgical admissions and delays in assessment by senior physicians from the mental health liaison team in admitted patients. There are plans in place to address all these thematic findings.

5.2 Current SJR position

5.2.3 The SJR process was temporarily suspended on 11 January as a consequence of Trust pressures created by the COVID-19 pandemic.

6 Medical Examiner service

6.1 During quarter 3, the Medical Examiners referred 19 cases for SRJ.

6.2 In October and November 2020 there were 283 deaths and the Medical Examiners reviewed 45 of these (16%). The reason for this low figure is that the medical examiner service was in transition with new appointments being made and the current position is that we have a fully compliant service according to the National Model with the requisite compliment of Medical Examiners and Medical Examination Officers

6.3 During the second wave of the pandemic, Medical Examiners and other consultant volunteers were completing Medical Certificates of Cause of Death instead of junior doctors, due to COVID-19 ward pressures.

7 Next steps

7.1 Next steps planned include:

Track and gain assurance that the recommendations from the ITU NHSE deep dive are being met at Quality Committee.

8 Risks

8.1 None identified.

9 Recommendation

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

Name of Director
Dr Anna Wood

Date 25 February 2021

Trust Board
March 2021

Title of the paper	**Pay Gap Report 2019/2020**
Agenda Item	**13/88**
Presenter	**Andrew McMenemy, Chief People Officer**
Author(s)	**Arfan Bhatti, Inclusion & Diversity Manager**
Purpose	*Please tick the appropriate box* *For approval* ☐ *For discussion* ■ *For information* ■
Executive Summary	This report was previously presented and discussed at PERC on 7 January 2021 and evaluates our BAME as well as gender pay gap. It is therefore provided to Board as a requirement and assurance that PERC has an overview of the main themes and actions to mitigate risks. All data in the reports are taken from April 2019 – March 2020 unless otherwise stated. In this snapshot, 78% of staff identify as female and 40% identify as BAME on our Electronic Staff Record (ESR) system. **BAME Pay Gap Report** • The mean pay gap is 7.39% higher for BAME staff than White staff. • The median pay gap is 1.3% higher for BAME staff than White staff. This can be attributed to: • BAME staff demonstrate 47% of all Consultants, in comparison with 40% of BAME staff overall. It should also be noted that 22% of staff employed at Band's 8b-9 are BAME, in comparison with 70% white staff for the same pay bands. Therefore, this demonstrates the influence that our BAME medical workforce has in the demonstration of our pay gap. Unlike the gender pay gap, publishing the BAME pay gap is not legally mandated. However, undertaking and demonstrating the analysis for both categories is seen as best practice. **Gender Pay Gap Report** • The mean pay gap is 27.3% lower for females than for males. • The median pay gap is 11.96% lower for females than for males. This can be attributed to: - males consisting of 61% of all Consultants, in comparison with 22% of staff overall. It should also be noted 74% of staff employed at Band's 8-9 are female, in comparison with 26% of males for the same pay categories.

	Where consultants are removed from the analysis, our mean gender pay gap would be less than 5%. **Next steps** Interventions are wide ranging and include: • Developing strategies that support the creation of equitable culture, policies and awareness for areas such as flexible working, menopause and maternity. • Updating our recruitment policy to ensure diversity in interview panels and the development of values based recruitment. • Implementing the recommendations identified in the Clinical Excellence Awards reforms. • Creating Divisional inclusion plans in recognition of the varying pay gaps highlighted in this report. • Creating career and development workshops for staff with an emphasis on BAME and gender to provide equity of opportunity. Implementation of these next steps will be embedded and monitored in the Trust's People Strategy Implementation plans and meeting. Progress will be measured and presented to PERC at regular intervals and Board will be provided an update and further analysis in 12 months.
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: PERC – Date: 7 January 2021

Action required	The Board is asked to receive this report for discussion and for information.

Agenda Item: 13/88

Trust Board – March 2021

Pay Gap Report 2019/2020

Presented by: Andrew McMenemy, Chief People Officer

1. Purpose

On 31 March 2017, it became mandatory for public sector organisations with more than 250 employees to report annually on their gender pay gap.

The requirement is to publish six key measures of the gender pay gap:

Mean gender pay gap	The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees
Median gender pay gap	The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees
Mean bonus gap	The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees
Median bonus gap	The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees
Bonus proportions	The proportions of male and female relevant employees who were paid bonus pay during the relevant period
Quartile pay bands	The proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile pay bands

This paper goes beyond our legal requirement and also reports on our mean BAME pay gap.

The ‘snapshot date’ in this report is from 31 March 2019 – 31 March 2020, unless otherwise stated.

2. Background

The gender pay gap is the average earnings difference between all male employees and all female employees in an organisation, regardless of the nature of their work.

The BAME pay gap is the average earnings difference between staff who identify as Black, Asian or Minority ethnic employees and all staff who identify as White.

It is important to distinguish between the pay gap and equal pay. Equal pay concerns differences between the actual earnings of male/female or BAME and White staff carrying out the same role.

An organisation may be an equal pay employer yet it may still have a pay gap. This is because, there are different numbers of employees working in different roles for which they are paid differently.

The Gender Pay reporting requirements have been introduced via statute to make the differences in pay between men and women more transparent across all industry sectors, enabling employers to consider the reasons for any differences and to take any corresponding action.

For gender pay gap reporting, employees is everyone under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under NHS terms and conditions, medical staff and very senior managers.

The NHS has a national pay structure, job evaluation system and contractual terms and conditions for medical and non-medical staff which have been developed in partnership with trade unions. This national framework provides a robust set of arrangements for pay determination.

3. Analysis/Discussion

3.1 Gender Pay Gap

We have reduced our mean pay gap by 0.6% to 27.3%.

This is above the Office for National Statistics (ONS) national mean of 15.5%.

We have however reduced our median pay gap by 3% to 11.96%.

This is still slightly higher than the ONS provisional national median of 9.9%.

We remain confident that we have identified the key drivers of our gender pay gap: the over representation of men at consultant level in our workforce. There are almost 3 times as many male Consultants (61%) than broader male representation across the Trust (22%).

	Women's earnings in 2020	**Women's earnings in 2019**
Mean gender pay gap in hourly pay	**27.3% lower**	**27.9% lower**
Median gender pay gap in hourly pay	**11.96% lower**	**14.99% lower**

3.2 Gender breakdown of pay quartiles

To understand the pay gap in more detail, it is helpful to look more closely at the pay quartile data, and representation of male and female staff across pay grades.

Quartile	Female	Male	Female %	Male %
1. Upper	816	423	65.86	34.14
2. Upper middle	1019	220	82.24	17.76
3. Lower middle	990	250	79.84	20.16
4. Lower	1012	225	81.81	18.19

Like the NHS workforce as a whole, our workforce is predominantly female; 77% female and 22% male.

This ratio is broadly reflected in our pay quartiles with the exception of the upper pay quartile; this is a clear indicator of our median pay gap.

Pay quartiles are calculated by ranking the hourly pay rates for each employee from lowest to highest, before splitting the ranking into four equal-sized groups and calculating the percentage of males and females in each group.

Male representation in the lower and lower middle quartiles has increased slightly and is therefore the causation behind the slight reduction of pay gap this year. Female representation in the upper quartile is almost exactly the same than in the previous year.

While NHS's pay system safeguards against equal pay issues, there is a gender pay gap owing to the distribution of male and female employees. The impact of the top-heavy

distribution of male employees skews the male median pay, even though male employees are significantly outnumbered by female employees in the other three pay quartiles.

3.3 Bonus payments

Only Consultants are in receipt of bonus payments; this is because Clinical Excellence Awards (CEA) payments are regarded as ‘bonus pay’. The CEA scheme is intended to recognise and reward those Consultants who perform ‘over and above’ the standard expected for their role.

Awards are given for quality and excellence, acknowledging exceptional personal contributions towards the delivery of safe and high-quality care to patients and to the continuous improvement of NHS.

The difference between the mean and median bonus paid to male and female medical consultants during the reporting period is as follows (and is almost exactly the same as our 2018 bonus pay gap).

Gender	2019 - 2020 Mean bonus	2019 - 2020 Median bonus
Male	14,143.49	12,063.96
Female	10,282.71	6,411.73
Difference	3,860.78	5,652.24
Pay Gap %	**27.30**	**46.85**

70 male and 42 female Consultants were in receipt of a bonus in this reporting period, which represents a very small over-representation of male colleagues in receipt of bonus payments of 1% when compared to broader Consultant representation.

However, males consist of 61% of all Consultants, in comparison with 22% of the workforce overall.

3.4 Representation across pay grades

Consultants and other medic roles are two of the roles in the upper quartile, which disproportionately inflates our mean pay gap.

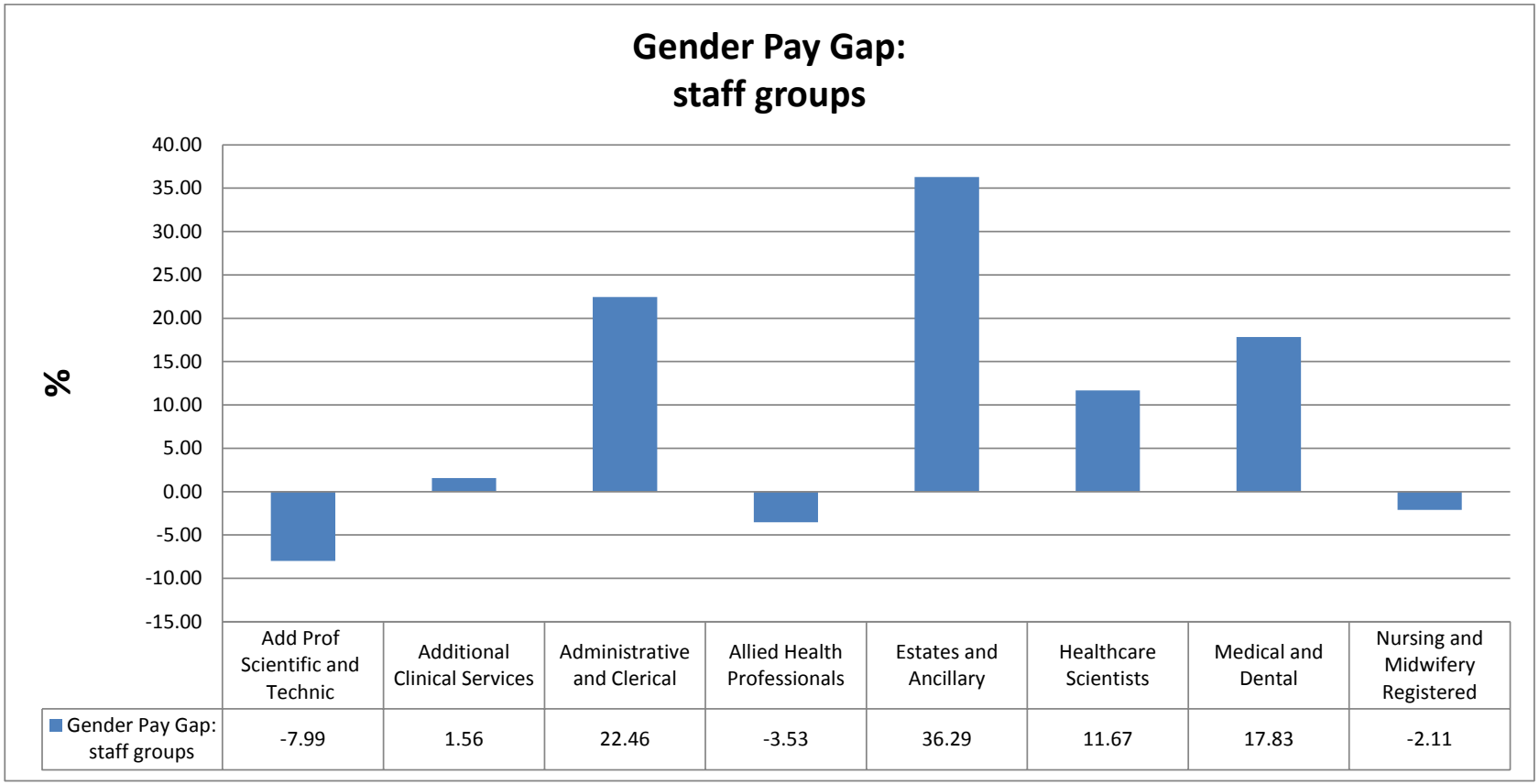
PSED Band	Female % per band	Male % per band	Number of employees
Band 1	66%	33%	9
Band 2	80%	20%	746
Band 3	85%	15%	596
Band 4	85%	15%	471
Band 5	85%	15%	966
Band 6	88%	12%	744
Band 7	84%	16%	505
Band 8	77%	23%	275
Band 9	17%	83%	6
Consultant	39%	61%	265
Director	64%	36%	11
Non-Exec	20%	80%	5
Other Medic	49%	51%	368
Grand Total	**3911**	**1056**	**4967**

As the below table shows, our mean pay gap in all job roles from Band 2 – Band 9 does not exceed 6.01%.

Female mean pay is also higher at Band's 8d, 8b, 7 and 6.

AfC Pay Grade	Female hourly pay (£)	Male hourly pay (£)	Difference	Pay Gap % 2019
Band 1	10.49	9.38	-1.10	-11.76
Band 2	10.74	11.09	0.36	3.22
Band 3	10.56	10.53	-0.02	-0.24
Band 4	12.04	12.25	0.21	1.70
Band 5	15.14	15.33	0.19	1.25
Band 6	18.44	18.01	-0.43	-2.41
Band 7	21.31	21.25	-0.06	-0.29
Band 8a	25.00	25.33	0.33	1.31
Band 8b	29.55	27.87	-1.67	-6.01
Band 8c	34.66	35.65	0.99	2.77
Band 8d	43.17	40.74	-2.43	-5.96
Band 9	49.63	52.13	2.51	4.81
Other	32.59	38.36	5.76	15.03

3.5 Mean gender pay gap across staff groups



	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Gender Pay Gap: staff groups	-7.99	1.56	22.46	-3.53	36.29	11.67	17.83	-2.11

3 staff groups have a pay gap in favour of females.

It should be noted that while Estates & Ancillary have the largest pay gap, they are the smallest group with 76 employees in comparison with Nursing & Midwifery's 1545 employees.

3.6 Recruitment conversion rate

Recruitment data show a higher success rate for females. The following table provides a breakdown of the various stages in the recruitment process by gender.

Males made up 29% of applications and 17% of appointments. Females made up 71% of applications and 82% of appointments. This is consistent with the previous year's data.

	All applications	All Shortlisting	All in Interview	All in Offer	All in Starting	Recruited
Male	3841 (29%)	2768 (33.5%)	848 (22.2%)	17 (13.2%)	6 (16.7%)	140 (17.4%)
Female	9351 (70.6%)	5465 (66%)	2971 (77.6%)	112 (86.8%)	30 (83.3%)	662 (82.3%)
Not disclosed	52 (0.4%)	42 (0.5%)	8 (0.2%)	0 (0%)	0 (0%)	2 (0.2%)
Total	13244 (100%)	8275 (100%)	3827 (100%)	129 (100%)	36 (100%)	804 (100%)

3.7 Promotions

Promotion data from 2018/2019 is almost identical as the data in 2017/2018. Notable exceptions include the number of men receiving promotions (which decreased) and the number of women whose band decreased (which decreased).

Gender	Band decreased	Band increased	No Change	Overall	Band decreased	Band increased
Female	22	357	3143	3522	0.6%	10.1%
Male	5	61	644	710	0.7%	8.6%
Grand Total	**27**	**418**	**3787**	**4232**	**0.6%**	**9.9%**

3.8 Our BAME pay gap

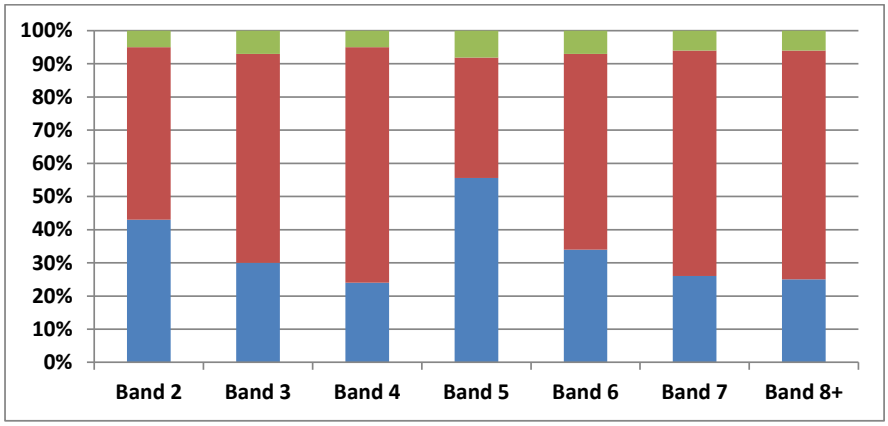
This is the first time we have published our BAME Pay Gap. The ONS reports significant variances in mean averages in England which in London is 24% (the largest) and East of England's is 8.6% (both in favour of White staff).

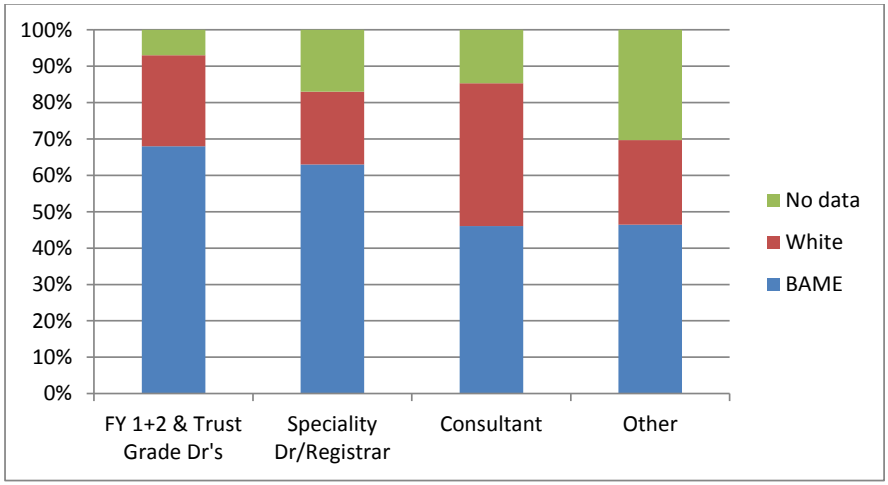
	BAME staff earnings in 2020
Mean pay gap in hourly pay	**7.39% higher**
Median pay gap in hourly pay	**1.3% higher**

The ONS found that median hourly earnings in for White staff were on average more than 2% higher.

3.9 BAME representation across Pay Band & Staff Groups

BAME staff representation varies significantly from the 40% overall figure:



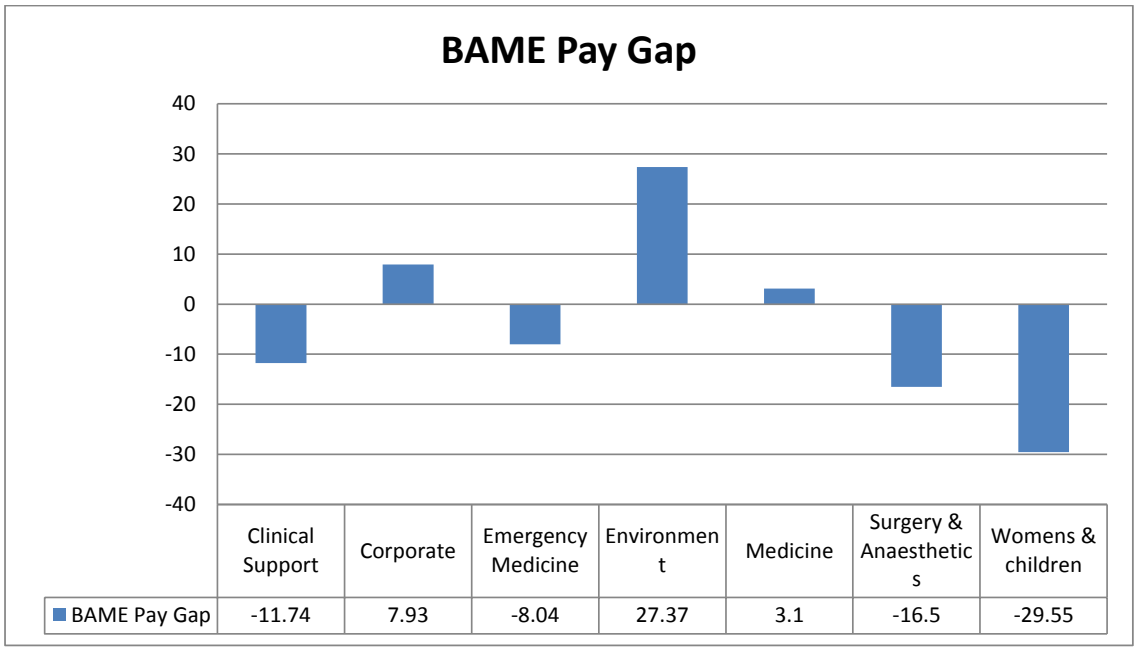


Our workforce is significantly more diverse than the local population which ranges from 9% in Hemel Hempstead to 19% in Watford.

A major factor in relation to over-representation at Band 5 is our international recruitment of staff nurses. Since 2017 we have recruited more than 360 mainly from India and the Philippines.

We are above the national average for BAME representation at Board level, which is 8% and East of England which is 6%. London's average is 17%. However, at voting level that equates to one BAME individual.

Our latest Workforce Race Equality Standard report and action plan looks into representation, recruitment, development for BAME colleagues in further detail.



3 staff groups have a pay gap in favour of White staff: Corporate, Environment and Medicine.

4 staff groups have a pay gap in favour of BAME staff: Clinical Support, Emergency Medicine, Surgery & Anaesthetics as well as Women's & Children.

It should be noted that numbers of staff within these staff groups vary significantly.

3.10 Conclusion

There was very little progress in relation to reducing our mean gender pay gap and a slight improvement in relation to our median gender pay gap.

We remain confident that we have identified the key drivers of our gender pay gap: the over representation of men at consultant level in our workforce. There are almost 3 times as many male Consultants (61%) than broader male representation across the Trust (22%).

Without consultants, our mean gender pay gap is less than 5%. However, due to the way consultants are paid, it should be noted that this pay gap is calculated by assignment, which is different to the way the pay gap is calculated in the rest of this Report.

The Consultant demographic also skews the analysis of BAME staff pay across the Trust, given the majority of our Consultants identify as Black, Asian or Minority Ethnic.

We are conscious that in order to achieve gender pay equality at a quicker rate, we cannot be complacent, which is why we have looked at a Divisional/Staff role breakdown of our pay gaps.

4. Risks

7% of staff have not shared their ethnicity on ESR, meaning our BAME Pay Gap data does not include data for more than 350 employees.

This report has kept with the 2001 ONS guidelines to help us create comparative data. This means our BAME data does not examine the pay gaps in relation to White colleagues who originate from non-UK countries.

There is also much more scope to examine potential differences in pay within our BAME staff demographic to help ensure we are not adopting a “one size fits all” approach.

Colleagues have to identify as male or female on ESR, excluding non-binary colleagues who identify as non-binary or gender-fluid.

5. Recommendation

West Hertfordshire Hospitals NHS Trust is committed to actively promoting inclusion and diversity. We believe that people who use our services, their carers and our staff should be treated with respect and dignity. As a public body, the Trust is committed to taking positive steps to ensure equitable access to services for all.

Our diversity and inclusion strategy sits within the 2020-2023 People Strategy and has four key pillars: finding the right people, looking after our people, developing our people and moving forwards.

The specific and measurable actions that help achieve the vision sit within our Inclusion Charter, which is operationalised via our People Strategy Implementation Plan and group.

An outline in relation to the relevant action for this paper is provided below:

1. Enabling flexible working

Despite progress in wider society in relation to gender equality and the introduction of shared parental leave which the Trust have embedded into policy; women continue to take on most of the household and familial duties.

We aim to ensure this does not have a detrimental impact in the workplace by:

- Ensuring employees contribute to rostering where possible to ensure their home life needs are also met with staff reporting effective rostering including medical staff.

- Supporting our staff who have caring responsibilities and personalising our approach to how we manage and care for our team. Greater take up of agile working and use of technology to support staff to work remotely where possible

- Embedding our flexible working policy

The nurseries at our Watford and St Albans hospital sites also offer high quality, affordable childcare for children aged three months to five years. The nurseries are open 7am-7pm. Subsidised places are currently available to all permanent staff. Other nurseries in Hemel Hempstead, Watford and St Albans also offer a discount for our staff.

NHS England's People Plan also sets out a number of actions to for the Trust to take on in relation to flexible working. These include:

- Be open to all clinical and non-clinical permanent roles being flexible
- Cover flexible working in standard induction conversations for new starters and in annual appraisals.
- Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade
- Board members must give flexible working their focus and support
- Roll out the new working carers passport to support people with caring responsibilities

2. Promoting maternity policies

The Trust will continue to ensure that:

- pregnant staff of any gestation should be offered the choice of whether to work in direct patient-facing roles during the COVID-19 pandemic
- pregnant women up to 28 weeks will be offered the choice of whether to work in direct patient-facing roles or not.

Our Family Leave policy also sets out a number of provisions, including "Keeping in touch" (KIT) days that employees can opt it in to and potentially make it easier when it is time to come back to work. An employee can carry out up to 10 KIT days without this bringing their maternity leave to an

3. Understanding root causes

Our newly launched Diversity Dashboard will also enable us to annually monitor key workplace trends monthly across metrics and Divisions such as: formal capability processes, training and recruitment.

4. Making West Herts more menopause friendly

A significant amount of our staff are female and aged 50 or over. Training will take place to help ensure line managers have the right conversations and provisions are embedded into a policy.

5. Clinical Excellence Awards reforms

In 2020 West Herts contributed to a major consultation exercise intro proposed reforms of CEA bonus payments. The key recommendations were highlighted in an August Trust Board and included:

- Continuing with the current system of 'blind' scoring of applications scored by a large panel of assessors (12-14 assessors). This scoring panel must be properly representative of the clinical body both in terms of roles and diversity

- There should be a greater role for Divisional Directors and Divisional General Managers in acting as a 'gateway' role for doctors wishing to be considered for the scheme

- Exceptionally part time workers should be allowed full CEAs where it can be shown that there was significant amount of their own time and effort put into the subject of their submission

- In order to try to address gaps between different groups, more proactive communication should be provided.

6. Race equality

Despite the Trust having a pay gap in favour of BAME staff there are many senior roles where BAME staff are under-represented, particularly in roles graded at 8a and above.

Our comprehensive Workforce Race Equality Plan 2020 sets out in detail how the Trust wishes to address this, including diverse and trained interview panels.

Andrew McMenemy
Chief People Officer

Trust Board Meeting
March 2021

Title of the paper	**Sharing Good Practice to Improve our People Practices (Disciplinary)**
Agenda Item	**14/88**
Presenter	**Andrew McMenemy, Chief People Officer**
Author(s)	**Caroline Lankshear, Acting Deputy Director of HR and Justine Powell, HR Projects Manager**
Purpose	*For approval*: ; *For discussion*: X ; *For information*: X
Executive Summary	The purpose of this paper is to provide an overview of the changes made to the Trust's disciplinary practices following the publication of Imperial Colleges Healthcare Trust's Disciplinary Policy. This policy has been shared by NHS England & NHS Improvement as an example of good practice. Its publication follows recommendations made by an external enquiry at Imperial College Healthcare NHS Trust which reviewed their disciplinary practices following the suicide of an employee after being summarily dismissed. The independent external inquiry concluded that, in addition to serious procedural errors made, throughout the investigation and disciplinary process the employee was treated very poorly, to the extent that his mental health was severely impacted. We compared the recommendations of the enquiry with our current practices and developed an action plan to improve elements of the procedure where necessary. On publication of the Imperial Colleges Healthcare Trust's Disciplinary Policy we have now reviewed our practices and policy further to ensure that we are taking an inclusive, compassionate and people-centred approach when concerns are raised. A revised policy has been introduced, the emphasis is clear that our priority is learning from mistakes and that formal action should be a last resort, in line with Just Culture principles. When we do need to follow the formal procedure people will be treated with care and compassion in line with our values.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care – *Objectives 1-4*: ; **Aim 2** Great team – *Objectives 5-8*: X ; **Aim 3** Best value – *Objective 9*: ; **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?

<table>
<tr><td></td><td>☐Is there a culture of high quality, sustainable care?
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<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>PERC</td><td>February 2021</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to receive this report for assurance on the Trust’s revised Disciplinary Policy.</td></tr>
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NHS
West Hertfordshire Hospitals
NHS Trust

Agenda Item: 14/88

Trust Board March 2021

Sharing Good Practice to Improve our People Practices (Disciplinary)

Presented by: Andrew McMenemy, Chief People Officer

1. Purpose

1.1 The purpose of this paper is to provide an overview of the Trust's revised disciplinary practices following the publication of Imperial College Healthcare NHS Trust Disciplinary Policy, an example of good practice.

2. Background

2.1 In late 2015, Amin Abdullah, Band 6 Nurse and Deputy Ward Manager at Imperial College Healthcare NHS Trust was subjected to disciplinary proceedings. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life.

2.2 An independent inquiry was commissioned, the findings of which were reported to the board and NHSI in August 2018. The report concluded that, in addition to serious procedural errors made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted.

2.3 Subsequently, NHSI established a 'task and finish' Advisory Group to consider to what extent the failings were unique to Imperial or more widespread across the NHS, and what learning can be applied. The Group conducted an independent analysis of both the report findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. The analysis highlighted several key themes, namely: poor framing of concerns and allegations; inconsistency in the fair and effective application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

2.4 In June 2019 the ER team at West Herts compared these recommendations with practices at the time and developed an action plan to improve elements of the procedure where necessary.

2.5 Since June 2019 the action plan has been followed and progress made, it has also incorporated further actions following the publication of Imperial's Disciplinary Policy.

3. Analysis/Discussion

3.1 The Trusts Disciplinary policy was reviewed when NHSE/I shared Imperial College Healthcare NHS Trusts Disciplinary Policy as an example of good people practice. Changes were made to West Herts Disciplinary Policy following the recommendations from the external review which were shared by NHSE/I in May 2019, however it was clear that further improvements could be made to our policy and procedure.

3.2 A new policy was developed by the ER team in January 2021 and discussed with staff side who are supportive of the changes.

3.3 There is a requirement for a new Disciplinary policy to be raised at a public board and published on our external website by the end of this financial year.

4. Issues arising / Actions taken to address issues

4.1 The tone of the Disciplinary policy has been adapted in line with the best practice example shared by NHSE/I which is also in line with the principles of Just Culture. There is a move away from language which insists on compliance and a move towards resolution. We emphasis that our priority is learning from mistakes and that formal action should be a last resort.

4.2 A small number of senior managers at band 8c and above will be identified and be given the authority to agree that a matter should be investigated. This will be after reviewing a preliminary checklist which has been developed in line with the principles of the Incident Decision Tree. This tool and the referral to a senior manager have been identified as models of good practice in the NHS Workforce Race Equality Standard strategy. Once the investigation has been completed the 8c manager will also need to give authority to proceed to a hearing. These managers will be seeking assurance on behalf of the Trust that cases are being handled fairly and proportionately.

4.3 Managers will be expected to put in place a communication plan and wellbeing interventions to support all those who are involved in a process. The senior manager will review this communication plan and ensure the manager is supported.

4.4 We currently provide a staff liaison for employees who have been suspended from the Trust. In recognition that being subject to disciplinary proceedings can also be distressing these employees will also be assigned a staff liaison contact. It is proposed that the Speak Up Champions take on this responsibility.

4.5 An investigation and/or hearing can have a detrimental impact on not only the employee who is the subject of any complaint but also others involved in the process. This can be exacerbated by the length of time it takes for hearings to be arranged. To lessen the anxiety for those concerned an ‘agreed outcome’ process has been introduced. If an employee is likely to receive a first written warning from a hearing it can now be suggested by either party that an agreed outcome is reached prior to a hearing.

4.6 At the time of a sanction being issued the employee may have been involved in a disciplinary process for a number of months, causing stress and uncertainty. A fairer

approach to sanctions has been introduced; the start date of a warning will now be from the date of the incident rather than the date of the hearing.

4.7 The ER team already monitors the diversity of hearing panels to, where possible, reflect any protected characteristics of the person involved in the hearing. A senior member of the ER team will now review the makeup of all panels to ensure panels are diverse in representation, have appropriate seniority and have knowledge, skills, experience and training that are relevant to the case in question.

4.8 A comprehensive suite of training will be developed for managers, case investigators and panel members to ensure the Trust's new approach to disciplinary matters is embedded.

4.9 The policy is to be reviewed annually and made available on the Trust's external website.

5 Risks

5.1 If the actions recommended above are not implemented and we don't adopt an approach of seeking to resolve the majority of issues through resolution we will not be ensuring our people practices are inclusive, compassionate and people-centred, with an overriding objective as to the safety and wellbeing of our people. Values which are central to the NHS People Plan.

5.2 If employees feel valued and safe they are more engaged in the workplace which has implications for retaining staff and improved patient outcomes. If our Disciplinary Policy and process in not changed as suggested these factors may be negatively impacted.

5.3 If we do not roll out sufficient training this may impact on the consistency of processes and decisions made.

5.4 Line managers do not fully appreciate how they can resolve matters informally and are inexperienced in dealing with conflict.

5.5 We cannot identify a sufficient number of senior (8c) managers with the capacity to be consulted regarding disciplinary matters.

5.6 Failure to comply with recommendations the good practice demonstrated by Imperial College Healthcare Trust's disciplinary policy we have the potential to find ourselves in a similar position to Imperial.

6 Recommendation

6.1 The Board is asked to note the report for information.

Andrew McMenemy
Chief People Officer, February 2021

Trust Board
04 March 2021

Title of the paper	**Strategic Priorities Update**
Agenda Item	**15/88**
Presenter	**Helen Brown, Deputy Chief Executive**
Author(s)	**Esme Walsh, Strategy Delivery Office**
Purpose	*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: 15/88

Trust Board – 04 March 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 The engagement draft of the **Clinical Strategy** was approved at the February Trust Board, and public engagement has now commenced.

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. Estimate build, staffing and equipment costs have already been developed, though the timeline has been pushed back to allow for a more thorough review of activity and income with system partners. The revised timeline for the OBC is now March TMC.

2.4 Virtual **SMART (Senior Medics Assigning & Re-designing the Take**) - Although the pilot has ended, the Respiratory team continue to work the Virtual SMART model in the interim. The VSMART SOP has been amended, for presentation at the Emergency Medicine Governance meeting. Cardiology Leads are renewing a focus on job plans, as currently, only one substantive consultant has SMART built into their job plan in addition to three locums.

2.5 The **Vascular Hub Project** is at the impact assessment/ Outline Business Case finalisation stage, though it is currently impacted by operational pressures. The current timeline is for the OBC to be completed in April 2021.

2.6 The focus of the **Integrated Care Partnership (ICP)** over the last month has been:

- Reviewing the strategic milestones and updating the programme plan to recognise the impact of Covid over the last year.
- Starting work to develop the integration strategy.
- Considering our ambitions for how we want to deliver care differently over the next five years, and ensuring that this is consistent with the assumptions underpinning our redevelopment outline business case.

We will finalise the programme plan in April once we have a better sense of how much Covid is likely to continue to have an impact next year. We are currently working on the assumption that there is a six month slippage in our ICP establishment plans.

The key development for the Integrated Care Systems (ICS) has been the publication of the Health White Paper. The ICS will be considering the implications of this as we get greater clarity on the Government's intentions.

2.7 The Mount Vernon Cancer Centre (MVCC) Review process continues with an active programme of stakeholder engagement underway. The acute redevelopment team have been liaising with the UCLH programme team to scope out technical requirements and progress initial feasibility work on how cancer centre services could be accommodated on the WGH site in future and inform the next stage of the process. Clinical meetings were paused due to Covid but will recommence in March 2021.

3.0 Integrated Care Joint QIPP (part of Transformation Plan)

3.1 Frailty outreach continues to identify frail patients in the Emergency Department (ED) identified through the Clinical Frailty Score (Rockwood) to support options for admission avoidance.

The frailty unit was required to temporarily close in December due to unprecedented staffing pressures across the Trust. The plan is to reopen as a soft launch on 01 March 2021. Partners will be informed of the restart after a week or two of stability of service and staffing.

Work to deliver a single clinical offer for community teams and primary care to include Rapid response and frailty hotline will be reconvened

Community MDTs and Rapid Response with care of the elderly consultant clinical support have continued through each wave. The community clinics are paused because of the resource requirements for the increased demand of Covid admissions and deployment of clinicians to support the emergency department and the isolation wards. Staff recruitment in the Medicine Division for consultant care of the elderly clinicians to support the community requirements is underway.

3.2 Outpatient Transformation - Agreed priority areas for transformation jointly agreed between WHHT and Herts Valleys CCG (HVCCG) to include Urology, Dermatology and Rheumatology now and Neurology from April 2021 to align with the community service plans.

The scoping of opportunities from a WHHT perspective have been completed for Urology, with Rheumatology expected to go live in March 2021. A highly engaged team with clear criteria for patient suitability, escalation plans and safety netting have been agreed. Integrated Care System workshops for Gastroenterology and Cardiology are planned.

Meetings have been undertaken with the Electronic Patient Record (EPR) team and clinic template validation and revisions in line with Cerner requirements and EPR roll out has commenced.

Clinic Outcome Forms (COFs) are being updated to support the collection of activity, next steps for patients include virtual follow up, transport and translator requirements. The move to electronic collection has commenced with Gynaecology and Rheumatology as the pilot services.

Following completion of the validation to return a clean waiting list, including supporting patients whose symptoms may have changed, this workstream has now been closed with clinical agreement. Residual referrals were clinically agreed between WHHT & HVCCG to be closed with GPs having the opportunity to refer if and when required as business as usual. The active work to reinstate cancelled consultant to consultant referrals is on its way to completion with a clear tracker to provide assurance.

Standard operating procedures for managing patient’s appointment and referrals in wave 2 was clinically and operationally agreed and implemented. Reviews will continue at the Operational Recovery Group.

3.3 Children and Young People - The Integrated Care Partnership level Paediatric Transformation Board is now well established with good clinical and operational engagement. The overall aim of the group is to review current paediatric and young person's service models and identify opportunities for transformation.

Focused areas of work for the first stage include:

- GP & Community hotline to a consultant paediatrician to seek advice and guidance and potentially avoid a referral / unplanned attendance.
- MDT for children with complex health needs.
- Establish a single point of access for all referrals to ensure right place right time access.
- Develop a nurse led model of clinically appropriate admission avoidance for children with respiratory issues.

A project group with clinical and operational leadership has been established to support delivery

3.4 Watford General Hospital (WGH) Urgent Treatment Centre – Due to the impact of the Covid second wave some temporary adjustments were made to the service provision of the UTC in order to support the WHHT Emergency Department. Most are now re-instated with Directory of Services (DoS) now including WGH UTC once again from 10 February. The governance framework is working well and an improvement plan is in place to increase the proportion of patients seen in the UTC and embed re-direction.

3.5 Hemel Hempstead Hospital UTC - Current contract arrangements with HUC have now been formally signed off and a contract variation has been agreed for the current contract to run to March 2022.

3.6 St Albans City Hospital (SACH) Minor Injuries Unit / urgent care services for the St Albans and Harpenden locality – The MIU is temporarily closed due to the pandemic. WHHT and Herts Valleys CCG are working together to develop an appropriate urgent care service model to meet the needs of the local population. Future plans will be aligned to the national strategy, taking into account the needs of the locality and the trust's future plans for St Albans City Hospital.

The St Albans GP federation have confirmed that they support this approach and are keen to be part of any primary care led service. An outline programme plan has been developed and submitted to the Joint Urgent Care Programme Board. A multi stakeholder working group is now in place and a programme manager has been appointed.

4.0 Capital Programme

4.1 The Emergency Department Development project is currently at the detailed design stage in preparation for the Full Business Case (FBC), the target date for which was March 2021 Trust Board, though realistically, this will now be April, as a result of operational pressures, final detailed work on the modular design and the final financial analysis/Project Board. The start date of work following Trust Board approval will be dependent on regulator approval.

The Outline Business Case and £350k investment needed for creation of FBC has been approved via TMC and included in the capital plan.

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 previous EAU expansion. The unit is now in place, though the completion of the work has been slightly delayed (from January 2021 to February), due to unforeseen groundwork and connectivity issues. The unit is expected to be operational in March 2021.

4.3 The **WGH Theatres Reconfiguration Programme** has commenced as planned. The works to PMoK Level 7 are complete. The decontamination team has fully relocated and are operational. The first construction phase will be handed over sequentially as they complete. This includes the creation of the dirty receipt & dispatch for theatre instruments, the creation of the boundaries of the new Theatre 5 suite and the reconfiguration of new office accommodation to Levels 5 & 6. The last of these will be handed over in June 2021.

A Commissioning Task & Finish Team will be convened well in advance of each Handover stage. The sequencing of this phased Programme necessitates a consequential handover to Vinci to start their next construction phase. This has to be carefully managed to avoid any delays to Vinci's timetable.

The overall programme is currently around four weeks behind programme which is not particularly unusual in the early phase of the programme, as contractual relationships are tested before establishing more timely communications and processes. It is anticipated, with around a year to go, that this will settle down and become more routine, enabling the programme to get back in line with plan. All affected department and clinical leads continue to be updated with progress and adaptions to daily construction routines and the movement of protective hoardings.

The design layout for Theatre 5 has been reviewed and approved by the Department Leads. It is currently with the Trust's Authorised Engineers for approval and final sign off. This has enabled the cost to be clarified and firmed up with the Contractor. Agreement on the final design also enables the opportunity to procure the specialist equipment ahead of the start of the construction works.

4.4 Backlog Maintenance (Including Critical Infrastructure Risk) (BLM/CIR) - The majority of the 20 projects that comprise this programme are in a phase of preparation and procurement and the Capital Team are generally content with this position as long as there are no delays in raising the necessary purchase orders.

The main projects within the programme are starting to get underway on site, with the most urgent needs being addressed first. This includes projects such as **vital boiler installations** to ensure the delivery of heat and heated water to key areas during this seasonal cold weather, **medical gas support systems** and updating other key systems whilst the areas are empty and available.

March will see a flurry of activity in external areas for many as **road repairs and structural projects** within the programme commence once the current cold snap passes.

Procurement remains key in maintaining progress and the procurement team have worked well with the Capital Team and have been very proactive throughout the process.

Irrespective of how these projects had been previously recorded in the Trust's most recent 6 Facet Survey, the projects currently included in the BLM/CIR Programme are designed to address the Trust's overall commitment to reduce backlog maintenance. Similarly, the works included in the programme, were risk appraised to ensure that the items bearing the greatest risk (if not done) are undertaken as a priority.

4.5 **Fire Safety Improvements - Emergency Lighting** bids have been received and an analysis is being undertaken by C&D Partnerships (specification designer). The expected value combined for St Albans City Hospital (SACH) and Hemel Hempstead Hospital (HHH) installations is around £1.2m of which a significant spend this financial year is anticipated.

Return bids for the **Fire Alarm replacement** works at SACH have been delayed by a further week. However, it is still anticipated a financial spend in the current financial year.

Fire door installations continue as planned with completion expected this financial year of the 375 identified. This will conclude the works arising from surveys at the three primary sites approximately four years ago.

The Capital Team in conjunction with the Fire Safety Group has:

- Endorsed the continued use of Golden Thread to identify and repair doors throughout the PMoK Main Building. A waiver has been agreed (and subsequently arranged). The group agreed this given Golden Thread's unique ability within in the industry to offer certification upon repair of a damaged fire door;
- Endorsed the removal of the 'OASIS' modular unit adjacent to the front entrance of WACs. This will then be replaced, temporarily by a double stacked container arrangement for the use of designated project contractors.
- Agreed to the arrangement of fire door surveys on the Trusts primary buildings (WACs, Moynihan, Verulam, Gloucester, AAU, Pathology) given the recent audits of Fire compartmentation lines by the Authorised Engineer (AE) for Fire. The surveys will identify compartments for repair or a replacement.
- Agreed the appointment of 'ALPHA Fire and Air' (fire compartment repair contractor) to survey the integrity of the main primary PABX I.T. server rooms at WGH, SACH and HHH. Repair works will then be agreed and undertaken.

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

4.7 The **Windows 10 Deployment** continues at pace and on schedule. Currently over 1000 devices have been deployed across the estate and a comparable number of Windows 7 devices removed from the estate also.

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 a good level of interest, returns are expected from each bidder by 19 February, then a two-week evaluation process is allowed for. Building work is expected to commence mid-April.

A full planning decision is expected by end of February, but the Trust has received confirmation that it will be granted subject to two conditions (1) Travel Plan required for first 5 years including the fact that staff will continue to park on WGH site and walk across, and (2) Change of Use is granted for NHS only. This project is currently on track for August completion and September move in.

Lease negotiations have now commenced. Draft documents have been received by Capsticks and are being reviewed.

4.9 The TMC request for approval of the **Health Records Full Business Case (FBC)** is temporarily on hold pending confirmation of funding as part of the 2021-2022 budget setting process. The team are now reviewing the programme start date and funding options.

The agreed next steps are:

- Ascertain a decision on whether funds can be made available from the 2021-22 budget for the programme.
- TMC, F&P and Trust Board approval to follow.

4.10 **MRI SACH** - Funding for the modular has been confirmed. The MRI scanner has been ordered and ground works are about to commence. Delivery of modular and scanner is scheduled for 21 March 2021.

4.11 **CT WGH** - Emergency Department room refurbishment is now complete. The CT scanner for level 1 AAU has been ordered and the Purchase Order for the turnkey element has been raised. Works commence on site third week in February 2021.

4.12 **Cardiac Cath Lab** 2 was due for February 2021 completion, however due to unforeseen additional steel work requirements the Lab will now be completed in March 2021. Cath Lab 1 works are due to be completed in July 2021.

The team continue to manage the finances very closely to ensure we are in line with the budget and to ensure as much spend as possible, if not all, falls in this financial year. The team have requested the costs for vesting and storage for the new Siemen 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 timeline using lessons learned, such as steel work requirements for Cath Lab 2.

Ventilation works require use of the Cath lab which will impact on surge bed availability. Mitigation options are being considered which will allow some surge beds to remain available. The builders are setting out the proposed plans which will be presented for executive approval.

IT works continue and are currently within the allocated budget.

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 approved. Order has been raised. Delivery lead time 4 weeks	
Epidural Volumetric Pump (x25)	£60k	Business case approved. Order has been raised. Delivery lead time 4 weeks	
Tourniquet machines (x6)	£28k	This will be transferred to 2021-2022 and business case will be submitted by theatres	
Defibrillators (x108)	£400k	Order raised/delivery date 01 March 2021	
Total	£1000k		

4.14 The **Multi-Storey Car Park (MSCP)** FBC was approved by the Finance & Performance Committee (FPC) under delegated powers from the Trust Board in December 2020 and forwarded to NHSI for approval. The target date for contract signature is 15 March 2021.

4.15 Face to face dialogues with bidders have now begun for **Outsourcing Pathology Services**, with representatives from the Pathology, Estates, IT and Finance teams forming teams with representatives from other organisations in the Integrated Care System to finalise the invitations for best and final offers (BAFOs).

The Chief Financial Officer reports that initial meetings have progressed well with all parties entering into discussions with the genuine aim to share information and improve understanding to ensure that bidders have the best chance of improving the service to patients. The meetings will run through to April with an expectation that the invitations for BAFOs to be issued in June and an appointment of a preferred bidder in 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. The wider hospital redevelopment programme is ideally supported by vacating the WGH pathology building by the summer of 2022. The feasibility of this is still being discussed in bidder face to face dialogues.

5.0 Recommendation

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

Trust Board Meeting
4 March 2021

Title of the paper	**Corporate Risk Register Report**
Agenda Item	**16/88**
Presenter	**Dr Mike van der Watt, Chief Medical Officer**
Author	**Chux Ihekwereme, Risk Lead**
Purpose	*For approval* ✓ | *For discussion* ✓ | *For information*
Executive Summary	The purpose of this report is to provide an update on the status of the Corporate Risk Register (CRR) to the Trust Board. This report captures the decisions made by the Risk Review Group (RRG) on 16 February 2021. Data for this report was extracted from Datix on 02 February 2021 following updates made at the RRG meeting; a total of 24 open risks were registered on the CRR at that time. The report contains 10 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. During the on-going Covid-19 pandemic, this report also contains any risk which is considered outside of the Risk Review Group (RRG) and has received chairs actions. The report was reviewed by Quality Committee in February 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 February 2021 • Quality Committee in February 2021
Action required	The Trust Board is asked to discuss and review the corporate risk register and endorse the changes.

Agenda Item: 16/88

Trust Board Meeting – 4 March 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 16 February 2021. Data for this report was extracted on 02 February 2021 with a few updates made following the RRG; a total of 24 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 16 February 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 October 2019.

Division	**Risk ref**	**Table 3 – Movement of risks on the Corporate Risk Register**																																		
			Oct 2019		**Nov 2019**		**Dec 2019**		**Jan 2020**		**Feb 2020**		**Mar 2020**		**April 2020**		**May 2020**		**June 2020**		**Jul 2020**		**Aug 2020**		**Sept 2020**		**Oct 2020**		**Nov 2020**		**Dec 2020**		**Jan 2021**		**Feb 2021**	
Clinical Informatics	3894		20	→	20	→	20	→	20	→	20	→	16	↓	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
	3899		20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→	20	→	20	→	20	→	20	→	20	→
	4116		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
	4197		20	→	16	↓	16		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
	4283																15		15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
Clinical Support Services	2755		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	**20**	↑
Corporate	4362																																		15	
	3828		15	→	15	→	15	→	15	→	15	→	12	↓	15	↑	15	→	15	→	20	↑	20	→	**20**	→	20	→	20	→	20	→	20	→	20	→
	3120		20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	**20**	→	20	→	20	→	20	→	20	→	20	→
	4191		15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	**15**	→	15	→	15	→	15	→	15	→	15	→
	4207		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
	4319																								**20**	→	20	→	20	→	20	→	20	→	20	→
	4292																		15		15	→	15	→	**15**	→	15	→	15	→	15	→	15	→	15	→
	4280																				20		15	↓	**20**	↑	20	→	20	→	20	→	20	→	20	→
	4304																						15		**15**	→	15	→	15	→	15	→	15	→	15	→
	4279																										**20**		20	→	20	→	20	→	20	→
	4300																										**20**		20	→	20	→	20	→	20	→
	4356																																**15**		**15**	→
Emergency Medicine	3995		16	↑	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
Environment	4332																										**15**		15	→	15	→	15	→	15	→
	2795		16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
Medicine	4357																																20		20	→
Surgery & Cancer	2951										16		16	→	16	→	16	→	16	→	16	→	16	→	**16**	→	16	→	16	→	16	→	16	→	16	→
	4334																																20		20	→
Women & Children	4339																														**16**		16	→	16	→

Key: Purple = Closed risk Yellow = Archived Data Orange = De-escalated risk Green = New risk/Escalated risk* Blue = Merged

3.4 **Risk activity**
The following provides an overview of risk activity as discussed at the Risk Review Group on 16 February 2021:

3.4.1 New risks (1)

One new 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
4362	Corporate Services	15	Appropriate cohorting of all COVID-19 contact patients using a pre- and post-7-day exposure timeframe	Potential for patients to become symptomatic or present with severe illness from nosocomial exposure to COVID -19 whilst sharing a range of facilities and communal space which has been identified as COVID-19 positive. Cause: With increased amounts of Covid inpatients and a high rate within the community the long incubation period (14 days) and asymptomatic presentation of COVID-19, can prevent segregation of COVID pathways (red/amber/green). Patients negative on admission, those incubating or asymptomatic could be placed in the same area as those on non Covid pathways. Leading to possible transmission of COVID – 19 and resulting in these exposed contact patients requiring isolation for 14 days. Effect: Cohorting these "contact" patients together risks re exposure of patients to the virus, while sharing same facilities and communal space Impact: Risk of illness from transmission and subsequent development of COVID-19 while exposed in hospital setting (nosocomial infection).	Carter, Tracey - Chief Nurse and DIPC

3.4.2 Escalated risks (0)
During this reporting period, no risk was escalated to the RRG for approval.

3.4.3 De-escalated risks (0)
There were no de-escalated risk presented to the RRG meeting for acceptance onto the Corporate Risk Register (CRR):

ID	Division	Current Risk Rating	Risk title	Rationale	Exec Lead

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 (1)
One risk was considered for increase in current risk rating at the RRG meeting:

ID	Division	Current Risk Rating	Risk title	Rationale	Exec Lead
2755	Clinical Support	20	Risk of failure of the MRI scanner at HHGH and deterioration in image quality	Cause: The MRI scanner at HHGH is 17 years old and was installed in 2003(average life expectancy of an MRI scanner is 10 years). This unit has been used during the normal working week and in addition during evenings and weekends and is experiencing mechanical wear and tear i.e., coils need replacing and table movement needed a repair. There is one MRI scanner at HH and one at WGH. Effect: it could break down with the result that no patients could be scanned at Hemel. Consequences: The Trust would not be able to meet the 6-week diagnostic target for MRI and would incur financial penalties. Patient lists would need to be cancelled and patients transferred to Watford or other sites for their scans, resulting in a poor patient experience. There would be an increase in operational costs due to additional out of hours activity at Watford or outsourcing. WHHT would be unable to offer seamless care with potential reputational damage.	Sally Tucker

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 10 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 Trust Board is asked to discuss and review the corporate risk register and endorse the changes.

Dr Mike van der Watt
Chief Medical Officer

February 2021

Appendix 1

Corporate Risk Register – Data extracted from Datix on 02 February 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 inpatients. Clinicians are indicating when patients should not be 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.	20	Sally Tucker - Chief Operating Officer
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 - Chief Information Officer

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. •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.	16	Sean Gilchrist - Chief Information Officer
No	3899	12/06/2017	ICT Trust Bleep System	20	Project in-flight to replace bleep system	20	Sean Gilchrist - Chief Information Officer
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 - Chief Information Officer
No	4283	20/05/2020	Vulnerabilities causing a cyber security incident (Penetration Test)	15	TBA	15	Bannister, Paul - Chief Information Officer
Corporate Services (12)							

Yes	4362	14/01/2021	Appropriate cohorting of all COVID-19 contact patients using a pre- and post-7-day exposure timeframe	20	None	15	Tracey Carter - Chief Nurse and Director of IPC
No	4304	28/07/2020	End of Life IT [Medical] Devices/Systems	15	The Trust is working towards migrating off the legacy estate	15	Bannister, Paul - Chief Information Officer
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 – Chief Medical Officer
No	4207	12/09/2019	Inadequate post inpatient 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 outpatient 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. - Options Appraisal Paper to be presented to at TMC in Feb 2021.Conversation had with Tracey Carter on 4th Jan 2021 to reflect current position. Risk stays the same.	16	Sally Tucker - Chief Operating Officer

Yes	4279	28/04/2020	Increased Absence Levels	16		20	Andrew McMemeny Chief People Officer
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 be sent by June.	20	Paul Bannister- Chief Information Officer
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	Andrew McMemeny
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 - Chief Operating Officer

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 - Chief Nurse and Director of IPC
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	Andrew McMemeny Chief People Officer
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 – Chief Medical Officer

Yes	4280	28/04/2020	Workforce Wellbeing	16	Wellbeing 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	Andrew McMemeny Chief People Officer
Emergency Medicine (1)							
No	3995	06/03/2018	Challenges in Recruitment of Emergency Medicine Medical Workforce	20	New consultant to start in February 2021	16	Dr Michael van der Watt – Chief Medical Officer
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 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	16	Patrick Hennessy-Director of Environment

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- Director of Environment
Medicine (1)							
Yes	4357	08/01/2021	Ability to deliver safe care to the current increase in patients testing COVID 19 positive and requiring NIV/ respiratory manage	20	Monitoring staff sickness against organisational requirements to ensure patient safety remains priority and where ratios are not met against national guidance this is escalated, risk assessed and fed into the workforce review group. That this RA sits within the Trusts overall staffing review to provide safest care within a COVID 19 pandemic	20	Tracey Carter - Chief Nurse and Director of IPC
Surgery & Cancer (1)							
No	2951	05/12/2013	Insufficient anaesthetic staffing levels impacting on patient care (national shortage)	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 recruitment 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	Andrew McMemeny Chief People Officer

No	4334	14/01/2021	Limited capacity for bedding infectious patients within the ICU	20	Issue: 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 In the January 2021 Risk Review Group Meeting, it was agreed this should be split into two different risks (one for staffing and one for capacity). The current risk was agreed to be suspended due to the pandemic and these risks split up to replace it temporarily. Previously the rating for this risk was 20. Due to the nature of the risk and in light of the Covid-19 Pandemic this risk continues to be monitored for potential fluctuation in rating.	10	
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 - Chief Nurse and Director of IPC

Agenda Item: 17/88

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Board meeting:	**04 March 2021**
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 27 January 2021.
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 27 January 2021** • The Deputy CEO presented the Clinical Strategy update. • The COO presented the Covid-19 update. • The Deputy Chief Nurse presented the Covid-19 nurse in-patient ward establishment review and this was approved. • The Director of Performance provided Access & Performance and IPR updates. • The CFO presented the Finance updates and the Internal Audit Plan. • The CMO provided feedback from CAG. • The CN provided feedback from PAC. • The Trust's Internal Auditors provided their internal audit annual briefing.
Risks to refer to the risk register	None

Item 18/88

Report to:	Trust Board
Title of Report:	People, Education and Research Committee Assurance Report to Trust Board
Date of Board meeting:	4 March 2021
Recommendation:	For information and assurance
Chairperson:	Natalie Edwards, Non-Executive Director
Purpose	The report summarises the assurances received by the People, Education and Research Committee at its meeting on 18 February 2021.
Background	The Committee normally meets bi-monthly. The meeting on 18 February 2021 focused on providing assurance to the Trust Board with particular attention to managing the workforce challenges and issues which have been presented by the COVID-19 pandemic.

Key business undertaken

Joint Corporate Risk Register and Board Assurance Framework

The Committee received information and assurance on the four corporate risks relating to workforce and for the attention of PERC. There were no new risks relating to PERC and no risk scores had been increased/reduced in the month.

However, the risks relating to “workforce well-being” and “nationally NHS staff from BAME background are disproportionately impacted and outcomes from COVID-19” will be reviewed based on the recent staff survey results.

In terms of BAF workforce related risks, PERC were assured that these were being managed. However, the Acting Chief People Officer did confirm that ongoing review was required.

Report on Workforce Performance with Covid update

The Committee received the information and assurance on the key HR performance indicators:

- Bank usage and mandatory training compliance targets were being achieved.
- Sickness continued to be above target, some of which is attributable to COVID-19 related absence.
- The vacancy rate remained at 10% with hotspots in four divisions (Environment, Medicine, Emergency Medicine and W & C). The overseas recruitment will reduce the vacancy rate in nursing. In addition, there continues to be a heavy focus on the recruitment of

Health Care Assistants.
- Overall, appraisals were below target and HR Business Partners were working with the Divisions to increase the rates for non-medical staff (to increase to 90%)

Vaccination and Testing Programme Update

The Committee received the Vaccination and Testing Programme update, with actions being taken and the mitigations in place to reduce the COVID 19 transmission risk.

The uptake for the vaccine was low in some BAME groups and student nurses. There was also some reluctance from staff who are pregnant. The Trust was working on reaching out to all staff groups using approaches like walk abouts for reaching out and working with local community leaders.

The vaccination programme was due to close on or around 15th February 2021 and would reopen for second doses on or around 15th March 2021 for a period of around 6-8 weeks. As of 7 February 2021, 73.42% of the WHHT staff had been vaccinated.

The Committee acknowledged that overall, the vaccination roll out had been successful.

Workforce Process and Issues

The Committee received an update on further developments regarding the covid hub, absence hub and key covid related workforce issues:

- The Trust was in receipt of 8000 kits for lateral testing to be used for both staff testing and for partners of patients using maternity services and NICU. The Trust continued to provide PCR testing for both staff and patients (inpatient and elective) at the drive through at Watford and at St Albans.
- The absence Hub continued to provide an enhanced support service to employees who were absent from work for COVID 19 related reasons.
- Policy decisions had been made to include clarity on annual leave carry over, travelling abroad and home working.

Staff Engagement, Education and Well Being Update

The Committee received an update on education, staff well-being and engagement and the initiatives that are underway. Recent concerns were raised regarding the increasing number of hours staff are spending at VDU and the potential impact on eyesight and posture.

- The ‘changing hearts’ campaign-looking to refurbish staff rest rooms and outdoor staff facilities was making good progress.
- The Committee was assured that the Teaching Hospital project would at most be delayed by a month due to the redeployment of

communications resources. A further update will be provided at the next meeting.

- Discussions regarding meeting the required standards for the proposed accommodation for medical students at the WRAP were continuing.

Diversity Update – Reasonable Adjustments Passport

The Committee received a progress report on the proposal for the Reasonable Adjustments Passport which was designed to improve some outcomes in the Trust's WDES, WRES and gender pay gap reports. The passport will be launched in May 2021 once feedback has been received from all the key groups and meetings.

Research & Development Update

The Committee received an overview of the current research activity at WHHT including an update on progress against the Trust strategy and Key Performance Indicators (KPIs) alongside current activity. The Directors for Research Strategy and Research & Development- Governance had been appointed and were introduced to the Committee.

There had been a significant increase in eligible patients for the NIHR studies and WHHT had recruited more participants than ever before. This included the well-publicised Urgent Public Health Covid-19 clinical trials which had contributed so much to the evidence on effective treatments for our patients with Covid-19.

There was a small increase in the funding for 2021/22 but challenges still remained in staffing and IT (there had also been issues with e-mails). Studies had been affected because of equipment that had been switched off by error at the Watford site.

Disciplinary Policy Review

The Committee received assurance that the Trust's disciplinary practices had been revised following the publication of Imperial Colleges Healthcare Trust's Disciplinary to follow good practice in view of disciplinary practices following the suicide of an employee after being summarily dismissed.

There is now more focus on resolution and learning from mistakes rather than punitive measures.

Management Response to Internal Audit Recommendations – Medical Resourcing

The Committee received the internal audit report and were asked to consider the risks identified in the audit report and to receive assurance that there were management actions aligned to each of the risks.
A further audit would be conducted to review the progress of actions.

	PERC Workplan The work plan would be updated to incorporate the COVID agenda and revert back to bi-monthly meetings.
Risks to refer to risk register	None
Key decisions taken	There were no key decision that were taken.
Items for the Board to note	The updated Disciplinary process was recommended for Board approval as part of the required authorisation process for all NHS organisations.
Challenges and exceptions	None.
Future exceptional items	None

Present

Natalie Edwards, Non-Executive Director (Committee Chair)
Tracey Carter, Chief Nurse
Andrew McMenemy, Acting Chief People Officer
Edwin Joseph, Non-Executive Director

In attendance:
Jill Jaratina, Assistant Trust Secretary (minutes)
Arfan Bhatti, Equality and Diversity Manager
Tania Marcus, Deputy Director of HR, People Services
Caroline Lankshear, Interim Deputy Director of HR, People Services
Benjamin Sheath, Staff side representative
Tejal Vaghela, Connect Network Chair
Paul Mendes, Head of Education, Learning and Development
Tom Galliford, Consultant Endocrinology
Dr Mike Van Der Watt, Chief Medical Officer

Verbal update given under item: 21/87 at February Board meeting

Report to:	Trust Board
Title of Report:	People, Education and Research Committee Assurance Report to Trust Board
Date of meeting:	4 February 2021(verbal report given)
Recommendation:	For information and assurance
Chairperson:	Natalie Edwards, Non-Executive Director
Purpose:	The report summarises the assurances received by the People, Education and Research Committee at its meeting on 7 January 2021.
Background:	The Committee normally meets bi-monthly It provides assurance on: • Workforce strategy • Equality and diversity • Induction • Bullying and harassment • Guardian of safe working • Job planning • Occupational health • National surveys • Staff health and wellbeing programme • Revalidation • Appraisals • Fit and proper persons • Whistle-blowing/Freedom to speak up • Education and training • Leadership development • Talent management • Flu vaccination programme • Apprenticeships • Staff engagement • Relevant external review body reports • Safe staffing • Research and development.
Key Business Undertaken:	**Report on key workforce indicators plus COVID-19 workforce dashboard** The Committee received an overview of key workforce indictors summarising current workforce metrics against targets and an update on progress in improvements. Targets were being achieved for vacancy rates and mandatory training compliance. The sickness rate had increased from 4.2% (November) to 11.6%. The Committee was assured by the general direction of the performance metrics. **2019-20 Gender and race pay gap report** The following matters were highlighted; • The mean gender pay gap had reduced by 0.6% to 27.3%. • BAME staff were underrepresented at Band 7 and above. • The Trust was going to introduce diversity panels for senior staff recruitment. • Work was on-going to understand the pay gaps, drivers and

demographics.

General Update on Education & Development
Learning and development for 2019/20 was disrupted by COVID and the ELD staff were re-deployed. Two leadership sessions for first line and senior clinical leadership had continued from 2019 and the senior leadership sessions were almost ready for delivery in the spring and autumn of 2021. Bite size training had done well and had been well attended. There were plans to increase the number of coaches as current demand does not meet supply.

Proposal to introduce workforce diversity dashboard
The Committee received the diversity dashboard which would enable the Trust Board to review on an ongoing basis, relevant information and to make a more tangible approach to diversity.

Review of Guardian of well- being
The Trust had appointed Ms Natalie Edwards, NED as Guardian of wellbeing for WHHT who would be responsible for challenging the Board to ensure that the Trust has the appropriate mechanisms to ensure the well-being of staff.

Update on Teaching Hospital
The Committee received an update on the work being done towards the teaching hospital status. The Committee was assured that there would not be a delay and the application would be submitted in March 2021.

Update on COVID vaccination
The Committee noted that Covid vaccination programme had commenced on 4 January 2021 and it was anticipated that all the staff would receive their first vaccination by the end of January 2021.

Risks to refer to risk register:	None
Key decisions taken:	None
Issues to escalate:	None
Challenges and exceptions:	The areas of challenge were associated to the increase in the number of Freedom to Speak up cases and the higher rates of absence both of which were highlighted in the workforce performance report.
Future exceptional items:	None

Present:
Natalie Edwards, Non-Executive Director (Committee Chair)
Tracey Carter, Chief Nurse
Paul da Gama, Chief People Officer
Edwin Joseph, Non-Executive Director

In attendance:
Jill Jaratina, Assistant Trust Secretary (minutes)
Arfan Bhatti, Equality and Diversity Manager
Tania Marcus, Deputy Director of HR, People Services
Andrew McMenemy, Deputy Director of HR, Business Partnering and Learning
Caroline Lankshear, Interim Deputy Director of HR, People Services
Benjamin Sheath, Staff side representative
Victoria Houghton, Staff Side Chair and RCN Representative
Phil Townsend, Trust Chair
Tejal Vaghela, Connect Network Chair
Jane Barret, Head of Training and Development
Paul Mendes, Head of Education, Learning and Development
Tom Galliford, Consultant Endocrinology

Apologies
Dr Mike Van Der Watt, Chief Medical Officer

Report to:	Trust Board – Part 1
Title of Report:	Assurance report from Finance and Performance Committee
Date of meeting:	25 February 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 25 February 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

The Trust Chair emphasised the importance of a review of benefits realisation from major projects for proper assurance and FPC confirmed that this will be added to the agenda and regular workplan of FPC in 21/22. The relationship with Great Place Committee was discussed and the importance of the two committees working consistently with each other. The proposed Capital Control Schedule showing the timetable of business case approvals will be helpful in ensuring all is covered appropriately and nothing is unexamined. In most other respects, the workplan for 2021/22 is expected to be broadly similar to the current year.

Risk

There was discussion around risks 3828 on long waits and 4269 on impact of Covid-19 on emergency access standards and these were now felt to be appropriately classified between Quality Committee (primary risk) and Finance Committee (secondary). After brief general discussion, FPC approved the proposed Finance risks on the risk register.

Performance

FPC noted that most performance statistics were challenged by the virulence of Covid-19 during January (now peaked and declining) but was

assured by the high quality of clinical and operational conversation at FPC surrounding plans for exiting the current Covid-19 wave across all the specialities and all three sites. FPC was assured by the intent to open all specialities in St Albans from the beginning of March. It was difficult for FPC to assess confidently WHHT performance in the continued absence of model hospital benchmarking statistics. FPC is keen to understand progress on the plan to reopen at the next FPC meeting.

FPC noted the new urgent care pathway performance measures. FPC appreciated the pungent analysis of the deputy CMO and is keen to understand how new ways of working and relationships with the Care sector implied by the new ICS regime will lead to an improvement in the measurement and improvement of performance around efficient and humane discharge of patients from WHHT.

FPC was particularly interested in gaining greater understanding of the high increase in A&E attendance in WHHT compared to other trusts and asked that assurance was obtained by the CFO from the ICS that if this is now a permanent feature of our health environment, that this is properly reflected in the financial expectations of WHHT in 21/22.

Finance Performance

With only 3 months to go, the CFO is confident that we will at least meet the -£4.2m target for the year. Following a general discussion, and that much of our income is in the form of block grant and Covid-19 payment assurances, FPC is assured that this is indeed the likely outcome for the year.

CIPS Productivity improvement for this year and next was discussed. The 4% target (£16m) probably expected of WHHT in 21/22 is consistent with what has been achieved in our better years but will require focus to achieve. FPC was assured by the draft list of ideas that would underpin productivity improvement and the quality of supporting discussion. It was noted that care will need to be taken in learning from Covid-19 in determining what is baked into the 'business as usual' budget and what is separated out as a CIP.

The new national financial regime for 21/22 has still not been set.

Capital Projects

FPC continues to be a bit uncomfortable with the large proportion of projected annual spend on Capital projects that is planned to be spent in the final quarter of the year. The CFO outlined a number of steps that are being taken to ensure that the pace of capital spend was maintained at an appropriate rate and is confident that the plan will be met. Much of the shortfall relates to work commenced not yet invoiced or booked. In

addition, it is expected that spending will accelerate now on approved projects including the Cath Lab, Fire safety, other backlog estates work, LABV/MSCP items and EPR. FPC is keen to discuss again at the next meeting in March.

Business Case

Following a detailed and articulate presentation by the team and subsequent discussion, FPC approved the business case for the Emergency Assessment Unit

The meeting ended 10 minutes early to enable prompt attendance at a vital NHSI round table on the new hospital development and so it was agreed to postpone the discussion of Planning Process, Procurement Strategy and the Capital Control Schedule until the March meeting; Review of Finance policies had previously also been deferred to the March meeting.

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

Agenda item 20/88

Report to:	Trust Board
Title of Report:	Assurance report from Quality Committee
Date of Board meeting:	4 March 2021
Recommendation:	For information and assurance
Chairperson:	Ginny Edwards, Non-Executive Director
Purpose	The report summarises the assurances received and approvals of recommendations made by the Quality Committee at its meeting on 28 January.
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 14 January 2021. Twenty-three open risks were registered on the CRR at that time. One new risk was presented to the RRG for acceptance onto the Corporate Risk Register and had been accepted: The ability to treat by surgical intervention patients with a diagnosis of cancer within national guidance and in safety during the COVID 19 pandemic. The risk relating to: Limited capacity for bedding infectious patients within the ICU was escalated. There were no de-escalated or closed risks. The Committee noted that Risk Leads are required to provide updates on the nine open risks arising from the Covid-19 pandemic at least once a month on Datix. The Committee received the Board Assurance Framework (BAF) and noted that the assigned Leads had reviewed and updated the elements of the BAF aligned to the Quality Committee. **COVID-19 briefing report.** The Committee received a report on the management of the current phase of the COVID-19 pandemic. • The Ethical Advisory Panel had been re- established to provide clinical support due to the increasing pressures and hospital

admissions of patients with COVID-19 and their terms of reference had been updated to reflect the additional responsibilities of the panel, lessons learnt from the first wave and the intensity of the second wave which had resulted in more operational pressures and further reduction of inpatient bed capacity.

- Discussions were in place with the East of England Ambulance Service (EEAST) to seek support, utilising them to take and record all observations in line with the corridor management model.
- The Trust had revised the zoning reconfiguration to adapt to clinical demand and the delivery of clinical care.
- A safest care approach had been introduced using the principles of *'check and challenge'* to understand the impact in providing safest care during COVID 19.
- The Clinical Decision panel continued to meet weekly to focus on cross cutting clinical issues, clinical prioritisation and guidance.
- A Covid 19 update would be provided at the Board meeting in February 2021**.**

Infection Prevention and Control Board Assurance Framework (IPC BAF) and nosocomial update

The Committee received an update on the IPC activity and management of nosocomial infection from COVID.

The Trust had reported 12 nosocomial outbreaks on the Watford site since October 2020.The increase in the number of reported nosocomial infections and the identification of the new variant of COVID-19 from the end of November resulted in a significant rise in the number of inpatients with COVID-19 towards the end of December (at least 50% of bed base assigned to COVID-19). North West London Hospitals network offered the Trust genome sequencing Twenty (20) samples from December were sent to the COG-UK sequencing centre. The samples results indicated that a high percentage of the samples sent were the UK variant virus VOC-202012/01.

The IPC BAF ten core standards are monitored to give high level assurance and it reflects the learning from outbreaks reviews and changes to systems and processes around infection, prevention and control practice, cleaning, decontamination and identification of known transmissions with mandatory external reporting of nosocomial infections to Public Health England.

The Committee received the assurance of actions taken to manage the outbreaks in line with the IPC BAF and compliance with Health and Social Care Act 2008.

Ockendon report and assurance framework

The Director of Midwifery and Gynaecology & Nursing and Divisional Director, Women and Children's Division provided assurance 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) had been reviewed to ensure that maternity services at WHHT are compliant and any areas for improvement are identified and mitigated. The second report will be published later in the year.

The Quality Committee received a paper in December 2020 to provide assurance that the Morecambe Bay (2015) recommendations had been reviewed to ensure that West Hertfordshire's Hospitals NHS Trust maternity services were compliant and any areas for improvement were identified and risks mitigated. The maternity quality deep dive which accompanied the paper highlighted performance against national maternity safety and quality indicators, areas for improvement and challenge and the associated mitigations and 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

The Ockendon report requested that Trust Boards confirm that they have a plan in place for the Birthrate Plus (BR+) standard by 31 January 2020, timescales for implementation, funding allocated for maternity staff training is ring-fenced, any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety and for the Trust Board to have oversight of safety in the maternity services. NHSE/I had asked Trusts to complete and present the Assurance Assessment Tool (to their Trust Boards), which draws together elements including all 7 IEAs of the Ockenden report, NICE guidance relating to maternity, compliance against the CNST safety actions, and a current workforce gap analysis. As part of the Trust's immediate response, the Women and Children's Clinical strategy was updated to include this urgent and immediate action and will be presented at Trust Board in February 2021. A responsive action plan will be developed and managed through the Divisional Governance process.

Although workforce (recruitment and retention) was a challenge for the Trust, the department was being creative on staff utilisation in these challenging times of the COVID-19 pandemic.

The Committee received the Assessment and Assurance tool, Ockendon Gap analysis, Priority action plan, the Trusts's response to the Regional Chief Midwife, Director of Nursing, East of England, NHS England and NHS Improvement and the Ockenden Review of Maternity Services Compliance Submission Statements for Immediate and Essential Actions and recommended it for Board approval.

Maternity harm level and investigation classification review

The Committee received evidence of assurance from the Maternity harm level and investigation classification review and the progress update on Maternity Safety Strategy actions and the NHSR incentive scheme. The Trust had undertaken a retrospective multidisciplinary review of all maternity incidents categorised as root cause analysis, serious incidents and externally led HSIB investigations declared between 1 December 2019 and 1 December 2020. The national criteria set by the Serious Incident Framework, NHS England (March 2015) was used to catalogue the incidents and also in line with the Trust's Incident policy.

Maternity Safety Strategy actions and NHSR incentive scheme
The Committee received an outline of the NHS Resolution Scheme and details of what is being done to ensure that the Trust can evidence the required safety actions and recover the maternity incentive scheme element of the CNST premium.

Trusts that demonstrated the achievement of all the ten safety actions would recover the component of their CNST contribution for the maternity incentive fund (10% of the maternity premium) and would also receive a share of any unallocated funds. Trust Boards were expected to consider the evidence demonstrating achievement of each of the ten actions for a data set for a six-month period and to complete a Board declaration form for submission on/by 20 May 2021.

The Committee noted the plan in place to meet the maternity incentive scheme and approved the updated timeline to meet the new national submission date (15 July 2021)

Maternal newborn and infant clinical outcome review programme (MBBRACE)
The Committee received the MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity (includes surveillance data on women who died during or up to one year after pregnancy between 2016 and 2018 in the UK). The chapters in the report covered surveillance of maternal deaths, neurological conditions, medical and general surgical disorders, anaesthesia, morbidity from pulmonary embolism, haemorrhage and amniotic fluid embolism and sepsis.

The Committee noted the new recommendations to improve care for professional organisations, for policy makers, service planners/commissioners and the recommendations identified from existing guidance requiring improved implementation. The Committee noted some of the work the maternity service had commenced i.e launching its first Watford COCT team and were working putting a second team together, areas of deprivation had been mapped and maternal medicine network had been introduced.

The Committee received assurance that the maternity service is benchmarking its service against the key recommendations to identify

areas of compliance and further improvement.

Quality integrated performance report

The Committee received the quality indicators for safe care and improving outcomes, caring and responsive services and incidents. The following matrices were highlighted;

- The Trust reported 2 cases of MRSA and 4 cases of Cdiff. Promoting good infection prevention and control practice and standards of cleaning continue to be a focus for the Trust.
- There were 15 serious incidents and patient safety incidents that are harmful has increased to 19% (previous month 11.9%).
- Complaints response times were below target at 66.7% with 6 reactivated complaints received in the month.
- Hand hygiene remained above target at 95%.
- Mandatory training was compliant at 90.7%.
- 5% of the pressure ulcers that were reported were not present on admission.
- Thirty-one policies and clinical guidelines were reviewed at the Policy & Guideline Review Group (PGRG) from December 2020 to January 2021. Of these documents, twenty-six met the Trust's required standards and are recommended to QSG for approval and ratification.

It was discussed that the Board and Quality Committee IPR slide is updated to not just show overall SI's but a breakdown in all divisions so that Maternity can be seen clearly within this. The SI report to the Trust Board will contain further detail on actions and learning from maternity SIs and HSIB cases.

The Committee received the Quality Integrated Performance report and noted the areas for improvement and the actions that were being taken to improve performance.

GIRFT: Dentistry

The Committee received assurance that the GIRFT recommendations and actions highlighted through the clinical deep dive visits were being taken forward and implemented by the relevant clinical teams and there had been some positive outcomes.

GIRFT: Radiology

The Committee received assurance that the GIRFT recommendations and actions were being taken forward and implemented by the relevant clinical teams and noted that the pandemic had delayed implementation of some actions. Two actions relating to IR and Finance were yet to be completed.

The Committee noted the challenges with the limited number of scanners and that interventional radiology required high level support to

communicate to the Partners.

A Business case was in progress to support the request for capital.

The Committee noted assurance reports from 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	COVID update briefing **CNST**-Trust Boards were expected to consider the evidence demonstrating achievement of each of the ten actions for a data set for a six-month period and to complete a Board declaration form for submission on/by 20 May 2021. **CNST**-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. **CNST**-To approve the completed Assurance Assessment Tool for national submission with our LMNS by the 15 February 2021.
Recommendations to the Board	To approve for submission to the Trust Board for sign and national submission with our LMNS by the 15 February 21 a completed Assurance Assessment Tool and gap analysis against the Ockenden 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
Mike van der Watt	Chief Medical Officer

In attendance	
Jill Jaratina	Assistant Trust Secretary (minutes)
Paddy Hennessy	Director of Environment

Attendees for specific items

Mr Shahme Farook	Oral and maxillofacial Surgery Consultant and Clinical Lead
David Thorpe	Deputy Chief Nurse
Simon West	Divisional Director Surgery, Anaesthetics and Cancer
Colette Mannion	Director of Midwifery & Gynaecology Nursing
William Forson	Divisional Director for Women's and Children
Shilpan Patel	Consultant Radiologist and Clinical Lead

Apologies

None

Agenda Item: 21/88

Report to:	The Trust Board
Title of Report:	Audit Committee Assurance Report to Board
Date of board meeting:	4 March 2021
Recommendation:	For assurance
Chairperson:	Edwin Josephs, Non-Executive Director
Purpose	The report summarises the assurances received by the Audit Committee at the meeting held on 19 February 2021.

Background

The Committee meets four times a year for regular business and has two additional meetings in relation to the year-end sign off process. It provides assurance to the Board:

- on all aspects of internal, external audit and counter fraud, integrated governance and internal control and to ensure that they are in place and functioning to support the achievement of the Trust's objectives
- where there are issues of internal control that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee.

Business undertaken

Review of Terms of Reference and work plan

- The Committee reviewed its *Terms of Reference* confirming that the Chief Nurse and Director of Governance should attend each meeting to ensure clinical input. A deputy would only need to attend if both the Chief Nurse and the Director of Governance were unavailable. It was resolved that the terms of reference would be amended to reflect this.

Financial overview

The Committee received the following assurance on the Trust's finances from the Chief Financial Officer:

- the Trust's initial projected overspend was in line with the agreed plan with NHSEI. Covid-19 cost pressures had been higher than planned but had been offset by lower-than-expected elective care costs.

- the forecast end of year deficit would, at worst, remain in line with the deficit agreed by NHSE/I. Explorative work was underway to see if the position could be improved to break even.
- that 2020/21 was a significant year for spending on critical infrastructure works which would improve the Trust's resilience.
- the current and forecast cash position at 31 March 2021 was healthy.

Timetable review for the Annual Accounts, Annual Report and Annual Governance Statement

Timetable

The Committee received information from the Chief Financial Officer about the accounting timetable and noted that it would meet on 30 April to review the draft accounts and 24 June 2021 to approve the audited accounts which would need to be submitted by 29 June 2021.

It considered and approved the request to apply for an extension to the accounting deadline as a contingency to deal with any issues arising from Covid-19. The external auditors confirmed that they were advising all Trusts to apply for the extension.

Accounting/Audit

It asked for and received assurance that:

- an external audit report on the accounting treatment of the Multi-Storey Car Park had been received in line with the demands from NHSE/I.
- the timing of the external audit *Exit Meeting* would not be affected by the external auditor's proposal for less substantive testing during the interim audit.

The Committee approved the following accounting treatment which would be tested through audit:

- the charitable funds accounts should not to be consolidated due to their level of materiality to the Trust
- the Trust's accounts to be prepared on a *going concern* basis.

Internal audit reports, outstanding recommendations and annual plan

Medical Resourcing: The Committee received the internal auditor report and noted the limited assurance level in relation to the efficiency and effectiveness of the service.

The internal auditor reported the team's positive response to the report and the Committee noted that it would receive assurance on implementation and progress of actions in the follow up report. It further noted that assurance had been received at PERC that many of the recommendations had already been implemented.

It noted the internal auditors progress report and the follow-up report. It asked for and received assurance from the Chief Financial Officer that the delays in implementing overdue recommendations (approximately 30%) from the previous years' audits would be raised

with TMC and the Chief Officers to ensure that these would be appropriately actioned.

The Committee noted and approved the internal audit annual plan and charter for 2021/22.

Local counter fraud

The Committee received assurance:

- that the Fraud Prevention Guidance impact assessment had been submitted and
- on the progress of the local counter fraud service.

It received reports for information on the new requirements to meet Government functional standard and annual counter fraud benchmarking information.

External audit

The Committee noted the progress report from the external auditor.

Review of waiver and tender register

The Committee noted the report and received assurance on the process for waivers.

Staff salary overpayments

The Committee noted the decrease in staff salary overpayments due to improved systems to capture leaving dates of employees. It asked for and received assurance on Medical and Dental staff overpayments which were higher than other areas.

The Committee noted that work had been done to address job planning changes and impact and the CFO was confident that this would result in the frequency of overpayments falling.

Losses and compensation register

The Committee noted the report and received assurance on the process for overseas visitors and private patients.

Use of Trust seal

The Committee noted the report.

Conflicts of interest register

The Committee noted the report and asked for the separation of declarations and conflicts of interests on the register.

Risks to refer to risk register None

Issues to escalate None

Agenda item: 22/88

Report to:	Trust Board
Title of Report:	Assurance report from Great Place Committee
Date of meeting:	4 March 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 23 February 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. The Committee Chair pointed out that the main purpose of this additional meeting in February was to give committee members an opportunity to understand and consider emerging findings from the shortlist appraisal in preparation for formal decision making later in the year.

Acute Redevelopment Draft Programme Dashboard

The Committee received the draft Acute Redevelopment Programme dashboard which was being trialled and had been used by Chase Farm Hospital for their hospital redevelopment. The dashboard/RAG ratings would reflect the overall performance on the deliverables i.e project vital signs, Outline Business Case (OBC) completeness, Capital Investment Appraisal Model (CIAM) progression, budget tracker, key master programme milestones, people updates and risks/issues. Delivery against the programme budget will be added to the dashboard.

Response to Clinical Senate recommendations

The Committee received a report setting out the Trust's response to the recommendations made by the Clinical Senate and received assurance that each recommendation was being taken forward through the development of the OBC. The Committee noted that the letter from the Senate and the response from WHHT would be published on the redevelopment pages of the Trust website.

WHHT & RFLPS review of the Naxton report
The Committee received assurance that the Programme Director & RFLPS had formally reviewed the Naxton report (which had been published by the New Hospitals Campaign group in December 2020) and had not identified any substantive issues which would change the overall conclusions of the long list options appraisal (i.e. not to shortlist any 'greenfield' / 'new site' options for emergency care). The Trust had issued a statement to the press in relation to the report.

The Committee noted the response to the Naxton report and confirmed no change to the October shortlist decision.

Acute Redevelopment route to affordability
The Committee received updates on the new hospital programme shortlist appraisal, upcoming milestones to Board approval, revised demand and capacity modelling, 'work in progress' capital costs, risks and immediate next steps.

The Committee noted the following.

- Demand and Capacity assumptions have been reviewed and updated. There was a good discussion about the level of ambition and learning from recent months.
- The importance of all partners in the ICP signing up to the assumptions regarding system transformation was noted and work is ongoing to develop more detailed delivery plans across partners.
- It was noted that capital cost estimates for the preferred option currently exceed the 'indicative envelope' previously notified to the Trust.
- The shortlist appraisal process will clearly set out the costs and benefits of the different options for delivering future hospital requirements.
- The Trust will liaise very closely with regulators and the New Hospital Programme (NHP) to minimise risk of delay due to concerns re affordability. The first key step is to agree the activity and capacity assumptions and a request was being made to the NHP for a formal review of our modelling.
- The timeline for formal decision making on the preferred option has been pushed back one month to allow for further dialogue with regulators and the NHP on demand and capacity and capital costs.

Communications and engagement activity and plans
The Committee noted that the Trust has launched an engagement programme on our clinical strategy and redevelopment clinical brief. This

	sets out a clear vision for each of our three hospital sites. The engagement will run in two phases, with a pause to analyse feedback received in the first phase during the pre-election period ahead of local elections in May. Final versions of the clinical strategy and clinical brief will then be brought forward for formal approval later in the summer. It was noted that Hertfordshire County Council's Health Scrutiny Committee had supported the engagement approach to involve the public and the committee in discussions about hospital site and service redesign proposals.
Risks to refer to risk register	None
Issues to escalate	The Committee recommends the following update for information to Part 1 of the March 2021 Board: